The Regulation and Quality Improvement Authority

Beech Ward

Tyrone and Fermanagh Hospital

Western Health and Social Care Trust

Unannounced Inspection Report

Date of inspection: 20 July 2015

npm national preventive mechanism

informing and improving health and social care

www.rqia.org.uk

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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 Purpose and Aim of this Inspection

To review the ward's progress in relation to recommendations made following previous inspections.

To meet with patients to discuss their views about their care, treatment and experiences.

To assess that the ward physical environment is fit for purpose and delivers a relaxed, comfortable, safe and predictable environment.

To evaluate the type and quality of communication, interaction and care practice during a direct observation using a Quality of interaction Schedule (QUIS).

2.1 What happens on inspection

What did the inspector do:

- reviewed the quality improvement plan sent to RQIA by the Trust following the last inspection(s)

- talked to patients, carers and staff
- observed staff practice on the days of the inspection
- looked at different types of documentation

At the end of the inspection the inspector:

- discussed the inspection findings with staff
- agreed any improvements that are required

After the inspection the ward staff will:

- send an improvement plan to RQIA to describe the actions they will take to make any necessary improvements

3.0 About the ward

Beech is a 12 bedded male ward on the grounds of the Tyrone & Fermanagh Hospital site. The purpose of the ward is to provide rehabilitation and continuing care to patients' who require ongoing support to manage their mental health needs. There were 8 patients on the ward on the day of the inspection none of these patients' were detained under the Mental Health (NI) Order 1986.

The multidisciplinary team consists of a team of nursing staff and health care assistants, a medical registrar, a consultant psychiatrist and a resettlement social worker. Patients' have access to psychology services through a referral system.

4.0 Summary

Progress in implementing the recommendations made following the previous inspections carried out on 26 February 2015 were assessed during this inspection. There were a total of 32 recommendations made following this inspection, 12 of these had been restated from the previous inspection on 18 September 2013.

It was good to note that 27 recommendations had been implemented in full.

Four recommendations had been partially and one recommendation had not been met. Two recommendations will be restated for a third time and one recommendation will be restated for a second time. A new recommendation will be made in relation to two recommendations that were partially met following this inspection.

The lay assessor met with six patients on the ward. However, due to patients limited understanding they were unable to complete patient questionnaires. The lay assessor spoke briefly to these patients who made positive comments about their experience of the ward and raised no concerns regarding their care and treatment.

The ward atmosphere was calm and relaxed. Patients on the ward required support with activities of daily living and staff were observed attending promptly to patients' care needs. Observations were noted to be positive with staff showing a genuinely interested in patients whilst engaging patients in conversations. Staff appeared to know the patients very well.

The ward environment was observed as a homely environment. However the inspectors were concerned to note that there was a lack of signage throughout the ward to assist in orientating patients around the ward. It was good to note that patients could independently access the outside space as patients were all aware of the code to the entrance door. Patients were observed moving freely on and off the ward throughout the day of the inspection. The garden areas were well maintained with appropriate outside seating available for patients.

4.1 Implementation of Recommendations

12 recommendations which relate to the key question "**Is Care Safe**?" were made following the inspection undertaken on 25 and 26 February 2015. Eight of these recommendation had been restated from the previous inspection on 18 September 2013.

These recommendations concerned the deficits in mandatory training, how staff training is monitored and the absence of a mechanism to monitor training of bank staff. Concerns were raised in relation to the use of profiling/metal frame beds without the appropriate risk assessments in place and incomplete risk screening tools and comprehensive risk assessments. Recommendations were made in relation to the monitoring of patients' money and how the ward manages records of the staff member who holds the key to the safe. A recommendation was also made in relation to to the practice of staff sleeping in specified areas on the ward during their allocated breaks.

The inspectors were pleased to note that nine recommendations had been fully implemented.

- Ten staff had received up to date training in safeguarding vulnerable adults and the ward had a plan in place for the rest of the nursing staff to receive this training.

- Out of the 15 nursing staff 13 staff had completed initial MAPA training. A date was set on 26 August 2015 for the two remaining nursing staff to complete this training .

- There was evidence in the 'record book' that two staff members check receipts on the ward. The acting ward manager also completes a weekly check of records.

- A ‘safe key register book’ was held on the ward which recorded who obtained the key to the safe where patients’ money was stored and this was signed by two members of staff.

- The acting ward manager had completed a weekly audit of receipts received and had checked this against expenditure.

- The Trust had reviewed the use of the beds on the ward and were in the process of replacing same. There was evidence that patients who were using profiling/metal frame beds had a risk assessment and care plan in place which was reviewed regularly.

- Risk screening tools and comprehensive risk assessments were completed in full in accordance with the Promoting Quality Care Guidance Document.

- The Trust had an electronic colour coded matrix system in place which detailed staff training records.

- A directive was sent from the Assistant Director of Mental Health Services which stated that staff are not authorised to sleep in specified areas on the ward during their allocated breaks.

However, despite assurances from the Trust, three recommendations had not been fully implemented. All staff had not received up to date mandatory training and there was no mechanism to monitor the training of bank staff. Two policies relating to managing patients’ money had not been updated.

14 recommendations which relate to the key question “**Is Care Effective**?” were made following the inspection undertaken on 25 and 26 February 2015. Three of these recommendation had been restated from the previous inspection on 18 September 2013.

These recommendations concerned the auditing of care records and the absence of regular staff meetings and staff appraisals. Recommendations were made in relation to the reviewing of and completion of person centred care plans with the involvement of patients, the absence of discharge care plans, the recording of patients’ progress and the accuracy of records. Recommendations were also made in relation to the completion of records from the outcome of MDT meetings and the reviewing of policies and procedures. Concerns were raised in relation to the practice of transferring acutely unwell patients from Lime ward to Beech ward.

The inspector was pleased to note that 12 recommendations had been fully implemented.

- The acting ward manager was completing electronic monthly audits of a sample of care records.

- Staff appraisals had been completed.

- Care plans were reviewed as prescribed with a summary of the outcome for each care plan.

- Care plans were in place in relation to patients' discharge plans. There was evidence that these care plans were reviewed and updated after each resettlement meeting.

- Patients' signatures were recorded on all relevant assessments and care documentation.

- Assessments and person centred care plans were in place for patients.

- Nursing staff had completed a detailed record of patients' care and treatment in patients' progress records.

- The ward had developed a new multidisciplinary (MDT) template which detailed timescales agreed and any actions carried forward following an MDT meeting so that progress can be monitored and tracked.

- Interim local practice guidance had been issued in relation to the transfer of patients between Lime and Beech ward. In addition to this interim local practice a further review meeting had been arranged for 4 August 2015 to discuss and formally review of this process.

- Patients' medical notes evidence that recent case summaries had been completed.

- Records were clearly legible and the writer and designation of the writer could be established.

- Staff meetings were held monthly on the ward. Minutes evidenced that there was a clear agenda set each week, with action plans/outcomes.

However, despite assurances from the Trust, two recommendations had not been fully implemented. The ward had not updated a number of policies and procedures and members of the MDT had completed documentation incorrectly with the incorrect date and time recorded in patients' care records.

Six recommendations which relate to the key question "**Is Care Compassionate**?" were made following the inspections undertaken on 25 and 26 February 2015. One of these recommendation had been restated from the previous inspection on 18 September 2013.

Recommendations concerned the completion of risk assessments and care plans with the involvement of patients and if appropriate their carers. Staff assessing patients' consent to daily care and treatment, the completion

individualised care plans that reflected the rationale and assessment of any individual or blanket restrictions. Recommendations were made in relation to patients having the opportunity to be involved in a structured recreational programme if they did not avail of day care services and the recording of patient forum meetings to include a follow up from the previous meeting. A recommendation had also been made in relation to developing staffs understanding of the Human Rights legislation, restrictive practice, capacity, consent and Deprivation of Liberty safeguards.

The inspector was pleased to note that all six recommendations had been fully implemented.

- Care plans and risk assessments had been discussed with patients and when appropriate their carers.
- Nursing staff assessed patients' consent to daily care and treatment.
- Patients had deprivation of liberty care plans in place which detailed the rationale and assessment of any individual/blanket restrictions.
- Staff recorded each day the activities patients had participated in on ward.
- A number of staff had received training in Human Rights, restrictive practice, capacity, consent and Deprivation of Liberty safeguards. Staff demonstrated through their practice and their records an understanding and competence in relation to the above areas.
- Patient forum meetings were held every three months and were attended by staff and patients. An agenda evidenced that actions were listed and at the next meeting an update was recorded of the progress made.

5.0 Ward Environment

"A physical environment that is fit for purpose delivering a relaxed, comfortable, safe and predictable environment is essential to patient recovery and can be fostered through physical surroundings." Do the right thing: How to judge a good ward. (Ten standards for adult-in-patient mental health care RCPSYCH June 2011)

The inspector assessed the ward's physical environment using a ward observational tool and check list.

Summary

The ward was spacious, clean, tidy and well maintained. The ward atmosphere was calm and relaxing. The ward is a single sex environment.

There were bay areas and single bedrooms available for sleeping. There was a number of private and quiet areas for patients to retreat to. The ward provided appropriate space and privacy to facilitate relatives/carers visits. The inspector noted adequate seating was available throughout the ward. The majority of furniture reviewed by the inspector were clean, well maintained and appropriate to the needs of the patient group. However three pieces of furniture in the main lounge were worn, ripped and required replacing. This was discussed with the staff present at feedback.

The inspector was informed that there was currently no ward information booklet available. The inspector also noted that there was no information displayed in relation to the wards performance.

Patients admitted to the ward could access the ward's independent advocate as required. Patients could also attend the patient staff meetings. Information regarding the next patient forum meeting was not displayed. Patients could access a phone in private as required. This included the payphone and cordless phone that was available.

On the day of the inspection the number of staff available was appropriate to meet the needs of the patients. There were four staff on duty however not all the staff wore a name badge. The names of nursing staff only were displayed on the notice board. There was limited signage available throughout the ward.

Patients had their own room or curtains available around their bed. Patients' could lock their bedroom door and bathroom/toilet doors as required. Staff could access bathroom and toilet areas if needed. Patients could access all areas independently. Bedrooms were open throughout the day and communal toilets were also noted to be open.

Patients could independently access the outside space. The garden areas were well maintained. There was appropriate outside seating available in the ward's garden. The ward's main entrance door was locked however patients could independently enter a code to exit. Restrictions that were in place were reflected in the individual patients care plans.

The inspector reviewed the last ligature risk assessment and action plan which was completed on 25 July 2015. Ligature points were identified in this assessment however there was no timescale set for when this work would be completed. There was evidence that care plans/risk assessments were in place in relation to patients using profiling/metal frame beds. However risk assessments were not in place to detail how environmental risks were being managed on the ward for each individual patient. Staff assured the inspector that there were no patients on the ward who had suicidal ideation. A recommendation has been made in relation to this.

A private and confidential staff base was available. Computers were located in the office. Patients' records and personal details were not on public view. The inspector noted that confidential records were being stored appropriately. The medical room was spacious, clean, organised and appropriately maintained. The resuscitation equipment was checked daily.

The majority of patients attend an external day care facility and in addition a ward activity schedule was displayed. Activities were provided by the nursing staff team. Patients had individual records of the activities that they had participated in. Staff do not currently record the information when activities are cancelled.

There was a weekly ward round held with the ward registrar.

Patients were informed of meal times on a notice board in the dining room. Meal times were protected. Outside of set times patients could not independently access fluids however they could ask staff if they require a drink. Information regarding the ward's menu was available in the dining room. The dining area was noted to be clean and comfortable. Patients reported no concerns regarding the choice of meals. The ward's menu included meals for people with different dietary requirements.

Patients could control their level of social contact. Inspectors noted no concerns regarding overcrowding. Day rooms were appropriately designed and organised to meet the needs of the patient group.

The inspectors identified the following areas which should be reviewed by the ward manager to improve standards on the ward in accordance with good practice guidance. These include:

- Developing a ward information booklet
- Displaying information about the ward's performance e.g. information in relation to incidents, compliments and complaints.
- Replacing three pieces of furniture in the main lounge which were worn and ripped.
- Ensuring staff on duty wear names badges.
- Displaying details of the ward round, ward doctor and other members of the multi-disciplinary team.
- The name of the patients' named nurse should be displayed as well as the name of the staff member who has been allocated one to one therapeutic time with the patient.
- Displaying signage to orientate patients and visitors in a format that meets the patients' communication needs.

- Information should be displayed of when the next patient forum meeting will be held.

- Records in patients' care documentation should detail when activities have been cancelled with the reasons why. There should be a mechanism for informing patients.

The detailed findings from the ward environment observation are included in Appendix 2.

6.0 Observation Session

Effective and therapeutic communication and behaviour is a vitally important component of dignified care. The Quality of Interaction Schedule (QUIS) is a method of systematically observing and recording interactions whilst remaining a non- participant. It aims to help evaluate the type of communication and the quality of communication that takes place on the ward between patients, staff, and visitors.

The inspector completed a direct observation using the QUIS tool during the inspection and assessed whether the quality of the interaction and communication was positive, basic, neutral, or negative.

Positive social (PS) - care and interaction over and beyond the basic care task demonstrating patient centred empathy, support, explanation and socialisation

Basic Care (BC) – care task carried out adequately but without elements of psychological support. It is the conversation necessary to get the job done.

Neutral – brief indifferent interactions

Negative – communication which is disregarding the patient's dignity and respect.

Summary

The formal session involved an observation of interactions between staff and patients/visitors. Three interactions were noted in this time period. The outcome of these interactions were as follows:

Positive	Basic	Neutral	Negative
100%	0%	0%	0%

Interactions observed between patients and staff during the course of the inspection were noted to be positive on each occasion. Staff were attentive

and responsive to patients needs. Staff were continually available throughout the ward and responded to patients' requests. Staff remained supportive and reassuring to patients throughout the day. Patients appeared relaxed and at ease in their surroundings.

The detailed findings from the observation session are included in Appendix 3.

7.0 Patient Experience Interviews

The lay assessor spoke briefly to six patients on the ward to talk about their care, treatment and experience as a patient. Five of these patients appeared to have limited ability to discuss their care and treatment in detail. However one of the patients stated that they were from the local area and would like to go home. They stated the food was 'ok' on the ward.

One patient stated they were well looked after and that the staff were 'great'. They said they were well treated, that they 'got smokes every hour'. They also said the staff gave them their medication. They said they went for walks and practiced 'Tai Chi' and watched the TV.

None of the patients raised any issues or concerns about their care or treatment.

8.0 Other areas examined

During the course of the inspection the inspector met with :

Ward Staff	**2**
Other ward professionals	**1**
Advocates	**0**

Ward Staff

Inspectors met with two members of nursing staff on the day of inspection. Staff who met with the inspector did not express any concerns regarding the ward or patients' care and treatment.

Ward Professional

Iinspectors met with the senior medical registrar who provided a summary of their role and input into the ward. The registrar did not express any concerns regarding the ward or patients' care and treatment. The registrar advised the inspectors of their role and input into the monthly multi-disciplinary meetings. They stated they were due to leave their post in August 2015. The registrar was unaware at this time of a replacement for Beech ward. When discussed with staff at feedback they were unaware of a replacement. Iinspectors recognise the beneficial impact this role has in patient care, treatment and

resettlement and would be concerned should a replacement of the registrar not be provided by the Trust.

Advocate

The inspection was unannounced. No advocates were available to meet with the inspectors during the inspection.

9.0 Next Steps

A Quality Improvement Plan (QIP) which details the areas identified for improvement has been sent to the ward. The Trust, in conjunction with ward staff, must complete the QIP detailing the actions to be taken to address the areas identified and return the QIP to RQIA by 14 September 2015

The lead inspector will review the QIP. When the lead inspector is satisfied with actions detailed in the QIP it will be published alongside the inspection report on the RQIA website.

The progress made by the ward in implementing the agreed actions will be evaluated at a future inspection.

Appendix 1 – Follow up on Previous Recommendations

Appendix 2 – Ward Environment Observation
This document can be made available on request

Appendix 3 – QUIS
This document can be made available on request

Appendix 1

Follow-up on recommendations made following the unannounced inspection on 25 and 26 February 2015

No.	Recommendations	No of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the nurse in charge introduces a formalised system for auditing and ensures that all care files are regularly audited.	3	There was evidence that the acting ward manager had completed electronic monthly audits on a sample of care records.	Met
2	It is recommended that in line with regional guidance 'Safeguarding Vulnerable Adults – A Shared Responsibility' (2010), the nurse in charge ensures that all staff undertake training in relation to responding to, recording and reporting concerns about actual or suspected adult abuse.	2	Out of the 15 nursing staff on the ward 10 had up to date training in safeguarding vulnerable adults. A plan was in place to ensure that all staff receive up to date training in this area.	Met
3	It is recommended that the Trust ensures that all staff working on the ward complete training in restraint appropriate to their role and responsibility.	2	Out of the 15 nursing staff 13 staff had completed initial MAPA training. A date was set 26/8/15 for the two remaining nursing staff to complete this training.	Met
4	It is recommended that the nurse in charge ensures that all staff working on the ward undertake all mandatory training appropriate to their	2	There was evidence that progress had been made in relation to mandatory training however there were still some deficits. Out of the 15 nursing staff on the ward:	Partially met

	role.		**Vulnerable adult training.** 5 nursing staff did not have up to date training. **Infection control** 5 nursing staff did not have up to date training. (1 staff member was booked to attend training in Sept 2015). **Fire Training** 6 nursing staff did not have up to date training. (3 staff booked to attend training in September 2015) **Child protection** 6 nursing staff did not have up to date training. (5 staff booked to attend training in September 2015) This recommendation will be restated for a third time.	
5	It is recommended that the Trust ensure that a system is put in place so that the nurse in charge can ensure that bank staff have the appropriate training skills and knowledge to work on the ward.	2	The head of adult mental health crisis services/lead nurse advised inspectors that they were developing a 'passport system' which will evidence that bank staff have up to date mandatory training in place. This system should be in place by September 2015 They advised that 90 % of the staff who currently work on the bank system are regular trust staff who work on the hospital site and would have up to date mandatory training in place. However this was not evidenced in Beech ward on the day of the inspection as there were deficits in the mandatory training. The head of adult mental health crisis services/lead nurse also advised that a new regional team will be set up to	Not Met

			manage bank staff, however at present there is no system to govern bank staff training. This recommendation will be restated for a third time.	
6	It is recommended that the nurse in charge ensures that ward meetings are held regularly.	2	Inspectors reviewed minutes of staff meetings which were held monthly on the ward. Minutes evidenced that there was a clear agenda set each week, with action plans/outcomes and a record of staff attendance. Next meet was arranged for 30 July 2015.	Met
7	It is recommended that the nurse in charge ensures that risk assessments and care plans are discussed with the patient and if appropriate their carer. This should be evidenced within the care documentation.	2	Inspectors reviewed three sets of care records and there was evidence that care plans and risk assessments had been discussed with patients and were appropriate their carers. These were signed by the patient and if they had not been signed a record of the reason for this was recorded.	Met
8	It is recommended that the Trust reviews the current practice for authorisation of larger purchases, including eliminating the practice of the same staff authorising the purchase and verifying the receipt. A policy and procedure should be developed and implemented.	2	Inspectors reviewed records regarding authorisation of larger purchases and there was evidence of 3 signatures to authorise the purchase, purchase the item and to verify receipts. However two policies in relation to this practice had not been reviewed and updated - the Cash Handling Policy Sept 2011 and the Patient Property Policy which had not been updated since March 2012 to reflect this new practice. A new recommendation will be made in relation to reviewing these two policies and procedures.	Partially met
9	It is recommended that the nurse in charge introduces a weekly audit of receipts	2	Inspectors reviewed financial records held on the ward. The acting ward manager had completed a weekly audit of receipts received and had checked this against expenditure.	Met

	against expenditure on this ward.			
10	It is recommended that the Trust introduces a secondary check of expenditure records on this ward.	2	There was evidence in the financial records that two staff members had checked receipts on the ward. The acting ward manager also completed a weekly check of records.	Met
11	It is recommended that the nurse in charge ensures that a record of all staff who obtain the key to the safe where patients' money is stored is maintained including the reason for access.	2	Staff had recorded who obtained the key to the safe in the "Safe Key Register" book; this was signed by two members of staff. A book was also held to record the reason for access to the safe. This was audited each week by two members of staff.	Met
12	It is recommended that the charge nurse ensures that all staff working on the ward receive an annual appraisal.	2	Appraisals from last year were completed apart from two which were not completed due to personal reasons of the staff members. The acting ward manager had commenced appraisals for 2015/16.	Met
13	It is recommended that the Trust urgently review the continued use of the current beds on the ward. The outcome of the review should be clearly reflected in the environmental and ligature risk assessment. Patients who continue to use the beds should have a clear rationale in their care file supported by a risk assessment and care plan.	1	There was evidence that the Trust had reviewed the continued use of the current beds on the ward. The Trust proposes to procure new anti-ligature beds for the ward. Inspectors reviewed evidence which confirmed that plans were in place to replace all profiling/metal frame beds. The outcome of this reviewed was reflected in the environmental risk assessment 'health and safety generic risk assessment' which was updated on 25 July 2015. Patients who continue to use profiling/metal frame beds had a risk assessment and care plan in place which was reviewed regularly.	Met
14	It is recommended that the acting ward manager ensures	1	Inspectors reviewed three sets of care records and there was evidence that risk screening tools and comprehensive	Met

	that risk screening tools and comprehensive risk assessments are completed in full. As outlined in the Promoting Quality Care Guidance Document – Good Practice on the Assessment and Management of Risk in Mental Health and Learning Disability Services- May 2010.		risk assessments were completed in full in accordance with the Promoting Quality Care Guidance Document.	
15	It is recommended that the nurse in charge ensures that staff assess patients' consent to daily care and treatment; this should be recorded in the patients' individual care plans and continuous nursing notes.	1	There evidence in the three sets of records reviewed by inspectors that nursing staff had continually assessed patients' capacity to consent to daily care and treatment. This was evident in the patients' progress notes and nursing care plans. Throughout the day of the inspection inspectors observed staff seeking consent from patients prior to providing patients with care and treatment.	Met
16	It is recommended that the acting ward manager ensures that all patients' care plans are reviewed as prescribed. Reviews of care plans should ensure that care plans are measurable and that the outcome of goals is reviewed.	1	There was evidence in the three sets of care documentation that care plans were reviewed as prescribed with a summary of the outcome for each care plan. One care plan had not been updated when a patient had been reassessed as no longer required enhanced observation. This was discussed with nurse in charge who agreed to update this care plan.	Met
17	It is recommended that the nurse in charge ensures that all patients have a person centred discharge care plan that indicates the actions to	1	In the three sets of care documentation there were care plans in place in relation to patients' discharge plans. There was evidence that these care plans were reviewed and updated after each resettlement meeting.	Met

	support and prepare patients for discharge.			
18	It is recommended that the nurse in charge ensures that each patient has an individualised care plan that reflects the rationale and assessment of any individual or blanket restrictions. The care plan should incorporate the Deprivation of Liberty Safeguards.	1	In the three sets of care records reviewed by inspectors there was evidence that each patient had a deprivation of liberty care plan in place which detailed the rationale and assessment of any individual/blanket restrictions.	Met
19	It is recommended that the nurse in charge ensures that patient signatures are available on all relevant assessment and care documentation. Staff should record evidence of patient involvement.	1	There was evidence in the three sets of care records reviewed by inspectors that patients' signatures were recorded on all relevant assessments and care documentation.	Met
20	It is recommended that the nurse in charge ensures that individualised and person centred care plans are created for all new admissions and that whilst an assessment of the individual is ongoing an interim care plan should be agreed and put in place by the multi-disciplinary team (MDT).	1	There were no new admissions on the ward. This recommendation was in relation to one patient. The inspectors reviewed this patient's care records and there was evidence that assessments and person centred care plans were in place.	Met
21	It is recommended that the	1	In the three sets of care records reviewed by inspectors	Met

	nurse in charge ensures that a detailed record of care delivered is contemporaneously documented per shift in accordance with the Nursing and Midwifery Council standards on record keeping.		there was evidence in the patients' progress records that nursing staff had completed a detailed record of patients' care and treatment.	
22	It is recommended that the nurse in charge provides an opportunity for structured and meaningful recreational activity for those patients who do not avail of external day care services; this should consider the individual needs and views of the patients.	1	In the three sets of care records reviewed there was evidence that staff recorded each day the activities patients had participated in on ward. The patients who met with the inspectors did not raise any concern regarding activities on the ward.	Met
23	It is recommended that the Trust ensures all policies and procedures are subject to a systematic and comprehensive three yearly review.	1	At the last inspection inspectors noted four policies and procedures that had not been updated or fully implemented The inspectors reviewed the operational guidelines for safeguarding vulnerable adults and noted that the guidelines were updated in October 2014 and now fully implement and due review again in October 2015. The inspectors reviewed the Trust complaints policy and procedure which was devised in May 2011 and noted that this had been revised in March 2015 and was due review again in May 2017. However the Cash handling Policy Sept 2011 and the	Partially met

			Patient Property Policy March 2012 had not been updated. As detailed in recommendation 8 a new recommendation will be made in relation to reviewing these two policies and procedures.	
24	It is recommended that the Trust urgently review the current system and process for the collation, recording and maintenance of staff training records.	1	The Trust had an electronic colour coded matrix system in place which identified the staff whose training was in date, staff that were booked on training, and the staff whose training was out of date.	Met
25	It is recommended that the Trust ensures that timescales are agreed against any actions carried forward following an MDT meeting so that progress can be monitored and tracked.	1	The ward had developed a new multidisciplinary (MDT) template which detailed timescales agreed and any actions carried forward following an MDT meeting so that progress can be monitored and tracked. However this template was inconsistently used on the ward as a number of staff were still recording the outcome of MDT meetings in the progress notes and not in this new template. New recommendation will be made in relation to this.	Met
26	It is recommended that the Trust ensures that all ward based staff are provided with training in: Human Rights, restrictive practice, capacity, consent and Deprivation of Liberty safeguards.	1	Inspectors noted from reviewing the training matrix that 9 of the 15 staff had completed formal training in Human Rights, restrictive practice, capacity, consent and deprivation of liberty safeguards. There was no evidence of arrangements in place to train the remaining staff team. However, despite this the inspectors noted that staff demonstrated through their practice and their records an understanding and competence in relation to the above areas. Inspectors had no concerns regarding staffs understanding in relation to same.	Met
27	It is recommended that the	1	Inspectors reviewed records which confirmed that on three	Met

	Trust urgently review the current practice of transferring acutely unwell patients from Lime ward to Beech ward. If this practice is to continue an urgent review of the sleeping area and safe staffing arrangements must be completed**.**		occasions the same patient from Lime Ward spent an overnight in Beech ward 9, 12, 13 June 2015. Inspectors discussed this with the head of adult mental health crisis services/lead nurse who advised that interim local practice guidance has been issued in relation to the transfer of patients between Lime and Beech ward. This details the actions staff need to take to ensure of patients' safety. This includes: Transfers were only taking place in the context of a MDT risk assessment which takes into account whether the transfer is safe. The interim guidance states that the risk assessment will take into account : *"1: the environment that the patient is being transferred to include any need for ligature risk assessment of the sleeping area and general environment in the context of the patients' needs.* *2: The care and support needs of the patient including whether staffing levels in Beech are adequate to provide safe and effective care* *Decisions to transfer should be based on the above through agreement of the respective nurses in charge and a thorough handover of the patients profile and assessed needs should occur at the point of transfer and be fully*	

			recorded. Any requirement for additional staff to support the patient must be in place at the time of transfer. Where a transfer from Lime to Beech is agreed consent should be sought and recorded and the patient and their family/ carers should be actively involved in the process". In addition to this interim local practice a further review meeting has been arranged for 4 August 2015 to discuss and a formal review of this process. The Trust plan to *"develop local systems in accordance with the Regional Protocol including bed escalation systems and local standards for transfers to assure quality and safety and optimum patient experience.*	
28	It is recommended that the Trust confirms if staff are authorised to sleep in specified areas on the ward during their allocated breaks. If so authorised, it is recommended that the Trust provides guidance for staff in relation to sleeping on authorised breaks, including specifying the arrangements for the governance of this practice to ensure optimum patient safety and supervision at all times.	1	The nurse in charge and the head of adult mental health crisis services/lead nurse confirmed that this practice no longer takes place on the ward. A directive was sent from the Assistant Director of Mental Health Services which stated that this practice should not be happening on wards.	Met
29	It is recommended that all members of the MDT ensure that documents such as the most recent case summaries	1	The inspectors reviewed three sets of care records and there was evidence in the patients' medical notes that recent case summaries had been completed.	Met

	are held in the current volume of records.			
30	It is recommended that all members of the MDT must ensure that the correct date and time is recorded in patients' care records. An audit of records should be undertaken to ensure accuracy.	1	There was evidence that the acting ward manager had completed audits of the care records. However in three sets of care records reviewed two records had incorrect dates on the care plans and four MDT records did not have a record of the date of the meeting. This recommendation will be restated for a second time.	Partially Met
31	It is recommended that the Trust review the current arrangements for the hand written recording of MDT records so to ensure information is clearly legible and that the writer and designation of the writer can be established.	1	The ward had developed a new multidisciplinary (MDT) template. There was evidence in the three records reviewed by the inspectors that each patient had a record completed which detailed staff in attendance, if the patient attended the meeting, a summary of the patients' progress and action to be taken. All records were clearly legible and the name and designation of the author could be identified. However as stated in recommendation 25 this template was inconsistently used on the ward as a number of staff were still recording the outcome of MDT meeting in the progress notes and not in this new template.	Met
32	It is recommended that the nurse in charge ensures that agreed actions following patients' meetings are implemented and followed up at the next meeting.	1	The inspectors reviewed the minutes of the patient forum meetings and there was evidence that these meetings were held every three months. Meetings were attended by staff and patients. An agenda was set for each meeting and an updated was recorded of the progress made/outcome. Minutes were comprehensively completed and detailed patients' views.	Met

Western Health
and Social Care Trust

Ref EW.00849/JMcM

11th September 2015

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

Dear Sir/Madam

Please find enclosed completed quality improvement plan in relation to the unannounced inspection of Beech Ward, Tyrone & Fermanagh Hospital, which was undertaken on the 20th July 2015.

Should you require any further information, please do not hesitate to contact me.

Yours sincerely

ELAINE WAY CBE
CHIEF EXECUTIVE

Encs

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Inspection

Beech Ward, Tyrone and Fermanagh hospital

20 July 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with the nurse in charge and the head of adult mental health crisis services/lead nurse on the day of the inspection visit.

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

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
Is Care Safe?					
1	5.3.1 (a)	It is recommended that the Trust ensures that a risk assessment /care plan is completed for each individual patient detailing how environmental risks are going to be managed and reviewed to ensure patient safety.	1	Immediate and ongoing	Environmental Risk Assessments have been completed. All patients have ongoing and dynamic risk assessments that are reviewed and updated regularly. Any identified risk is managed via a person centred care plan, based on a thorough knowledge of the individual and the environment.
2	5.3.1 (a)	It is recommended that the Trust complete a detailed action plan from the environmental ligature risk assessment of the ward. This action plan should detail the actual timescales agreed for this work to be completed to ensure the safety of patients on the ward	1	31 October 2015	The Acting Ward Manager in Beech Villa completed a risk assessment which identified potential ligature points in patient accessible areas. These included door hinges approx.25, window handles approx. 78 and profiling beds 12. Replacement beds have been ordered. A business case for procurement of replacement beds has been submitted and will be considered by Business Case Review Group. A Minor Capital Works request has been submitted. This work will be considered through Directorate CSCG for inclusion in Risk Register and prioritised accordingly.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
3	4.3 (m)	It is recommended that the nurse in charge ensures that all staff working on the ward undertake all mandatory training appropriate to their role	3	30 November 2015	The Acting Ward Manager has prioritised attendance at mandatory training It is anticipated that outstanding training needs will be met by December 2015 despite course training places being very limited (staff will have to travel outside of the WHSCT to access mandatory training). Details of proposed training. • 4 staff outstanding in Vulnerable Adults/ Child Protection -all staff booked for Sept and Nov 2015 • 2 staff outstanding in MAPA - both staff booked for Nov 2015 • 8 outstanding in DOLs, Capacity and Consent, Restrictive Intervention, Human Rights - all staff booked for Oct and Nov 2015 • 3 outstanding in Moving and Handling -all 3 booked for Nov and Dec 2015 • 7 outstanding in ILS -all booked for Sept, Oct Nov and Dec 2015 • 6 outstanding in fire safety - all booked for Sept and Nov 2015

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
4	4.3 (m)	It is recommended that the Trust ensure that a system is put in place so that the nurse in charge can ensure that bank staff have the appropriate training skills and knowledge to work on the ward.	3	30 November 2015	The Lead Nurse is working on a passport system to ensure that all bank staff have a record of registration, revalidation, supervision, appraisal and completed mandatory training that they can present to the Ward Manager when they report for duty. It is anticipated that this will be completed for all bank staff by March 2016.
Is Care Effective?					
5	5.3.1 (f)	It is recommended that the Trust ensures the following procedures are reviewed and updated. • Cash Handling Policy Sept 2011 • The Patient Property Policy which should be reviewed to reflect the new practice in relation to the requirement of 3 staff signatures when authorising larger purchases on behalf of patients. (To include a signature to authorise the	1	31 December 2015	The Trust have revised the Draft Cash Handling Procedures Policy Sept 2015. A copy is available on the ward. The Draft Patient Property Policy has also been reviewed by the Trust Finance Department and reissued September 2015. A copy is also available on the ward pending final sign off by the Senior Finance Team on 21/09/15. 3 ward staff currently authorise purchases whilst the Trust Policy indicates that 2 signatures is sufficient.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		purchase, purchase the item and to verify receipts)			
6	5.3.1 (f)	It is recommended that all members of the MDT must ensure that the correct date and time is recorded in patients' care records. An audit of records should be undertaken to ensure accuracy.	2	Immediate and ongoing	The Acting Ward Manager in Beech Villa regularly audits patient notes using the WHSCT Audit Tool. Section A of this Audit Tool (Mandatory Requirements) includes correct date and time in the audit indicators. An independent record keeping audit was conducted by the Governance Lead and a Psychology Trainee in June 2015. No omissions or errors were noted at that time. It has been agreed that medical staff will use a recognised audit tool to audit medical notes.
Is Care Compassionate?					
		No recommendations			

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

NAME OF WARD MANAGER COMPLETING QIP	Jim Duffy
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	

Inspector assessment of returned QIP		Yes	No	Inspector	Date
A.	Quality Improvement Plan response assessed by inspector as acceptable	X		A McLellan	24/9/15
B.	Further information requested from provider		X	A McLellan	24/9/15