The Regulation and Quality Improvement Authority

Tobernaveen Upper

Holywell Hospital

Northern Health and Social Care Trust

Unannounced Inspection Report

5 October 2015 – 9 October 2015

npm national preventive mechanism

informing and improving health and social care

www.rqia.org.uk

Ward Address: Tobernaveen Upper,
Holywell Hospital,
60 Steeple Road,
Antrim,
BT41 2RJ

Ward Manager:

Telephone No: 028 9441 3601

E-mail: team.mentalhealth@rqia.org.uk

RQIA Inspectors: Alan Guthrie and Dr S.M Rea

Telephone No: 028 9051 7500

Our Vision, Purpose and Values

Vision

To be a driving force for improvement in the quality of health and social care in Northern Ireland

Purpose
The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

Values
RQIA has a shared set of values that define our culture, and capture what we do when we are at our best:

- **Independence** - upholding our independence as a regulator
- **Inclusiveness** - promoting public involvement and building effective partnerships - internally and externally
- **Integrity** - being honest, open, fair and transparent in all our dealings with our stakeholders
- **Accountability** - being accountable and taking responsibility for our actions
- **Professionalism** - providing professional, effective and efficient services in all aspects of our work - internally and externally
- **Effectiveness** - being an effective and progressive regulator - forward-facing, outward-looking and constantly seeking to develop and improve our services

This comes together in RQIA's Culture Charter, which sets out the behaviours that are expected when employees are living our values in their everyday work.

Contents

1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

RQIA's programmes of inspection, review and monitoring of mental health legislation focus on three specific and important questions:

Is Care Safe?

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

Is Care Effective?

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

Is Care Compassionate?

- Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support

2.0 Inspection Outcomes

This inspection focussed on the theme of Person Centred Care.

Person Centred Care

This means that patients are treated as individuals, with the care and treatment provided to them based around their specific needs and choices. On this occasion Tobernaveen Upper has achieved the following levels of compliance:

Is Care Safe?	**Partially met**
Is Care Effective?	**Partially met**
Is Care Compassionate?	**Met**

3.0 What happens on Inspection

What did the inspector do?

- looked at information sent to RQIA before the inspection
- talked to patients, carers and staff
- observed staff practice on the days of the inspection
- looked at other documentation on the days of the inspection
- checked on what the ward had done to improve since the last inspection

At the end of the inspection the inspector:

- discussed the inspection findings with staff
- agreed any improvements that are required

After the inspection the ward staff will:

- send an improvement plan to RQIA to describe the actions they will take to make the necessary improvements
- send regular update reports to RQIA for the inspector to review

4.0 About the Ward

Tobernaveen Upper is a 24 bedded admission ward situated within the Holywell hospital site. The purpose of the ward is to provide care and treatment to patients with acute mental illness.

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

On the day of the unannounced inspection there were seven patients detained in accordance with the Mental Health (Northern Ireland) Order 1986. Two patients were receiving enhanced one to one nursing care.

5.0 Summary

5.1 What patients, carers and staff told inspectors

During the inspection inspectors met with six patients. Four patients completed questionnaires. Each of the patients who met with inspectors reflected that their experience of the ward had been positive. Patients stated that they felt safe and secure on the ward and they had been involved in planning their care and treatment plans.

Two patients reflected that they felt activities on the ward did not always happen in accordance to the activity plan. One patient reported that they were only

informed of results of assessments and investigations when they asked. The patient also stated they felt that staff did not always consider their views. Despite these concerns the patient felt the ward was helping them to recover and staff treated them with dignity and respect.

Patient comments included:

"*Being here gives me time to think";*

"I would like more occupational therapy on the ward";

"I feel I was in PICU (psychiatric intensive care unit) longer than I should have been";

"I couldn't rate the staff highly enough";

"The front door is not locked…that's a good feeling";

"There isn't a lot to do";

"I am very much involved in my care and treatment";

"The nurses chat to me every day;"

"You get plenty to eat";

"I like the way men and women are separated"

"The staff are very attentive";

"You're not forced to do anything".

During the inspection no patient representatives/relatives were available to meet with inspectors. Inspectors left a number of questionnaires with the ward manager to distribute to carers/relatives as required. One patient representative returned a questionnaire.

The relative commented that they felt all ward staff were accessible and available to speak to as required. The relative also reported that they had been offered the opportunity to be involved in decisions regarding the care and treatment of the patient

Inspectors met with ten members of the ward's multi-disciplinary team. Staff told inspectors that they felt the ward's multi-disciplinary team (MDT) was effective and worked well together. Staff reported that the ward was busy and provided care to patients presenting with a wide range of mental and physical health care needs.

Medical staff informed inspectors that there were challenges regarding the rota arrangements for junior doctors. Staff explained that the shift rotas from 5pm to 9pm and from 9pm onwards resulted in less continuity of direct ward based medical support. Concern was also expressed regarding the challenges of ensuring the required medical cover during periods of staff annual leave and study leave. It was positive to note that these issues were being discussed at the hospital's medical staff meetings and these concerns were being addressed by the trust.

Nursing staff reported that they felt the ward's MDT was supportive, considered the views and opinions of all staff and provided a good standard of care to patients. Staff reflected that staffing levels were good and any rota issues were addressed quickly. Nursing staff relayed no concerns regarding their ability to access supervision and training.

Staff comments included:

"This is a busy but good ward";

"I feel well supported and the MDT listens to me and I find the team to be approachable";

"It's really good here";

"Relationships and interactions with patients are good";

"My opinion is valued by other members of the team";

"The bed management meetings are really helpful";

"There is good cooperation between professionals working on this ward";

"Sometimes it can be difficult to get community mental health team staff to attend patient discharge meetings";

"It can be difficult to get time of the ward to complete letters, audits and other administrative tasks".

Patient experiences of the ward are reported in Appendix 2.

5.2 What inspectors saw during the inspection

Ward Environment

"A physical environment that is fit for purpose delivering a relaxed, comfortable, safe and predictable environment is essential to patient recovery and can be fostered through physical surroundings." Do the right thing: How to judge a good

ward. (Ten standards for adult-in-patient mental health care RCPSYCH June 2011)

Inspectors assessed the ward's physical environment using a ward observational tool and check list.

Summary

The ward was clean with good ventilation. The ward's atmosphere was relaxed and warm. There were a number of notice boards located throughout the ward and these displayed information relevant to patients and carers. Patients could access information regarding the advocacy service, the Trust's complaints procedure and the adult safeguarding procedures. The ward also supplied information in relation to Human Rights, the Mental Health (Northern Ireland) Order 1986 and the Mental Health Review Tribunal.

Patients could access sitting rooms, an activities room, a large lounge area and outside spaces. Inspectors noted that there were a large number of ligature points located within the ward. These included door fixtures, blinds, handles and other fixtures. Two ligature risk assessments had previously been completed. One had been completed in February 2014 and the other in August 2015. Inspectors noted that the assessments had been completed using different formats. Inspectors were concerned that a large number of ligature risks identified during the previous assessment completed in February 2014 remained in place. Inspectors were unable to evidence a proposed action plan and there was no evidence of the interim governance arrangements regarding the management of ligature points.

The ward promoted a least restrictive environment. This was evidenced through: the ward's front door remaining open; from reports provided by patients and from patient care records reviewed by inspectors. Patients who met with inspectors reported no concerns regarding the ward's regime. The ward's main patient areas were noted to be well maintained and continually accessible to patients. Patients could access the ward's dining area. The dining area was limited for space as it could only provide 17 settings at meal times despite there being 24 patients admitted to the ward. The trust had reviewed this issue and assessed that there was no short term solution and that provision of a new acute facility was the only viable option. Inspectors were informed that planning for a new facility was still ongoing.

Despite the limited space inspectors observed that the provision and protection of mealtimes was well managed. An inspector joined patients during two meals and noted that meals were staggered to ensure all patients received their meal. None of the patients who spoke to the inspector during mealtimes, reported any concerns regarding their ability to access the dining area. However, inspectors noted that the ward's kitchen, adjoining the dining area, retained two large machines which did not work and had been broken for significant periods of time. This included the ward's dishwasher and a chilling cabinet. The proposal to repair or replace both items was discussed at feedback.

During the inspection two patients were receiving enhanced observations. Nursing staff providing this level of support were observed positively engaging with patients and treating them with respect and dignity throughout the day.

The detailed findings from the ward environment observation are included in Appendix 3.

Observation

Effective and therapeutic communication and behaviour is a vitally important component of dignified care. The Quality of Interaction Schedule (QUIS) is a method of systematically observing and recording interactions whilst the inspector remains a non- participant. It aims to help evaluate the type of communication and the quality of communication that takes place on the ward between patients, staff, and visitors.

Inspectors completed direct observations using the QUIS tool during the inspection and assessed whether the quality of the interaction and communication was positive, basic, neutral, or negative.

Positive social (PS) - care and interaction over and beyond the basic care task demonstrating patient centred empathy, support, explanation and socialisation

Basic Care (BC) – care task carried out adequately but without elements of psychological support. It is the conversation necessary to get the job done.

Neutral – brief indifferent interactions

Negative – communication which is disregarding the patient's dignity and respect.

Summary

Observations of interactions between staff and patients/visitors were completed throughout the days of the inspection. Four interactions were recorded in this time period. The outcomes of these interactions were as follows:

Positive	Basic	Neutral	Negative
%	%	%	%
100	0	0	0

Inspectors observed interactions between staff and patients during each day of the inspection. Inspectors noted that interactions between staff and patients were friendly, informal and supportive. Staff were observed engaging with patients in a respectful, courteous and caring manner. Staff demonstrated a high level of competence including appropriate use of verbal and non-verbal communication skills. Inspectors noted staff to be available throughout the main ward areas and remaining proactive when engaging with patients.

Patients receiving enhanced observations appeared relaxed and at ease with staff members. Staff demonstrated understanding in relation to each patient's individual needs and responded to patients in a caring manner.

The findings from the observation session are included in Appendix 4.

5.3.1 Is Care Safe?

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

Compliance Level	**Partially met**

What the ward did well

✓ There were enough staff available during the inspection to meet the needs of the patients admitted to the ward.

✓ Patients' treatment and care plans focussed on patient's strengths. Care plans had been regularly reviewed.

✓ The multi-disciplinary team worked well together.

✓ Staff were provided with regular supervision and appraisal

✓ Patients were complementary regarding the care they received.

✓ Patients could access well maintained outside spaces.

✓ Patient's progress records were completed to a good standard.

Areas for improvement

- **Environmental safety**

X There were a number of ligature points within the ward. *Quality Standard 4.3(i)*

X Two kitchen appliances were broken and had not been repaired. *Quality Standard 5.1.1(f)*

- **Governance**

X A ligature risk assessment was available however, an adjoining timetabled action plan was not available during inspection. *Quality Standard 4.3(i)*

5.3.2 Is Care Effective?

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

Compliance Level	**Partially met**

What the ward did well

✓ Patients were involved in planning their care and treatment.

✓ Patient care was based on individualised and comprehensive assessment.

✓ Patients were encouraged to participate in their care and care was delivered by consent.

✓ The multi-disciplinary was effective and supportive.

✓ The ward provided care and treatment to patients with a wide range of complex needs.

✓ The ward provided a clean, open and least restrictive environment.

✓ Use of restrictive practice(s) was based on patients individually assessed needs.

Areas for improvement

- **Personal well-being plans**

X Two comprehensive risk assessments had not been completed in accordance to regional and trust policy and procedure. *Quality Standard 5.3.1 (a)*

- **Staffing**

X The senior management team had been unable to appoint a temporary occupational therapist. *Quality Standard 5.3.3 (d)*

- **Governance**

X The trust's locked door policy for open wards policy and the use of observation policy were out of date and required review. *Quality Standard 5.3.1 (c)*

5.3.3 Is Care Compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support

Compliance Level	**Met**

What the ward did well

✓ Patients and relatives reported no concerns regarding the care and treatment provided by the ward.

✓ Patients were complimentary regarding the attitude and caring nature of ward staff.

✓ Staff sought consent from patients prior to providing an intervention and acted in patients' best interests.

✓ Patients reported that they felt included in planning their care and treatment.

✓ The ward used a limited number of essential blanket restrictions.

✓ The multi-disciplinary team was effective and patient focussed.

Areas for improvement

Inspectors noted no areas for improvement in relation to compassionate care.

6.0 Follow up on Previous Inspection Recommendations

Six recommendations were made following the last inspection on 8 June 2015. The inspector was pleased to note that all six recommendations had been implemented in full.

See attached Appendix 1 for detail.

7.0 Other Areas Examined

No other areas were examined during the inspection.

8.0 Next steps

Areas for improvement are summarised below. The Trust, in conjunction with ward staff, should provide an improvement plan to RQIA detailing the actions to be taken to address the areas identified.

Area for Improvement		Timescale for implementation in full
Priority 1 recommendations		
	There are no recommendations requiring priority 1.	
Priority 2 recommendations		
1.	There were a number of ligature points on the ward.	14 December 2015
2.	Ligature risks identified within the ward did not include a clear plan as to how they would be managed to help ensure patient safety.	14 December 2015
3.	The ward's dishwasher and cooling cabinet located in the ward's kitchen were broken.	1 February 2016
4.	Two comprehensive risks assessment had not been completed in accordance to regional and trust standards.	14 December 2015
Priority 3 recommendations		
5.	The outcome of the ligature risk assessments completed in 2014 and 2015 had not been fully actioned completion of required works.	1 February 2016
6.	The procedures to appoint a temporary occupational therapist were not robust.	1 May 2016
7.	The trust's use of observation and locked door policy for open wards required review.	1 May 2016

Definitions for prority recommendations

PRIORTY	TIMESCALE FOR IMPLEMENTATION IN FULL
1	This can be anywhere from **24 hours to 4 weeks from the date of the inspection** – the specific date for implementation in full will be specified
2	Up to **3 months** from the date of the inspection
3	Up to **6 months** from the date of the inspection

Appendix 1 – Previous Recommendations

Appendix 2 – PEI Questionnaires

This document can be made available on request.

Appendix 3 – Ward Environmental Observation Tool

This document can be made available on request.

Appendix 4 – Quality of Interaction Schedule

This document can be made available on request.

Appendix 5 – Is Care Safe?

This document can be made available on request.

Appendix 6 - Is Care Effective?

This document can be made available on request.

Appendix 7 - Is Care Compassionate?

This document can be made available on request.

Appendix 1

Follow-up on recommendations made following the unannounced inspection on 8 June 2015

No.	Reference.	Recommendations	No of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	5.3.1.(a)	It is recommended that the ward manager ensures that all risk screening tools are completed in accordance with the Promoting Quality Care-Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services.	2	Inspectors reviewed four sets pf patient care records. Each set of records evidenced that each patient's risk screening tool had been completed in accordance with regional guidance. However, one set of patient records did not contain a comprehensive risk assessment despite the patient experiencing a serious attempt to self –harm during their admission. One comprehensive risk assessment was not signed and one comprehensive risk assessment was not completed.	Met
2	4.3 (i)	It is recommended that the trust update the environmental ligature risk assessment for the ward following the management and removal of profiling beds.	1	The ward's environmental ligature risk assessment had been updated. During the inspection it was noted that the ward retained one profiling bed for a patient who had physical health needs. The use of the bed had been risk assessed for the patient. The bed was being managed in accordance to the Trust's ligature risk assessment and associated ligature risk management plan.	Met
3	5.3.1(e)	It is recommended that the ward manager ensures that the corridor interlinking the ward to Tobernaveen centre remains clean and clutter free.	1	The corridor interlinking the ward to Tobernaveen centre was clean, clutter free and appropriately maintained.	Met
4	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	2	Inspectors reviewed four sets of patient care records. Multi-disciplinary zoning team meeting minutes contained within each record evidenced that all members of the team completed tasks delegated to them. In circumstances where a task was not achieved an explanation was provided.	Met

		this is not achieved an explanation should be clearly documented in the patient's notes.			
5	5.3.3.(f)	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.	2	Not assessed. The timeline for the implementation of this recommendation is the 31 December 2015.	Not assessed
6	6.3.2 (g)	It is recommended that the ward manager provides an opportunity for all patients to attend structured therapeutic/recreational activities which includes evenings and weekends. This should consider the individual needs and views of the patients.	2	Patients who met with inspectors reported varied experiences regarding their ability to access therapeutic/recreational activities, including activities in the evenings and at weekends. One patient reported that there was "nothing to do" whilst another patient explained that they could take part in activities but chose not to. All of the patients who met with inspectors detailed that activities available in the evenings and weekends were limited. It was good to note that the ward posted a weekly activity schedule recording the activities available each morning, afternoon and evening (including weekends). The ward's activity book recorded activities that had taken place. The activities book evidenced ongoing daily activities. The inspector was informed that activities were not always available	Met

				due to the necessity of nursing staff having to prioritise clinical interventions including supporting patients during their admission and discharge. Inspectors noted that the wards occupational therapist was on long term leave. Inspectors were concerned that interim arrangements were not meeting the needs of patients. This issue is discussed further in the main body of the report.	
7	5.3.1 (e)	It is recommended that the Trust reviews the ward's dining area and ensures that there is adequate space and seating to meet the needs of all patients admitted to the ward.	1	The trust had completed a review of the ward's dining area. This included the feasibility of moving the three large vending machines located in the dining area. Inspectors were informed that the ward's vending machines could not be moved as suitable alternative space was not available. The outcome of the trust's review concluded that extending the dining room was not a viable option due to building design. Subsequently, the ward would continue to provide two sittings to ensure all patients could access their meals in the dining area. It was positive to note that the provision of appropriate spacious dining areas had been incorporated in the Trust's outline business case for a new acute admissions mental health facility. Inspectors reviewed the ward's dining arrangements and spoke to patients regarding mealtime routines. Patients reported no concerns regarding their ability to access meals or to use the dining area. Inspectors observed the dining room during a lunchtime and teatime sitting. Inspectors noted no concerns regarding the management of mealtimes and patients ability to access the dining area.	Met

HSC Trust Improvement Plan

WARD NAME	Tobernaveen Upper	WARD MANAGER	Janette Acton	DATE OF INSPECTION	5 October 2015 – 9 October 2015
NAME(S) OF PERSON(S) COMPLETING THE IMPROVEMENT PLAN	Janette Acton and Rosie Mooney	NAME(S) OF PERSON(S) AUTHORISING THE IMPROVEMENT PLAN	Dr Tony Stevens		

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

The areas where improvement is required, as identified during this inspection visit, are detailed in the inspection report and improvement plan.

The completed improvement plan should be completed and returned to team.mentalhealth@rqia.org.uk from the HSC Trust approved e-mail address, by 27 November 2015.

Please password protect or redact information where required.

PRIORTY	TIMESCALE FOR IMPLEMENTATION IN FULL
1	This can be anywhere from **24 hours to 4 weeks from the date of the inspection** – the specific date for implementation in full will be specified
2	Up to **3 months** from the date of the inspection
3	Up to **6 months** from the date of the inspection

Part A

Priority 1: Please provide details of the actions taken by the Ward/Trust in the timeframe **immediately** after the inspection to address the areas identified as **Priority 1**.

Area identified for Improvement	Timescale for full implementation	Actions taken by Ward/Trust	Attached Supporting Evidence	Date completed
There were no priority 1 concerns				

Part B

Priority 2: Please provide details of the actions proposed by the Ward/Trust to address the areas identified for improvement. The timescale within which the improvement must be made has been set by RQIA.

Area identified for improvement	Timescale for improvement	Actions to be taken by Ward	Responsibility for implementation
Key Outcome Area – Is Care Safe? A ligature risk action plan was not available on the day of the inspection. **Minimum Standard 4.3 (i)** This area has been identified for improvement for the **first** time.	14 December 2015	The anti-ligature audit has been completed. A final meeting arranged for 26/11/15 is being held to formulate and prioritise an action plan to have this work completed. The final version of the action plan will be sent to RQIA by 14 December 2015.	Nursing Services Manager
There were a number of ligature points within the ward **Minimum Standard 4.3(i)** This area has been identified for	14 December 2015	The anti-ligature audit has been completed..	Estates Services / Nursing Services Manager / Head of Acute

improvement for the **first** time.			
Two Kitchen appliances were broken and had not repaired. ***Minimum Standards 5.1.1(f)*** This area has been identified for improvement for the **first** time.	11 January 2016	The dishwasher has now been condemned, in the interim a decision has been taken by the General Catering Manager that all dishes are to be transported to the main kitchen and returned to the ward. Catering service are to ensure there is ample supply of crockery available on the ward. The replacement of the dishwasher and fridge has been approved and will be delivered by 1 February 2016.	Catering Services and Ward Manager
Key Outcome Area – Is Care Effective? Two comprehensive risks assessment had not been completed in accordance with regional and trust standards **Minimum Standard 5.3.1 (a)** This area has been identified for improvement for the **first** time.	14 December 2015	The Comprehensive Risk Assessments have now been fully completed. The staff involved in the two assessments which were not completed have been spoken with directly.	MDT and Ward Manager

Part C

Priority 3: Please provide details of the actions proposed by the Ward/Trust to address the areas identified for improvement. The timescale within which the improvement must be made has been set by RQIA.

Area identified for improvement	Timescale for improvement	Actions to be taken by Ward	Responsibility for implementation
Key Outcome Area – Is Care Safe? The outcome of the ligature risk assessments completed in 2014 and 2015 had not been fully actioned. **Minimum Standard 4.3 (i)**	11 April 2016	A final meeting arranged for 26/11/15 is being held to formulate and prioritise an action plan to have this work completed. A copy will be forwarded to RQIA by 14 December 2015.	Estates and Nursing Services Manager

This area has been identified for improvement for the **first** time.			
Key Outcome Area – Is Care Effective? The procedures to appoint a temporary occupational therapist were not sufficiently robust. **Minimum Standard 5.3.3 (d)** This area has been identified for improvement for the **first** time.	11 April 2016	Procedure now in place for long term cover. OT in place on ward Monday - Thursday	Occupational Therapy Manager
The trust's use of observation and locked door policy for open wards required review. **Minimum Standard 5.3.1 (c)** This area has been identified for improvement for the **first** time.	11 April 2016	Both policies reviewed. The updated policies were shared with all staff and placed on the Trust's information and policy HUB.	Nursing Services Manager

Part D

Outstanding Recommendations: Please provide details of the actions proposed by the Ward/Trust to address outstanding recommendations, identified at previous inspections. The timescale within which the improvement must be made has been set by RQIA.

Recommendation	Timescale for improvement	Actions to be taken by Ward	Responsibility for implementation
There were no outstanding recommendations.			

TO BE COMPLETED BY RQIA

Inspector comment (delete as appropriate)	Inspector Name	Date
I have reviewed the Trust Improvement Plan and I am satisfied with the proposed actions or ~~I have reviewed the Trust Improvement Plan and I have~~ requested further information	Alan Gowrie	15/12/2015
I have reviewed additional information from the Trust and I am satisfied with the proposed actions	Alan Gowrie	15/12/2015.