The Regulation and Quality Improvement Authority

Inspection Report

Unannounced Inspection Report
23 and 24 July 2019

Northern Health and Social Care Trust

Acute Mental Health Inpatient Admission Wards

Holywell Hospital
60 Steeple Road
Antrim
BT41 2RJ
Tel No: 028 9441 5221

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Northern Health and Social Care Trust (the Trust)	**Responsible Person:** Dr Anthony Stevens, Chief Executive Officer Northern Belfast Health and Social Care Trust (NHSCT)
Person in charge at the time of inspection: Mrs. Diane Spence Assistant Director Northern Health and Social Care Trust	**Number of commissioned beds:** Tobernaveen Upper: 20 Tobernaveen Centre: 20 Tobernaveen Lower: 20
Categories of care: Mental Health (MH) Acute Admission	**Number of beds occupied in the wards on the day of this inspection:** Tobernaveen Upper: 20 Tobernaveen Centre: 20 Tobernaveen Lower: 20
Brief description of the accommodation/how the service operates: There are three Mental Health acute admission wards on the Holywell Hospital site. Tobernaveen Upper ward (TNU); Tobernaveen Centre ward (TNC); and Tobernaveen Lower ward (TNL). The wards provide assessment and treatment to patients aged 18 – 65 years with acute mental health needs. TNC also provides assessment and treatment to patients with acute mental health needs over the age of 65 years. All three wards are mixed gender and consist of a mixture of dormitory style accommodation and single bedrooms. Patients are admitted either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).	

2.0 Inspection summary

An unannounced inspection took place to the MH acute admission wards in Holywell Hospital. The inspection commenced on 23 July 2019 at 0900hrs and concluded on 24 July 2019 with feedback to the Senior Management Team (SMT). The inspection included an early morning visit on 24 July 2019, commencing at 07:30hrs to observe the nursing hand-over from night shift to day shift and to speak with night staff.

The inspection was carried out by a combination of care and pharmacy inspectors with input from RQIA's Clinical Lead.

We undertook this inspection in response to intelligence we had received relating to all Tobernaveen wards. The intelligence related to information from a number of serious adverse incidents (SAI's) reported to us over the last two years and recent concerns raised by patients and relatives. In addition, we sought to assess progress with issues raised in the last quality improvement plans (QIP) for each ward.

This inspection focused on ten key themes: management of incident/accidents; environment; adult safeguarding; restrictive practices; medicines management; infection prevention control; patient care and treatment; records management; patient experience; and governance and leadership.

Patients told us they were treated with dignity and respect and felt that staff actively listened to them and attended their needs. Patients were observed being supported by compassionate staff who took all necessary steps to maintain their dignity, privacy and comfort at all times. The use of restrictive practices was low and the multidisciplinary worked well together. Patients had access to a good advocacy service.

Patients physical and mental health care needs were comprehensively assessed and care plans and treatment plans were person centred and addressed the needs of patients.

Staff feedback was positive with the majority of staff confirming that they enjoyed their role and the environment they worked in.

A total of 13 areas for improvement (AFIs) were identified. Areas that require improvement relate to incident/accident management, environment, adult safeguarding, medicines management, infection prevention control, records management, patient experience and governance and leadership.

Two areas for improvement were escalated to serious concerns these were in relation to incident management and environment (ligature risks).

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. To do this, we gather and review the information we hold about the service, examine a variety of relevant records, meet and talk with patients, relative's, staff and management and observe practices throughout the inspection.

The information obtained is then considered before a determination is made on whether the service is operating in accordance with the relevant legislation and quality standards.
Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the Trust to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

4.0 What people told us about the service

Posters were placed throughout wards inviting patients and staff to complete an electronic questionnaire.

Patients indicated that they were satisfied their care was safe and effective, that they were treated with compassion and that the service was well led.

Staff we met with indicated that they felt patient care was safe and effective, patients were treated with compassion and that the service was well led. Most staff indicated that they felt supported in their roles and that the senior management team were visible on wards and responsive.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspections of the three wards undertaken from TNU (24 -25 July 2017), TNC (31 January 2019), and TNL (13 March 2018). A total of 14 areas for improvement were identified across the three wards.

The methodology used for this inspection included a systems wide inspection this means that the three wards were inspected by the team at the same time. Each of the nine previous areas for improvement have each been subsumed into one new area for improvement. Three areas for improvement were assessed as fully met and one area was not assessed during this inspection.

<table>
<tr><th colspan="3">Areas for improvement from the last inspection at Tobernaveen Upper on 24 – 25 July 2017</th></tr>
<tr><th colspan="2">Action is required to ensure compliance with The Quality Standards for Health and Social Care DoH (March 2006)</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 5.1
Criteria: 5.3.1(a)

Stated: Second time</td><td>The Northern Health and Social Care Trust shall ensure comprehensive risk assessments (CRA) are completed in accordance with regional and Trust standards.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
During this inspection we found patients' comprehensive risk assessments were completed in accordance with regional and Trust standards.

This area has been assessed as met.</td></tr>
</table>

Area for improvement 2 **Ref**: Standard 8.1 Criteria: 8.3 (h) **Stated**: First time	The Northern Health and Social Care Trust shall ensure all medical records are legible and easy to read.	**Not met**
	Action taken as confirmed during the inspection: During this inspection we identified concerns in relation to the legibility of some medication records. This area for improvement has not been met and has been subsumed into a new area for improvement as we identified a number of additional areas that require improvement in relation to medicine management. **Further detail is provided in section 5.2.9**	
Area for improvement 3 **Ref**: Standard 7.1 Criteria: 8.3(a) **Stated**: First time	The Northern Health and Social Care Trust shall ensure that • patients' overall experience is monitored and reviewed on the ward; • patient satisfaction surveys are completed; and • patient forum meetings are held on the ward.	**Not met**
	Action taken as confirmed during the inspection: During this inspection we identified that the arrangements in place to monitor and review patients' experience were not adequate and did not influence any service improvement. This area for improvement has been subsumed into a new area for improvement as we identified a number of additional areas that require improvement in relation to the patient experience. **Further detail is provided in section 5.2.9**	

Area for improvement 4 **Ref:** Standard 4.1 Criteria: 4.1 (j) **Stated**: First time	The Northern Health and Social Care Trust shall ensure occupational therapists receive training in child protection and safeguarding vulnerable adults.	**Met**
	Action taken as confirmed during the inspection: During this inspection we were able to confirm this area for improvement has been met and Occupational Therapists had received child protection and safeguarding training. This area for improvement has been assessed as met.	
Area for improvement 5 **Ref:** Standard 4.1 Criteria 4.3 (i) **Stated**: First time	The Northern Health and Social Care Trust shall address the number of ligature points identified in the ligature risk assessment dated 4 August 2017.	**Not met**
	Action taken as confirmed during the inspection: During this inspection we identified serious concerns with respect to the management of ligature risks. This area for improvement has been subsumed into a new area for improvement as we identified a number of issues that require improvement in relation to ligature risk management that pertains to all wards. Due to the serious nature of this risk it has been escalated to serious concerns in accordance with our escalation policy. **Further detail is provided in section 5.2.2**.	

<table>
<tr><th colspan="3">Areas for improvement from the last inspection at Tobernaveen Centre on 31 January 2019</th></tr>
<tr><th colspan="2">Action is required to ensure compliance with The Quality Standards for Health and Social Care DoH (March 2006)</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for Improvement 1

Ref: Standard 5.1
Criteria 5.3.1 (c)

Stated: First Time</td><td>The Northern Health and Social Care Trust 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.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
During this inspection we identified issues with respect to the management of adult safeguarding.

This area for improvement has not been met and has been subsumed into a new area for improvement as we evidenced additional findings relating to adult safeguarding during this inspection.

Further detail is provided in section 5.2.3</td></tr>
<tr><td rowspan="2">Area for Improvement 2

Ref: Standard 5.1
Criteria:5.3.1 (c).

Stated: First Time</td><td>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.</td><td rowspan="2">Carried forward to the next inspection</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.</td></tr>
</table>

Area for Improvement 3 **Ref:** Standard 6.1 **Criteria** 6.3.2 (g) **Stated:** First Time	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.	**Not met**
	Action taken as confirmed during the inspection: We identified that there was no system in place to record and review informal complaints or this information was used to drive improvements during this inspection. This area for improvement has not been met and has been subsumed into a new area for improvement as we evidenced additional findings relating to adult safeguarding during this inspection. **Further detail is provided in section 5.2.9.**	
Area for Improvement 4 **Ref:** Standard 5.1 Criteria 5.3.1.(f) **Stated:** First Time	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.	**Met**
	Action taken as confirmed during the inspection: During our inspection we identified good mitigating systems were in place to ensure staff always presented as professional and worked to their professional codes of conduct and Trust policies and procedures. Both patients and staff confirmed this during this inspection. This area for improvement has been assessed as met.	

Area for Improvement 5 **Ref:** Standard 5.1 Criteria: 5.3.1 (f) **Stated:** First Time	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.	**Not met**
	Action taken as confirmed during the inspection: During this inspection we again identified issues with fridge temperature monitoring and the cold storage. This area for improvement has not been met and has been subsumed into a new area for improvement as we identified a number of additional areas that require improvement in relation to medicine management. **Further detail is provided in section 5.2.5.**	
Area for Improvement 6 **Ref:** Standard 5.1 Criteria 5.3.1 (e) **Stated:** First Time	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.	**Met**
	Action taken as confirmed during the inspection: Following the most recent inspection of TNC, RQIA continued to engage with representatives of the senior management team in relation to this area of improvement. A yearlong plan of unannounced night-time visits to all inpatient acute mental health wards had been scheduled. On 27 December 2019, RQIA received information from the Trust that detailed the outcome of the night-time visits conducted by members of the senior management team and we were satisfied with their findings. This area for improvement has been assessed as met.	

<table>
<tr><th colspan="3">Areas for improvement from the last inspection at Tobernaveen Lower on 13 March 2018</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Quality Standards for Health and Social Care DoH (March 2006)</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 5.1
Criteria: 5.3.1 (f)

Stated: Second time</td><td>The Northern Health and Social Care Trust shall address the following matters with respect to PRN Medication;

• ensure that the indication for when PRN medication is used is recorded.
• the maximum dosage for medications is recorded.</td><td rowspan="2">Partially met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
During this inspection we identified an inconsistent practice with respect to the recording of first and second line PRN medicines.

The maximum dose was recorded.

This area for improvement has been subsumed into a new area for improvement as we identified a number of additional issues that require improvement in relation to medicine management.

Further detail is provided in section 5.2.5.</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 5.1
Criteria: 5.3.1 (f)

Stated: Second time</td><td>The Northern Health and Social Care Trust shall ensure the temperature of medical fridge is logged/ recorded daily in accordance with Trust policy.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
We again identified issues with adherence to the Trust policy relating to the recording of fridge temperatures.

This area for improvement has been subsumed into a new area for improvement as we identified a number of issues that require improvement in relation to medicine management across all three wards.

Further detail is provided in section 5.2.5.</td></tr>
</table>

Area for improvement 3 **Ref**: Standard 5.1 Criteria: 5.3.1 (j) **Stated**: Second time	The Northern Health and Social Care Trust shall ensure; • the outcomes of audits are displayed for patients' carers or members of the public visiting the ward to view; • there is information displayed in relation to patients' views of their care and treatment or their experience of the ward; and • use this information to help with service improvement in accordance with Personal and Public Involvement (PPI) Standards (March 2015).	**Not met**
	Action taken as confirmed during the inspection: During this inspection we found that up to date information in relation to audits and patients' experience were not displayed on the ward for patient's relatives and staff. This area for improvement has been subsumed into a new area for improvement as we identified a number of issues that require improvement in relation to patient experience across all three wards. **Further detail is provided in section 5.2.9.**	

5.2 Inspection findings

5.2.1 Incident Management

We reviewed incidents reported on the trust Datix system for all three wards from April to July 2019 and identified a number of concerns about the recognition and management of adverse incidents and near misses.

We noted that the grading of incidents on the Trust Datix system was based on the outcome of the incident and not on the inherent risk, resulting in a significant number of incidents being graded as low risk. We were concerned that incidents which were incorrectly categorised as low were not appropriately escalated.

We identified a lack of governance and oversight of incident management across the three wards. Information in relation to incidents occurring on one ward was not always shared with the other wards. This was evident when we identified this information was not shared when a patient was transferred from one to the other.

Incident data was not being routinely monitored, audited and analysed by ward managers, SMT or the Trust's governance department and therefore there is a risk that opportunities to learn and improve could be missed.

We identified a number of incidents which had not been reviewed or approved by ward managers which included incidents that had been categorised as a high risk incident.

We reviewed information recorded on safety briefs undertaken following an incident. We found the approach to safety briefs following incidents required improving. Information recorded on the safety briefs was descriptive with limited consideration given to analysis, identification of themes and trends, learning and how this data could be used to drive improvement.

From the evidence we reviewed during the inspection we have determined that this area for improvement required escalation to serious concerns.

5.2.2 Environment

We observed the environments throughout the three wards and reviewed each wards' ligature risk assessments. A significant number of ligature risks were identified across the three wards and the responsibility and expectation for managing these risks was heavily reliant on nursing staff who are not also present in areas accessed by patients.

We were further concerned that from the information we reviewed both prior to the inspection and during the inspection that a number of patients admitted to the wards had attempted self-harm using a ligature.

There was limited evidence available in relation to a robust governance mechanism that provided good oversight and assurances in relation to the management of ligature risks. The Trust's ligature risk management plan had not been updated to reflect the regional learning identified from a Serious Adverse Incident involving a ligature point that had occurred in another Trust.

The need to remove these ligature points was identified on the Trusts ligature risk assessment completed on October 2017 (TNC), October 2018 (TNU) and April 2018 (TNL).

We had also previously highlighted our concerns regarding the number of ligature points with the Trust's SMT following previous inspections and had also shared our concerns with the Department of Health (DoH) on the following dates: 10 June 2016; 7 December 2016; 7 March 2017 and; 19 December 2017.

Fire risk assessments reviewed were out of date. On observations of the each wards environment we found breaches of the Trust's Fire policy. These were addressed with the nurse in charge during the inspection and immediate action was taken. Firefighting equipment and the fire door check was completed monthly and the check to ensure the means of escape was clear from obstruction was also completed. The weekly fire alarm test was not always completed. We identified issues in relation to staff knowledge on the location and contents of the fire grab box and found the information contained in the box was out of date.

Two areas for improvement were made in relation ligature risk assessment and fire safety. We have determined that the area for improvement in relation to ligature risks required escalation to serious concerns.

5.2.3 Adult Safeguarding

We reviewed the processes for the recognition and management of adult (ASG) and identified a number of concerns in relation to adherence to regional guidance: Adult Safeguarding: prevention and Protection in Partnership Policy (2015).

We reviewed incidents on Datix and cross referenced with referrals made to the Adult Safeguarding team, we also reviewed staff training records and met with members of the MDT. Safeguarding referrals were appropriate and staff were up to date in their mandatory safeguarding training or had dates scheduled to attend training. Staff knowledge in respect of the recognition of ASG incidents and making appropriate referrals was good.

We found the training received with respect to the process, following a referral, was not fully embedded in practice as there was a lack of immediate patient protection plans in place and very little detail recorded in the patient's care records with respect to any follow-up actions taken. There were no records maintained on the ward to evidence the outcome following the referral to the safeguarding team.

An area for improvement has been made.

5.2.4 Restrictive Practices

We reviewed the processes for the management of restrictive practices throughout the three wards.

Restrictive practices were used infrequently and there was evidence of good utilisation of de-escalating techniques and staff that used the least restrictive approach when supporting patients who presented with challenging behaviours.

There were good patient centred risk assessments and care plans in place that detailed any restrictive practice required by a patient and there was good consideration given to Human Rights. Restrictive practices were monitored and regular reviewed by the MDT.

We found that there was a lack of a governance mechanism that would provide monitoring and oversight in relation to those occasions when ward exit doors are locked. Documentation used during these periods is filed in individual patient notes, but there was no system in place that provided an overall analysis / audit to establish themes and trends to identify learning. There was no recognition of the impact on other patients on the ward. The Trust's SMT should consider how this restriction could monitor and analysed; due to the impact this may have on other patients who do not require this level of restriction. This was highlighted to the Trust SMT at feedback.

5.2.5 Medicines Management

We reviewed the pharmacy support arrangements in place across the three wards. The pharmacist cover to the wards is one full time member of staff covering all wards in the Holywell site including Tobernaveen wards and a pharmacy technician who visits the wards regularly to assist with stock control.
We spoke with nursing staff who confirmed that pharmacist support was seen as a fundamental part of the care of the patients in providing information, guidance and overall medicines management.

We found most of the kardexes were well maintained and all the relevant information was recorded. On some occasions we noted the prescribing doctor's details were not legible. This area for improvement was made following and previous inspection and will be subsumed into a new area for improvement as additional areas were identified during this inspection.

We examined medicines prescribed on a "when required" (Pro ne Rata /PRN) basis. We acknowledged that the indication for the medicine and first line and second line treatment were recorded on some occasions, however this practice was not always consistent. On occasion, we noted that two PRN medicines were administered simultaneously. Where PRN medicines were administered, the reason for and outcome of the administration was not always recorded; this should be routinely recorded when staff make a decision to administer these medicines. The management of PRN medicines was identified as an area of improvement at the last inspection of Tobernaveen Lower and will be subsumed into a new area for improvement as additional issues were identified during this inspection.

Whilst we were advised that the patient's kardex is brought to the weekly MDT meetings, the pharmacist does not attend and is not involved in any decision making in relation to changes to prescribing. There was no audit system in place to monitor the recording of medicines on kardexes.

The benefit of writing kardexes in a quiet area to assist with safe and accurate transcribing had already been highlighted by the Trust; however, there was limited evidence that this was actioned. This was highlighted at feedback to the Trust.

The process in place for obtaining supplies of medicines changed on the day of the inspection with medicines no longer being dispensed on site. We observed this had an impact on patients discharge arrangements by causing a delay. We identified missed doses of medication were not considered as a reportable incident.

We examined the medicine storage areas, found medicines were stored securely, and medicine areas were clean, tidy and organised. Staff in Tobernaveen Upper (TNU) and Tobernaveen Centre (TNC) advised that the medicine trolleys only contained medicines for current patients. On the medicine trolleys in Tobernaveen Lower (TNL), we identified loose blisters of medicines; all medicines should be stored in original or pharmacy containers.

We identified improvements were necessary in the temperature monitoring regarding the cold storage of medicines. Maximum temperatures must not exceed $8^{O}C$ and the refrigerator thermometer should be reset every day. This is essential to ensure appropriate storage of medicines and ensure medicines are viable for use. The cold storage of medicines had also been highlighted at the last inspection to TNL and TNC.

We reviewed the emergency resuscitation bags and noted they could not be accessed by all staff. There were some expired medicines in these bags, which were removed during the inspection, and the outer containers of some injectable medicines were damaged due to the lack of space in the bags. The regular checks in place had failed to identify and replace the out of date medicines.

The governance arrangements for medicines management were discussed. We were advised that controlled drugs were audited on a quarterly basis by a designated pharmacist from NHSCT. However, there was limited information available regarding other regular medicine related audits and any outcomes.

In relation to incidents, staff advised of the process at ward level; however, medicine related incidents were not routinely shared with the ward pharmacist and there was no evidence of the outcomes of incident review at ward level. During our discussions with medical and nursing staff on duty they had limited knowledge of a recent SAI, which had occurred. We were advised that all medicine related incidents were discussed at a medicines incident sub group of the Drugs and Therapeutic Committee with oversight from the Medicines Governance Committee. However, we were not assured of the process to share and implement any learning following Trust review.

Four areas for improvement have been made in relation to medicines management.

5.2.6 Infection Prevention Control (IPC)

We reviewed IPC arrangements in all three wards during this inspection.

We observed the standard of cleaning generally good throughout the three wards. However there was evidence of damaged fixture and fittings, walls and floors throughout the ward.

We examined the linen stores and noted them to be visibly clean**,** free from damage and linen was stored appropriately. Staff was knowledgeable in the management of soiled/contaminated linen. Clinical rooms, patient equipment and clinical waste were managed in accordance with Trust policy and procedures.

Hand washing facilities were available throughout wards and good hand hygiene practice was observed by all staff disciplines. However, we noticed that not all staff adhered to the Trust uniform policy.

During the inspection, we were informed that a decision had been made by senior management to remove all personal protective equipment (PPE) dispensers from all patient accessible ward areas due to risks identified in relation to patient self-harm. The removal of these dispensers was undertaken without consultation with the IPC team and presented a number of challenges with the timely access to PPE.

Records evidenced that water outlets within the ward were being flushed in line with the Trust water safety policy. We observed that flushing records for water outlets in en-suites were held in enclosed plastic poly pockets attached to walls.

Three areas for improvement have been made in relation to IPC.

5.2.7 Patient care and treatment

We reviewed how patients were supported with their physical and mental health care needs.

We found patients' physical health care needs were being appropriately assessed and managed and there were good liaison arrangements in place between the acute inpatients staff and their colleagues in Antrim Area Hospital (AAH).

However, consultants reported that there were some issues with receiving adequate paperwork/ information for patients being transferred back to the Tobernaveen wards from Antrim Area Hospital we were assured that this has been escalated within the Trust.

During our review of case notes, we observed timely onward referral to specialist services and regular input from the diabetic nurse specialist and the consultant specialising in supporting patients with eating disorders.

Tobernaveen lower had commenced a pilot to enhance a purposeful admission, known as the Purposeful Inpatient Admission (PIpA) model. The PIpA model is considered a new approach to managing a patient's journey from admission through to discharge which focuses on delivering care and treatment to the patient on a formulation of their needs. This model is designed to reduce the time patients remain in hospital and helps support them to leave as soon as they are well enough. The SMT informed us following completion of this pilot, the PipA model will be rolled out across all mental health admission wards within the Trust.

We were told by staff that completing the documentation required for the PIpA model was challenging and staff stated this was due to the insufficient use of computers. Staff also reported to us their concern that the model didn't allow the opportunity to record one to one therapeutic time with patients and without documented evidence they may be at risk of failing in their professional accountability. We acknowledged staff concerns and advised them to raise these issues with their line managers so that a solution can be found prior to PIpA being phased out to other wards. We also highlighted this at feedback to the SMT.

We reviewed therapeutic activities available to patients across all three wards. We found that each ward had an activity timetable scheduled and reports from patients, nursing and OT staff were positive in relation to access to both ward and non-ward based activities.

We reviewed patient care records and spoke to patients and staff. We found evidence that care delivery was person centred. Patients were provided with information and involved in decisions about their care and treatment. There was also evidence that staff sought consent before care delivery.

5.2.8 Records Management

We reviewed patient records and noted that there were different standards across the three wards. In TNU and TNC, care records were found to be satisfactory and contained all the necessary information.

In TNL, we found patient files to be disorganised and this made it difficult to follow a patient's journey from admission. We observed some patient files had not been updated to reflect their detention status. An area for improvement in relation to records management was made on previous inspections.

We found appropriate and regularly reviewed care plans in place for all patients. However we observed some templates were photocopied, of were poor quality and were difficult to read. We highlighted these findings to the Trust during feedback and recommended templates are updated and refreshed.

5.2.9 Patient Experience

We reviewed the management of complaints at ward level across all three wards. The management of informal complaints was inconsistent in all three wards.

Staff in TNU were recording and managing informal complaints in a timely way, however this process was not evident in TNC and TNL.

We reviewed a number of minutes of patient/staff meetings and noted that issues raised by patients, however we could not find any documented evidence that these issues had been resolved. Patient/staff meetings were not held on a consistent basis in any of the three wards.

We also asked to see the patient suggestion box. Staff on one ward did not know where the key was and had to search for it. When it was opened, there were a number of suggestions and complaints in the box, which were not responded to or actioned.

Information, that would inform patients and their relatives on the standard of care of care on the ward and patients views were not displayed on the ward.

An area for improvement has been made.

5.2.10 Governance and Leadership

We were notified of a number of Serious Adverse Incidents that had occurred involving patients who had been admitted to the Tobernaveen wards. We met with the SMT to discuss these. The SMT informed us that a system was in place for discussion and tracking SAI's but there was no robust mechanism in place to determine if recommendations and learning from these incidents had been implemented or sustained over a period of time. We were advised that this was the responsibility of the governance team.

We identified some learning was shared amongst the medical team through the medical governance meeting and through email correspondence. However this was not the practice amongst the remainder of the MDT.

We could not find evidence where any learning from SAIs or incidents had driven service improvements or even highlighted areas of good practice on each ward.

We found the governance oversight of incident management was insufficiently robust to capture and analyse incidents that occurred at ward level. We could not find evidence on any of the wards of any thematic review of incidents or service evaluation, relating to: safeguarding vulnerable referrals; incidents resulting in restrictive practices; incidents relating to patients going absent without leave (AWOL); incidents relating to medication errors; and times when the locked door policy was applied.

An area for improvement has been made.

6.0 Conclusion

Based on the inspection finding thirteen new areas for improvement were identified. Eleven were in relation to safe and effective care and two were in relation to the service being well-led. Details of these can be found in the Quality Improvement Plan.

Enforcement action resulted from the findings of this inspection. Two areas for improvement in relation to the management of incidents / accidents and ligature risks were escalated to serious concerns.

We requested the Trust submit an action plan to address these issues and were invited to attend a serious concerns meeting. At this meeting the Trust agreed to submit further action plans to RQIA to evidence that progress was being made. We will undertake a further unannounced inspection to assess this progress.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

	Standards
Total number of Areas for Improvement	13

Areas for improvement and details of the Quality Improvement Plan were discussed with representatives of the SMT and both ward managers as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action is required to ensure compliance with The Quality Standards for Health and Social Care DoH (March 2006)

Area for improvement 1 **Ref**: Standard 5.1 **Criteria:** 5.3.1 (c) **Stated:** First time **To be completed by:** 31 May 2019	The Northern health and Social Care Trust shall ensure 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. **Ref: 5.2.9**
	Response by registered person detailing the actions taken: The Trust has a policy in respect of children visiting the acute mental health units (Children Visiting an Adult Mental health Ward Policy NHSCT/19/1285). This policy indicates the following: For the purpose of these guidelines, children are defined as under 16 years. 1. An Adult must accompany all children visiting such a facility. 2. Children must remain within sight and control of the adult at all times. 3. Children who leave the vicinity of the adult should be directed to return to the adult or taken back to their responsible adult. 4. Responsible adults must be informed of their responsibility in maintaining control over visiting children. 5. Any concerns regarding a child visiting the facility should be discussed with the person in charge and any deviation from the above recorded with a clear rational and risk management plan. 6. Children who wish to visit a parent who have not a responsible adult to accompany them will be facilitated via interface with Social Worler, Children's services and or nursing. 7. Wards and units should provide a suitable area for Children to visit where supervision is made as easy as possible for the responsible adult with the child. Each of the wards have identified family rooms in operation and information on booking these is given to patients and their loved ones on admission in the form of an information leaflets. This forms part of the orientation to the ward for both

	staff and patients new to the ward. The family rooms across the wards are situated in different locations which all the teams will ensure this is always risk assessed against the activities and patient mix on the ward.
Area for improvement 2 **Ref**: Standard 5.1 Criteria: 5.3.2 (a) **Stated:** First time **To be completed by:** 23 January 2020	The Northern Health and Social Care Trust shall address the following issues in respect of the recognition and management of adverse incidents and ensure; • appropriate training is provided to staff to recognise and manage adverse incidents and near misses and record them appropriately in Datix; • there is a robust assurance mechanism that will identify data entry errors or omissions in a timely manner; • there is incident debriefs conducted following any significant incident; • that learning arising from the incident is shared across teams, wards and disciplines and services in a timely manner; • a robust assurance mechanism that will test the implementation of relevant learning is embedded in practice; • that potential new risks are taken into account when planning the actions required to address current risks; and • strengthen the current processes using data to analyse patterns and trends from incidents and near misses, to inform future planning. **Ref: 5.2.1**
	Response by registered person detailing the actions taken: Training on the use of Datixweb was provided and continues to be provided to staff by the divisional governance leads which helps staff to recognise and manage adverse incidents and near misses and record them appropriately on Datix. The Trust reviewed and increased the number of approvers to ensure timely review of incidents as well as introducing a weekly patient safety forum led by senior management, that reviews all incidents reported in the previous week to ensure accuracy of reporting and proper categorisation of the incident and risk grading. The Trust has established Daily Safety Briefings attended by acute inpatient wards and senior managers to ensure issues and risks are discussed as a service while also offering an opportunity to review and debrief these incidents. This also

	ensures that relevant steps are taken to identify early learning from significant incidents occurs but more importantly appropriate guidance is provided to all staff and adherence to Trust/regional Policies. The Trust has forums in which learning from significant incidents is shared across all teams and disciplines such as the six weekly Acute care Forum where all AHP disciplines are represented and the weekly senior nurse forum. Thematic academic afternoons have been set up to also share learning from recent incidents as well as safeguarding, SAIs and complaints. Periodic Audits to ensure that learning is embedded are now being conducted by the service managers and results shared with all senior staff. The Trust has also developed 'Topic of the month' posters as a mechanism of sharing learning from SAI investigations, learning letters and early alerts. The Trust has also developed a Divisional Governance Report that uses data to analyse patterns and trends from incidents and near misses, to inform future planning. This report is populated in the form of a booklet that is tabled at the Divisional governance meeting, after being approved there it is then cascaded down to service lines, through forums such as the Acute Care Forum, Senior Nurse meeting and individual ward business/staff meetings.

Area for improvement 3 **Ref**: Standard 4.1 Criteria: 4.3 (i) **Stated:** First time **To be completed by:** 31 March 2020	The Northern Health and Social Care Trust shall address the following issues in respect of managing ligature risks ensure; • an update and review of the ligature risk assessments for each ward is completed to ensure that relevant risk assessments accurately reflect the ligature points to include weight bearing capacity; • in conjunction with the Estates department, the identification of capital works required, associated costs and timescales for completion of the removal or replacement of ligature points is completed; • improved governance and assurance mechanisms at service manager level to identify, prioritise and manage risks through to completion; • an improved process to identify the status of and progression of minor capital works requested through to completion; and • the plans to strengthen the current assurance framework to ensure that the directorate governance team are updated with respect to ongoing risks. **Ref: 6.3.4**
	Response by registered person detailing the actions taken: In conjunction with Estates Services, the Trust identified ligature works required across all the wards along side associated costs and timescales for completion. Monthly meetings have been scheduled with Estates Services. This provides an improved process to monitor the status of capital works through to completion. A process to identify the status of and progression of minor capital works requested through to completion has been established with estates. Estates attend the Senior Nurse meeting with Service Managers on the last Tuesday of the month and go through each individual ward's minor works and ascertain it's status while giving feedback to the service manager and respective Ward Manager. The Trust has developed a Divisional Governance Report to strengthen the current assurance framework to ensure that the Divisional Governance Team are updated with respect to ongoing risks associated with ligatures and appropriate action taken. The Trust has also reviewed and updated the Ligature Risk Assessment Tool to ensure that relevant risk assessments accurately reflect the ligature points of weight bearing capacity.

Area for improvement 4 **Ref:** Standard 5.1 Criteria: 5.3.1 (c) **Stated:** First time **To be completed by:** 23 August 2019	The Northern Health and Social Care Trust shall ensure: • staff's knowledge and training in respect of safeguarding is embedded into practice; • front line staff implement immediate protection plans for those patients for whom a safeguarding referral has been made; and • the patient's notes detail the follow-up action taken following a referral. **Ref: 5.2.3**
	Response by registered person detailing the actions taken: All staff attend Mandatory training in relation to Adult Safeguarding and Safeguarding Children. There is a monthly table collated and forwarded to Nursing Service Managers for information and address any outstanding training deficits and raise with respective Ward Managers. Safeguarding has also been cooperated into the weekly seniors meeting as a standing agenda item whereby any recent Safeguarding incidents are discussed, protection plans reviewed and actions taken to address any deficits. Safeguarding has also been added as a topic for the academic afternoons to share learning from recent safeguarding incidents. Service Managers conduct periodic audits of case notes to review record keeping and actions plans from recent safeguarding incidents.

Area for improvement 5 **Ref**: Standard 4.1 Criteria: 4.3 (i) **Stated:** First time **To be completed by:** 23 November 2019	The Northern Health and Social Care Trust shall ensure; • each ward has an up-to-date fire risk assessment completed • items that require addressed are actioned and recorded when completed, by whom and by what date. • appropriate governance of the adherence to the fire policy in respect of: fire doors remaining closed and weekly fire alarms are conducted; and • all staff know where to locate the fire grab box and are familiar with what it should include and that all contents and the information contained within it is in date and correct. **Ref: 5.2.2**
	Response by registered person detailing the actions taken: Fire Officer complete yearly fire risk assessments and update the designated lead wardens for each ward. Fire wardens and fire officers in each ward audit the fire risk assessment and address any areas that require action.This is recorded in the Fire Log which is held on ward. Fire alarm tests are completed on a weekly basis and this is recorded on the fire log which is monitored by ward managers. All staff have been shown where the Grab box is on their wards and advised of its content. This information is also shared at new start inductions. The information on the Grab box has been updated to ensure all staff know of location and contents and reflect the recommendation above. Service Managers and Fire Officers conduct unannounced walk arounds to ensure that fire doors are being kept clear of obstructions.

Area for improvement 6 **Ref**: Standard 5.1 Criteria: 5.3.1 (f) **Stated:** First time **To be completed by:** 23 November 2019	The Northern Health and Social Care Trust shall address the following issues in respect of medicine management and ensure; • all medical records are legible and easy to read; • ensure that the indication for when PRN medication is used is recorded identifying first and second line medication, the reason for it and whether or not the administration had the desired outcome; and • there is a system in place to check the prescribing during a patients stay on the ward in relation to rewriting kardexes, prescribing new medicines and making changes to dosages in medicines. **Ref: 5.2.5**
	Response by registered person detailing the actions taken: Following an SAI recommendaion, all drug kardexes, are written in print by the prescibing Doctor. PRN medication usage is audited by the Ward Manager. PRN medication is recorded in the patients progress records,this will include detail, why PRN was used and if it had the desired effect,or not. These records form part of the audit trail to ensure compliance with this recommendation. Re-written kardexs are now checked by two practitioners to ensure that there is no errors in prescribing. Pharmacy reconcillation is completed by the pharmacist, on patient admission and discharge. There remains a resource issue in availability for pharmacy input. A business case has been forwarded for incresesd pharmacy input into the wards.

Area for improvement 7 **Ref**: Standard 5.1 Criteria: 5.3.1 (f) **Stated:** First time **To be completed by:** 23 November 2019	The Northern Health and Social Care Trust shall address the following issues in respect of medicine management and ensure; • all medicines are stored in original or pharmacy containers; • there is a robust daily 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; and • access to emergency resuscitation bags are not delayed by locating the key to the treatment room; the contents of the bags are regularly inspected to take account of expired medicines and damaged packaging. **Ref: 5.2.5**
	Response by registered person detailing the actions taken: Pharmacy Technicians complete random checks to monitor that all medications are stored in original containers. they will report if there are any breaches to the nurse in charge and Lead Pharmacist. Fridge temperatures are recorded daily by nursing staff to ensure that this standard is met. The emergency resusitation bag is checked weekly to ensure that all contents are in date and intact. The emergency responder is identified at the start of each shift. They carry the emergency bleep and key to access the emergency bag.

Area for improvement 8 **Ref**: Standard 5.1 Criteria: 5.3.1 (f) **Stated:** First time **To be completed by:** 23 November 2019	The Northern Health and Social Care Trust shall address the following issues in respect of medicine management and ensure; • missed doses are reported as an incident; • medical and nursing staff have knowledge of all medicine related SAI's and there is recorded evidence of how learning is shared and implemented following discussion at the medicines incident sub group of the Drugs and Therapeutic Committee; and • medicine related incidents are routinely shared with the ward pharmacist and there is evidence of the outcomes of incident review maintained at ward level. **Ref: 5.2.5**
	Response by registered person detailing the actions taken: Missed doses have now clearly been defined to the staff to ensure that a reason is clearly indicated on the Kardex and in the patient's case notes why the medication was not given and any doses without a reason is classed as a missed dose and so an incident form should be completed to reflect the same. Ward managers have included this in their weekly audit of kardexs to ensure that any missed doses are then reported as incidents. There is also a Mental Health Medicine committee meeting, which meets on a quarterly basis. Missed dose incident forms and other medication related incidents as well as SAI's on medication are discussed at this forum. This information and any learning is then shared at Acute Care Forum and weekly Seniors meeting.

Area for improvement 9 **Ref**: Standard 4.1 Criteria: 4.3 (b) **Stated:** First time **To be completed by:** 23 November 2019	The Northern Health and Social Care Trust shall address the following issues in respect of medicine management and ensure; • the governance arrangements for medicines management are robust and include regular medicine management audits and outcomes. **Ref: 5.2.5**
	Response by registered person detailing the actions taken: Our pre-reg/pharmacy students each year will complete medication audits on a variety of issues such as PRN Px, Benzo Px, Lithium etc. In addition, the pharmacist completes adhoc audits on areas of concern- for e.g. discharge script audit, monitoring of Lithium or Clozapine etc In 2019 - POMHUK Audits on Prescribing in Depression and Monitoring of patients prescribed Lithium . It benchmarks the Trust against all other Trusts participating.
Area for improvement 10 **Ref**: Standard 5.1 Criteria: 5.3.1 (f) **Stated:** First time **To be completed by:** 23 November 2019	The Northern Health and Social Care Trust shall ensure; • immediate maintenance work is undertaken to improve the fixtures, fittings, walls and flooring and en-suite facilities in all Tobernaveen wards. **Ref: 5.2.2**
	Response by registered person detailing the actions taken: All maintenance work has been completed in each Tobernaveen. The works were raised with the Estates Action desk, who provided job numbers for completion. Monthly meetings are scheduled with Estates Services. This provides an improved process to monitor the status of estates works through to completion.

Area for improvement 11 **Ref**: Standard 5.1 Criteria: 5.3.1 (f) **Stated:** First time **To be completed by:** 23 August 2019	The Northern Health and Social Care Trust shall ensure; • an immediate risk assessment on the use of PPE and plastic material is carried out. This should be completed in conjunction with the IPC team in order to ensure the potential risks to patient safety are managed; and • an assurance system should be introduced to monitor action and reviewing patient safety, staff practice and risk assessment. **Ref: 5.2.6**
	Response by registered person detailing the actions taken: A risk assessment was completed in conjuntion with IPC colleagues and the agreed action was that PPE and plastic materials can still be used on a case by case basis following a risk assessment. Restricted items such as plastic bags are removed for patient safety. Plastic bin liners were replaced with paper liners as the direct result of an SAI. Each ward stores its plastic materials in designated locked area which only staff have access to. PPE is also stored behind locked doors and is on a portable trolley. Dani Centres were relocated to areas that could be easily accessed and monitored by staff to mitigate the risk of patients misusing the plastic materials within them. The information on restricted items is on display on each ward, and also in patient information leaflet. Datix is reviewed by Ward Managers, and incidents discussed at weekly Seniors meeting, this will include any that involve PPE or plastic materials.

Area for improvement 12 **Ref**: Standard 6.1 Criteria: 6.3.2 (g) **Stated:** First time **To be completed by:** 23 November 2019	The Northern Health and Social Care Trust shall ensure; • patients' overall experience is monitored and reviewed on the wards; • patient satisfaction surveys are completed; and patient forum meetings are held on the ward. • the outcomes of audits are displayed for patients' carers or members of the public visiting the ward to view; • there is information displayed in relation to patients' views of their care and treatment or their experience of the ward; and • use this information to help with service improvement in accordance with Personal and Public Involvement (PPI) Standards (March 2015). **Ref: 5.2.9**
	Response by registered person detailing the actions taken: Patient satisfaction is monitered by the MDT by 1:1 engagements, these are evidenced in ICP and records. Patient satisfaction survey is provided on discharge, these are returned to Ward Manager, they are held at ward level. Audits on incidents/ accidents, violence and aggression, falls, and absconding satistics are displayed on notice boards in wards. The staff /patient meetings held on each ward to discuss and identify areas for improvement were changed from monthly to weekly with actions from previous meetings discussed and agreed. The minutes of these meetings are also displayed in patient areas. Locally managed complaints and compliments with outcomes are also shared at this forum. Cards from service user/carer/ family are displayed at entrance to each ward. This information will be used to develop change initiatives within each ward. This new learning will then be discussed at Seniors meeting and shared at Acute Care Forum. An example of this is complaints received on menu choice. This was addressed and improvements were made to this area.

Area for improvement 13 **Ref**: Standard 5.1 Criteria 5.3.2 (a) **Stated:** First time **To be completed by:** 31 March 2020	The Northern Health and Social Care Trust shall ensure; • all SAI's are tracked to ensure actions identified in the action plan are implemented by the responsible owner and within the timeline identified; • a robust assurance mechanism is in place to capture, question and analyse incidents that occur at ward level; • that the process for disseminating learning from Serious Adverse Incident Investigations, learning letters and early alerts are working effectively; • a robust assurance mechanism is in place to test and determine if learning has been implemented and sustained over a period of time; and • key clinical service measures /reports in relation to incidents are evidenced. Examples should be recorded where these have driven service improvement or even highlighted areas of good practice on each ward. **Ref: 5.2.10**
	Response by registered person detailing the actions taken: The Trust has developed 'Topic of the month' posters as a mechanism of sharing learning from SAI investigations, learning letters and early alerts. Academic Afternoons have been established to share learning, reflect on practice and generate discussion across staff groups. Daily Safety Briefings are attended by acute inpatient wards to ensure issues and risks are discussed as a service and pressures are discussed. A Band 7 Governance Support Officer has been appointed to support the Divisional Governance Lead in following up on SAI action plans with identified responsible lead officers.The Governance lead is also responsible for ensuring that all SAIs are tracked and ensure that identified action plans are implemented by the responsible person within specified timelines as well as gathering all the evidence for same. The Divisional Safety & Quality Forum meeting which is conducted the first Wednesday of every month is were all learning and action plans from SAIs are tabled and approved for follow up actions, following this the Acute Care Forum which is conducted on a 6 weekly basis is were the approved actions are tabled and action operationalised via the Senior Nurse meeting which is weekly. Timeframes for implementation are agreed at this forum as well as lead officers being identified.

Please ensure this document is completed in full and returned via the Web Portal

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