Mental Health and Learning Disability Inpatient Inspection Report
20 – 22 March 2017

Ash

Acute Psychiatric Admission
Tyrone and Fermanagh Hospital
Omagh

Tel No: 028 82833100

Inspectors: Alan Guthrie, Dr John Simpson and Alan Craig

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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

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 one patient who had been detained in accordance with the Mental Health (NI) Order 1986.

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

3.0 Service Details

Responsible person: Elaine Way
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 date 20 – 22 March 2017.

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

- Relatives were actively involved with patients and the ward promoted a culture of openness and transparency.
- The ward maintained comprehensive patient clinical care records that were easy to follow.
- Inspectors evidenced that patients were supported by an enthusiastic and motivated staff team.
- Patient care plans were patient centred, regularly reviewed and appropriate to the needs of each patient.
- The ward's environment was clean, fresh smelling and maintained to an appropriate standard.
- Staff treated patients with dignity and respect.

Areas requiring improvement

Two areas requiring improvement were identified as a result of the inspection. The first area for improvement relates to the ward's environment, specifically the management of ligature points by ward staff. The second area for improvement relates to the availability of computers and access to Wi-Fi.

Area 1

Inspectors were concerned that the layout of the ward presented a number of ligature risk concerns. The Trust had completed a ligature risk management plan and significant anti-ligature work was scheduled to be completed in the near future. This work will require that he ward closes for a period of approximately six weeks. Appropriate alternative accommodation

for patients had been identified. However, the ward's ligature risk management plan recorded that a large number of ligature points would remain. Inspectors were concerned that there was no plan to identify how the remaining ligature points would be managed. This concern is reflected in the ward's provider compliance plan.

Area 2

Inspectors evidenced that ward staff did not have sufficient access to computers or Wi-Fi. This included access to a laptop. It was positive to note that the ward's senior management team had taken appropriate steps to address this which included ordering a laptop. This area for improvement is discussed in the provider compliance plan to be addressed and implemented as soon as possible.

Patients Views:

During the inspection inspectors and the lay assessor met with a number of patients and observed patient staff interactions. Patients who met with inspectors did not complete a questionnaire. The use of questionnaires was not an appropriate method with which to capture this group of patients' experience. Subsequently, to review patient experience inspectors and the lay assessor spent time with patients during ward based activities, mealtimes and throughout the three days within which the inspection was completed. Observations of patient-staff interactions evidenced ward staff to be available throughout the ward. Staff were also noted to be supportive, attentive and patient focused.

Nursing staff demonstrated good use of observation and de-escalation skills and appropriate use of verbal and non- verbal communication. Staff had knowledge of each patient and applied appropriate intervention commensurate with each patient's presentation, likes and dislikes and character. The ward atmosphere was relaxed, quiet and patients presented as being comfortable in their surroundings. Patients who became upset or agitated were quickly reassured and appropriately supported. Inspectors identified no concerns regarding patients being treated with dignity and respect.

Patients who spoke with RQIA staff reported no concerns regarding the care and treatment they received within the ward. Patients presented as being at ease in the company of staff and it was good to note that the ward had incorporated John's Campaign and was in the process of finalising a trust wide patient experience questionnaire. John's Campaign is a national initiative designed to encourage acute services providing care and treatment to patients suffering from dementia to provide care and treatment in partnership with patients, their relatives and or carers.

Relatives Views:

Inspectors met with two relatives during the inspection. Relatives stated that they had no concerns regarding the care and treatment provided to patients. Relatives spoke positively about their relationships with the ward staff team and it was good to note that both relatives felt that staff kept them informed about the patient's progress.

Staff Views:

Inspectors met with 13 members of the ward's MDT. Staff reflected positively regarding the care and treatment provided by the ward. Staff stated that they enjoyed working on the ward and that they were clear regarding their role within the ward's MDT. Staff evidenced good understanding and knowledge regarding the needs of the patient group and the challenges faced by relatives and carers.

Several staff reflected on challenges in maintaining the required nurse staff levels for each shift. Inspectors also noted that the ward were also in the process of trying to appoint a permanent Consultant Psychiatrist and a temporary Clinical Psychologist. Whilst there were staffing pressures inspectors evidenced that the ward's senior management team were taking the necessary steps to address staffing pressures and concerns.

Staff presenting as being confident in their role and that they understood their position within the MDT and the ward. Staff informed inspectors that they felt the ward's MDT was supportive and inclusive. Staff reported that their opinion and view was sought and respected. Inspectors were informed that the MDT were continuing to review and enhance therapeutic interventions and effectiveness as a means to improving patient care pathways and experience. This included ongoing evaluation of treatment and therapeutic interventions and associated outcomes for patients.

Inspectors met staff from each professional group represented within the ward's MDT. Medical staff stated that the ward provided care and treatment to patients presentng with a wide range of physical health problems, mobility problems and challenging behaviour. Medical staff reflected that they felt the MDT was effective and ward staff were knowledgeable, skilled and patient centred. Working relationships within the MDT were described as good. Medical staff expressed no concerns regarding the quality of care and treatment provided to patients.

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:

"Good communication between ward staff and the community team".

"Good experience for families".

"The ward provides and effective service".

"There is flexible visiting for relatives".

"I enjoy working here".

"It can be stressful".

"Nice place to work".

"Great team".

"The younger staff are very positive".

"Everyone's view is considered at MDT meetings".

"I have no major concerns regarding bank or agency staff".

"Care is good here 99% of relatives are happy".

"The ward has a good culture and is a pleasant place to work".

"Very well run unit".

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	Two

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 review 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 four service users, thirteen staff and two service users' visitors/representatives.

A lay assessor Alan Craig was present during the inspection and his comments are included within this report.

The following records were examined during the inspection:

- Care documentation in relation to four patients.
- 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.
- Incident and 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 improvements/ recommendations/ made at the last inspection. An assessment of compliance was recorded as met.

The preliminary findings of the inspection were discussed at feedback to the service at the conclusion of the inspection.

6.0 The Inspection

6.1 Review of Areas for Improvement / Recommendations from Last Inspection dated 22-24/06/2016

Areas for Improvement		Validation of Compliance
Recommendation 1 **Ref**: 4.3(m) **Stated:** Second Time	It is recommended that the ward sister ensures that all staff have up to date mandatory training completed which includes fire training, vulnerable adult safeguard training, moving and handling training and immediate life support (ILS).	**Met**
	Action taken as confirmed during the inspection: Inspectors reviewed the nursing staff training matrix. The matrix was up to date and clearly identified deficits in nursing staff mandatory training. Inspectors noted a small number of training deficits. These deficits related to staff who were not available to work and training sessions had been booked.	
Recommendation 2 **Ref**: 5.3.1 (a) **Stated:** Second Time	It is recommended that the trust ensures that medical staff complete the relevant medical section in the patients 'Person Centred Integrated Care Pathway for Dementia Assessment Unit'.	**Met**
	Action taken as confirmed during the inspection: Patient care records reviewed by inspectors evidenced that medical staff completed the relevant section in the patients Person centred integrated care pathway for dementia assessment unit.	
Recommendation 3 **Ref**: 6.3.2 (a) **Stated:** Third Time	It is recommended that the ward sister ensures that there is a surplus supply of curtains available on the ward. This is to ensure that once curtains are removed for washing or routinely cleaned that they are replaced from the supply immediately to maintain patient privacy and dignity.	**Met**
	Action taken as confirmed during the inspection: Inspectors reviewed all of the patient sleeping areas located within the wards three dorm areas. Inspectors evidenced that curtains were available around each bed area and there was a surplus supply of curtains. One rail had been pulled down by a patient and this was scheduled to be repaired. Inspectors witnessed estates services staff attending the ward to replace the curtain rail.	

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 is 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

The ward's ligature risk management plan recorded a large number of ligature points present within the ward. Whilst it was positive to note that he trust was investing in removing a large number of ligature points this work would not address every risk. Subsequently, the Trust should review the ward's ligature risk management plan to detail the arrangements for the monitoring of ligature risks.

Number of areas for improvement	One

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 patients admission.

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

Areas for Improvement

The Trust should ensure that ward staff have sufficient access to computers/laptops and Wi-Fi.

Number of areas for improvement	One

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	Nil

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 he MDT worked well together.

The ward has 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 he 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

No areas for improvement were identified during the inspection.

Number of areas for improvement	Nil

8.0 Provider Compliance Plan

Areas for improvement identified during this inspection are detailed in the provider compliance plan. Details of the provider compliance 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 provider compliance plan are addressed within the specified timescales.

8.1 Actions to be taken by the Service

The provider compliance 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 provider compliance plan by 11 May 2017.

Provider Compliance Plan Ash Ward	
Priority 2	
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:** 24 June 2017	The Trust should ensure that the ward's ligature risk assessment and associated action plan including post completion of the anti-ligature works, accurately reflects the role of ward staff in monitoring ligature points within the ward's environment.
	Response by responsible person detailing the actions taken: Environmental Ligature risks will remain under continuous review through annual health and safety risk assessments. Individual risk assessment will be undertaken for all patients in accordance with regional risk assessment tool and individual care plans will be developed, reviewed and evaluated by Multi-disciplinary Team (MDT).
Priority 3	
Area for Improvement No. 2 **Ref: 5.3.1 (f)** **Stated:** First time **To be completed by:** 24 September 2017	The Trust should ensure that ward staff have access to Wi-Fi and a sufficient number of computers including at least one laptop.
	Response by responsible person detailing the actions taken: Laptop has been ordered and approved. Awaiting advice from I.T. department regarding feasibility and access to Wifi. Update will be provided by the end of August.

Name of person(s) completing the provider compliance plan	Nicola Hayes		
Signature of person(s) completing the provider compliance plan		**Date completed**	08 May 2017
Name of responsible person approving the provider compliance plan	Elaine Way		
Signature of responsible person approving the provider compliance plan		**Date approved**	18 May 2017
Name of RQIA inspector assessing response	Alan Guthrie		
Signature of RQIA inspector assessing response		**Date approved**	19 May 2017

The Regulation and Quality Improvement Authority

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

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews