The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Tobernaveen Upper, Holywell Hospital

Northern Health and Social Care Trust

15 and 16 January 2015

national preventive mechanism

informing and improving health and social care

www.rqia.org.uk

Contents

1.0 General Information

Ward Name	Tobernaveen Upper, Holywell Hospital
Trust	Northern Health and Social Care Trust
Hospital Address	60 Steeple Road Antrim BT41 2QB
Ward Telephone number	028 94465211
Ward Manager	Janette Acton
Email address	manager.tnu@northerntrust.hscni.net
Person in charge on day of inspection	Janette Acton – Ward Sister
Category of Care	Acute Mental Health Inpatient
Date of last inspection and inspection type	Patient Experience Interviews - 21 May 2014
Name of inspector	Kieran McCormick

2.0 Ward profile

Tobernaveen Upper is a 24 bedded admission ward set within the grounds of Holywell Hospital. The purpose of the ward is to provide assessment and treatment to adult male and female patients who require care and treatment in an acute psychiatric environment. Tobernaveen Upper is the designated ward within the Northern Health and Social Care Trust that can facilitate the admission of young people under the age of 18 in an emergency situation only. On the days of inspection there were no young people on the ward. Patient sleeping accommodation is provided in two and three bedded dormitories and single bedrooms. The ward maintains an open door policy; on the days of inspection the main entrance doors to the ward were open.

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

The inspector noted the ward was welcoming. The ward was well lit, well maintained, clean and fresh smelling. There were separate day spaces and dining areas for patients. Patients in Tobernaveen Upper receive input from a multidisciplinary team which incorporated psychiatry, nursing, occupational therapy and social work. A patient advocacy service was also available.

3.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Northern Ireland's health and social care services. RQIA was established under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to drive improvements for everyone using health and social care services. Additionally, RQIA is designated as one of the four Northern Ireland bodies that form part of the UK's National Preventive Mechanism (NPM). RQIA undertake a programme of regular visits to places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment, upholding the organisation's commitment to the United Nations Optional Protocol to the Convention Against Torture (OPCAT)**.**

3.1 Purpose and Aim of the Inspection

The purpose of the inspection was to ensure that the service was compliant with relevant legislation, minimum standards and good practice indicators and to consider whether the service provided was in accordance with the patients' assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

The aim of the inspection was to examine the policies, procedures, practices and monitoring arrangements for the provision of care and treatment, and to determine the ward's compliance with the following:

- The Mental Health (Northern Ireland) Order 1986;
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006
- The Human Rights Act 1998;
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003;
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

Other published standards which guide best practice may also be referenced during the inspection process.

3.2 Methodology

RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the inspection standards.

Prior to the inspection RQIA forwarded the associated inspection documentation to the Trust, which allowed the ward the opportunity to demonstrate its ability to deliver a service against best practice indicators. This included the assessment of the Trust's performance against an RQIA Compliance Scale, as outlined in Section 6.

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.
Specific methods/processes used in this inspection include the following:

- analysis of pre-inspection information;
- discussion with patients and/or representatives;
- discussion with multi-disciplinary staff and managers;
- examination of records;
- consultation with stakeholders;
- file audit; and
- evaluation and feedback.

Any other information received by RQIA about this service and the service delivery has also been considered by the inspector in preparing for this inspection.

The recommendations made during previous inspections were also assessed during this inspection to determine the Trust's progress towards compliance. A summary of these findings are included in section 4.0, and full details of these findings are included in Appendix 1.

An overall summary of the ward's performance against the human rights theme of Autonomy is in Section 5.0 and full details of the inspection findings are included in Appendix 2.

The inspector would like to thank the patients, staff and relatives for their cooperation throughout the inspection process.

4.0 Review of action plans/progress

An unannounced inspection of Tobernaveen Upper was undertaken on 15 and 16 January 2014.

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

The recommendations made following the last announced inspection on 10 December 2013 were evaluated. The inspector noted that seven recommendations had been fully met.

However, despite assurances from the Trust, one recommendation had not been fully implemented and will require to be restated for a **third time**, in the Quality Improvement Plan (QIP) accompanying this report.

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

The recommendations made following the patient experience interview inspection on 21 May 2014 were evaluated. The inspector was pleased to note that all recommendations had been fully met.

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

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

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

Two serious adverse incidents occurred on this ward on 1 January 2013 and 18 October 2013. Relevant recommendations made by the review team who investigated the incidents were evaluated during this inspection. It was good to note that compliance had been achieved in relation to two of the recommendations; three recommendations were not assessed. One recommendation had not been fully implemented.

5.0 Inspection Summary

Since the last inspection the ward has addressed a number of previous recommendations and implemented a number of positive changes. Patients on the ward had access to mobile phones provided by the ward, this allowed for contact with family and friends and the independence of having a conversation in private. The ward has also provided additional bedside storage space for all patients through the provision of double wardrobes. There was evidence of regular staff meetings and patient meetings. It was positive to note that patients meetings were chaired by the independent advocate. The inspector noted this had improved communication between the staff team and patients.

The following is a summary of the inspection findings in relation to the Human Rights indicator of Autonomy and represents the position on the ward on the days of the inspection.

On the days of the inspection the ward provided information displayed on posters and leaflets for patients and visitors in relation to complaints; independent advocacy services; keeping healthy; capacity; and consent; independent voluntary services; Mental Health (Northern Ireland) Order; Mental Health Review Tribunal; locked door procedures and ward visiting times. A ward information leaflet and suggestion box was also available for patients and relatives. Staff were familiar with how to access and utilise advocacy services.

The inspector observed discreet and respectful interaction between staff and patients, staff were responsive to patient's needs. During the course of the inspection the inspector observed a registered nurse spending 1-1 time discussing a discharge care plan with a patient who was being discharged.

Staff that met with the inspector confirmed their knowledge on capacity to consent and informed the inspector of the steps they took to ensure patients consented to care and treatment. Staff informed the inspector of how they would know if a patient was not consenting and the steps they would then take to assess understanding. This included staff respecting the patients' wishes and then returning to the patient again after a period of time to offer assistance. Staff advised they would also have a different member of staff speak with the patient. Ward staff who met with the inspector demonstrated their knowledge of patients' communication needs. Staff were familiar with individual patient needs, their likes, dislikes and choices.

The inspector reviewed three patients care records. Records evidenced an initial assessment completed upon admission by nursing and medical staff using the Integrated Care Pathway (ICP). Post completion of the initial assessment, the clinical team responsible for the patient's care create an interim care and treatment plan. In two of the patients' files reviewed the interim care plan had been appropriately completed and signed however in the other file the care plan had not been signed by all parties. A recommendation has been made in relation to this.

Each patient had a number of care plans in place however the care plans had been created using a standard generic format; care plans were not person centred or individualised. Although patient progress notes were contemporaneous there was no evidence of consideration for consent within these or within patients' care plans. Staff had not been provided with a written plan for assessing a patient's capacity to consent or the actions to take if a patient was not consenting. Care plans reviewed evidence in some instances where patients had signed their care plan, where they had not signed an explanation for no signature was included; however this was not consistent in all files. There was also no evidence that patients who had been unable to sign their care plans, due to being unwell, had been afforded an opportunity at a later date to review their content and sign their care plan. A recommendation has been made in relation to this.

It was positive to note that a patient subject to detention had a detention care plan in place. There was evidence that restrictive practice care plans were in place for patients subject to specific restrictions, such as enhanced observations. Care plans however did not provide an individualised management plan for the restriction in place. Of the care files reviewed the inspector was provided with no evidence that patients care plans were reviewed weekly as indicated on the documentation. There was no assessment of whether or not the actions specified in the care plan were effective or if they required amendment.

The inspector reviewed the care file for a patient whose first language was not English. The patient's records evidenced pro-active arrangements in place to promote the patient's involvement in their care. There was evidence that an interpreting service was regularly used, particularly during 1-1 consultations with the consultant. However there was no care plan in place regarding the patient's communication needs. A recommendation has been made in relation to this.

Training records for staff indicated that capacity, consent and human rights training had not been provided for ward staff. The ward manager and assistant nursing services manager stated that a programme of training was currently being rolled out. A recommendation has been made in relation to this.

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

indicated in a tick box that patients' human rights were considered. However there was no elaboration or descriptor of the specific actions taken to consider patients' individual human rights. A recommendation has been made in relation to this. Multi-disciplinary (MDT) notes evidenced the involvement of patients and relatives in the decision making process. Staff who met with the inspector, including the ward social worker, advised that daily zoning meetings are used to track patient progress and identify those nearing discharge.

In all three of the patients' files the Comprehensive Risk Screening tool was available with associated reviews. In two of the patients' files the inspector noted that risk screening tools were reviewed and 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 May 2010. However in one of the three files there was no indication provided as to the 'further action needed'. A recommendation has been made in relation to this.

Patient's individualised assessments and plans for therapeutic and recreational activity plans are completed by the ward Occupational Therapist (OT) following referral from a member of medical staff. Patients referred to OT have personalised daily schedules which they devise in conjunction with the OT department. Patient participation in activities was recorded in the OT daily progress notes. The ward has its own OT room. The OT and ward staff advised that access to the room is available at all times. There were entries detailed in the activity diary of ward based activities. This primarily involved 1-1 talking therapy with patients and in addition there was evidence in nursing progress notes of 1-1 nursing time spent with individual patients. One of the three patients who spoke with the inspector advised that it can be difficult to fill the day as there was little to do on the ward. There was no evidence of a ward based activity schedule for those patients who had not been referred to OT or who choose not to engage with the OT department. A recommendation has been made in relation to this.

The inspector observed that there were no ward based activities taking place during the course of the two day inspection. The OT also stated that off ward activities are primarily held within 'The Villa', which is a facility within the hospital grounds that facilitates recreational activities. Patients can access craft groups, woodwork, relaxation therapy, gym, computer classes, cooking classes, pool and board games.

The inspector was advised that patients in Tobernaveen Upper do not have access to inpatient psychology services. A recommendation has been made in relation to this. However, patients can be referred to psychology services but at present this was a community based service and therefore patients are only seen when discharged from the ward. Family and friends visiting Tobernaveen Upper are welcome onto the main ward; a private room was available for visits. Visitors were observed visiting the ward over the course of the two day inspection.

The inspector noted that a blanket restriction was in place regarding sharp items, including razors and scissors; these were removed from patients to help ensure the safety of everyone on the ward. The removal of these items was discussed in the patient information leaflet and patients could access these items as required and upon request to staff. Care documentation reviewed by the inspector did not demonstrate that the removal of items from patients had been discussed and recorded for each patient. A recommendation has been made in relation to this.

Three of the five relative questionnaires returned indicated they were aware of restrictive practices on the ward.

Training records reviewed evidenced that only 19 (63%) of the 30 staff working in Tobernaveen Upper had received up to date training in physical interventions. A recommendation has been made in relation to this.

Three ward staff interviewed by the inspector demonstrated their knowledge and understanding of the trust policy and procedure on the use of restrictive practices and were familiar with the Human Rights Act.

The inspector reviewed evidence of pro-active work undertaken to prepare patients for discharge. In one case this included comprehensive MDT involvement for a patient being received into guardianship on discharge. Evidence from MDT meeting minutes reflected the patient's views and involvement in choosing somewhere that they would like to live. The ward social worker advised that preparation for discharge commences early in the admission. The MDT will review the patient's history, complete any necessary capacity assessments, review the previous living arrangements and complete a Comprehensive MDT Assessment (CMA). Advice and guidance for staff on the planning for discharge of patients is included at the beginning of the ICP and also within the CMA. The ward manager advised that there were no patients on the ward who were delayed in their discharge from hospital.

The inspector met with three patients. The patients indicated that they had been involved in their care and treatment plans, multi-disciplinary meetings, one to one time with their primary nurse and consultant psychiatrist. Patients also expressed that they did not feel pressured into being discharged and felt their views had been considered throughout their inpatient stay so far. The inspector also met with a patient's relatives. The relatives stated that they had been kept informed and involved in their relative's care and treatment.

The inspector was advised that the independent advocate attends the ward as and when required and also chairs the monthly patients' meetings. Minutes of meetings reviewed evidence those in attendance and matters arising.

The inspector noted the atmosphere within the ward to be relaxed. Nursing staff were continually available and patients appeared at ease in their surroundings. Bedrooms and sleeping areas were not locked on the days of the inspection.

During the course of the inspection the inspector noted a number of additional concerns, these included, assessment of risk of ligature and staff training. Each of the matters of concern was discussed with the ward manager and with the Assistant Nursing Services manager; further details are included later in the report.

Details of the above findings are included in Appendix 2.

On this occasion Tobernaveen Upper has achieved an overall compliance level of **Substantially Complaint** in relation to the Human Rights inspection theme of “Autonomy”.

6.0 Consultation processes

During the course of the inspection, the inspector was able to meet with:

Patients	**3**
Ward Staff	**3**
Relatives	**3**
Other Ward Professionals	**4**
Advocates	**0**

Patients

The inspector met with three patients. Patients that met with the inspector spoke positively regarding time spent on the ward and also spoke positively of the ward sister and staff. The patients also confirmed their involvement in their care throughout their admission. Patients informed the inspector about their daily activities and involvement with OT. One patient expressed that it can be difficult to fill your day on the ward. Patients who met with the inspector were satisfied with the overall care they were receiving on the ward. Patients stated:

"I get great help"

"the staff do a brilliant job"

Relatives/Carers

The inspector met with three relatives. Relatives who met with the inspector spoke positively regarding the care and treatment delivered on the ward. Relatives were able to confirm that they had been involved in the decision making process and felt they were kept up to date with information. Relatives addressed a number of minor concerns with the inspector. These were brought to the attention of the nurse in charge who took immediate action to address these concerns. Relatives who met with the inspector were satisfied with the overall care provided. Relatives stated:

"the staff do a great job, they are all so friendly"

"the place is spotless"

Ward Staff

The inspector met with three nursing staff on the ward. All staff stated they felt well supported and that the ward manager was approachable. The staff stated that they felt the ward had a good working team and all felt equally

involved in the operations of the ward. Staff who spoke to the inspector expressed concerns regarding the upcoming loss of their ward social worker and that additional OT resources would be beneficial. Nursing staff stated that patients were well cared for and that all patients are treated as individuals.

Other Ward Professionals

The inspector met with three visiting ward professionals over the course of the two day inspection. Professionals that met with the inspector were able to provide an explanation as to their role and function within the ward. Professionals were also able to provide a summary of their perception of how the ward was performing.

The ward based Occupational Therapist (OT) explained they are employed full time however their time is split between Tobernaveen Upper and another ward on the hospital site. The OT provided a detailed overview of the recreational and therapeutic activities that take place on and off the ward, their involvement in the assessment process and the role they undertake in the discharge planning process. The OT spoke positively regarding the care and treatment delivered to patients on the ward.

The ward based Social Worker provided a detailed overview of their involvement in assessment and planning for discharge. The social worker advised that they were due to finish their post in the coming fortnight. This was discussed with the nursing services manager, who reassured that social work cover will be available from the redeployment of staff within the Trust. The Social Worker spoke positively regarding the care and treatment delivered to patients on the ward.

The Hospital Nurse Co-Ordinator met with the inspector and provided an explanation regarding their daily responsibilities for the hospital. This included the management of patient transfers, admissions and discharges. This service is provided on site 24 hours a day seven days a week. The nurse co-coordinator also acts as the senior out of hours nurse on site, for advice and guidance for ward staff.

Advocates

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

Questionnaires

Questionnaires were issued to staff, relatives/carers and other ward professionals in advance of the inspection. The responses from the questionnaires were used to inform the inspection process, and are included in inspection findings.

Questionnaires issued to	Number issued	Number returned
Ward Staff	20	10
Other Ward Professionals	5	3
Relatives/carers	23	5

Ward Staff

10 questionnaires were returned by ward staff

The inspector noted that information contained within the staff questionnaires demonstrated that only one member of staff was aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance. Five of the 10 staff members had received restrictive practice training and were aware of restrictive practices on the ward. Examples of restrictive practices as reported by staff included "1:1 observations", and "MAPA". Four of the 10 staff members indicated they had received training in the area of Human Rights. None of the 10 staff had received capacity to consent training.

It was observed that staff responded appropriately and promptly to patients' needs. All 10 staff members reported that patients had access to therapeutic and recreational activities and that these programmes meet the patients' needs, however not all patients choose to access OT services.

Concerns regarding gaps in staff training were highlighted to the ward manager and assistant nursing services manager, who agreed to review the deficiencies identified.

Other Ward Professionals

Three questionnaires were returned by ward professionals in advance of the inspection. It was noted that information contained within the professional's questionnaires demonstrated that only one of the three professionals was aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance. None of the three professionals had received training in restrictive practices. All three professionals indicated they had received training in the areas of human rights; two of the staff had received training on capacity to consent.

Two of the three ward professionals stated they had received training on meeting the needs of patients who require support with communication. All three staff indicated that patients' communication needs are recorded in their assessment and care plan. Professionals recorded that they were aware of alternative methods of communicating with patients. All professionals stated that these were used in the care setting and that the ward had processes in place to meet patients' individual communication needs. All three ward professionals reported that patients had access to therapeutic and recreational activities and that these programmes meet the patients' needs.

Relatives/carers

Five relative questionnaires were returned prior to the inspection. Relative's comments included:

"my daughter has been treated with the utmost care and respect"

"the care in Tobernaveen Upper has been excellent. Staff are polite, very friendly and happy to help me with any concerns I may have. If staff cannot help me they will get a doctor to contact me"

"there are male patients residing in the female section of the ward"

"staff should be more forthcoming with information"

Any concerns identified by relatives were discussed with the ward manager during the course of the inspection.

7.0 Additional matters examined/additional concerns noted

Complaints

Prior to the inspection RQIA received a record of the number of complaints made during the period of 1 April 2013 and 31 March 2014. The inspector reviewed the record of complaints held on the ward and, in discussion with the ward manager, clarified the details. The ward manager advised that all complaints had been fully investigated in accordance with policy and procedure and were now fully resolved. The ward manager advised that there were currently no complaints under investigation.

Adult Protection Investigations

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

The inspector was provided with an overview of 25 substantiated allegations. The ward social worker advised that there was one ongoing investigation, regarding a patient currently on the ward. The social worker advised that referrals for safeguarding investigation by ward staff were promptly completed and that protection plans were put in place.

Additional concerns noted

Under 18 Admissions

Tobernaveen Upper is the designated ward within the Northern Health and Social Care Trust for the admission of persons under the age of 18 who require inpatient mental health care. The inspector spoke with three members

of nursing staff who provided a detailed explanation regarding the process for accommodating a young person. The ward manager advised that the deputy ward manager is the Child and Adolescent Mental Health Service (CAMHS) link nurse for the ward. The inspector was advised that there were currently no young people on the ward. The inspector was advised that young people when admitted are reviewed by a CAMHS consultant and receive continued input from the community team. Staff advised that when admitted young people remain on continuous observation. Staff informed that young people do not receive education input whilst in Tobernaveen Upper. The inspector reviewed the child protection training for staff. The inspector noted concerns in relation to staff who have not completed child protection training. This was discussed with the ward manager and assistant nursing services manager, who agreed to review the deficiencies identified.

Training

The inspector reviewed the training records for 30 members of the staff team. The inspector was concerned to note a number of significant gaps in staff attendance at training, as detailed below:

Training Topic	NHSCT **required frequency** of training	Number of staff with a **recorded expired** training **date**	Number of staff with **no recorded date** of attendance at training	**Total number** of staff without recent training **from** an establishment of **30**
Management of Actual and Potential Aggression (MAPA)	Update annually	11	0	**11 (37%)**
Fire training	6 monthly update	22	1	**23 (77%)**
Cardio-pulmonary resuscitation (CPR)	Update annually	16	0	**16 (53%)**
Infection control	Update annually	10	4	**14 (47%)**
Moving and handling	Update 2 yearly	4	5	**9 (30%)**
Control of Substances Hazous to Health (COSHH)	Update 3 yearly	1	13	**14 (47%)**
Corporate safeguarding - Child protection	Update 3 yearly	0	22	**22 (73%)**

The training records were insufficient to assure the inspector that staff had the necessary skills and knowledge to fulfil their designated roles and responsibilities. The training records did not provide assurances that staff could respond appropriately to serious incidents such as, a fire, a medical emergency, an incident that involves behaviour which challenges staff, a fall, an outbreak of infection or child protection concerns. The concerns regarding training were brought to the attention of the ward manager and the Assistant Nursing Services Manager.

Care Plans

Tobernaveen Upper has been recommended on two previous occasions to implement individualised and person centred care plans. During the course of this inspection the inspector noted that care plans remain generic and do not consider patients individual needs. As a result of the recommendation not being met it will be restated again for a **third time**.
The inspector brought this concern to the attention of the ward manager and assistant nursing services manager. Both managers were advised by the inspector that due to the continued failure to comply with the recommendation this may warrant escalation proceedings. The managers were unable to provide the inspector a time frame in which this recommendation would be met.

Profiling beds

A serious adverse incident resulting in a fatality concerning the use of a profiling bed as a ligature point occurred in 2013. In December 2013 The Health and Social Care Board requested that all HSC Trusts take appropriate actions in accordance with The Northern Ireland Adverse Incident Centre Estates and Facilities Alert EFA/2010/006. The exposed bed frame on this profiling bed presents the same level of risk associated with ligature points as was the case when the fatality occurred.

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

The inspector reviewed the care file for a patient that was currently occupying one of the beds. The inspector noted that a care plan was in place for the use of the bed however there was no evidence that the care plan had been reviewed since it original creation. There was no other mention or rationale included in the patient's files for the use of the profiling bed. The matter was brought to the attention of the ward manager and the Assistant Nursing Services Manager. The assistant nursing services manager advised that following recent inspections of other acute wards on the site, the hospital management intended to proceed with the removal of profiling beds on this ward.

8.0 RQIA Compliance Scale Guidance

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable	Compliance with this criterion does not apply to this ward.	A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant	Compliance will not be demonstrated by the date of the inspection.	A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the inspection year.	In most situations this will result in a recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a recommendation, being made within the Inspection Report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and being made within the inspection report.

Appendix 1 – Follow up on Previous Recommendations

The details of follow up on previously made recommendations contained within this report are an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Appendix 2 – Inspection Findings

The Inspection Findings contained within this report is an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Contact Details
Telephone: 028 90517500
Email: Team.MentalHealth@rqia.org.uk

Appendix 1

Follow-up on restated recommendations made following the announced inspection on 10 December 2013

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensures that care-plans are person-centred and individualised. **(twice)**	The inspector reviewed three patients care records. Care plans contained with each file were not person centred or individualised. Care plans had been created using a generic format. The ward manager advised that there was a working group currently developing the introduction of person centred care plans.	**Not met**

Follow-up on recommendations made following the announced inspection on 10 December 2013

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	2 (37.7)	It is recommended that the ward manager ensures that everyone attending patients meetings signed the minutes.	The inspector reviewed the minutes of patients meetings. There was evidence that meetings were held monthly and facilitated by the advocate. Minutes of meetings recorded the names of those patients in attendance and matters arising.	**Fully met**
2	2 (4.14)	It is recommended that the ward manager ensures that the minutes of staff meetings are signed by all staff.	The inspector reviewed the minutes of staff meetings and daily briefing meetings. There was evidence that meetings were held monthly. Minutes of meetings recorded the names of those in attendance and matters arising. Minutes of monthly and daily briefing meetings had been signed by all those in attendance.	**Fully met**
3	2 (22.1)	It is recommended that the Trust ensures adequate seating is available to patients during meal-times.	The inspector observed the meal time routine on both days of the inspection. On each occasion there was ample seating to meet patients' needs. Patients and staff	**Fully met**

			expressed no concerns regarding the dining room facilities.	
4	17 A 6.3.2	It is recommended that the Trust ensures adequate storage for patient's belongings is provided.	A double wardrobe was provided at each patient's bedside. Patients who met with the inspector expressed no concerns regarding storage space.	**Fully met**
5	2 (18.1)	It is recommended that the ward manager ensures a risk assessment of the ward environment in relation to ligature points is carried out according to Trust policy.	The inspector was provided with a copy of the most recent 'Ligature Audit Tool' for the ward, completed in February 2014. The assistant nursing services manager stated that post completion of the audit tool an action plan is completed. They also stated that the audit is due to be undertaken again in February 2015.	**Fully met**
6	2 (22.3)	It is recommended that the Trust reviews the bedframes used on patients beds as they present as a ligature point for vulnerable patients.	A tour of the facility evidenced that the trust had progressed in the installation of anti-ligature beds throughout the ward. The completed ligature audit tool identified those beds where a ligature risk was prevalent. The inspector observed two profiling beds on the ward that were not compliant with recent guidance. The assistant nursing services manager had advised that these beds are going to be removed from the ward. A separate recommendation in relation to the profiling beds has been made.	**Fully met**
7	2 (18.1)	It is recommended that the ward manager ensures that patients clothing that have cords attached are risk assessed as they are a potential ligature point and pose a risk to patients	The ward manager stated that patient's identified as a risk at the point of admission are individually risk assessed. When patients property is being booked in on admission, if a piece of clothing with a cord is identified these are sent home with family or are locked away in the store. The ward manager advised that there were no patients on the ward at present that this concern applies to.	**Fully met**

Appendix 1

Follow-up on recommendations made following the patient experience interview inspection on 21 May 2014

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	6.3.2 (a)	It is recommended that the ward manager ensures that the ward's mobile phones for patient use are in working order and available for patients to use.	The inspector was shown four mobile phones that belong to the ward and that are for patient use. The ward manager explained the process of signing the phones in and out for use.	**Fully met**

Follow-up on recommendations made at the finance inspection on 2 January 2014

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensures that all items brought into the ward on admission that are removed by relatives are recorded. Record of receipt by the relative should be obtained.	The ward manager advised that the following recommendation had not been achieved.	**Not met**
2	It is recommended that the ward manager ensures that records are kept at ward level of the withdrawals made by patients from the cash office.	The inspector reviewed cash requisition forms. Requisition forms were signed and evidenced withdrawals from the cash office.	**Fully met**
3	It is recommended that the ward manager ensures that individual patient statements are received from the cash office in order to verify that transactions are correct.	The ward manager advised the inspector that at present they do not receive statements from the cash office. The ward manager has agreed to take this forward for immediate action.	**Not met**

Appendix 1

Follow up on the implementation of any recommendations made following the investigation of a Serious Adverse Incident

No.	SAI No	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	NT-SAI-13-04	It is important that the Trust takes all the reasonable steps to maintain a drug free environment in the hospital. To this end, it was recommended that mental health management team discuss with the PSNI a proactive approach which would discourage substance misuse or illicit substances being brought into the ward environment. This may include regular visits from the PSNI and search of the grounds.	The ward manager stated that a working group has been set up for the creation of the 'Drug Free Environment' policy and procedure. The ward manager advised that hospital management maintain regular contact with the Police Service of Northern Ireland (PSNI). The hospital has two identified Police Community Liaison Officers. The ward manager advised that the ward maintains links with voluntary services for advice and support and that the ward has two identified addictions link nurses. The ward manager and nursing staff advised that there were currently no concerns in relation to this matter on the ward.	**Fully met**
2	NT-SAI-13-97	Bed Management for the acute inpatient psychiatric wards must be safe, effective and equitable (and in line with regional bed management policy.)	The inspector met with the hospital nurse co-ordinator. The nurse co-ordinator stated that bed management meetings are held each Monday and are attended by all members of the multi-disciplinary team including senior hospital management. Additional bed management meetings are also held on a Wednesday and Friday. The nurse co-coordinator provided a comprehensive explanation regarding her daily responsibilities and management of patient transfers, admissions and	**Fully met**

			discharges, this service is provided on site 24 hours a day seven days a week. The nurse co-coordinator also acts as the senior on site nurse out of hours for advice and guidance for ward staff.	
3	NT-SAI-13-97	All case notes including ICPs must be completed in full.	The inspector identified a number of blank and incomplete records throughout each of the three patients care records reviewed. These concerns were brought to the attention of the ward manager and assistant nursing services manager.	**Not met**
4	NT-SAI-13-97	CRHTT referrals: From 9am-5pm Monday to Friday - If a CMHT decides that a referral to CRHTT is indicated for any of their patients (open to them) then must refer their own patients directly to CRHTT rather than delegate this referral to other services.	Not assessed.	**Not applicable to inspection**
5	NT-SAI-13-97	Urgent CMHT Case Discussions: If a CMHT patient is referred to acute care (Inpatient Unit or CRHTT) on 3 or more occasions in a 6 month period then CMHT Leader and Keyworker to arrange urgent CMHT case discussion to review the case and formulate a management plan – The level and format of that discussion (e.g. who should attend) will depend on the case and will be determined by the Team Leader and medical staff.	Not assessed.	**Not applicable to inspection**
6	NT-SAI-13-97	CMHT including consultant Physiatrist must seek guidance and support from the Northern Health and Social Care Addiction Team to support the management of patients physical and mental health and chaotic use of diazepam is identified.	Not assessed.	**Not applicable to inspection**

Quality Improvement Plan

Announced/Unannounced Inspection

Tobernaveen Upper, Holywell Hospital

15 and 16 January 2015

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with the ward manager and other hospital personnel on the day of the inspection visit.

It is the responsibility of the Trust to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	5.3.1 (a)	It is recommended that the ward manager ensures that care-plans are person-centred and individualised.	3	8 May 2015	Care Plans are now all individualised, person-centred and reflect recovery based principles.
2	5.3.1 (c)	It is recommended that the ward manager ensures that all items brought into the ward on admission that are removed by relatives are recorded. Record of receipt by the relative should be obtained.	2	5 June 2015	A notice has been placed on the patients 'information board requesting patients/ others to inform staff when removing items . All items removed by relatives/significant others with the patients consent are recorded. The integrated care pathway has been amended accordingly. Receipt for these items will be retained in the patients file and a copy will be given to the individual.
3	5.3.1 (c)	It is recommended that the ward manager ensures that individual patient statements are received from the cash office in order to	2	5 June 2015	Staff request accounts to provide a statement on receipt of cash for individual patients which if obtained is retained in the patients notes.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		verify that transactions are correct.			
4	5.3.1 (f)	It is recommended the ward manager ensures all case notes including Integrated Care Plans (ICP) are completed in full. All patient referral forms and multidisciplinary records should be signed by the relevant staff.	1	8 May 2015	ICP's audited monthly and staff instructed re completing documentation fully. MDT care plans are signed by those attending the Zoning meetings.
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.	1	6 July 2015	The Trust is working in collaboration with commissioners to secure funding and recruitment of a psychologist to provide ward based psychological input to acute care. Skills based training has been identified as a 3 year rolling programme through the course commissioning programme for nursing staff to include motivational interviewing, KUFF,WRAP, anxiety and depression self-help commissioning process
6	5.3.1 (a)	It is recommended that the ward manager ensures that a care plan is in place and regularly reviewed	1	8 May 2015	Care Plans now in place for all patients on the ward in relation to Deprivation of Liberty. These are discussed and signed when patients are

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		for any patient subject to any individual restriction, blanket restriction or deprivation of liberty. This should be discussed and agreed where possible with the patient and documented accordingly.			agreeable to same and are reviewed daily to ensure care is delivered using the least restrictive and appropriate option. .
7	5.3.1 (a)	It is recommended that the ward manager ensures that a person centred care plan in in place for all patients with an identified communication need.	1	8 May 2015	Care plans now in place for identified communication deficit.
8	8.3 (j)	It is recommended that the ward manager ensures that patient's assessments, care plans and continuous nursing notes are reflective of the patient's capacity to consent to care and treatment.	1	8 May 2015	ICP's assessments, care plans and notes now reflect patients' capacity and consent is obtained from the patient for all intervention and is recorded in the care plan and nursing notes. Issues regarding capacity are recorded and addressed at the relevant zoning meeting.
9	5.3.1 (a)	It recommended that the ward manager ensure that all patients care plans are reviewed as prescribed by the named nurse. Reviews of care plans should ensure that care plans are	1	8 May 2015	Care plans now have a specific review template which identifies the date as well as patient and nurse signatures . Care plans are reviewed with patients on a weekly basis or as often as necessary. The review is recorded in the running

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		evaluated and that the outcome of goals is being assessed.			recorded and is marked as review..
10	5.3.1 (a)	It is recommended that all members of the multi-disciplinary team, with delegated tasks following a Zoning meeting, ensure that tasks are completed. Where this is not achieved an explanation should be clearly documented in the patients notes.	1	Immediate and ongoing	Zoning forms are completed fully following zoning meetings and reviewed at the beginning of the next zoning meeting for the specific patient to ensure actions are completed. Any actions not completed are followed up with the delegated person and where necessary will be escalated to the appropriate lead i.e. ward manager, consultant NSM.
11	5.3.3 (b)	It is recommended that the ward manager ensures that patients previously unable to review their care plans are provided with an ongoing opportunity to review their care plans as their mental state improves. This should be recorded and/or signed by the patient.	1	Immediate and ongoing	As stated previously, new care plans now have a dedicated review template and nurses must ensure that they are signed and needs reviewed as necessary. Reviews will be discussed with the patient and repeated attempts will continue to gain the patients involvement as their mental state improves.
12	5.3.1 (a)	It is recommended that the ward manager ensures that patients' care plans reflect consideration of the Human Rights Act,	1	Immediate and ongoing	Care plans now reflect the Human Rights Act for those patients subject to restrictive practice and all care provided is discussed at zoning meetings to ensure the least restrictive and proportionate

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		particularly for those patients that are subject to any form of restrictive practice.			practice occurs.
13	4.3 (i)	It is recommended that the trust urgently review the continued use of profiling beds on the ward. The outcome of the review should be clearly reflected in the environmental and ligature risk assessment.	1	20 February 2015	All beds on the ward are now anti-ligature beds. No profiling beds remain.
14	4.3 (m)	It is recommended that the ward manager ensures that all staff complete up to date mandatory training which includes; fire awareness; moving and handling; management of behaviours that challenge; Cardio-pulmonary resuscitation (CPR); Infection control; Control of Substances Hazardous to Health (COSHH); and, Child Protection. The trust should also ensure that all ward based staff are provided with training in: Capacity and Consent; Restrictive Practices; Deprivation	1	5 June 2015	Mandatory Training is currently in process of being completed by all staff – Fire Training , MAPA, Manual Handling, CPR, Infection Control, Capacity and Consent, Deprivation of Liberty, Restrictive Practices, Human Rights – will all be 100% by all staff 20th March 2015. COSHH and Child Protection will be completed by end May 2015. Additional checks have been put in place to ensure mandatory training is completed by the due date.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		of Liberty; and, Human Rights.			
15	6.3.2 (g)	It is recommended that the ward manager provides an opportunity for structured recreational activity for those patients who do not avail of OT services; this should consider the individual needs and views of the patients.	1	5 June 2015	Structured Recreational Activity now takes place afternoons and evenings and weekends, except in circumstances where there may be medical or other emergency. This explanation is recorded, on the activity board.
16	5.3.1 (f)	It is recommended that the Trust ensures all policies and procedures are subject to a systematic and comprehensive three yearly review.	1	5 June 2015	The Trust Policy Group meet monthly to ensure all policies are reviewed within identified time scales.
17	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.	1	8 May 2015	All Risk Screening Tools reviewed weekly at zoning reviews and updated daily if necessary to reflect risks and update management plans as required..

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

NAME OF WARD MANAGER COMPLETING QIP	Sr Janette Acton
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Dr Tony Stevens

Inspector assessment of returned QIP		**Yes**	**No**	**Inspector**	**Date**
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Kieran McCormick	10/03/15
B.	Further information requested from provider		x	Kieran McCormick	10/03/15