The Regulation and Quality Improvement Authority

# Brook Lodge

# Lakeview Hospital

# Western Health and Social Care Trust

# Unannounced Inspection Report

## Date of inspection: 7 – 11 September 2015

npm national preventive mechanism

**Ward Address**: Brook Lodge
Lakeview Hospital
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## 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 |
|---|

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 Brook has achieved the following levels of compliance:

| | |
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| **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:

- reviewed information sent to RQIA before the inspection
- talked to patients, carers and staff
- observed staff practice on the days of the inspection
- reviewed 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 trust and 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

Brook Lodge is a six bedded ward situated in Lakeview hospital. The purpose of the ward is to provide assessment and treatment to male and female patients with a learning disability who need to be supported in an acute psychiatric care environment.

On the days of the inspection there were six patients on the ward. None of the patients were detained under the Mental Health (Northern Ireland) Order 1986. There were two patients whose discharge from hospital was delayed.

Patients within Brook Lodge receive input from a multidisciplinary team which incorporates psychiatry and nursing. Patients can access clinical psychology, behaviour support, dietetics, podiatry, and speech and language services through referral. A patient advocacy service is also available.

The person in charge of the ward on the days of the inspection was the hospital manager.

## 5.0 Summary

### 5.1 What patients, carers and staff told inspectors

During the inspection patient representatives were asked to complete questionnaires.

Three patient representatives returned completed questionnaires.

Responses from carers were positive. Carers said they felt listened to and that all staff were approachable, accessible and available to speak to. Carers said they were involved in decisions about their relatives care, had been informed of a diagnosis and felt that their relative was getting better. Carers stated that they felt their relative's dignity and privacy was respected.

Two carers quoted the following;

*"The staff are excellent and I feel confident leaving my son in their care. I would like to see more activities available to patients but otherwise I am very happy with the care my son receives. The staff are very approachable and helpful."*

*"Staff have always been very helpful for X (X denotes the name of the patient) and always willing to meet his needs"*

During the inspection the inspector was able to meet with:

**1** Patient

**1** Carer
**5** Staff members

**The patient told inspectors that:**
They felt safe and they knew what to do if they felt unhappy. They knew who their doctor and named nurse was and felt they were being well cared for. The patient stated "*Me and X (X denotes the name of the staff nurse) get on the best. We have a good relationship. I like all the staff. I get one to one time with X. Anytime I ask to go out for a walk X takes me."*
The patient strongly indicated that being in hospital was helping them. The patient told inspectors that they go to meetings about them and felt like they were getting better. The patient said *"Staff tell me I am doing well."* The patient confirmed that staff take time to talk to them about their care and treatment plans. The patient stated "*Staff spoke to me about my medication and asked me if I agreed to take it."* The patient stated they were informed the ward door was locked and told the inspectors they felt "g*rand about this"* The patient indicated that staff had explained the reason why the door was locked and stated *"the door was locked in case someone goes out onto the road and they may be unwell and get knocked down."*
The patient said "*I am comfortable at night, I have my own TV and radio in my bedroom, the food is grand and there was nothing that would make the ward better"*

**The carers told inspectors that:**
The carer stated they were always involved in any decisions in relation to their relatives care and treatment. They felt staff listened to them and supported them as a carer. The carer stated that their relative was treated with dignity and respect and staff were very caring. The relative was concerned that there was not enough "day-care" on the ward. They also had the additional concern about the proposed placement in community for their relative. They said they were well supported by their community key worker in raising this concern.

**Staff told inspectors that:**
They felt supported by managers and had attended up to date supervision and appraisals. Staff were asked specifically about the incidents on the ward. Staff were familiar with the policy and procedure for addressing incidents; however staff were unaware of the number of incidents and the governance arrangements in place to review these incidents.

See attached Appendix 2.

## 5.2 What inspectors saw during the inspection

The ward environment was clean, clutter free and odours were neutral. Patients had their own bedrooms. Pictorial signage was available throughout the ward and helped patients to orientate themselves. There were three communal areas for patients to retreat to. Patients could meet with their visitors in their bedrooms.

The dining room was bright and spacious and there was ample seating for staff to support patients with their meals. There was open access to a well maintained garden area. Furnishings throughout the ward were well maintained.

The patient's charter; the wards philosophy of care; the date and time of the next patient forum meeting; advocacy services and how to make a complaint was all displayed. The ward had a large amount of easy read information available for patients. This included information in relation to Human Rights, the Mental Health (Northern Ireland) Order 1986, The Mental Health Review Tribunal and patients' right to accessing information held about them.

Information about the nursing staff on the ward was displayed along with their photographs. Information about who was on duty was not displayed. The ward manager explained this was not displayed because some patients can become fixated on this and this can become distressed. Activities available on the ward were displayed. Information about the multi-disciplinary team was not displayed. Details about which staff were allocated one to one time with patients was also not displayed.

The ward had a number of profiling beds and other areas that could be considered as a ligature risk, however the ward had an up to date ligature risk assessment and action plan in place to address this.

On the days of the inspection staffing levels were adequate to meet the needs of the patients. There were six patients on the ward, the number reduced during the day as patients went to day care. There were five staff and the ward manager on duty at all times during the inspection. One patient was in receipt of enhanced observations of one to one. Staff carried these out with dignity and respected the patients right to privacy.

Inspectors observed positive interactions between staff and patients. Staff were present and supervised the patients in the communal areas at all times during the inspection. Staff were skilled at communicating with patients who required support with their communication. Staff were also observed as attentive and responsive to patients nursing care needs and observed seeking consent before care delivery. Staff responded promptly to a patient who was displaying behaviours that were distressing. Staff quickly de-escalated the incident, and respected the patient's dignity and privacy.

Whilst the staff to patient ratio and supervision levels were high, inspectors did not observe much engagement between staff and patients. Other, than accompanying patients off ward to day care. Inspectors observed a total of two recreational activities over the days of the inspection. There was no evidence of any other recreational or therapeutic activities on the ward on the days of the inspection.

See attached Appendices 3 and 4.

## 5.3 Key outcomes

### 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

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|---|---|
| **Compliance Level** | **Partially met** |

See attached Appendix 5

### What the ward did well

- ✓ Staff had attended regular supervision meetings and received appraisals with their line manager in the last year.
- ✓ There were enough staff available during the inspection to meet the needs of the patients in the ward.
- ✓ All of the staff had attended up to date mandatory training to help them look after patients.
- ✓ An up to date ligature risk assessment and action plan was available for this ward.
- ✓ The ward was clean, clutter free and signage around the ward was good.
- ✓ Patients had access to safe outside spaces.
- ✓ Easy to read information in relation to patients' rights was available.
- ✓ Each patient had a safety plan in place, which evidenced patient and representative involvement.
- ✓ Safety plans were reviewed and were noted to be up to date.
- ✓ Patients and their representatives had been informed how to make a complaint.
- ✓ Staff responded promptly when help was needed.

## Areas for improvement

### Environmental safety

- ✘ The resuscitation trolley had not been checked in accordance with policy and procedure. *Quality Standard 5.3.1 (f)*

### Patient care

- ✘ None of the patients had a behaviour management plan in place to inform the actions on the safety plan. *Quality Standard 5.3.1 (a)*

- ✘ The safety plans were noted to be reactive, did not draw on personal strengths of the patients and were not enabling. *Quality Standard 5.3.1 (b)*

- ✘ There were a lot of medications prescribed as Pro Re Nata (PRN). There were no indications written, no minimum intervals indicated and there was no indication of which drugs should be used 1st line in the event that the indication for some different drug was the same. If used as prescribed patients would have received over the maximum 24-hour recommended dose recommended in the British National Formulary (BNF). *Quality Standard 5.3.1(f)*

### Staffing

- ✘ Average number of banking hours per week was 188 hours. *Quality Standard 4.3 (n)*

- ✘ Staff did not appear to have the necessary training to update their knowledge and skills in order to develop and implement preventative and proactive strategies to inform the action of patient's safety plans. *Quality Standard 5.3.3(d)*

### Governance

- ✘ There were 527 recorded incidents for the hospital with 362 incidents specific to Brook Lodge in one year. The majority of incidents were regarding patient to patient assaults. There was no evidence of robust trust governance mechanisms to review, analyse and learn from incidents. *Quality Standard 5.3.2 (a) (c)*

- ✘ Relevant information from clinical and social care governance meetings was not shared with ward staff. *Quality Standard 5.3.2 (c)*

✘ There was no mechanism for debriefing and learning from incidents at ward level. *Quality Standard 5.3.2(a) (c)*

## 5.3.2 Is Care Effective?

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

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|---|---|
| **Compliance Level** | Partially met |

See attached Appendix 6

## What the ward did well

- ✓ Patients and their carers knew who their doctor and named nurse was.
- ✓ Patients and their carers felt that being in hospital was helping them to get better.
- ✓ Staff told patients how they were progressing.
- ✓ Patients and their carers were involved and participated in their care and treatment plans.
- ✓ Care plans were individualised, person centred and holistic.
- ✓ Where appropriate patients had consented to their care and treatment plans.
- ✓ Since the last inspection two patients had been discharged and resettled into the community.
- ✓ Patients and their representatives were offered the opportunity to attend their weekly ward round.
- ✓ Discharge planning had commenced early and discharge care plans were in place.
- ✓ Patients had open access to an outside space and their bedrooms.
- ✓ The ward environment was enabling.
- ✓ Staff considered and clearly documented the human rights implications of any care and treatment.

✓ Staff made reasonable adjustments to help patients understand their care treatment. There was information available in an easy to read format.

## Areas for improvement

- **Personal well-being plans**

✘ Two of three files did not include treatment goals, safety goals, family & social goals, health and lifestyle goals and support recovery and /or maximise health and well-being. *Quality Standard 5.3.3(a)*

✘ Patients had not been appropriately referred to psychology services. *Quality Standard 5.3.3 (f)*

✘ There was no evidence of any psychological or therapeutic interventions by staff on the ward. *Quality Standard 5.3.3(f)*

✘ There was limited behaviour support for patients and guidance for staff. *Quality Standard 5.3.3(f)*

✘ None of the patients had a functional assessment of their behaviours completed. *Quality Standard 5.3.3(f)*

✘ There was evidence that high dose anti-psychotic medications were being prescribed for patients who were not suffering from psychotic illness. The medication was prescribed to manage challenging behaviour. In the absence of a behaviour support plan and psychological therapies this is not in keeping with NICE guidelines. *Quality Standard 5.3.3(f)*

✘ PRN medication was administered following incidents of challenging behaviour. Staff had not recorded the rationale for administration of the medication or its therapeutic effects. *Quality Standard 5.3.1(f)*

✘ Patients daily and PRN medication was not reviewed regularly in keeping with best practice. *Quality Standard 5.3.1(f)*

✘ There were few recorded contacts between the patients and consultant psychiatrist outside the ward rounds. *Quality Standard 5.3.1 (a)*

✘ There was no cross reference to the previous ward round or the person responsible for implementing the agreed actions and the timeframe in the ward round minutes. *Quality Standard 5.3.1 (a)*

- ✘ Recreational and therapeutic activity plans were not comprehensive. *Quality Standard 5.3.1 (a)*

- ✘ The door to the ward was locked and exit was controlled by staff, even though there was a high staff to patient ratio. *Quality Standard 5.3.1(a)*

- ✘ Due to the absence of functional behaviour assessments, behaviour management plans, and therapeutic interventions to address the needs of the patients, the restrictions experienced by the patients could not be viewed as proportionate, necessary and not as a last resort. *Quality Standard 5.3.1(a)*

## 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

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|---|---|
| **Compliance Level** | Met |

See attached Appendix 7

## What the ward did well

- ✓ Staff sought consent before every intervention.

- ✓ Staff had made reasonable adjustments by using available methods to assist independent decision making. Staff had documented when these methods were ineffective.

- ✓ On occasions where it was evident that patients had limited capacity to understand decisions about their care and treatment, there was evidence that their representative was consulted and involved in the decision making.

- ✓ Staff used each patient's preferred name.

- ✓ Patients and their carers felt listened to.

- ✓ Restrictive practices were explained to the patients and their carers.

- ✓ Staff respected patients right to refuse.

- ✓ Staff responded promptly and compassionately to patients who were in pain or distress.
- ✓ Staff respected patient's privacy.
- ✓ Patients and carers were complimentary about how they were being cared for.

## Areas for improvement

- ✘ Information about the multi-disciplinary team was not displayed on the ward for patients.
- ✘ Details about which staff were allocated 1:1 time with patients was not displayed.

## 6.0 Follow up on Previous Inspection Recommendations

Eight recommendations were made following the last inspection on 6 and 7 May 2015. The inspector was pleased to note that six recommendations had been implemented in full.
Two recommendations were not met and will be restated for a second time. These recommendations are in relation to the management of patient's finances and patient's not having access to a ward based occupational therapist. These recommendations will be transferred on to the Improvement Plan accompanying this report.

See attached Appendix 1

## 7.0 Other Areas Examined

## 7.1 Serious Concerns

RQIA wrote to the trust following the inspection on 17 September 2015. There were a number of concerns that needed to be addressed as a priority. The trust was asked to submit an action plan to RQIA by the 30th September 2015 to address the following;

- Governance arrangements for the review of incidents
- Learning from incidents
- Person centred assessment, care planning and the use of proactive strategies in response to behaviours that challenge
- Patient access to clinical psychology
- Leadership and lack of oversight of management.

The trust returned their action plan on 30th September 2015.

## 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 improvements** | | |
| 1 | The resuscitation trolley had not been checked in accordance with policy and procedure. | 11/12/15 |
| 2 | There were no robust trust governance mechanisms in place to review, analyse and learn from incidents. | 30/09/15 |
| 3 | Relevant information from clinical and social care governance meetings was not shared with ward staff. | 30/09/15 |
| 4 | There was no mechanism for debriefing and learning from incidents at ward level. | 30/09/15 |
| 5 | There were a lot of medications prescribed as Pro Re Nata (PRN). There were no indications written, no minimum intervals indicated and there was no indication of which drugs should be used 1st line in the event that the indication for some different drug was the same. | 30/09/15 |
| 6 | If PRN medications were used as prescribed the maximum in some cases would have been significantly over the 24-hour maximum recommended dose. | 11/09/15 |
| 7 | There was limited of review of patients daily and PRN medication. | 30/09/15 |
| **Priority 2 improvements** | | |
| 1 | Staff did not appear to have training to update their knowledge in relation to evidence based practice. Staff did not appear to have the necessary knowledge and skills to develop and implement preventative and proactive strategies to inform the action on patient's safety plans. | 11/12/15 |
| 2 | Patients had been prescribed medication that was not in keeping with NICE guidelines. | 11/10/2015 |
| 3 | All three of the patients reviewed did not have an evidenced based functional assessment of their behaviours and a subsequent behaviour management plan completed. This would have informed the actions recorded on the safety plan. | 11/12/15 |
| 4 | All three of the safety plans reviewed were noted to be reactive, did not draw on personal strengths of the | 11/12/15 |

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| | patients and were not enabling. | |
| 5 | Patients had not been appropriately referred to psychology and behaviour support services. | 30/09/15 |
| 6 | 2 out of 3 files reviewed did not include treatment goals, safety goals, family & social goals, health and lifestyle goals and support recovery and /or maximise health and well-being. | 11/12/15 |
| 7 | There was no evidence of the implementation any psychological therapeutic interventions by staff on the ward. | 11/12/15 |
| 8 | There was limited behaviour support for patients and guidance for staff. | 11/12/15 |
| 9 | Staff had not recorded the effectiveness of the PRN medication or had documented a clear rationale for its use every time the medication was administered. | 11/12/15 |
| 10 | Recreational and therapeutic activity plans were not comprehensive. | 11/12/15 |
| 11 | Due to the absence of functional behaviour assessments, behaviour management plans, and therapeutic interventions to address the needs of the patients, the restrictions experienced by the patients could not be viewed as proportionate, necessary and not used as a last resort. | 11/12/15 |
| 12 | Information about the multi-disciplinary team was not available for patients.<br><br>Details about which staff were allocated 1:1 time with patients was not displayed. | 11/12/15 |
| 13 | There was no cross reference to the previous ward round or the person responsible for implementing the agreed actions and the timeframe in the ward round minutes. | 11/12/15 |
| **Priority 3 improvements** | | |
| 1 | Average number of banking hours per week was 188 hours. | 11/03/16 |
| 2 | There were few recorded medical contacts between the patients and the consultant psychiatrist outside the ward rounds. | 11/03/16 |
| 3 | The door to the ward was locked and exit from the ward was controlled by staff, even though there were high staff to patient ratio. | 11/03/16 |

## Definitions for priority 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 announced inspection on 6 and 7 May 2015**

| No. | Reference. | Recommendations | Number of time stated | Action Taken (confirmed during this inspection) | Inspector's Validation of Compliance |
|---|---|---|---|---|---|
| 1 | Section 5.3.1(a) | It is recommended that the Ward Manager ensures that staff completing comprehensive risk screening tools and comprehensive risk assessments and management plans, do so in accordance with Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. | 2 | Inspectors reviewed the comprehensive risk screening tools, comprehensive risk assessments and management plans for three patients.<br>Inspectors noted that the documentation had been completed in accordance with Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010.<br>Where appropriate patients and / or their carers had signed the documentation.<br>The documentation was also signed by the staff member completing it, the hospital manager and the patient's consultant psychiatrist.<br>Inspectors also noted the documentation had been reviewed and up dated in accordance with the guidance. | Met |
| 2 | Section 5.3.1 (f) | It is recommended that the ward manager ensures that patient's monies are managed retained in the ward's safe is managed in accordance to Trust policy and procedure. | 1 | Inspectors reviewed the systems in place to manage patient's monies on the ward.<br>There were errors noted on one patient's ledger.<br>Inspector noted that on two occasions one patient had over £50 in the safe. This was not in keeping with trust policy and procedure.<br>Although a monthly audit of the contents of the safe had been completed. There was no audit completed of each patients recorded balance, against the money | Not met |

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| | | | | retained in the safe. There was also no audit of patient's ledgers to ensure these had been completed in accordance with trust policy and procedure. This recommendation will be restated a second time. | |
| 3 | Section 5.3.1 (e) | It is recommended that the Trust complete a ligature risk assessment of the ward. This should include a subsequent action plan to address any identified risks. Details of this action plan should be forwarded to RQIA by 31 July 2015. | 1 | The ward had an up to date ligature risk assessment and subsequent action that addressed identified risks. The risk assessment had been completed 15 June 2015. | Met |
| 4 | Section 5.3.1. (c ) | It is recommended that the Ward Manager ensures that updated training in the management of patients' finances is prioritised for all staff. | 3 | Inspectors were informed a training package had been developed by the hospital manager. The training package was available and reviewed by inspectors and included the trust policy and procedure on the management of patient's property.<br>Inspectors reviewed the record of attendees at the training. All staff were recorded as having attended the training.<br>The training was delivered by the hospital manager and deputy ward manager. | Met |
| 5 | Section 5.3.1 (a) | It is recommended that the Ward Manager ensures that all patients have an assessment of their therapeutic and social activity needs and an individualised therapeutic and social activity plan developed. | 2 | Inspectors reviewed care documentation in relation to three patients.<br>Each patient had an assessment of their therapeutic and social activity needs completed by nursing staff.<br>Each patient had an individualised therapeutic and social activity plan completed.<br>This recommendation has been met however further improvements are required in this indicator and will be included in the inspection report. | Met |

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| 6 | Section 5.3.3 | It is recommended that the Ward Manager ensures that each patient has a discharge pathway documented in their care plan. This should include definitive action plans, responsible person for their delivery and timescales. | 2 | Inspectors reviewed care documentation in relation to three patients.<br>A discharge pathway had been completed for each patient; these included definitive action plans, the responsible person for their delivery and timescales for completion. | Met |
| 7 | Section 5.3.3 (d) | It is recommended that the Trust ensures that patients can access ward based occupational therapy support. | 1 | Inspectors noted a letter was sent to the Assistant Director for Mental Health and Disability at the Health and Social Care Board (HSCB) on 24th July 2015 from assistant director Adult Learning Disability Services.<br>The letter requests support and assistance for a 1.0 WTE occupational therapist from the HSCB to address this recommendation as the trust does "not have a source of funding". | Not met |
| 8 | Section 5.3.3 (a) | It is recommended that the ward manager ensures that information in relation to the MDT, when the ward round is held, who is on duty and patients' named nurse/associate nurse is displayed. Information should also be displayed to assist in orientating patients to the day of the week, the date, when meals are held and what activities are available on the ward each day. | 1 | Inspectors completed a ward environmental checklist and noted the following information was displayed;<br>Information when the ward round is held and information about nursing staff which included their photographs.<br>Information orientating patients to the day of the week, and the available activities was also displayed.<br>This information was displayed in an easy to read format.<br>Further improvements on the available information will be included in the report. | Met |

# HSC Trust Improvement Plan

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|---|---|---|---|---|---|
| WARD NAME | Brook Lodge | WARD MANAGER | Lorraine Clarke | DATE OF INSPECTION | 7 September 2015 |
| NAME(S) OF PERSON(S) COMPLETING THE IMPROVEMENT PLAN | Lorraine Clarke | NAME(S) OF PERSON(S) AUTHORISING THE IMPROVEMENT PLAN | | | |

**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 28 October 2015.**

**Please password protect or redact information where required.**



| PRIORITY | 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 |
|---|---|---|---|---|
| ***Key Outcome Area – Is Care Safe?***<br><br>The resuscitation trolley had not been checked in accordance with policy and procedure.<br><br>**Minimum Standard 5.3.1 (f)**<br><br>This area has been identified for improvement for the **first** time. | 7 September 2015 | Completed | Enclosure 1 - copy of current resuscitation trolley checklist | 07.09.15 |

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| There was no evidence of trust governance mechanisms to review, analyse and learn from incidents.<br><br>**Minimum Standard 5.3.2 (a) (c)**<br><br>This area has been identified for improvement for the **first** time. | 30 September 2015 | Multi-disciplinary Incident Review Meetings were being held, involving the Consultant Psychiatrist, Hospital Manager and Head of Service.<br><br>Unfortunately involvement of a wider cohort of professionals, other than medical and nursing was difficult to obtain, as our community facing team has been recognised as being seriously depleted over the past year.<br><br>We do accept that summer meetings were missed due to annual leave of staff but wish to assure RQIA that a review of all Datix entries was undertaken by Risk Management and the Head of Service on a monthly basis. Minutes of such incident meetings held throughout 2014 to 2015 are available if required.<br><br>Minutes of the most recent meeting held (12th October 2015) are enclosed , involving the Consultant Psychiatrist, Hospital Manager and Head of Service.<br><br>All recent incidents were reviewed and trends considered for the following – perpetrator/victim trends as well as environmental impacts, times, use of PRN medication, and Mapa etc. Minutes are enclosed for reference | Enclosure 2 – Minutes of most recent Multi-Disciplinary Incident Review Meeting | 30.09.15 |

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| | | Overall analysis information was provided from Risk Management each month (details from which were previously sent) and was available to medical and Hospital Management for their information.<br><br>We do accept that the same information was not readily available for ward staff, or the minutes arising from Governance meetings held where incidents were discussed. Minutes from prior meetings were uploaded to a designated folder by the 30th September. | | |
| Relevant information from clinical and social care governance meetings was not shared with ward staff.<br><br>**Minimum Standard 5.3.2 (a) (c)**<br><br>This area has been identified for improvement for the **first** time. | 30 September 2015 | We accept we should have ensured all staff on the ward had better information available, relating to the analysis of incidents which had occurred in their respective settings.<br><br>We have remedied this and now ensure minutes of all meetings are available for staff at ward level and discussed at staff meetings. | Information available for review within Trust folders on site | 30.9.15 |

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| There was no mechanism in place for debriefing and learning from incidents at ward level.<br><br>**Minimum Standard 5.3.2 (a) (c)**<br><br>This area has been identified for improvement for the **first** time. | 30 September 2015 | We accept our frequency of debrief events and associated recorded learning outcomes could be improved.<br><br>We now monitor closely the debriefing opportunities provided by ward manager and nurses in charge, as well as the uptake by the relevant staff involved in any incident.<br><br>We will take remedial measures if we do not see a local improvement occurring. | Enclosure 3 - debrief form for completion – post Mapa intervention or serious event review.<br><br>Please also find enclosed a Managers Checklist developed to assist staff where a staff member may have been subject to a serious assault. | 30.9.15 |
| There were a lot of medications prescribed as Pro Re Nata (PRN). There were no indications written, no minimum intervals indicated and there was no indication of which drugs should be used 1st line in the event that the indication for some different drug was the same. | 11 September 2015 | The Medical team undertook a review of all inpatient medication kardexes and ensured all appropriate amendments which ensured contra-indications were noted, and which medication should be given as the 1st line of support, alongside maximum dosages per twenty four hour period. | Enclosure 4 – Anonymised updated Kardex | 11.9.15 |
| If PRN medications were used as prescribed patients would have received over the maximum 24-hour | 11 September 2015 | A monitoring form has been operationalised which allows audit of all administrations, with oversight of medical colleagues at least weekly | Enclosure 5 – New PRN monitoring form in use (anonymised) | 11.9.15 |

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| recommended dose as recommended in the British National Formulary (BNF).<br><br>There was limited review of patients daily and PRN medication.<br><br>**Minimum Standard 5.3.1 (f)**<br>This area has been identified for improvement for the **first** time. | 30 September 2015 | As above | | 11.9.15 |
| ***Key Outcome Area – Is Care Effective?***<br><br>None of the areas for improvement identified as a result of this inspection are required to be completed within this priority. | | | | |
| ***Key Outcome Area – Is Care Compassionate?***<br><br>None of the areas for improvement identified as a result of this inspection are required to be completed within this priority. | | | | |

**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 |
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| ***Key Outcome Area – Is Care Safe?***<br><br>Staff did not appear to have training to update their knowledge in relation to evidence based practice. Staff did not appear to have the necessary knowledge and skills to develop and implement preventative and proactive strategies to inform the action of patient's safety plans.<br><br>**Minimum Standard 5.3.3 (d)**<br><br>This area has been identified for improvement for the **first** time. | 11 December 2015 | All staff on the ward had participated in Management of Actual and Potential Aggression. This training provides composite overview and knowledge of the role of behaviours, the impact of the environment etc.<br><br>The roll out of Positive Behaviour Support training was planned for 2016/17. Following learning from the inspection, we now have in place a plan to roll this to all ward available before the 11th December 2015, with more detailed training rolling out next year.<br><br>We received NICE guidelines 101 and 110 for the management of Challenging Behaviours and had been advised by the HSCB, that we were at a position of review and had up to a year to implement, to provide sufficient time to update staff skills and numbers and associated suitable adjustments to working roles etc | Head of Service<br>Consultant Clinical Psychologist |

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| All three of the safety plans reviewed were noted to be reactive. Safety plans did not draw on the personal strengths of the patients and were not enabling.<br><br>**Minimum Standard 5.3.1 (b)**<br><br>This area has been identified for improvement for the **first** time | 11 November 2015 | Advice and guidance was provided by the behaviour therapist at Ward Rounds, which given the level of resource within the Trust's behaviour support services was the agreed level of support provided historically.<br><br>The Trust is currently establishing a new Behaviour Support Team, of which there are four posts. The Band 7 post remains vacant at this time, therefore reducing capacity of the behaviour service to the ward at this time.<br><br>Three of the four plans reviewed were recent admissions to the ward from the community. All three had previously been known to the overall Psychological Therapies team under the management of Dr Galbraith, Consultant Clinical Psychologist. As a result, the ward team had not been making new referrals when a patient was admitted but have agreed to review this position in tandem with a multi-disciplinary review of our current nursing care pathway for Lakeview.<br><br>Where a new admission to the hospital has no prior history with behaviour support services, a referral will be made to the Psychological Therapy team for an appropriate assessment.<br><br>We will ensure copies of all completed functional assessments and behaviour support plans are obtained from the behaviour support team within forty | Head of Service/ Consultant Clinical Psychologist |

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| | | days (excluding weekends) from admission. These will thereafter support the nursing staff in their assessment and care planning.<br><br>We will also ensure the Lakeview inpatient pathway is amended to clarify such new learning as refresher referrals for a patient known to the psychological therapies team for reassessment on ward etc.<br>We will forward the revised inpatient pathway, for your information once we consolidate input from medical, psychological therapy, speech and language and occupational therapy colleagues by the date stipulated.<br><br>In context to the reactive plans –<br>The risks of aggression, known and as described from their community placement or family home setting, had a risk management plan written to guide staff throughout the period of time the patient was getting known on the ward and an assessment of their needs / communication, psychological and health needs understood.<br><br>As the staff became more knowledgeable, in partnership with other professionals involved, more proactive interventions for the individual would be written into their care plans. Other patients on the wards have previously been identified, as having a mix of proactive and reactive plans in place following prior inspections.<br><br>We utilise patient centred passports on the wards. It | |

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| | | is important to note that all patients had a person centred, 'All About Me' completed, which highlighted key aspects for each patient, such as 'What I like', 'What I don't like', 'Important To and 'Important For' to give staff an overall pen picture of the person. | |
| ***Key Outcome Area – Is Care Effective?***<br><br>Patients had not been appropriately referred to clinical psychology and / or behaviour support services.<br><br>**Minimum Standard 5.3.3 (f)**<br><br>This area has been identified for improvement for the **first** time | 11 December 2015 | Please see above. | Head of Service/ Consultant Clinical Psychologist |
| All three of the patients reviewed did not have an evidenced based functional assessment of their behaviours and a subsequent behaviour management plan completed. This would have informed the actions recorded on the safety plan.<br><br>**Minimum Standard 5.3.3 (f)**<br><br>This area has been identified for | 11 December 2015 | Referrals for someone admitted to hospital were not routinely made if they were already live on psychology team data base. The Consultant Clinical Psychologist had advised new referrals for cases already open to Psychology are not required. This will be reviewed as part of our planned review of the Lakeview Inpatient Nursing Pathway to extend to include the role of other disciplines in line with the patients journey and planned outcomes. | Head of Service/ Consultant Clinical Psychologist |

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| improvement for the **first** time | | | |
| 2 out of 3 files reviewed did not include treatment goals, safety goals, family & social goals, health and lifestyle goals and support recovery and /or maximise health and well-being.<br><br>**Minimum Standard 5.3.3 (a)**<br><br>This area has been identified for improvement for the **first** time | 11 December 2015 | This objective appears to relate more to The Mental Health Care Pathway. No strategic roll out of the Mental Health Pathway had taken place in Learning Disability settings including Lakeview. We do state goasl within our care plans which seek to demonstrate recovery or enablements strategy | Head of Service/Hospital Manager |
| There was no evidence of the implementation of any psychological therapeutic interventions by staff on the ward.<br><br>**Minimum Standard 5.3.3 (f)**<br><br>This area has been identified for improvement for the **first** time | 11 December 2015 | There is currently no psychology staff specifically dedicated to the ward, as the Trust Psychology staff covers both adult and children services. The Consultant Clinical Psychologist will review this deficit to maximise availability with the aim to have a definitive position by the timeframe allocated of 11.12.15 | Consultant Clinical Psychologist |

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| | | We had requested that one of the qualified nurses complete a Specialist Practitioner course to support ward staff undertake more robust psychological assessments or behaviour monitoring. Unfortunately funding was deferred by the HSCB towards District Nursing but we have been advised this course will be prioritised for 2016/17 academic year. The Trust continues to support this course once available. | |
| There was limited behaviour support for patients and guidance for staff.<br><br>**Minimum Standard 5.3.3 (f)**<br><br>This area has been identified for improvement for the **first** time. | 11 October 2015 | This is being reviewed by senior management to seek maximum availability of behaviour support for staff in response to presenting patients need on the ward.<br><br>Until recently the Trust had only one behaviour support practitioner; however we are pleased to report recent recruitment of three additional staff. The Trust continues to raise its underfunded position, within the Trust and with the HSCB. There is clear recognition of the need for a rebalancing of investment across the programme. The impact of under investment is reflected in the very small specialist teams working across community and hospital settings. While diverting specialist resources to the hospital, this will result in an increase in waiting times for community referrals.<br><br>Staff from psychology and behaviour support services attend the weekly ward rounds and undertake localised training, with all staff having received updated behaviour support training by the | Consultant Clinical Psychologist |

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| | | 11th October 2015. | |
| Patients had been prescribed medication that was not in keeping with NICE guidelines "Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges" (2015)<br><br>**Minimum Standard 5.3.1 (f)**<br><br>This area has been identified for improvement for the **first** time. | 11 October 2015 | While every effort is made to avoid prescribing, some cases, which are very difficult such as those in hospital do require appropriate medication to reduce anxiety and therefore help reduce challenging behaviour.<br><br>This prescribing is not out of step with prescribing by other LD psychiatrists | Consultant Psychiatrist |

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| Staff had not recorded the effectiveness of the PRN medication or had documented a clear rationale for its use every time the medication was administered.<br><br>**Minimum Standard 5.3.1 (f)**<br><br>This area has been identified for improvement for the **first** time | 11 October 2015 | This has been amended. A new form has been introduced which nursing staff complete when administering any PRN medication. This is then subsequently monitored weekly by medical colleagues.<br><br>We undertook an analysis of PRN usage against the 95 prior incidents reported for the period Jun – September 2015, Of the 95 incidents, 71 related to aggression, of which a total of 5 PRN administrations were required, to support the management of the patient involved in the incident.<br><br>The new PRN monitoring documentation will clearly state the rationale for the administration and nursing records will reflect effectiveness. | Consultant Psychiatrist /Hospital Manager |
| Recreational and therapeutic activity plans were not comprehensive.<br><br>**Minimum Standard 5.3.1 (a)**<br><br>This area has been identified for improvement for the **first** time | 11 October 2015 | The ward makes use of external day care and day opportunity settings for the provision of therapeutic activities for the patients on the ward where possible and works hard to maintain any off site placements in place on admission.<br><br>For those patients too unwell to continue, onsite activities are planned in line with their level of need in conjunction with medical colleagues.<br><br>At the time of inspection, the ward was providing inpatient care to seven patients. Three of these | Head of Service/Hospital Manager |

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| | | patients were attending comprehensive off site therapeutic activities and had overall social plans incorporating activities across the week.<br><br>Of the four remaining patients on the ward, three were under assessment in line with their recent admission and another a 'delayed transfer of care' patient, who due to particular needs was unable to attend off site activities or cope with high levels of active engagement / planned activity ( despite various programmes being attempted). This individual has taken up to a year to cope with attending three half hour sessions at our onsite daycare setting; such is the extreme need for predictability and low stimulus opportunities.<br><br>It is important to note, that unlike most in mental health, not all our inpatients seek, comply or cope with large volumes of planned activity across the course of a day, especially where individuals are in a heightened state of anxiety and / or self-injurious behaviours. | |

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| Due to the absence of functional behaviour assessments, behaviour management plans, and therapeutic interventions to address the needs of the patients, the restrictions experienced by the patients could not be viewed as proportionate, necessary and not used as a last resort.<br><br>**Minimum Standard 5.3.1 (a)**<br><br>This area has been identified for improvement for the **first** time | 11 December 2015 | Internal analysis has proven use of PRN medication and MAPA has not been restrictive, nor applied where it is not required. The Trust continues to promote the least restrictive approach at all times and while restrictive practice care plans has been prescribed the appropriate safeguards i.e. human rights and capacity assessments were in place and signed off by the patient, their representative, medical and community teams. .<br><br>The use of ongoing Locked Ward Doors is under review and we plan to undertake a pilot 'open ward' by the date specified. Should a patient under the Mental Health Order be received onto the ward throughout this time, we will have to cease the pilot.<br><br>Ongoing access to individual patient swipe cards ( to exit and enter the ward freely) continue to be available to all patients with appropriate capacity. We have enclosed a new monthly monitoring form which we will undertake monthly regarding review of all restrictive practice measures in place. Enclosure 6 | Consultant Psychiatrist /Consultant Psychologist /Head of Service |

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| There was no cross reference to the previous ward round or the person responsible for implementing the agreed actions and the timeframe in the ward round minutes.<br><br>**Minimum Standard 5.3.1 (a)**<br><br>This area has been identified for improvement for the **first** time | 11 December 2015 | Our multi-disciplinary ward minutes will ensure clear cross reference to any actions arising from the previous week and progress against same forthwith. | Hospital Manager/ Consultant Psychiatrist |
| ***Key Outcome Area – Is Care Compassionate?***<br><br>Information about the multi-disciplinary team was not available for patients. Details about which staff were allocated 1:1 time with patients were not displayed.<br><br>**Minimum Standard 5.3.3 (a)**<br><br>This area has been identified for improvement for the **first** time | 11 December 2015 | Details of the multi-disciplinary team will be available and in place by the time allocated.<br><br>Displaying the allocation of 1-1 time with patients is an area we wish to discuss further as we do not understand the benefits of displaying this information publicly. | Hospital Manager,<br><br>Head of Service |

**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 |
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| ***Key Outcome Area – Is Care Safe?***<br><br>Average number of banking hours per week was 188 hours.<br><br>**Minimum Standard 4.3 (n)**<br><br>This area has been identified for improvement for the **first** time | 11 March 2016 | We seek to recruit surplus staff to cover for planned annual leave but do find it difficult to legislate for staff sickness or other unexpected events. The average of 188 hours per week reflects approximately 18% of the staff rota delivered each week.<br><br>We will continue to manage staff absence and allocate annual leave as effectively and efficiently as possible. The Trust has an attendance initiative underway in Learning Disability and this will target people who have high/poor attendance levels. | Head of Service |
| ***Key Outcome Area – Is Care Effective?***<br><br>There were few recorded medical contacts between the patients and the consultant psychiatrist outside the ward rounds.<br><br>**Minimum Standard 5.3.1 (a)**<br><br>This area has been identified for improvement for the **first** time | 11 March 2016 | Medical staffing has been stretched with covering a large community caseload as well as a significant number of inpatients. This has been improved with the recent addition of a 2nd consultant (locum). This has improved contacts with patients on the ward. | Consultant Psychiatrist |

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| The door to the ward was locked and exit from the ward was controlled by staff, even though there was a high staff to patient ratio.<br><br>**Minimum Standard 5.3.1 (a)**<br><br>This area has been identified for improvement for the **first** time | 11 March 2015 | All patients on the ward have a positive risk management plan in place to take into account the restrictions and human rights impingements arising from the provision of a secure ward, as a result of the locked doors at the entrance and exit of the ward. We shall trial the use of non-locked doors (ward exit only), incrementally increasing if no adverse impact is identified.<br><br>We aim to commence the partial 'open egress/exit doors at ward level' from week commencing 23rd November, incrementally reaching the doors being unrestricted between the hours of 9am and 5pm.<br><br>A further review will be completed to ensure learning is identified and a revised strategy for extending unrestricted egress times thereafter, with finalised position regarding locked door requirements determined before 11th March 2016. Mindful of implications arising from any detained patients. | Head of Service |
| ***Key Outcome Area – Is Care Compassionate?***<br><br>None of the areas for improvement identified as a result of this inspection are required to be completed within this priority. | | | |

**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 |
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| ***Key Outcome Area – Is Care Safe?***<br><br>Staff were not managing patient's finances in accordance with trust policy and procedure.<br><br>**Minimum Standard 5.3.1 (f)**<br><br>This area has been identified for improvement for the **second** time | 11 October 2015 | We accept that two patients had personal funds held on the ward for a period of days over the timeline indicated by Trust policy.<br><br>As discussed this was as a result of a patient requesting to have funds available to facilitate shopping for new house furniture in support of a planned discharge to a new community home.<br><br>We removed funds over the Trust allowance of £50.00 back to patient's property the day following inspection.<br><br>We commenced a patient reconciliation to our weekly | Hospital Manager/ |

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| | | finance audits competed. | |
| ***Key Outcome Area – Is Care Effective?***<br><br>Patients could not access ward based occupational therapy support<br><br>**Minimum Standard 5.3.3 (d)**<br><br>This area has been identified for improvement for the **second** time | 11 March 2016 | We sought funding from the HSCB but were unsuccessful in obtaining additional funding. We are looking creatively at opportunities to reconfigure existing resources for maximum gain and aim to have this in place by March 2016.<br>This however, does require consultation with Trade Unions and the Trust to identify a source of funding to cover any additionality. | Assistant Director/Head of Service |
| ***Key Outcome Area – Is Care Compassionate?***<br><br>There are no outstanding recommendations in relation to compassionate care. | | | |

**TO BE COMPLETED BY RQIA**

| Inspector comment (delete as appropriate) | Inspector Name | Date |
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| I have reviewed the Trust Improvement Plan and I am satisfied with the proposed actions<br><br>or<br><br>I have reviewed the Trust Improvement Plan and I have requested further information | | |
| I have reviewed additional information from the Trust and I am satisfied with the proposed actions | Wendy M'Grego. | 9 November 2015. |