Mental Health and Learning Disability Inpatient Inspection Report
26-28 September 2016

Beech Ward

Rehabilitation and Recovery Ward
Tyrone and Fermanagh Hospital
1 Donaghanie Road
Omagh
BT79 0NS

Tel No: 02882835371

Inspectors: Audrey McLellan and Dr Oscar Daly
Lay Assessor: Alan Craig

www.rqia.org.uk

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

Beech Ward is a 12 bedded male ward on the Tyrone & Fermanagh Hospital site. The purpose of the ward is to provide rehabilitation and recovery to patients' who are experiencing enduring mental health difficulties. There were six patients on the ward on the day of the inspection two of these patients' were detained under the Mental Health (NI) Order 1986.

The multidisciplinary team (MDT) consists of a team of nursing staff, health care assistants, a medical registrar and a consultant psychiatrist. Patients receive Occupational Therapy input when they attend the Rowan Day Centre which is situated on the grounds of the hospital site. Speech and language therapy, dietetics, physiotherapy, podiatry and dentistry were available on a referral basis.

3.0 Service details

Responsible person: Elaine Way, CBE	**Position:** Chief Executive
Ward manager:	Denise O'Hagan
Person in charge at the time of inspection: Denise O'Hagan	

4.0 Inspection summary

An unannounced inspection took place over three days from 26 – 28 September 2016.

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

Evidence of good practice was found in relation to patients' involvement in completing their care plans, the interactions between staff and patients, patients' access to day care facilities and the positive working relationship between members of the multidisciplinary team (MDT).

Areas requiring improvement were identified in relation to patients involvement in completing their risk assessments, the completion of patients' risk assessments by staff, the recording of patients' capacity and patients not seen by the consultant psychiatrist outside the ward round. The ward also required updating with regard to the furnishing and the general environmental to make it a more therapeutic environment for patients. There was also no evidence in the governance meetings of any proactive strategies in place to look at reducing the number of incidents on the ward.

Escalation concerns resulted from the findings of this inspection. Concerns were raised in relation to the following areas:

- Under reporting of serious adverse incidents.
- The admission of a forensic patient onto the ward who did not have a mental health condition or a clear defined management plan in place.
- Environmental ligature points throughout the ward without a comprehensive risk assessment in place to include a clear management plan detailing the existing control measures and if any further action is required within a set timescale.

A serious concerns meeting was held on 3 October 2016 with senior trust representative to discuss these issues. An action plan was agreed at this meeting.

All four patients who met with the lay assessor stated they were happy on the ward and were involved in their care and treatment. They felt that being on the ward was helping them to recover and they stated staff treated them with dignity and respect.

Patients said:

"At the start I was against coming here but looking back it was the right thing to do…….there is a great respect for you…… and they understand your predicament and they are willing to sit and talk it through with you"

"It's ok to be honest"

"We go out on trips now and again……I feel like a king in here. A great spot now…..I can make an appearance….I'm not very good with formal meetings…..we go over to the centre every day and I do a bit of fishing in the river…I've improved a lot since I've been in here….you have a lot more freedom here…..I think it's great. It's a lot better than where I was before…..everything is great. No complaints at all"

"I feel safe and sound"

The inspectors spoke to three relatives on the phone. All three relatives stated they were happy with the care and treatment their relative was receiving on the ward. They stated staff were accessible to them when they visited the ward, were approachable and they felt their views were listened to. They had received information to support their relatives' recovery and they stated the care and treatment on the ward had benefited their relative.

Relatives said:

"The care on the ward is excellent and staff seem to understand X better than other wards X had been in"

"Staff are very friendly and approachable……the ward is building up X's confidence…..it's the best I have seen X in a long time"

"Staff are very understanding…we are very happy with the care on the ward we feel X is safe on the ward"

The inspectors spoke to five members of the MDT who all stated they enjoyed working on the ward and felt that the MDT worked well together. Staff confirmed that they had received supervision, had up to date appraisals in place and were given time to continue their professional development.(CPD). Staff stated that information from governance meetings was cascaded down to staff teams and individual clinicians.

The inspectors also spoke to a number of visiting professionals including the occupational therapist who works in the Rowan Day Centre which the patients attend and the manager of this day centre. These two professionals discussed how they provide a service for patients which is flexible in relation to patients' choice of attendance at the Rowan Centre. The OT stated they complete assessments with each patient and plan goals which are specific to patients' individual needs. They stated their aim is to improve patients' independent living skills and they do this by working on various different activities of daily livng within the day centre. They record patients

progress on the Epex system for staff to access. However, they do not regularly attend the MDT meeting each week.

The inspectors also spoke to a community social worker who was involved in completing assessments for one patient on the ward and the manager of a resident home who had attended a discharge planning meeting for one of the patients who was on a trial placement in the residential home they were managing. None of these professionals raised any concerns regarding the care and treatment of patients on 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	**17**

Findings of the inspection were discussed with the ward manager, the deputy ward manager, a health care assistant and a senior member of the trust as part of the inspection process and can be found in the main body of the report.

The escalation policies and procedures are available on the RQIA website.

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

5.0 How we Inspect

This 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/statement of purpose 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 patients, five staff, four visiting professionals and spoke to three of the patients' relatives.

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

The following records were examined during the inspection:

- Four sets of patient care records
- Multi-disciplinary team records
- Policies and procedures
- Staff roster
- Staff supervision timetable
- Clinical room records
- Policies and procedures
- Environmental risk assessment
- Health and Safety assessment
- Fire Safety assessment 2015
- Mandatory Training records
- Discharge planning
- Records relating to the use of restrictive practices and deprivation of liberty
- Incidents, accidents and serious adverse incident records.
- Records relating to adherence to statutory requirements of mental health legislation
- Records relating to the monitoring of average length of stay and discharge
- Minutes of patient experience meetings.
- Minutes of resettlement meetings.
- Minutes of ward manager meetings
- Minutes of a number of different goverance meetings

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

RQIA reviewed the recommendations made at the last inspection. An assessment of compliance will be recorded as met/partially met/not met.

6.0 The Inspection

6.1 Review of recommendations from the most recent inspection dated 20 July 2015

The most recent inspection of the ward was an unannounced inspection. The completed Quality Improvement Plan (QIP) was returned and approved by the responsible inspector. This QIP was validated by the responsible inspector during this inspection.

6.2 Review of recommendations from last inspection dated 20 July 2015

Recommendations		Validation of compliance
Number 1 **Standard**: 5.3.1 (a) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Risk assessments/care plans were in place for each patient which detailed how environmental ligature risks were going to be managed for patients. These were reviewed on a regular basis.	
Number 2 **Standard**: 5.3.1 (a) **Stated:** First time	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.	**Not Met**
	Action taken as confirmed during the inspection: An environmental ligature risk assessment was completed on 1 June 2016. However, this was not a comprehensive assessment of the ligature points within the ward. Senior representatives confirmed that this ward will be closing in approximately 18	

	months and therefore funding may not be approved to remove all ligature points on the ward. However, a comprehensive risk assessment needs to be completed to detail all environmental ligature points on the ward with a clear management plan which details the existing control measure in place and if any further action is required a timescale should be recorded. This recommendation will be restated as a priority one area of improvement.	
Number 3 **Standard**: 4.3 (m) **Stated:** Third time	It is recommended that the nurse in charge ensures that all staff working on the ward undertake all mandatory training appropriate to their role.	**Met**
	Action taken as confirmed during the inspection: A number of staff had to receive training in relation to fire safety, basic life support and COSHH. The ward manager had dates in place over the coming weeks for this training to be completed.	
Number 4 **Standard**: 4.3 (m) **Stated:** Third time	It is recommended that the Trust ensures 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.	**Met**
	Action taken as confirmed during the inspection: The WHSCT are now using a central bank system which has been in place since 18 January 2016. When the ward manager requires a bank staff member they make a request through this system identifying any specific duties they require from staff over and above general duties on the ward. A bank nurse co-ordinator monitors/validates the training needs of all staff who only have a bank contract. When staff need to update their mandatory training they request a place though the Clinical Education Centre (CEC). When a request is made their line	

	manager is notified by email and when the training has been completed their line manager is emailed again and sent a copy of the certificate.	
Number 5 **Standard**: 5.3.1 (f) **Stated:** First time	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 purchase, purchase the item and to verify receipts)	**Partially Met**
	Action taken as confirmed during the inspection: The inspectors reviewed the Cash Handling Policy and there was evidence that it had been reviewed and updated in September 2015. However the Patient Property Policy had not been reviewed and updated.	
Number 6 **Standard**: 5.3.1 (f) **Stated:** Second time	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.	**Partially Met**
	Action taken as confirmed during the inspection: The inspectors reviewed patients' care records and there were no concerns noted in relation to the recording of the correct date and time. The ward staff were completing an audit in relation to the mandatory requirements on the care documentation. However, there were sections of this audit tool which had not been completed as audit tool was not compatible with the care documentation used on the ward. A new area of improvement will be made in relation to this.	

6.3 Review of findings

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

Patients had individual risk assessment/management plans in place in relation to the ligature risks in the ward environment.

A generic health and safety assessment had been completed on 18 April 2106 with an action plan.

Staff knew who to raise concerns with when identified. There were no issues raised by staff in relation to the care and treatment of patients on the ward.

Staff who met with the inspectors stated they were well supported and the MDT team worked well together.

Staff confirmed they do not work beyond their role and experience.

There were no concerns raised in relation to the detention process.

Staff were observed gaining consent from patients prior to supporting them with their care and treatment.

Relatives stated they knew how to make a complaint.

Information regarding the complaints procedure was displayed throughout the ward.

Areas for Improvement

Risk assessments were not completed in accordance with the Promoting Quality Care - Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010.

- There was no evidence that patients and/or their representatives were actively involved in designing and managing their own risk management plans.
- In all four of the risk assessments reviewed there was no management plan or contingency plan completed.
- All four risk assessments were regularly reviewed each week. However, the review record detailed the discussions at the MDT meetings but did not always record an update on the current risks.
- One patient had a risk screening tool completed by only one member of staff.
- It was unclear who had been involved in completing risk assessments as there was no record of who contributed to the assessment.

An environmental ligature risk assessment was completed on 1 June 2016. However, this was not a comprehensive assessment of the ligature points within the ward. Senior representatives confirmed that the ward would be closing in approximately 18 months and therefore funding may not be approved to remove all ligature points. However, a comprehensive risk assessment had not been completed to include all environmental ligature points with a clear management plan detailing the existing control measures in place and if any further action is required within a set timescale.

Concerns were raised in relation to the admission of a forensic patient onto the ward who did not have a mental health condition. When inspectors reviewed this patient's care records there was no clearly defined management plan in place or comprehensive risk assessment This patient had not been regularly reviewed by the consultant who was responsible for their care.

The fire safety assessment and action plan was received after the inspection.(13/10/16) The inspector was concerned to note that there were areas identified as 'extreme risk' which required immediate action and 'high risk' which required action within three months but there was no date recorded of when these risks would be removed.

Number of areas for improvement	**4**

6.4 Is Care Effective?

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

Areas of Good Practice

There was evidence that patients' needs were assessed by nursing and medical staff and interventions were based on each patient's individual assessed need.

There was evidenced that care plans were updated when patients' needs had been reviewed to reflect the change to their care and treatment.

Care plans were completed to a good standard and based on the assessed needs of each patient. Each care plan had been signed by patients when they had agreed to the plan of care. If patients had disagreed this was also recorded.

Patients who met with inspectors stated they were involved in their care and treatment.

Patients told inspectors they felt being on the ward was helping them.

The Multi-Disciplinary Team (MDT) template was completed in full in each care record to detail decisions agreed, the responsible person for implementing agreed actions and the timeframe to complete the action plan. When patients did not attend their MDT meetings this was recorded on the MDT template.

There was evidence that appropriate referrals were made to other professionals when discussed and agreed at the MDT meeting. These included referrals to dietetics, physiotherapy, speech and language therapy, podiatry and the dentist.

The ward did not have an Occupational Therapist (OT) attached to the ward. However, patients attended the Rowan Day Centre on the hospital site and they received support from the OT in this facility.

Resettlement meetings were held with relevant professionals to discuss plans for each patient in the community.

When patients were discharged to a nursing or residential home a discharge planning meeting was held and staff from the facility attended the ward to complete their assessment and to discuss each patients' care needs.

There were areas for patients to relax on their own and there were communal areas were patients could meet up with each other.

The ward displayed large pictorial signs to orientate patients around the ward.

Deprivation of liberty (DOLS) care plans were in place in relation to the door on the ward which was locked but patients had access to the code.

There was evidence that the MDT reviewed patients' detention regularly to ensure patients were experiencing the least restrictive option

Areas for Improvement

There was no date recorded on patients' nursing assessments and no record of the patients' personal details (address/next of kin/family members) apart from their name, date of birth and health and social care number. There was no record of who had completed the assessment.

Patients' capacity was recorded. However, it was unclear which specific area the patient had been assessed as 'capable' or incapable' as this was not recorded. In one care record the patient was currently being assessed in relation to their capacity to understand a specific area of care, however, their records stated 'capable' in this section.

Patients were not seen by the consultant psychiatrist outside the ward round.

The Occupational Therapist (OT) did not attend the MDT meeting each week. Therefore information regarding patients' progress in this area was not part of the discussions at the MDT meetings.

The ward required updating with regard to the furnishings and the general maintenance of the ward environmental required attention.

- Curtains were hanging off some of the rails and the general maintenance of the ward was poor which included the outdoor space.
- A number of pieces of furniture in the main lounge were worn, ripped and required replacing.
- The sinks in the patients' bedrooms did not have a cold tap but had a soap dispenser instead.
- There were two summer seats in the ward's garden which required painting.
- There was a picnic bench situated at the entrance to the ward which required painting and the main entrance was overgrown with weeds.
- The garden areas were not well maintained. Grass and weeds were evident, there were no plants and the patio areas required cleaning.

A toilet was closed due to environmental work that required to be completed (the floor needed to be replaced). However, staff informed the inspectors that this was reported 6 months previously and the work had still not been completed.

Number of areas for Improvement	6

6.5 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

Patients informed the lay assessor that they were treated with dignity and respect

The inspectors completed a number of observations/interactions during the three day inspection. All interactions between staff and patients were observed as positive.

There was evidence in the patients' care records and by speaking to patients' relatives/carers that they were given the opportunity to be involved in their care and treatment

Staff explained the need for the use of any restrictive practice, ensured this was understood and supported patients accordingly.

Patients and relatives who spoke to the inspectors stated they were happy with the care on the ward.

An advocate from the Foyle Advocacy Service visits the ward every fortnight to support patients on the ward.

Areas for Improvement

No areas for improvement were identified during the inspection.

Number of areas for Improvement	0

6.6 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

Staff who spoke to the inspectors demonstrated a good understanding of their role in relation to safeguarding, child protection, escalation and whistleblowing.

Governance arrangements were in place to monitor the prescription and administration of medication.

There was governance oversight of patients' discharge.

Staff meetings were held on the ward and there was evidence that information was cascaded to the team from governance meetings.

All staff who were interviewed by the inspectors stated that the MDT worked well together.

Patient forum meetings were held on the ward each month. There was evidence that actions were devised and implemented to address areas of improvement identified by patients on the ward.

There was a defined organisational and management structure in place.

Staff confirmed that they had received supervision and had an up to date appraisals in place.

There were plans in place for health care assistants to receive supervision.

There were some gaps in the staffs' mandatory training however the ward manager had dates booked to ensure all staff had up to date mandatory training in place.

There were effective staffing arrangements in place to ensure staff shortages are responded to and governance arrangements were in place to monitor the use of bank staff.

Areas for Improvement

The Guidance on Deprivation of Liberty was due to be reviewed in February 2016 but at the time of the inspection had not been reviewed

Concerns were raised in relation to the under reporting of serious adverse incidents.

- Two incidents of a sexual nature which happened in November 2014 and in May 2016 perpetrated by the same patient had not been reported to RQIA as per the Health and Social Care Boards Procedure for Reporting and Follow up of Serious Adverse Incidents, (October 2013).

The inspectors reviewed minutes of the governance meetings and there was no evidence that staff were analysing information so that services could be improved. Although the data was available and discussed through the governance mechanism there was no evidence of any proactive strategies to look at reducing the number of incidents.

The audit tool used to reviewed care documentation was not compatible with the care documentation currently used on the ward. Therefore staff could not complete all sections of this audit tool and a full audit of care records was not completed.

There was no psychology input on the ward. Patients can be referred to psychology services in the community however there is a waiting list for this service.

There is no longer a social worker attached to the ward to assist with the resettlement of patients.

RQIA were concerned to note that medical staff had not been actively involved in discussions regarding the future of the ward and in the planning of future services. It was concerning to note that medical staff were not aware of the plans in place to close the ward when the new facility is built. Staff and senior trust representatives were unable to provide details of how rehabilitation and recovery will be provided to patients in the future.

Number of areas for improvement	**7**

7.0 Provider Compliance Plan

Areas for improvement identified during this inspection are detailed in the provider compliance plan. Details of the provider compliance plan was 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.

7.1 Areas for Improvement

This section outlines recommended actions, to address the areas for improvement identified, based on quality care standards, the Mental Health (Northern Ireland) Order 1986 and relevant evidenced based practice.

7.2 Actions to be taken by the Service

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

Provider Compliance Plan Beech Ward	
Priority 1	
Area for Improvement No. 1 **Stated:** First time **Standard:** 5.3.2 (a, b,c) **To be completed by:** 26/10/2016	The responsible person must ensure the following findings are addressed: Concerns were raised in relation to the under reporting of serious adverse incidents.
	Response by responsible person detailing the actions taken: The response was forwarded to your office on 26th October 2016
Area for Improvement No. 2 **Stated:** First time **Standard:** 5.3.1 (a) **To be completed by:** 26/10/2016	The responsible person must ensure the following findings are addressed: Concerns were raised in relation to the admission of a forensic patient onto the ward who did not have a mental health condition. When inspectors reviewed this patient's care records there was no clearly defined management plan in place or comprehensive risk assessment. This patient had not been regularly reviewed by the consultant psychiatrist who was responsible for their care.
	Response by responsible person detailing the actions taken: The response was forwarded to your office on 26th October 2016
Area for Improvement No. 3 **Stated:** Second time **Standard:** 5.3.1 (a) **To be completed by:** 26/10/2016	The responsible person must ensure the following findings are addressed: An environmental ligature risk assessment was completed on 1 June 2016. However, this was not a comprehensive assessment of the ligature points within the ward. Senior representatives confirmed that the ward would be closing in approximately 18 months and therefore funding may not be approved to remove all ligature points. However, a comprehensive risk assessment had not been completed to include all environmental ligature points with a clear management plan detailing the existing control measures in place and if any further action is required within a set timescale.
	Response by responsible person detailing the actions taken:

	A Comprehensive Enviromental Ligature Risk Assessment of the Ward has been completed on 5th October 2016, by Denise O'Hagan Ward Manager, Jim Duffy Charge Nurse and Eamonn Duffy Staff Nurse. Senior Management will review and authorise the Estates Department to provide estimate of cost. Time scale to complete costing for the work identified in Enviromental Ligature Risk assessment is end of January 2017
Area for Improvement No. 4 **Stated:** First time **Standard:** 5.3.1 (f) **To be completed by:** 26/10/2016	The responsible person must ensure the following findings are addressed: The fire safety assessment and action plan was received after the inspection.(13/10/16) The inspector was concerned to note that there were areas identified as '**extreme risk'** which required immediate action and **'high risk'** which required action within three months but there was no date recorded of when these risks would be removed.
	Response by responsible person detailing the actions taken: A local smoking protocol has been devised, October 2016. This will be reviewed by Denise O'Hagan Ward Manager and Jim Duffy Charge Nurse October 2017. At present the protocol is being disseminated to all staff . A signed record of staff acknowledgement will be kept in the Fire Log file along with the protocol. Clinical Room: No signage to inform staff of oxygen present in the clinical room, this has been requested via Estates Department. A laminated coloured sign is in place temporarily. All key locks have been removed from external doors All staff will have Fire Training by the end of November 2016 One member of staff requires Nominated Fire Officer Training and he is booked to attend November 2016
Priority 2	
Area for Improvement No. 5 **Stated:** First time **Standard:** 5.3.1 (a) **To be completed by:** 21/12/2016	The responsible person must ensure the following findings are addressed: Risk assessments were not completed in accordance with the Promoting Quality Care - Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. • There was no evidence that patients and/or their representatives were actively involved in designing and managing their own risk management plans. • In all four of the risk assessments reviewed there was no

	management plan or contingency plan completed. • All four risk assessments were regularly reviewed each week. However, the review record detailed the discussions at the MDT meetings but did not always record an update on the current risks. • One patient had a risk screening tool completed by only one member of staff. • It was unclear who had been involved in completing risk assessments as there was no record of who contributed to the assessment.
	Response by responsible person detailing the actions taken: Staff will ensure that patients and if appropriate, relatives are involved in formulating risk management and contingency plans. A pro forma has been designed which will evidence that patients and or their representaives have been involved with their risk management and contingency plans. The proforma will be reviewed by staff and then discussed at a Team Meeting arranged for December 2016. The Multi-Displinary Team will dedicate time to complete the risk management and contingency plans at the ward meeting. One assessment per week will be completed. All relevant members of the team will have input and record who has been involved in the process. The Risk Screening tool has been amended to record the 2 signatures required.
Area for Improvement No. 6 **Stated:** First time **Standard:** 5.3.1 (f) **To be completed by:** 2/11/2016	The responsible person must ensure the following findings are addressed: There was no date recorded on patients' nursing assessments and no record of the patients' personal details (address/next of kin/family members) apart from their name, date of birth and health and social care number. There was no record of who had completed the assessment.
	Response by responsible person detailing the actions taken: Beech Ward now has a dedicated nursing assessment adapted from the Older People's Care Pathway which will replace the front sheet in all of the patient's notes. This will be reviewed by staff and discussed at the Team Meeting in December 2016. All patient's to have a completed assessment in place by January 2017.
Area for Improvement No. 7	The responsible person must ensure the following findings are addressed:

Stated: First time **Standard:** 5.3.1(f) **To be completed by:** 2/11/2016	Patients' capacity was recorded. However, it was unclear which specific area the patient had been assessed as 'capable' or 'incapable' as this was not specified. In one care record the patient was currently being assessed in relation to their capacity to understand a specific area of care. However, their records stated 'capable' in this section. This requires to be updated.
	Response by responsible person detailing the actions taken: There is a dedicated assessment tool included in new proforma. (Area of Improvement No 6). Capacity will be assessed depending on the decisions required. This will be specific to the area of capacity being questioned and will be documented in the medical and nursing notes.
Area for Improvement No. 8 **Stated:** First time **Standard:** 5.3.3(f) **To be completed by:** 23/11/2016	The responsible person must ensure the following findings are addressed: Patients were not seen by the consultant psychiatrist outside the ward round.
	Response by responsible person detailing the actions taken: The patient's in Beech Villa are classified as recovery patients and are generally mentally stable. It has been agreed with the Consultant Psychiatrist that after the restructured Ward Conference where the patients will be discussed, the Consultant will then review the patients individually. Should a patient require to see the Consultant on other occasions he will make himself available.
Area for Improvement No. 9 **Stated:** First time **Standard:** 5.3.3(a) **To be completed by:** 23/11/2016	The responsible person must ensure the following findings are addressed: The Occupational Therapist (OT) did not attend the MDT meeting each week. Therefore information regarding the patients' progress in this area was not part of the discussions at the MDT meetings.
	Response by responsible person detailing the actions taken: Patients in Beech Villa who require input from an occupational therapist have access to a senior Occupational Therapist within Rowan Villa. All interventions are recorded on EPEX and the OT attends the ward meeting to discuss assessment findings and advise re ongoing treatment. This is discussed at ward meeting. It is not feasible or necessary for the OT to attend every weekly meeting. The OT carries out a number of joint interventions with ward staff and is in regular contact with them.

Area for Improvement No. 10 **Stated:** First time **Standard:** 5.3.3.(f) **To be completed by:** 21/12/2016	The responsible person must ensure the following findings are addressed: The ward required updating with regard to the furnishings and the general maintenance of the ward environmental required attention. • Curtains were hanging of some of the rails and the general maintenance of the ward was poor which included the outdoor space. • A number of pieces of furniture in the main lounge were worn, ripped and required replacing. • The sinks in the patients' bedrooms did not have a cold tap but had a soap dispenser instead • There were two summer seats in the ward's garden which required painting. • There was a picnic bench situated at the entrance to the ward which required painting and the main entrance was overgrown with weeds. • The garden areas were not well maintained. Grass and weeds were evident, there were no plants and the patio areas required cleaning.
	Response by responsible person detailing the actions taken: Requisitions have been forwarded to the Estates Department within the hospital site to start the process of ensuring that Beech Villa maintains a high standards of décor internally and externally. All curtains have been hung. Following discussions with Service Manager she will look at the possibility of funding for the furnishing of Beech Villa taking into account the movement of patient to the new build.. The Estates Department has visited Beech Villa to access the possibility of having cold water into the single bedrooms this has been deemed not viable, and the removal of the sinks from the single bedrooms may be an option. However the following has been put in place whereby patients will have a jug of cold water made available in the morning and in the evening. There are suffient bathroom for patients to access within Beech Villa . Works have started on Rathview which has a completion date of Spring 2018
Area for Improvement No. 11 **Stated:** First time	The responsible person must ensure the following findings are addressed: A toilet was closed due to environmental work that required to be completed (the floor needed to be replaced). However, staff informed

Standard: 5.3.3(f) **To be completed by:** 23/11/2016	the inspectors that this was reported 6 months previously and the work had still not been completed.
	Response by responsible person detailing the actions taken: A requisition has been generated and this has been tendered as per Trust processes 3/11/2016. These works are unlikely to be completed in the timeframe proposed
Area for Improvement No. 12 **Stated:** First time **Standard:** 5.2.3 (c) **To be completed by:** 21/12/2016	The responsible person must ensure the following findings are addressed: The inspectors reviewed minutes of the governance meetings and there was no evidence that staff were analysing information so that services could be improved. Although the data was available and discussed through the governance mechanism there was no evidence of any proactive strategies to look at reducing this number of incidents.
	Response by responsible person detailing the actions taken: The Ward Manager will contact the Risk Management Department on a quarterly basis and obtain a copy of comprehensive list of the Incidents/ Accidents to discuss at the team meeting. Any learning will be recorded in the minutes. Findings will then be escalated to the Goverance Lead should the need arise for further discussion.
Area for Improvement No. 13 **Stated:** First time **Standard:** 5.3.1 (f) **To be completed by:** 21/12/16	The responsible person must ensure the following findings are addressed: The audit tool used to reviewed care documentation was not compatible with the care documentation currently used on the ward. Therefore staff could not complete all sections of this audit tool and a full audit of care records was not completed.
	Response by responsible person detailing the actions taken: The current Audit tool does not meet the requirements of Beech Villa. The Charge Nurse will investigate to see if there are any other audit tools that can be adapted to meet the requirements of the audit and appropriate to Beech Villa. The Charge Nurse will discuss the present audit tool with Nursing Management. The Audit tool will be discussed at the RQIA interface meeting with the Goverance Lead and Lead Nurse. In the interim the audit tool will be completed in present form to ensure that the KPI'S can be recorded

Area for Improvement No. 14 **Stated:** First time **Standard:** 4.3 (j) **To be completed by:** 23/11/2016	The responsible person must ensure the following findings are addressed: There is no longer a social worker attached to the ward to assist with the resettlement of patients.
	Response by responsible person detailing the actions taken: The resettlement of patients has been completed except for one gentleman, therefore it is not necessary to have a social worker employed full time within Beech Villa. However, all patients have acess to a social worker. Social Work assistance/advice is provided through the Omagh Recovery team. Two of the Omagh team social workers are currently involved in follow up of any resettled patients. This ensures good communication and a seamless service for patients.
Area for Improvement No. 15 **Stated:** First time **Standard:** 6.3.1 (b) **To be completed by:** 23/11/2016	The responsible person must ensure the following findings are addressed: RQIA were concerned to note that medical staff had not been actively involved in discussions regarding the future of the ward and in the planning of future services. It was concerning to note that medical staff were not aware of the plans in place to close the ward when the new facility is built. Staff and senior trust representatives were unable to provide details of how rehabilitation and recovery will be provided to patients in the future.
	Response by responsible person detailing the actions taken: Medical staff confirmed that they had been involved with the planning of the new service. They were aware of the plans to close the ward in the long term. This was in response to DHSSPSNI directive to close long stay wards, and develop a more community orientated service. The 2 previous Ward Consultants would have had more involvement with initial planning of the replacement Rathview facility.
Priority 3	
Area for Improvement No. 16 **Stated:** First time **Standard:** 5.3.1 (f) **To be completed by:** 18/01/2017	The responsible person must ensure the following findings are addressed: The Guidance on Deprivation of Liberty was due to be reviewed in February 2016 but at the time of the inspection had not been reviewed
	Response by responsible individual detailing the actions taken: This has been reviewed by the (A) Head of Service/ Lead Nurse for Older Peoples Mental Health in September 2016

Area for Improvement No. 17 **Stated:** First time **Standard:** 4.3 (j) **To be completed by:** 18/01/2017	The responsible person must ensure the following findings are addressed: There was no psychology input on the ward. Patients can be referred to psychology services in the community however there is a waiting list for this service.
	Response by responsible person detailing the actions taken: Any referrals to psychology will be actioned by the Recovery Consultant Psychologist. They are prioritised and no patient has had to wait more than 2 weeks to be seen.

Previous Recommendations	
Recommendation No. 1 **Stated:** Second time **Standard:** 5.3.1 (f)	It is recommended that the Trust ensures the Patient Property Policy is 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 purchase, purchase the item and to verify receipts)
To be completed by: 26/11/2016	**Response by responsible person detailing the actions taken:** This has been addressed by the Finance Department and the procedure changed on the 9th November 2016.

Name of person completing the provider compliance plan	Denise O'Hagan		
Signature of person completing the provider compliance plan	Denise O'Hagan	**Date completed**	17th November 2016
Name of responsible person approving the provider compliance plan	Elaine Way Chief Executive Officer		
Signature of responsible person approving the provider compliance plan	Elaine Way	**Date approved**	
Name of RQIA inspector assessing response	Audrey McLellan		
Signature of RQIA inspector assessing response	Audrey McLellan	**Date approved**	24/11/16

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