Mental Health and Learning Disability Inpatient Inspection Report

13 – 14 August 2018

Ash

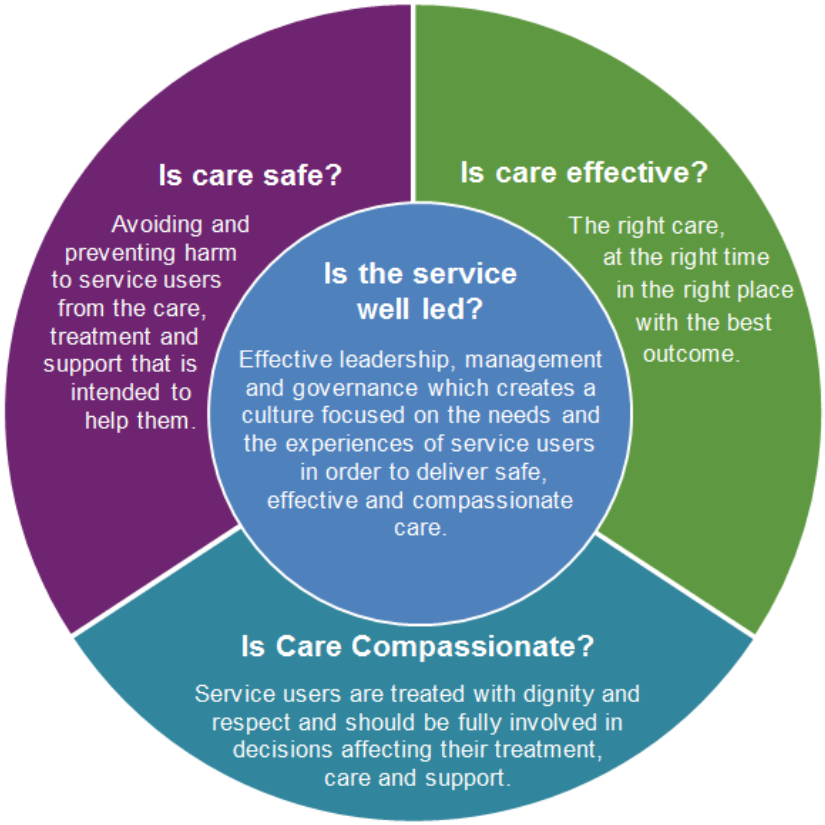
Acute Psychiatric Admission
Tyrone and Fermanagh Hospital
Omagh

Tel No: 028 8283 3100

Inspectors: Alan Guthrie and Dr John Simpson

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

Ash Ward is a ten bedded mixed gender ward set on the Tyrone and Fermanagh Hospital site. The ward provides assessment, care and treatment to patients with dementia. On the days of the inspection there were eight patients admitted to the ward. This included two patients who had been admitted to the ward in in accordance with the Mental Health (NI) Order 1986.

The multidisciplinary team (MDT) consists of nursing, psychiatry, occupational therapy, psychology and social work. The ward also has an activity co-ordinator. The ward sister was in charge on the days of the inspection.

3.0 Service Details

Responsible person: Anne Kilgallen
Ward manager: Nicola Hayes
Person in charge at the time of inspection: Nicola Hayes

4.0 Inspection Summary

An unannounced inspection took place over three days on 13 – 14 August 2018.

This inspection focused on the theme of Person Centred Care. This means that patients are treated as individuals, and the care and treatment provided to them is based around their specific needs and choices.

We assessed if Ash ward was delivering, safe, effective and compassionate care and if the service was well led.

Evidence of good practice

- Patients and relatives who met with inspectors were complimentary about the ward and the staff team.
- Patients admitted to the ward could access the Acorn centre. The centre provided recreational and therapeutic activities.
- The ward was relaxed and well maintained.
- Inspectors evidenced that patients' relatives were involved in the patient's care and treatment. Staff maintained good contact with relatives.

Areas requiring improvement

Two areas requiring improvement were identified as a result of the inspection. The first area for improvement relates to access to Wi-Fi. The second area for improvement focuses on a number of Trust policies that require review.

Area 1

A previous area for improvement requested that the Trust ensure that ward staff have access to Wi-Fi and a sufficient number of computers including at least one laptop. It was positive to note that the Trust had commenced addressing this area of concern. Staff who met with inspectors reported no concerns regarding their ability to access a computer including a laptop. Inspectors also evidenced that the Trust had recently approved the capital funding required to install an appropriate internet server to facilitate internet access throughout the ward. However, at the time of the inspection internet access was not available. Given the Trust has made progress in addressing this area for concern it will not be restated for a second time. A new area for improvement in relation to the completion of works has been made.

Area 2

Inspectors evidenced that a number of Trust policies relevant to the ward required review. These included:

- Risk Management Policy (Review required March 2017)
- Incident Reporting Policy (Review required August 2017)
- Policy for the Prevention of Slips Trips and Falls (Review required January 2018).
- Records Management Policy (Review required November 2017).

An area for improvement regarding the review of policies has been made and stated for the first time in the quality improvement plan at the end of this report.

Patients Views:

During the inspection inspectors met with three patients and observed patient staff interactions. Patients who met with inspectors stated they felt the ward was helping them and staff were approachable and easy to talk too. Patients reported no concerns regarding the care and treatment they were receiving. It was good to note that the ward was designed to ensure patients could walk freely throughout the main part of the ward.

Patient staff interactions were observed as being positive. Nursing staff were available throughout the ward and patient requests were responded to quickly. Nursing staff demonstrated a high level of observation and appropriate awareness of each patient's presenting needs. Staff evidenced good knowledge and understanding of each patient and applied appropriate use of verbal and non-verbal communication when supporting patients. The ward's atmosphere remained relaxed and settled throughout the inspection. Patients presenting as confused or upset were appropriately supported, reassured and comforted. Inspectors identified no concerns regarding patients being treated with dignity and respect. Patient's comments included:

"Most staff listen to me".

"Most of the time staff are great".

"The doctor doesn't always stop to talk to me".

"I feel safe and supported on the ward".

Relatives Views:

Inspectors spoke with one relative during the inspection. The relative was complimentary regarding their experience of the ward and the ward staff team. The relative described staff as being attentive and supportive. They spoke positively about their relationships with the ward staff team and stated that staff were very good at providing information and keeping them updated regarding the patient's progress. The relative reported no concerns regarding the care and treatment provided. The relative comments included:

"I am delighted ****** has been admitted to the ward".

“The food and the ward’s atmosphere are excellent”.

Staff Views:

Inspectors met with ten members of the ward’s MDT. Staff stated that they felt the ward was appropriately managed and the staffing compliment was generally good. Staff detailed that the patient staff ratios were good and in circumstances where more staff were required this was addressed and resolved quickly.

Staff informed inspectors that they felt the care and treatment provided on the ward was to a high standard and addressed the presenting needs of each patient. Staff who met with inspectors demonstrated good understanding of their role within the ward’s MDT. Staff evidenced good knowledge regarding the needs of patients and understanding regarding the challenges faced by relatives and carers.

Staff informed inspectors that they felt the ward’s MDT was supportive and inclusive. Staff stated that they felt the care and treatment provided to patients was effective and patient centred. Staff reported that their assessments, opinions and views regarding patients was sought and respected during MDT patient reviews. It was positive to note that the Trust had appointed a psychologist who supported patients and staff 1.5 days each week. The psychologist completed patient formulations, provided staff training and one to one psychological interventions with patients.

Inspectors met staff from each professional group represented within the ward’s MDT. Medical staff stated that they were appropriately supported and that the MDT was effective and supportive. Working relationships within the MDT were described as good. Medical staff expressed no concerns regarding the quality of care and treatment provided to patients. It was positive to note that he trust had introduced the Acorn day services centre. The centre was located in a former ward and during the inspection it was noted that occupational therapy and nursing staff continued to develop the centre. Patients participated in gardening, reminiscence groups, one to one OT therapy, OT assessments and activity groups in this centre.

None of the staff who met with inspectors reported any concerns regarding their ability to access training, supervision and appraisal. Staff were complimentary regarding the leadership within the ward and it was good to note that nursing staff felt supported. It was positive to note that staff who met with inspectors appeared motivated, enthusiastic and were patient centered.

Staff stated:

“The ward has a motivated and enthusiastic nursing team”.

“The ward has developed a positive therapeutic culture”.

“I am happy with the nursing staff levels”.

“The ward manager is very good”.

“It’s (Ash) well staffed”.

“Extra staff are brought in as needed”.

“It’s a good team”.

“I have absolutely no issues”.

“There is good communication within the ward”.

The findings of this report will provide the service with the necessary information to enhance practice and service user experience.

4.1 Inspection Outcome

Total number of areas for improvement	2

Findings of the inspection were discussed with the ward manager, members of the multi-disciplinary team and senior members of the Trust as part of the inspection process and can be found in the main body of the report.

Escalation action did not result from the findings of this inspection.

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.

Prior to inspection we reviewed a range of information relevant to the service. This included the following records:

- The operational policy for the ward.
- Incidents and accidents.
- Safeguarding vulnerable adults.
- Complaints
- Health and safety assessments and associated action plans.
- Information in relation to governance, meetings, organisational management, structure and lines of accountability.
- Details of supervision and appraisal records.
- Policies and procedures.

During the inspection the inspector met with three service users and ten staff.

The following records were examined during the inspection:

- Care documentation in relation to four patients.
- Nursing staff training records.
- Daily records.
- Accident and incident records.
- Patient medication charts.
- Patient information folder.
- Minutes of staff meetings.
- Staff supervision timetable.
- Records and record keeping audit/ checklist.
- Weekly record of the inspection of means of escape.
- Weekly record of fire alarm checks.
- Safeguarding records.

During the inspection the inspector observed staff working practices and interactions with patients using a Quality of Interaction Schedule Tool (QUIS).

We reviewed the areas for improvement made at the last inspection. An assessment of compliance was recorded as met.

6.0 The Inspection

6.1 Review of Areas for Improvement from Last Inspection dated 18-19 October 2017

Areas for Improvement		Validation of Compliance
Recommendation 1 **Ref**: 5.3.1(a) **Stated:** First Time	The ward's ligature risk assessment should clearly indicate the ligature points being locally managed by ward staff. These points can then be reviewed as required should the presenting needs of patients change.	**Met**
	Action taken as confirmed during the inspection: Inspectors reviewed the ward's most recent ligature risk assessment which had been completed on 1 April 2018. Ligature points being locally managed by ward staff were clearly indicated.	

Recommendation 2 **Ref**: 5.3.3 (d) **Stated:** First Time	Patients transferred from another ward should have the required dementia care pathway assessment completed.	**Met**
	Action taken as confirmed during the inspection: Dementia care pathway assessments were being completed on patients being transferred to Ash from other wards.	
Recommendation 3 **Ref**: 5.3.3 **Stated:** Second Time	The Trust should ensure that ward staff have access to Wi-Fi and a sufficient number of computers including at least one laptop.	**Met**
	Action taken as confirmed during the inspection: Inspectors reviewed access to Wi-Fi and the availability of laptop computers. Staff could access a laptop computer as required. Wi-Fi access to the ward had not been implemented. Inspectors reviewed the Trust's plan to implement Wi-Fi onto the ward. It was positive to note that monies had been secured and that Wi-Fi access would be available to patients, ward staff and visitors in the near future. Whilst the Trust have addressed this recommendation a new recommendation to check that Wi-Fi access is available throughout the ward has been made. This will facilitate RQIA checking that the Trust has implemented its plans in full.	

7.0 Review of Findings

7.1 Is Care Safe?

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

Areas of Good Practice

Relatives were actively involved in patient care and treatment.

Risk assessments are individualised, up to date and continually reviewed. There was effective flow of information between the community team and the ward.

Environmental risk assessments are completed and up to date.

The ward had good links with the Trust's estate services.

Inspectors evidenced comprehensive clinical care records which were easy to follow.

Staff reported no concerns regarding their relationship with the ward's management team.

Patients were being cared for in accordance to the Mental Health (Northern Ireland) Order 1986.

Areas for Improvement

No areas for improvement were identified during the inspection.

Number of areas for improvement	0

7.2 Is Care Effective?

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

Areas of Good Practice

Patient care records were comprehensive, up to date and well maintained.

Patients could access the range of professionals necessary to oversee their care and treatment.

The MDT worked well together and all views were valued and considered.

Patients could access specialist assessments as required.

Restrictive practices used within the ward were appropriately managed and specific to the individual needs of each patient.

Patients admitted to the ward continued to be supported by their community key worker.

Discharge planning started early in each patient's admission.

The Trust continued to develop the ward's information technology capability.

Areas for Improvement

The Trust should ensure that patients, visitors and ward staff have access to Wi-Fi.

Number of areas for improvement	1

7.3 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.

Areas of Good Practice

The ward's environment continued to be appropriately managed and, where possible, updated. This included replacing flooring and removing ligature points.

Staff treated patients with dignity and respect.

The ward was clean and smelt fresh.

Relatives were actively involved in the ward and there was a culture of openness and transparency.

The use of restrictive practices was appropriate, closely monitored and continually reviewed.

Patients could access an advocate as required.

Patients were supported by the appropriate range of professionals.

Areas for Improvement

No areas for improvement were identified during the inspection.

Number of areas for improvement	0

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

Patients were supported by a motivated and enthusiastic staff team.

Inspectors evidenced that the MDT worked well together.

The ward had good medical support including a general practitioner trainee post.

Challenges regarding staffing were being continually monitored and the senior management team had taken positive steps to help ensure appropriate staffing levels were maintained.

Staff reported no concerns regarding the support they received from the ward's management team and leadership.

Staff training was closely monitored and retraining was scheduled and completed as required.

Inspectors evidenced that the ward had appropriate governance arrangements in place to record and address safeguarding concerns, incident and accidents and complaints.

Patient experience was being monitored through the ward advocate, relative/carer involvement and via a new patient experience questionnaire.

Areas for Improvement

A number of trust policies relevant to the ward were out of date.

Number of areas for improvement	1

8.0 Quality Improvement Plan

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

The responsible person should note that failure to comply with the findings of this inspection may lead to further /escalation action being taken. It is the responsibility of the responsible person to ensure that all areas identified for improvement within the quality improvement plan are addressed within the specified timescales.

8.1 Actions to be taken by the Service

The quality improvement plan 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 quality improvement plan by 13 November 2018.

Provider Compliance Plan Ash Ward	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref: 5.3.1 (a)** **Stated:** First time **To be completed by:** 15 February 2019	A number of Trust policies relevant to the ward required review.
	Response by responsible person detailing the actions taken: **Risk Management Policy** This policy is still extant but review was postponed until the Trust adopted a replacement for the Regional model for Risk Management following the expiration of the license for the AS/NZS Risk Management standard. A regional working group was tasked with finding a replacement and in June recommended to DoH/HSCB the adoption of a paper which outlines a common regional HSC model for Risk Management based on the principles of ISO 31000 including a common Regional HSC Risk Matrix. This was subsequently approved by DoH and the Trust's policy is currently being updated to incorporate ISO31000 and the revised Governance reporting structure for completion by December 2018. **Incident Reporting Policy** A Regional Incident reporting policy is being developed by a regional group involving all Trusts, the HSCB and lead by DoH. Final comments were received from all ALBs in August and a final policy document was expected to be produced by September but has been delayed and not now expected until December 2018. When finalised, all Trusts will be adopting the regional policy and in the interim the current Trust policy is extant. **Records Management Policy** The policy was reviewed and approved at the Operational Corporate Management Team meeting held on 11th October 2018 and received final approval at Trust Board held on 1st November 2018. The Trust is now in the process of updating the Policy on the Intranet and other Trust Sites. **Falls /Slips & Trips Policy** A Falls Co-ordinator has been recruited within the Trust and a Falls Steering Group is being established to review the policy and will be brought to the Falls Collaborative meeting in January 2019 or review and approval before then proceeding through the Trust's agreed approval processes.
Area for Improvement No. 2	The ward required access to Wi-Fi.
	Response by responsible person detailing the actions taken:

Ref: 5.3.1 (f) **Stated:** First time **To be completed by:** 15 February 2019	This work will be completed by the end of November 2018

Name of person(s) completing the provider compliance plan	Nicola Hayes/Pauline Casey		
Signature of person(s) completing the provider compliance plan	*Nicola Hayes*	**Date completed**	09/11/18
Name of responsible person approving the provider compliance plan	Dr Bob Brown		
Signature of responsible person approving the provider compliance plan	*Dr Bob Brown*	**Date approved**	13/11/18
Name of RQIA inspector assessing response	Alan Guthrie		
Signature of RQIA inspector assessing response		**Date approved**	21 November 2018

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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