The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Tobernaveen Lower

Holywell Hospital

Northern Health and Social Care Trust

6 & 7 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 Lower, Holywell Hospital
Trust	Northern Health and Social Care Trust
Hospital Address	60 Steeple Road Antrim Co. Antrim BT41 2RJ
Ward Telephone number	028 94413103
Ward Manager	Ruth Headley
Email address	manager.tnl@northerntrust.hscni.net
Person in charge on day of inspection	6 January 2015 – Amol Jadhav – Deputy Charge Nurse 7 January 2015 – Ruth Hedley – Ward Manager
Category of Care	Acute Mental Health Inpatient
Date of last inspection and inspection type	Patient Experience Interview – 25 May 2014
Name of inspector	Kieran McCormick

2.0 Ward profile

Tobernaveen Lower is a 24 bedded admission ward set within the grounds of Holywell Hospital. The purpose of the ward is to provide assessment and treatment to adult male and female patients who require care and treatment in an acute psychiatric environment. Patient sleeping accommodation is provided in two and three bedded dormitories and single bedrooms. The ward maintains an open door policy; on the days of inspection the main entrance doors to the ward were open.

On the days of the unannounced inspection there were seven patients detained in accordance with the Mental Health (Northern Ireland) Order 1986.

The inspector noted the ward was welcoming. The ward was well lit, well maintained, clean and fresh smelling. There were separate day spaces and dining areas for patients.

Patients in Tobernaveen Lower receive input from a multidisciplinary team which incorporated psychiatry, nursing, occupational therapy and social work. A patient advocacy service was also available.

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 Lower, Holywell Hospital was undertaken on 6 and 7 January 2015.

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

The recommendations made following the last announced inspection on 8 October 2013 were evaluated. The inspector was pleased to note that all recommendations had been fully met.

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

The recommendations made following the patient experience interview inspection on 23 May 2014 were evaluated. However, despite assurances from the Trust, one recommendation had not been fully implemented. This will require to be restated for a second time in the Quality Improvement Plan (QIP) accompanying this report.

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

The recommendations made following the finance inspection on the 2 January 2014 were evaluated. However, despite assurances from the Trust, two of the three recommendations had not been fully implemented. Both recommendations will require to be restated for a second time in the Quality Improvement Plan (QIP) accompanying this report.

4.4 Review of implementation of any recommendations made following the investigation of a Serious Adverse Incident

A serious adverse incident occurred in the community on the 20 May 2014. The recommendations made as a result of a Serious Adverse Incident (SAI) were in relation to a patient who had been on leave from Tobernaveen Lower. The recommendations made by the review team were evaluated during this inspection. It was noted that compliance had been achieved in relation to three of the recommendations; one recommendation was not assessed and a further recommendation had not been met.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection the ward has addressed a number of previous recommendations and implemented a number of positive changes. The ward has introduced regular staff meetings and patient meetings. The inspector noted this had improved communication between the staff team and with patients. In addition to team meetings the ward held daily briefing meetings; this allowed for the sharing of information to all staff.

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.

On the days of the inspection information was available for patients in relation to the patient's charter; complaints; independent advocacy services; deprivation of liberty; capacity; and, consent. A ward information leaflet was available for patients and relatives. Staff were familiar with how to access and utilise advocacy services.

Staff who met with the inspector confirmed their knowledge of Capacity to Consent and informed the inspector of the steps they took to ensure patients consented to care and treatment. Staff informed the inspector of how they would know if a patient was not consenting and the steps they would take to ensure understanding. The inspector noted in patients' notes that there was no reference to patients' capacity to consent for care, treatment or invasive procedures. Care plans did not provide guidance to staff on how to obtain or assess consent on an individual basis or the actions to take if consent was not obtained. Patients' daily progress notes reviewed by the inspector made no reference that patients were involved or either agreed or disagreed to care and treatment on a daily basis. A recommendation has been made in relation to this.

The inspector reviewed three patients care records. Care plans for each patient had been created using a generic template; patient care plans were not individualised or person centred. There was some evidence that care plans had been signed by the patient or where they had not been signed an explanation had been inserted; however this was not the case in all records. Where a patient had not signed their care plan, due to their presenting mental health needs, there was no evidence that the care plan had been revisited at another time. A recommendation has been made in relation to this. It was positive to note that patients subject to detention had a detention care plan in place. This provided an explanation of the individual's rights whilst detained and had been signed by the patient.

Each patients care documentation included a family centred care plan, 'Think Child, Think Parent, Think Family'. The care plan was used as a tool to promote family involvement and maintain family connection throughout admission.

Care plans indicated that they should be reviewed weekly. The inspector reviewed evidence that patients' care plans were reviewed weekly. The reviews provided a summary of the previous week rather than an assessment of the goals identified in the care plan. There was no assessment of whether or not the actions detailed in the care plan had been achieved, remained relevant or required amendment. In one of the patient's records there was evidence of care plans that were no longer applicable to the patients' needs but had not been subsequently discontinued. Due to the generic nature of care plans there was no recorded reference made to the consideration of patients' human rights and capacity to consent. A recommendation has been made in relation to this.

Tobernaveen Lower hold daily "Zoning meetings". Patients are categorised into three areas red, amber and green. Patients can move between zones dependent upon their mental health. Zoning meetings allow the multi-disciplinary team (MDT) to review daily the plan of care for patients who are categorised red or amber. New admissions are automatically categorised as red and are reviewed consecutively for three days post admission. However in the files reviewed there were examples where the outcomes from zoning meetings were not accurately recorded and comprehensively completed. Actions identified at zoning meetings had not always been completed prior to the next meeting and care plans had not been updated to reflect the outcome of zoning meetings. A recommendation has been made in relation to this.

There was minimal evidence of human rights considered in patients care documentation. Zoning meetings conducted daily, indicate in a tick box, that human rights are considered. However, there is no elaboration or description of the specific considerations regarding patient's human rights. A recommendation has been made in relation to this.

It was positive to note that patients had been consulted with in relation to their care during 1-1 time with their named nurse. Patients files evidenced daily MDT review, or a minimum review once weekly by the ward consultant.

In two patients' files reviewed by the inspector, the Comprehensive Risk Screening tool was available with associated reviews. One of the patients files reviewed had the Comprehensive Risk screening Tool missing however the reviews of the tool were available. Comprehensive risk screening tools that were available had been completed in accordance with Promoting Quality Care, Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (2010).

The inspector observed therapeutic engagement and activities between staff and patients. Staff were discreet and responsive to patients' needs. Staff demonstrated their knowledge of patients' needs, were familiar with patients' likes, dislikes and choices. Staff who met with the inspector demonstrated an awareness of consent and Human Rights.

Patients referred to the Occupational Therapist (OT) had individualised assessments and plans for therapeutic and recreational activity. Patients had

their own daily schedules which they had devised in conjunction with the OT department. OT assessments and reports were included in the patients' care documentation. Patient participation in activities was recorded in the daily progress notes. The inspector noted a positive improvement in the availability of activities at the weekend; this is recorded in the activity diary.

However, there was no evidence of a ward based activity schedule for those patients who had not been referred to OT or who choose not to engage with the OT department. A recommendation has been made in relation to this. Patients who met with the inspector confirmed activities took place at the weekends.

The ward maintains an open door policy; on the days of inspection the main entrance doors to the ward were open. During the course of the two day inspection the inspector noted that the ward provided an environment with the least restrictions possible. Any restrictive practices used were specific to individual patients and in each case a rationale was provided within the patient's integrated care pathway (ICP). Care plans indicated that the restrictions were the least restrictive option; however the care plans were not person centred in each case. Patients subject to restrictions were discussed and reviewed by the MDT at the daily zoning meetings. The inspector noted that a blanket restriction was in place regarding sharp items, including razors and scissors; these were removed from patients to help ensure the safety of everyone on the ward, in accordance with policy and procedure. A further blanket restriction was for staff and patients to ensure that bed surround curtains are kept open at all times, apart from during times of personal care, this was brought to the inspectors attention from the staff questionnaires. Ward staff explained that this was for the purpose of observation of patients, particularly at night. A recommendation has been made in relation to this. Patients who met with the inspector expressed no concerns regarding the blanket restrictions and understood the rationale for each; patients advised the inspector that they did not feel that their dignity or privacy was compromised by any of these restrictive measures.

In the three patient files reviewed a Deprivation of Liberty care plan had been created, however this was a generic format care plan. A recommendation has been made in relation to this.

The ward social worker advised the inspector that there were two patients on the ward who were delayed in their discharge from hospital. Advice and guidance for staff on the planning for discharge of patients is included at the beginning of the ICP and also within the Comprehensive MDT Assessment (CMA). The inspector reviewed evidence of pro-active work undertaken to prepare patients for discharge. In one case this included joint working with an independent care provider to facilitate trial leave to a supported living scheme and in another case to arrange periods of trial leave to the family home. There was evidence of recorded discussions with the MDT, care provider, patient and their nearest relatives in preparation for trail leave and on the patient's subsequent return to the ward. The ward social worker advised that in preparation for discharge the MDT will review the patient's history, complete

any necessary capacity assessments, review the previous living arrangements and complete a CMA. However there was no formal guidance available to advise staff regarding the sharing of information with external care providers for patients going on leave or discharge. A recommendation has been made in relation to this. Staff advised the inspector that daily zoning meetings are used to track patient progress and identify those nearing discharge. Staff also advised that when a patient is nearing discharge members from the community team will be invited to the ward for a pre-discharge meeting, patients and relatives are also offered to attend. The social worker advised that patients whose discharge is delayed are discussed at weekly delayed discharge meetings and these are then escalated and reported appropriately. The inspector met with four patients, three of which were nearing discharge. The three patients that were preparing for discharge spoke positively regarding their time on the ward. Patients expressed that they did not feel pressured into discharge and felt their views had been considered throughout.

The inspector noted the atmosphere within the ward to be relaxed and patients presented as being at ease and comfortable in their surroundings. Nursing staff were continually available and nurse/patient interactions observed by the inspector were noted to be respectful and supportive.

During the course of the inspection the inspector noted a number of additional concerns, these included: assessment of risk of ligature; medication management; and, staff training. Each of the matters of concern were discussed with the ward manager and with the Assistant Nursing Services manager. In addition RQIA wrote to the Director for Mental Health and Disability Services to gather additional assurances regarding the management of these concerns; further information on each is detailed below.

Details of the above findings are included in Appendix 2.

On this occasion Tobernaveen Lower has achieved an overall compliance level of **Substantially Complaint** 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	**3**
Relatives	**0**
Other Ward Professionals	**2**
Advocates	**0**

Patients

The inspector met with four patients. Patients who met with the inspector spoke positively regarding time spent on the ward and also spoke positively about the ward staff. The patients also confirmed that they had been provided an opportunity to read and sign their care plans. Patients discussed their daily activities and involvement with OT with the inspector. It was good to note that patients who met with the inspector expressed overall satisfaction with the care they were receiving on the ward. Patients stated:

"nurses are a great help"

"the ward sister and staff are so good"

"staff are excellent"

Relatives/Carers

There were no relatives available to meet with the inspector on the days of the unannounced inspection.

Ward Staff

The inspector met with three nursing staff on the ward. All three staff stated they felt well supported and that the ward manager was approachable. The nursing staff stated they felt involved in the operations of the ward and that the ward had a great team ethos. Staff advised the inspector that they had regular training and development opportunities. Nursing staff stated that patients were well cared for and that all patients are treated as individuals.

Other Ward Professionals

The inspector met with two visiting ward professionals over the course of the two days. Professionals that met with the inspector were able to provide an explanation as to their role and function within the ward. Professionals were

also able to provide a summary of their perception of how the ward was performing. The ward based Occupational Therapist (OT) provided a detailed overview of the recreational and therapeutic activities that take place on the ward, their involvement in assessment and planning, and the role they have in the discharge planning process. The OT spoke positively regarding the care and treatment delivered to patients on the ward.

The ward based Social Worker provided a detailed overview of their involvement in assessment and planning for discharge. The Social Worker spoke positively regarding the care and treatment delivered to patients on the ward.

Advocates

There were no advocates available to meet with the inspector on the days of the unannounced inspection.

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	25	18
Other Ward Professionals	6	0
Relatives/carers	24	1

Ward Staff

18 questionnaires were returned by ward staff

The inspector noted that information contained within the staff questionnaires demonstrated that 14 staff were aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance. Four of the 18 staff members had received restrictive practice training and were aware of restrictive practices on the ward. Examples of restrictive practices as reported by staff included “1:1 observations”, and “MAPA”. Eight of the 18 staff members indicated they had received training in the area of Human Rights. Three of the 18 staff had received capacity to consent training.

Concerns regarding gaps in staff training were discussed with the ward manager and assistant nursing services manager, further information is included later in the report.

Other Ward Professionals

There were no ward professionals questionnaires returned prior to this inspection.

Relatives/carers

One relative questionnaire was returned. Relative's comments included:

"Staff are understanding, attentive to patients and are very helpful"

7.0 Additional matters examined

Complaints

Prior to the inspection RQIA received a record of the number of complaints made. The inspector reviewed the record of complaints held on the ward and in discussion with the ward manager clarified the details. The ward manager advised that all complaints had been fully investigated in accordance with policy and procedure and were now fully resolved this was confirmed on review of the complaint records. The ward manager advised that there were currently no complaints ongoing for the ward.

Adult Protection Investigations

The inspector met with the ward manager and ward social worker and discussed the safeguarding activity on the ward. The ward social worker advised that staff were familiar with the Safeguarding Vulnerable Adult policy and procedure and were making appropriate referrals in accordance with policy and procedure.

The inspector was provided with an overview of 18 substantiated allegations. The ward social worker advised that there were three ongoing investigations, one regarding a patient currently on the ward and two regarding patients who had now been discharged. The social worker advised that referrals for safeguarding investigation by ward staff were promptly completed and that protection plans were put in place.

Additional concerns noted

Assessment of risk of ligature

During the course of the inspection the inspector noted a profiling bed located within one of three bed bay areas. The inspector was advised by ward staff that the bed was primarily used for those patients with assessed physical or mobility difficulties. However, ward staff advised that this bed may also be used for any patient, if it is the only bed available on the ward.

A serious adverse incident resulting in a fatality concerning the use of a profiling bed as a ligature point occurred in 2013. 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. Although it is good to note that there was only one of these types of beds available on the ward, the exposed bed frame on this profiling bed presents the same level of risk associated with

ligature points as was the case when the fatality occurred. The matter was brought to the attention of the ward manager and the Assistant Nursing Services Manager during the inspection. RQIA has sought assurances from the Director for Mental Health and Disability Services regarding the management of this matter and the actions the Trust will take to fully implement the requirements of Estates and Facilities Alert EFA/2010/006.

Medication management

On arrival to the ward the inspector was provided a tour of the facility. On entry to the ward medical/treatment room the inspector observed pre-dispensed medications labelled for three patients positioned on top of the medicine trolley. The inspector brought this to the attention of the deputy charge nurse who was unable to provide a clear explanation of the findings. The matter was further discussed with the ward manager on day two of the inspection. The ward manager advised that the pre-dispensing of medication was not custom and practice on the ward and she was not familiar with any previous activity of this nature. This is a concerning matter in terms of the potential for mal-administration of medications, patient safety and nursing practice. RQIA has sought assurances from the Director for Mental Health and Disability Services regarding the investigation of this incident and the management of this matter.

Staff training

The inspector reviewed the training records for 27 members of the staff team. The inspector was concerned to note a number of significant gaps in staff attendance at training, as detailed below:

Training Topic	NHSCT **required frequency** of training	Number of staff with a **recorded expired** training **date**	Number of staff with **no recorded date** of attendance at training	**Total number** of staff without recent training **from** an establishment of **27**
Management of Actual and Potential Aggression (MAPA)	Update annually	13	0	**13 (48%)**
Fire training	6 monthly update	16	0	**16 (59%)**
Cardio-pulmonary resuscitation (CPR)	Update annually	12	1	**13 (48%)**
Infection control	Update annually	11	3	**14 (52%)**
Moving and handling	Update 2 yearly	8	3	**11 (41%)**

The training records were insufficient to assure the inspector and RQIA that staff had the necessary skills and knowledge to fulfil their designated roles and responsibilities. The training records did not provide assurances that staff could respond appropriately to serious incidents such as, a fire, a medical emergency, an incident that involves behaviour which challenges staff, a fall or an outbreak of infection. The concerns regarding training were brought to the attention of the ward manager and the Assistant Nursing Services Manager. RQIA has sought assurances from the Director for Mental Health and Disability Services regarding the actions the Trust will take to address these deficits in staff attendance at mandatory training.

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 8 October 2013

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	16 (4.0)	It is recommended that the ward manager reviews the restriction on bathing after 4pm and applies this restriction only when necessary following completion of individual risk assessments.	The ward manager and nursing staff advised the inspector that patients can access bath facilities after 4pm. Shower facilities are also available at all times. Patients who met with the inspector expressed no concerns regarding accessing bathing facilities.	**Fully met**
2	2 (38.1)	It is recommended that the ward manger ensures all staff record activities carried out with patients.	Activities facilitated by ward staff at evenings and weekends were documented and recorded in an activity diary. A record was also made in individual patients' daily progress notes.	**Fully met**
3	12	It is recommended that the ward manager ensures patients meeting are held and documented showing issues raised/action taken and outcomes.	The inspector reviewed minutes of patients meetings. Minutes of meetings recorded those in attendance and matters arising. The ward manager advised that patient meetings are facilitated by a user consultant; this has proved positive with patients and was reflective in the minutes.	**Fully met**
4	2 (4.14)	It is recommended that the ward manager ensures regular staff meeting are held and documented with issues raised/ action taken and outcomes	The inspector reviewed minutes of staff meetings. Minutes reviewed evidenced that meetings occur monthly and recorded those in attendance and matters arising. Staff also held a daily debrief prior to the commencement of each shift. This provided an opportunity for staff to discuss and receive an update regarding any patient or operational changes.	**Fully met**
5	2 5.13	It is recommended that the ward manager ensures minutes of all multidisciplinary team meetings are signed by the relevant staff.	Multidisciplinary meeting minutes reviewed by the inspector indicated those in attendance, matters arising and actions to be taken. Minutes of meetings were signed appropriately in each case.	**Fully met**

Appendix 1

Follow-up on recommendations made following the patient experience interview inspection on 23 May 2014

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	Section 5, 5.3.3.(f) Page 15	It is recommended that the Trust reviews the composition of and clinical specialities offered within the multidisciplinary team, and the availability of psychotherapeutic interventions to ensure that patients on the ward have access to the full range of evidence based therapeutic interventions to meet presenting needs	The ward manager and assistant nursing services manager advised that inpatients do not have access to the full range of psychology services. Managers advised that patients can be referred to psychology services, whilst an inpatient, and are then seen on discharge in the community.	**Not met**

Appendix 1

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.	The ward manager advised that the following recommendation had not been achieved. Following discussion with the inspector, the ward manager agreed steps to take in order to ensure the safeguarding of patients belongings in accordance with the recommendation.	**Not 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.	The inspector reviewed cash requisition forms. Requisition forms were signed and clearly evidenced withdrawals from the cash office.	**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.	The ward manager advised the inspector that at present they do not receive statements from the cash office. The ward manager has agreed to take this forward for immediate action.	**Not met**

Appendix 1

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	*NT-SAI-14-91 (MHD)*	Leave arrangements to supported living schemes should take into account availability of staff within the scheme, with return times agreed to ensure scheme staff are available to make face to face contact if required. If scheme staff will not be available at these times the ward and community staff should work to develop specific packages of care to meet the needs of patients	On review of patients care records the inspector evidenced that leave arrangements to supported living schemes was discussed and planned at individual patients zoning meetings.	**Fully met**
2	*NT-SAI-14-91 (MHD)*	Ward staff should ensure that clear communication is made with providers to confirm dates/times of overnight leave. Records should be held in patient file.	Patient's daily nursing and social work progress notes evidenced discussion and arrangements whilst patients are on leave. A record of leave arrangements was also recorded at individual patients zoning meetings.	**Fully met**
3	*NT-SAI-14-91 (MHD)*	Guidance about the sharing of information of significance with external providers should be developed.	The ward manager and assistant nursing services manager advised the inspector that guidance in relation to the recommendation has not been developed.	**Not met**
4	*NT-SAI-14-91 (MHD)*	As part of admission process ward staff should record next of kin and nearest relative (if different) at each admission.	The inspector reviewed three of 19 patients care records. In each file the next of kin for each patient was clearly recorded.	**Fully met**
5	*NT-SAI-14-91 (MHD)*	A representative from the supported living scheme should be invited to be part of the SAI review panel if the service user is a tenant (either temporarily or permanently).	Not assessed	**Not applicable to inspection**

Quality Improvement Plan

Unannounced Inspection

Tobernaveen Lower, Holywell Hospital

6 and 7 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 and other hospital personnel on the day of the inspection visit.

Matters requiring completion within 28 days of the inspection visit have also been set out in separate correspondence to Mr Oscar Donnelly (Director Mental Health and Disability Services).

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	5.3.3.(f)	It is recommended that the Trust reviews the composition and clinical specialities offered within the multidisciplinary team and the availability of psychotherapeutic interventions to ensure that patients on the ward have access to the full range of evidence based therapeutic interventions to meet presenting needs.	2	29 May 2015	The Trust is working in collaboration with commissioners to secure funding to provide ward based psychological input to acute care programmes by the recruitment of psychologist. Additional skills based training will be commissioned to equip ward staff to provide a range of psychological interventions which will include motivational interviewing, psychosocial interventions for the severe and enduring mentally ill. Training has been provided in WRAP, anxiety management and depression self help programmes.
2	5.3.1 (c)	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.	2	30 April 2015	A notice has been placed on the patients' information board requesting patients and relatives to inform staff when removing items. Items removed will be recorded and signed by staff and family member. A new form has been developed to

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
					act as a receipt for all items removed. A copy of which will be held in ICP
3	5.3.1 (c)	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.	2	30 April 2015	It has been highlighted at the front of the cash requisition book for staff to get statements from accounts when lifting monies and to file in patient's notes.
4	8.3 (i)	It is recommended that the trust creates guidance that will support the sharing of information with external care providers for patients going on leave or discharge.	1	30 April 2015	Wards have been provided with Information Sharing and Mental Health DOH(2009) Operational policy will be updated to add guidance in relation to information sharing and guidance will be placed in ICP to support discharge and leave arrangements of patients from acute inpatient wards
5	5.3.1 (a)	It is recommended that the ward manager ensures that a care plan is in place and regularly reviewed for any patient subject to any individual restriction, blanket restriction or deprivation of liberty. This should be discussed and	1	30 April 2015	Deprivation of Liberty Care Plans are in place. These plans are individualised for each patient.. They are reviewed regularly and co-signed. All care plans are formulated on recovery principles. Where the patient is detained under the mental health order (1986),the status is recorded in ICP.

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
		agreed where possible with the patient and documented accordingly.			This is supported by a care plan which upholds the persons rights and the patient is provided with written material to inform them of their rights. Ward based observation ,and special observation are reviewed on a daily basis with the ward clinical team and the patient. This is to ensure that the person receives acute care in the least restrictive way possible as their mental state improves
6	8.3 (j)	It is recommended that the ward manager ensures that patient's assessments, care plans and continuous nursing notes are reflective of the patient's capacity to consent to care and treatment.	1	30 April 2015	Were possible patients are involved in their care plans and sign them. Any concerns regarding capacity is discussed at zoning meetings for Multidisciplinary input and review. Consent is obtained from patient for all interventions and is recorded in nursing notes and care plan. Ward managers regularly audit on 3 monthly basis careplans
7	5.3.1 (a)	It recommended that the ward manager ensures that all patients care plans are reviewed as prescribed. Reviews of care plans should ensure that care	1	30 April 2015	A care plan review sheet is kept in patients records with review dates identified. These are reviewed weekly in or as often as necessary. The nursing progress sheet with review – marked at the

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		plans are measured and that the outcome of goals is being assessed. Care plans no longer relevant to patients care should be subsequently discontinued.			side.
8	5.3.1 (a)	It is recommended that all members of the multi-disciplinary team, with delegated tasks following a Zoning meeting, ensure that tasks are completed. Where this is not achieved an explanation should be clearly documented in the patient's notes.	1	Immediate and ongoing	At the zoning meetings the Form 1 records delegated task it also acts as a forum for review to ensure that delegated tasks have been carried out. Tasks which are not completed are carried forward and a rationale recorded. Tasks not completed are followed up with delegated person and where necessary they are escalated to Nursing Services Manager.
9	5.3.3 (b)	It is recommended that the ward manager ensures that patients previously unable to review their care plans are provided with an ongoing opportunity to review their care plans as their mental state improves, this should be recorded and/or signed by the patient.	1	Immediate and ongoing	Weekly reviews are carried out with the patient. Where this is not possible, a record is made in the care plan review sheet. The staff will make every effort to involve patient at the earliest opportunity to ensure inclusion.

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
10	5.3.1 (a)	It is recommended that the ward manager ensures that patients care plans reflect consideration of the Human Rights Act, particularly for those patients that are subject to any form of restrictive practice. Care plans should be person centred and incorporate the holistic and individualised needs of the patient.	1	30 April 2015	Individual, patient centred recovery care plans are in place for each patient. The principles of human rights are considered on formulation and review and are referenced though out the care plan. This is examined on 3 monthly audit of care plans completed by ward manager Mental Health Order Rights Care Plans. A programme of training has been identified to support staff in developing person centred recovery plans.
11	4.3 (i)	It is recommended that the trust urgently review the continued use of a profiling bed on the ward. The outcome of the review should be clearly reflected in the environmental and ligature risk assessment.	1	6 February 2015	These have been removed. No profiling beds remain in TNL

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
12	5.3.1 (f)	It is recommended that the trust ensures that the outcome of the investigation relating to the practice of pre-dispensing medication is forwarded to RQIA.	1	6 February 2015	Ward manager and NSM are undertaking random spot checks. A memo has been issued to remind staff of their responsibilities under NMC Guidelines A full investigation of the incident will take place and report sent to ROIA- Staff member is currently on sick leave and this cannot be pursued at present.
13	4.3 (m)	It is recommended that the ward manager ensures that all staff have up to date mandatory training completed which includes fire training, moving and handling training, Management of Actual and Potential Aggression (MAPA), Cardio-pulmonary resuscitation (CPR) and Infection control. The trust should also ensure that all ward based staff are provided with training in Capacity and Consent, Restrictive Practices, Deprivation	1	30 April 2015	A system has been developed to facilitate the review of all training needs of each ward for. mandatory training. A weekly training meeting occurs with training facilitator, Nursing Services Manager and ward managers to identify deficit's in training and to facilitate additional training to support 100% compliance. Staff who have training needs are identified and allocated training dates

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		of Liberty and Human Rights.			
14	6.3.2 (g)	It is recommended that the ward manager provides an opportunity for structured recreational activity for those patients who do not avail of OT services; this should consider the individual needs and views of the patients.	1	30 April 2015	The ward provides recreational activities in the evening . There are a wide range of games available . A notice has been placed on patients' information board giving an out line of activities available and the circumstances when a revision of this may be necessary.

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

NAME OF WARD MANAGER COMPLETING QIP	Sr Ruth Hedley
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	T Stevens

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Kieran McCormick	03/03/15
B.	Further information requested from provider		x	Kieran McCormick	03/03/15