Mental Health and Learning Disability Inpatient Inspection Report
24-25 July 2017

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

Northern Health and Social Care Trust

Tel No: 028 9441 3601

Inspectors: Audrey McLellan and Dr S. M. Rea

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Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of Service

Tobernaveen Upper is a 20 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 (MDT) which incorporates psychiatry, clinical psychology, nursing, occupational therapy, pharmacy and social work. An independent advocacy service is also available.

On the days of the unannounced inspection there were 19 patients on the ward. Four of these patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986. There were no patients receiving enhanced one to one observations and there were no patients delayed in their discharge from hospital.

3.0 Service Details

Responsible person: Tony Stevens
Ward manager: Janette Acton
Person in charge at the time of inspection: Janette Acton

4.0 Inspection Summary

An unannounced inspection took place over two days 24- 25 July 2017.

The inspection sought to assess progress with findings for improvement raised from the most recent previous unannounced inspection 5-9 October 2015. This inspection also assessed if Tobernaveen Upper Ward was well led.

Evidence of good practice was found in relation to the leadership within the ward. There was good oversight of mandatory training for staff and robust governance arrangements were in place to monitor incidents. It was also positive to note that the trust had employed a clinical psychologist who had provided training to staff on low level psychological interventions.

Areas requiring improvement were identified in relation to ongoing work which needed to be completed to remove environmental ligature points within the ward. Concerns were also raised regarding some of the medical records as a number were illegible or very difficult to read. There was no evidence that the ward was formally monitoring patient experience. Inspectors also evidenced that comprehensive risk assessments had not been completed in accordance with regional guidance and trust standards.

The ward environment was clean and tidy during the inspection and staff were available in the communal areas. Staff were observed sitting chatting to patients and encouraging them to participate in ward based activities. Patients appeared relaxed and comfortable in their surroundings.

Views of Patients

The inspectors spoke to four patients on the ward. Patients were generally complimentary about the care and treatment they were receiving. Patients confirmed they knew who to speak to if they were unhappy and that staff were always available for them to talk to. Patients stated they were involved in their care and treatment and they felt safe on the ward. One patient advised that they had been involved in an incident on the ward with another patient. The patient felt they had not been supported enough during the incident.

This was discussed with the ward manager who advised that they would review all the issues related to this incident with the patient involved. This patient also stated that they felt the ward ran more efficiently when the ward manager was on duty. They advised that one evening they had requested tea and toast from a staff member and they had refused this request. The ward manager agreed to discuss this with staff at the next ward manager's meeting. The ward manager assured inspectors that given the patient's presenting condition this should not have been refused.

Patients made the following comments:

"When the ward manager is on the ward the ward runs more efficient….the ward manager is good as she keeps everyone on their toes….and the food is good".

"The ward is run very well…….staff are all great on the ward, day and night…. Staff always have a smile on their face even when they are having a stressful time……Staff are friendly and caring…… I came onto the ward with no hope and I now have hope".

"Friendly ward, all staff are friendly and caring….I can't think of anything that could improve the ward".

"Friendly staff…psychiatrist is good… you can talk to them… food is good… I can't think of anything that could improve this ward".

Views of relatives

There were no relatives available to speak with the inspectors on the day of the inspection.

Views of staff

Inspectors spoke to five members of the multi-disciplinary team and two visiting professionals. Staff confirmed that they enjoyed working on the ward and stated they felt supported by the ward manager. Staff said the ward was safe and that the care and treatment was effective. Staff stated they had received up to date mandatory training and had up to date supervision and appraisals. However, the occupational therapist stated they had never received child protection training or safeguarding vulnerable adult training. An area of improvement has been made in relation to this.

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

4.1 Inspection Outcome

Total number of areas for improvement	Five

The total number of areas for improvement comprise:

- two areas for improvement restated for a second time
- three new areas for improvement

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

5.0 How we Inspect

The inspection was underpinned by:

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

The following areas were examined during the inspection:

- Care documentation in relation to four patients
- Ward environment
- Occupational therapy timetable
- Policies and procedures relating to the ward
- Incidents and accidents
- Complaints
- Health and Safety assessments and associated action plans
- Minutes of senior management meetings
- Supervision and appraisal records
- Staff duty rota
- Mandatory training records
- Minutes of ward manager meetings
- Medicine kardexes
- Clinical Psychology training plans/records

During the inspection the inspectors observed staff working practices and interactions with patients using a Quality of Interactions Schedule Tool (QUIS). All interactions observed between staff and patients were noted to be positive.

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

6.0 The Inspection

6.1 Review of Areas for Improvement from the Most Recent Inspection 5-9 October 2015

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

Areas for Improvement		Validation of Compliance
Number/Area 1 **Ref**: Standard 4.3(i) **Stated:** First Time	A ligature risk plan was not available on the day of the inspection.	**Met**
	Action taken as confirmed during the inspection: There was a ligature risk assessment and action plan available on the day of the inspection. This had been completed on 4 August 2017.	
Number/Area 2 **Ref**: Standard 4.3(i) **Stated:** First Time	There were a number of ligature points within the ward.	**Partially Met**
	Action taken as confirmed during the inspection: The ward had removed a substantial amount of ligature points throughout the ward which had been assessed as high risk. This included replacing all sinks, showers, toilets, blinds, and a number of door handles, window handles and curtain rails. However, there were still a number of environmental ligature points throughout the ward which the trust had identified within their ligature risk assessment. The trust are currently waiting on a works related timescale for when this will be	

	completed. The trust has confirmed that in the interim they will manage these risks locally on the ward. RQIA have requested the trust to provide progress reports regarding the completion of this work.	
Number/Area 3 **Ref**: Standard 5.1.1(f) **Stated:** First Time	Two kitchen appliances were broken and had not been repaired. **Action taken as confirmed during the inspection**: These items included a chilling cabinet which has been repaired and a dishwasher which has been replaced.	**Met**
Number/Area 4 **Ref**: Standard 5.3.1(a) **Stated:** First Time	Two comprehensive risk assessments had not been completed in accordance with regional and trust standards. **Action taken as confirmed during the inspection**: An inspector reviewed three comprehensive risk assessments. All three assessments had been reviewed weekly by the MDT however, the writing on the review sheet was illegible in a number of records. A new area of improvement will be made in relation to this. One risk assessment was due to be comprehensively reviewed by the MDT on May 2017 but this had not been completed (6 month review). One assessment had been comprehensively reviewed by the MDT on 11 July 2017. However, this information was completed in two different assessment forms therefore the risk management plan was unclear (6 month review). This area of improvement will be restated for a second time.	**Partially Met**

Number/Area 5 **Ref**: Standard 4.3(i) **Stated:** First Time	The outcome of the ligature risk assessment completed in 2014 and 2015 had not been fully actioned.	**Partially Met**
	Action taken as confirmed during the inspection: See response to area for improvement number 2. This area for improvement will be reworded and amalgamated with area for improvement number 2 in this report.	
Number/Area 6 **Ref**: Standard 5.3.3(d) **Stated:** First Time	The procedures to appoint a temporary occupational therapist were not sufficiently robust.	**Met**
	Action taken as confirmed during the inspection: The wards occupational therapist is now working fulltime on the ward and completing a variety of individual and group activities with patients.	
Number/Area 7 **Ref**: Standard 5.3.1(c) **Stated:** First Time	The trust's use of observation and locked door policy for open wards required review.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed these policies and there was evidence that both policies had been reviewed and updated. The Use of Observation and Therapeutic Engagement of Mental Health Inpatients in Holywell and Ross Thomson Unit had been review in January 2016 The Locking Doors to open Ward in Mental Health Settings had been reviewed in November 2015	

Follow-up on SAI recommendations on 8 August 2015

Areas for Improvement	
Number/Area 1	Acute admission wards should consider introducing trigger mechanism to help with the recognition and response to escalating/un-abating risk of self-harm in patients who are involved in multiple incidents.
	Action taken as confirmed during the inspection: • Ward staff now record all incidents involving patients in the patient's risk assessment. • When there have been a number of incidents that have involved risks to the patient or others the risk assessment is reviewed and updated i.e. incidents of self-harm, readmissions to the ward, escalation in behaviours that challenge. • Incidents are discussed each day at the wards 'zoning meetings' which can initiate a review of patients' risk management plans.
Number/Area 2	Consideration should be given to requesting specific input from the personality disorder team to help with confirming diagnosis of personality disorder and support with treatment and care planning.
	Action taken as confirmed during the inspection: • The personality disorder service has updated the ward staff on the process of completing a referral to this service so that consultation and support can be provided. • The referral process has been included in the acute operational policy.
Number/Area 3	The ward team should review how consistency is obtained when communicating to patients about the care and support they can expect to receive and ensure patient held written care plans are updated to reflect the agreed actions.
	Action taken as confirmed during the inspection: • Care plans are audited each month by the ward manager to ensure that patients' needs are reviewed and updated.

	• Care plans are discussed with patients and patients sign each care plan if they agree with the planned treatment.
Number/Area 4	Consideration should be given to acute wards teams undertaking awareness training in working effectively with people with personality disorders.
	Action taken as confirmed during the inspection: • The trust met with the personality disorder service to source MDT awareness training. • Focus workshops were held in September 2016 to agree strategies/appointment of clinical psychology to acute mental wards. • Bi-monthly personality disorder awareness raising talks were held and more in-depth courses have been commissioned and delivered by the Clinical Education Centre which staff have attended.
Number/Area 5 **Ref**: Standard 4.3(i) **Stated: First**/Second/Third Time	Consideration should be given to providing relatives with guidance on limiting potentially hazardous personal items brought into hospital.
	Action taken as confirmed during the inspection: • Posters are displayed on all wards to reinforce this with patients' relatives/carers/visitors.
Number/Area 6 **Ref**: Standard 5.3.3(d) **Stated: First**/Second/Third Time	Consideration should be given to reviewing the current camera monitoring arrangements in the vicinity of the acute admission wards to aid with the searching for patients who abscond.
	Action taken as confirmed during the inspection: • A review of the cameras was completed by the trust. One camera was moved to ensure staff have the best view outside the ward and staff have been informed to be extra vigilant at the entrance to the ward.

7.0 Review of Findings

7.4 Is the Service Well Led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

Areas of Good Practice

All staff who spoke to the inspectors knew what actions to take if they had concerns regarding the care and treatment of patients on the ward.

The ward had pharmacy support on a weekly basis. The pharmacist completed medication reconciliation, spoke to patients about their medication and completed quarterly controlled drug audits.

Policies and procedures relating to the ward were up to date.

Mandatory training records for nursing staff were up to date with dates arranged for staff that needed their training updated in the coming months.

Staff had completed their supervision and appraisal in accordance to professional and trust standards.

There was evidence that complaints were dealt with in accordance with trust policy.

There were appropriate systems in place to record and report incidents, accidents and serious adverse incidents. There was evidence that learning from incidents was cascaded down to staff via the ward manager's meetings.

There were governance arrangements in place to monitor admissions, discharges, patients' average length of stay on the ward and over occupancy.

The consultant psychiatrist was well support by management and attended regular clinical governance meetings attended by the clinical lead and clinical director.

There was a defined organisational and management structure in place and all staff who spoke to the inspectors confirmed they are aware of this structure and reporting mechanisms.

Staff who met with inspectors reported that the MDT worked well together and that the opinions and views of all staff were considered.

Medicine kardexes reviewed by inspectors evidenced that medication was prescribed within British National Formulary (BNF) guidelines.

It was good to note the appointment of a clinical psychologist to the MDT. The psychologist had provided extra training for ward staff in relation to the following subjects;

- Managing behaviours that challenge,
- Assessment of behaviours that challenge,
- Behavioural activation : Helping yourself to get on top of low mood,
- Emotional coping Skills : self- soothing, distraction, the effect of trauma on emotions, mindfulness, relax 'safe place',
- Compassionate focused approach,
- Emotional focused formulation,
- Making sense of a CRISIS.

The trust had recruited a peer support worker who assisted patients with raising concerns and ensured these were taken on board and dealt with in a timely manner. They also assisted patients in completing wellness recovery action plans (WRAPS).

Areas for Improvement

The occupational therapist had not received training in child protection and safeguarding vulnerable adults.

There was no evidence that patients' overall experience was formally monitored and reviewed on the ward. There were no patient satisfaction surveys completed and patient forum meetings were not held on the ward.

There were a number of records completed by medical staff that were illegible or very difficult to read.

Number of areas for improvement	Three

8.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed at feedback, as part of the inspection process. The timescales commence from the date of inspection.

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

8.1 Actions to be taken by the Service

The QIP should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed provider compliance plan to Team.MentalHealth@rqia.org.uk for assessment by the inspector by 19 September 2017.

Quality Improvement Plan Tobernaveen Upper	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** Standard 4.3 (i) **Stated:** Second time **To be completed by:** 25 August 2017	Comprehensive risk assessments had not been completed in accordance with regional and trust standards.
	Response by responsible person detailing the actions taken: Locality manager responsible for Community Mental Health teams was informed of the findings. Discussed RQIA inspection and findings re CRA's. Agreed need to adhere to policy and requirement for prompt update for clients. Also met with own ward team and emphasised need to monitor update dates and liaise with CMHT's to fulfil adherence to policy .Memo sent to CMHT's from locality manager also to advise all teams .
Area for Improvement No. 2 **Ref:** Standard 5.3.1(a) **Stated:** First time **To be completed by:** 25 August 2017	There were a number of records completed by medical staff that were illegible or very difficult to read.
	Response by responsible person detailing the actions taken: Medical staff were informed of the inspection findings and reminded of the legal and governance requirement for legible notes. Divisional Medical Director was informed and has sent communication to all medical staff Compliance will be monitored through documentation audits carried out on a quarterly basis, feedback and learning will be disseminated by way of the Acute Care Forum.
Area for Improvement No. 3 **Ref:** Standard 7.3 (b) **Stated:** First time **To be completed by:** 25 August 2017	There was no evidence that patients' overall experience was monitored and reviewed on the ward. There were no patient satisfaction surveys completed and patient forum meetings were not held on the ward.
	Response by responsible person detailing the actions taken: We have met with peer support team and user by experience consultant and are currently formulating a customer satisfaction questionnaire. Template will be available by mid-October .

Area for Improvement No. 4 **Ref:** Standard 4.1 (j) **Stated:** First time **To be completed by:** 25 October 2017	The occupational therapist had not received training in child protection and safeguarding vulnerable adults.
	Response by responsible person detailing the actions taken: Occupational Therapy Lead has been contacted by Ward Manager and asked that she enables all ward Occupational therapist to attend relevant training. O.T will apply for training and attend when next training date available. Ward Business meeting will also be used to audit compliance of training for all MDT members with a particular focus on new starters.
Area for Improvement No. 5 **Ref:** Standard 4.3 (i) **Stated:** Second Time **To be completed by:** 25 October 2017	An updated ligature risk assessment was completed on 4 August 2017 which confirmed that a number of ligature points have been removed. However, there were still a number of ligature points within the ward.
	Response by responsible person detailing the actions taken: The Ward Manager has liaised with Estate's Service manager and our nursing management. Further work orders have been escalated to meet the identified risks. Work currently being quoted for costing. Assistant director of mental health has authorised work as urgent. Estates are hoping to have works complete by end of November.

Name of person(s) completing the quality improvement plan	JANETTE ACTON		
Signature of person(s) completing the quality improvement plan		**Date completed**	13/09/17
Name of responsible person approving the quality improvement plan	DR TONY STEVENS - CHIEF EXECUTIVE		
Signature of responsible person approving the quality improvement plan		**Date approved**	20/9/17
Name of RQIA inspector assessing response	Audrey McLellan		
Signature of RQIA inspector assessing response	Audrey McLellan	**Date approved**	21/9/17

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