Unannounced Follow Up Inspection Report
13 March 2018

Tobernaveen Lower

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

Tel No: 028 94413105

Inspector: Wendy McGregor

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 Lower is a 20 bedded mixed gender ward. The purpose of the ward is to provide care and treatment to patients over the age of 18 who require assessment and treatment in an acute psychiatric environment.

Patients receive input from a multidisciplinary team (MDT) which includes a consultant psychiatrist, medical staff, nursing staff, occupational therapy staff, psychology staff and social work staff. An independent advocacy service is available.

On the days of the inspection there were 18 patients on the ward and three patients on leave. Three 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: Anthony Stevens	**Ward Manager:** Dorothy McGilton
Category of care: Adult Mental Health acute admission ward	**Number of beds:** 20
Person in charge at the time of inspection: Marie Convery	

4.0 Inspection summary

An unannounced follow-up inspection took place on 13 March 2018.

The inspection reviewed progress against findings for improvement identified from the previous unannounced inspection 22 – 24 November 2016.

The inspector noted that the ward had made improvements since the last inspection. Six out of the nine areas for improvement were assessed as met.

Patients no longer accessed the kitchen area. An area considered as high risk and should only be accessed by staff. Tea and coffee making facilities were available along with snack vending machines in communal areas on the ward.

Patient forum meetings were held every month and issues raised by patients were addressed and actioned.

Staff recorded when and why patient activities were cancelled.

The responsible person(s) or appropriate MDT team were identified for the actions agreed at the patient zoning (multidisciplinary team) meetings.

Ward flooring and the ward bath had been repaired and the medication fridge had been replaced and was locked securely.

The inspector noted that in the records reviewed that patients' progress notes were comprehensive, contemporaneous and evidenced that care was person centred. There was good communication between members of the multidisciplinary team. It was good to note a peer support worker had commenced employment on the ward.

There was good occupational therapy and psychology support on the ward and there were a number of activities available for patients both on the ward and in the occupational therapy department.

The inspector observed good therapeutic engagement between staff and patients on the day of the inspection.

Three areas for improvement were assessed as partially met. Some improvement was noted in relation to the completion of patients' medication prescription sheets. The name of the medication was recorded in capital letters; however the indication when the medication should be administered was not consistently recorded. The inspector noted that the maximum dose for some medications was also not consistently recorded.
The temperature of the medications fridge was not checked every day as per Trust policy.
There was one audit displayed in relation to ward cleanliness but there was no information displayed in relation to patient / relative / carer experiences of their care and treatment on the ward.

Patient's views

Feedback was received from eight patients. Patients indicated that they were satisfied that care on the ward was safe. Patients said that they felt safe and supported, could talk to staff if they had any concerns and were informed and understood their rights. Patients indicated that care was effective and were satisfied they were getting the right care, in the right place at the right time and were involved in all decisions about their care and treatment. Patients felt that the care and treatment provided on the ward was helping them to feel better. Patients indicated that they were very satisfied that the care met their expectations.
Patients said care was compassionate and they were treated with dignity and respect and their privacy maintained. Staff always sought consent, listened and took their views into account. All patients felt the ward was well led/managed. Patients knew who was in charge and that all staff had the necessary skills and training to carry out their job. All patients said they were satisfied with the information they had received on the ward and their views were sought about the quality of the service provided.

Patients said

"Staff can predict when I become agitated and help me, this prevents the need for any restrictive interventions"

"When I was restrained this was done properly, and I was not injured. I was comforted after the event. Staff are very aware of my triggers and do everything to keep me safe."

"Staff listen to me 100%"

Staff are brilliant and are always there when I need to talk to someone. The doctor goes out of their way and is always available".

"Being on this ward has helped me massively".

The OT service is great and has improved".

"There has been an improvement in the activities offered since last year".

"Doctor x is one of the best consultants I have ever met".

"Staff take part in the activities with the patients".

"I am very grateful how the staff treat me, understand me and don't dismiss me".

"All of the managers are very good".

"The staff seem to get along well together".

"I like the way the team works as there is consistency".

"Staff come down at the start of every shift and say hello to everyone and introduce themselves to new patients".

"Being a patient here has been a life saver for me. Couldn't fault any staff, all are compassionate and caring and for me they listen when needed."

Relative views

Feedback was received from one relative. The relative stated they were very satisfied that care was safe, effective, compassionate and the service was well led.

The relative said *"I am a relative. My daughter receives the best care possible. Staff are very friendly and very approachable. They are all so upbeat and on the ball. They always treat my husband and I with the utmost respect, considering my daughters needs at all times. In my opinion all care given here is excellent and very professional. Thanks to all the staff involved".*

Staff views

The inspector met with four members of staff. All staff felt the ward was safe. They said that the staffing levels reduce in the evening and this can make it difficult to provide activities. All staff indicated there was a culture of openness and could raise any concerns in relation to patient care and safety with the appropriate person. Staff said they had received a good induction and up to date mandatory training. Staff said patients are treated with compassion

and care and all staff engage compassionately with patients Staff said care was effective that patients had been assessed and were in the right place for their needs to be met. All staff said they were kept informed of any changes in patients care plans. All staff said the ward was well managed and there was a culture of staff empowerment and involvement in running the service.

Staff said

"*The managers are approachable".*

"Continuing practice development is encouraged".

"The multidisciplinary team works well together and relationships are effective".

"All care is person centred"

The findings of this report will provide the Trust with the necessary information to assist them to fulfil their responsibilities, enhance practice and service user experience.

4.1 Inspection outcome

Total number of areas for improvement	3

The total number of areas for improvement comprise:

- 3 restated for a second time

These are detailed in the Quality Improvement Plan (QIP).

Areas for improvement and details of the QIP were discussed with senior trust representatives, members of the multi-disciplinary team, the ward manager and ward staff as part of the inspection process. The timescales for completion commenced from the date of inspection.

5.0 How we inspect

The inspection was underpinned by:

- 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.

The following areas were examined during the inspection:

- Medication prescription sheets in relation to 15 patients.
- Care Documentation in relation to four patients.
- Ward environment.
- Activity schedule.

- Medication fridge temperature records.
- Minutes of patient forum meetings.
- The ward cleanliness audit.

We reviewed the areas for improvements made at the previous inspections and an assessment of compliance was recorded as met or partially met.

6.0 The inspection

6.1 Review of areas for improvement from the last unannounced inspection 22 – 24 November 2016.

The most recent inspection of Tobernaveen Lower Ward was an unannounced inspection. The completed QIP was returned and approved by the responsible inspector. This QIP was validated by the inspector during this inspection.

Areas for Improvement from last inspection		Validation of Compliance
Area for improvement 1 **Ref**: Standard 5.3.1 (f) **Stated:** First time	PRN medication did not have an indication of when it was to be used and on some occasions the name of medications were not written in capital letters. **Action taken as confirmed during the inspection**: The inspector reviewed medication prescription sheets for 15 patients and noted the following: • 14 out of 15 the names of the medications were written in capital letters. • 10 out of 15 the indications when the medication was to be administered were not recorded. • 8 out of 15 the maximum dose was not recorded. The inspector suggested that the Trust complete an audit of patients' medication prescription sheets. This area for improvement has been reworded and restated to include the finding that the maximum dose was not consistently recorded on all the medication prescription sheets.	**Partially met**
Area for improvement 2	Temperature of medical fridge was not logged/ recorded daily in accordance with Trust policy. The lock on medication fridge was broken.	

Ref: Standard 5.3.1 (f) **Stated:** First time	**Action taken as confirmed during the inspection**: The inspector reviewed the fridge temperature log sheet from 1 March to 13 March 2018 and noted that the temperature of the fridge was not recorded on a daily basis in accordance with Trust policy and procedures. The inspector noted that the medication fridge had been replaced and the lock was in working order. This area for improvement has been assessed as partially met as the temperature of the fridge was not recorded on a daily basis.	**Partially met**
Area for improvement 3 **Ref**: 5.3.1 (e) **Stated:** First time	The catering assistant raised a concern regarding patients accessing the ward kitchen in between meal and snack times. Where possible the catering assistant has agreed to make tea or coffee for patients outside of these times as long as the catering assistant has completed their other chores. However the catering assistant stated that they sometimes feel uncomfortable with patients who are newly admitted accessing the kitchen due to unknown risks and asked that this practice be stopped.	**Met**
	Action taken as confirmed during the inspection: The inspector spoke to staff on the ward who stated that patients do not enter the kitchen. There was signage displayed on the kitchen door informing patients that this was a “no patient zone”. Tea and coffee making facilities were available on the ward and were replenished when required. The inspector also noted several snack / vending machines were also available. This area for improvement has been assessed as met.	
Area for improvement 4 **Ref:** Standard 6.3.2 (g)	There was not consistent patient meetings/ forums. There was a gap between meetings of five months. Upon reviewing the minutes of meetings there was no evidence that progress was made on the previous issues raised.	

Stated: First Time	**Action taken as confirmed during the inspection**: The inspector reviewed the minutes from patient forum meetings from September 2017 to February 2018. Patient forum meetings were convened every month and had regular attendance from a representative from the Northern Trust patient council who had experience of mental health services within the trust. The minutes evidenced that the following information was shared: • Named nurse role. • Advocacy service. • Citizens Advice Bureau. • Medication concordance. • Relevant Trust policies such as the children visiting policy, smoke free policy and the use of mobile phones and the internet. • Discharge processes. • Multidisplinary review processes / meetings (zoning meetings). • Wellness and Recovery Programmes (WRAP). • Any suggestions on how the service could be improved. On review of the minutes there was good attendance from patients and staff. Issues arising were recorded and there was evidence that these were addressed. This area for improvement has been assessed as met.	**Met**
Area for improvement 5 **Ref**: Standard 5.3.1 (f) **Stated:** First Time	Actions arising from the zoning meeting were recorded however the person responsible for completing an agreed action point often stated "MDT" and did not identify any member of staff or discipline responsible. **Action taken as confirmed during the inspection**: The inspector reviewed the zoning (multidisciplinary team) meeting template in relation to four patients.	**Met**

	The appropriate and responsible person (s) / discipline / team was recorded for each of the agreed actions arising from the zoning meeting. This area for improvement has been assessed as met.	
Area for improvement 6 **Ref**: Standard 5.3.1 (e) **Stated:** First Time	The trusts should ensure damaged flooring is repaired or replaced as and when required. **Action taken as confirmed during the inspection**: The inspector noted that the damaged flooring observed during the last inspection on 22 – 24 November 2016 had been repaired. On further observation of the ward environment during the inspection there was no outstanding damaged flooring that required for repair / replacement. This area for improvement has been assessed as met.	**Met**
Area for improvement 7 **Ref**: Standard 5.3.1 (f) **Stated:** Second Time	The Trust replaces or repairs the bath on the ward. **Action taken as confirmed during the inspection:** The inspector noted that the bath on the ward had been repaired and was in working order. This area for improvement has been assessed as met.	**Met**
Area for improvement 8 **Ref**: Standard 5.3.1 (f) **Stated:** First Time	Nursing staff do not record when evening activities are cancelled or the reasons why. **Action taken as confirmed during the inspection**: The inspector reviewed the record maintained in relation to activities on the ward. Staff had recorded when activities were cancelled and the reason why. This area for improvement has been assessed as met.	**Met**

Area for improvement 9 **Ref**: Standard 5.3.3 (j) **Stated:** First Time	The outcomes of audits were not displayed for patients' carers or members of the public visiting the ward to view.	**Partially met**
	Action taken as confirmed during the inspection: The inspector noted that the only audit outcome displayed was in relation to ward cleanliness. There were no others audits displayed in relation to patient / relative experience of their care and treatment. The inspector discussed this with the ward team and trust senior management. Displaying information in relation to patient experience would facilitate service improvement and would meet the required standards in relation to Personal and Public Involvement (PPI) (March 2015). This area for improvement has been reworded and restated to include the lack of information displayed in relation to patient and relative/carer experience.	

7.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with senior trust representatives, members of the multi-disciplinary team, ward manager, and ward staff as part of the inspection process. The timescales commence from the date of inspection.

The responsible person must ensure that all areas for improvement identified within the QIP are addressed within the specified timescales. The responsible person should note that failure to comply with the findings of this inspection may lead to escalation action being taken.

7.1 Actions to be taken by the service

The quality improvement 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 via the web portal by **7 May 2018**.

Quality Improvement Plan	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** Standard 5.3.1 (f) **Stated:** Second time **To be completed by:** 14 June 2018	The indication for when PRN medication was not consistently recorded. The maximum dosage for medications was also not consistently recorded.
	Response by responsible individual detailing the actions taken: These issues have been escalated to the Divisional Medical Director and Pharmacist. All Junior Doctors have been made aware of the necessity of recording medication in line with policy. Medical Clinical Lead for Acute will work with ward team to monitor compliance.
Area for Improvement No. 2 **Ref: Standard 5.3.1 (f)** **Stated:** Second time **To be completed by**: 14 March 2018	Temperature of medical fridge was not logged/ recorded daily in accordance with Trust policy.
	Response by responsible individual detailing the actions taken: This activity had been placed on the daily briefing sheet for two weeks and was on the agenda at the staff meeting. An audit tool was devised by the nursing staff and the Ward Manager and/or Assistant Ward Manager are currently auditing this activity on a weekly basis.
Area for Improvement No. 3 **Ref**: Standard 5.3.3 (j) **Stated:** Second time **To be completed by:** 15 September 2018	The outcomes of audits were not displayed for patients' carers or members of the public visiting the ward to view. There was no information displayed in relation to patients' views of their care and treatment or their experience of the ward. This information could help with service improvement in accordance with Personal and Public Involvement (PPI) Standards (March 2015).
	Response by responsible individual detailing the actions taken: A lockable display cabinet is in the process of being ordered. Patients/Carers comments are currently displayed on a white board at the entrance of the ward. A system for capturing user and carer participation is being developed as part of AIMS accreditation process.

Name of person (s) completing the QIP	Dorothy McGilton		
Signature of person (s) completing the QIP		**Date completed**	4/5/2018
Name of responsible person approving the QIP	Dr Anthony Stevens		
Signature of responsible person approving the QIP		**Date approved**	4/5/2018
Name of RQIA inspector assessing response	Wendy McGregor		
Signature of RQIA inspector assessing response	Wendy McGregor	**Date approved**	9 May 2018

Please ensure this document is completed in full and returned to MHLD.DutyRota@RQIA.org.uk from the authorised email address

The Regulation and Quality Improvement Authority

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

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews