Unannounced Inspection Report
3 - 7 June 2019

Western Health and Social Care Trust

Carrick and Evish Wards
Grangewood Hospital; Gransha Park, Clooney Road, Londonderry
BT47 6TF

Tel No: 028 7186 0261 & 028 7186 4379

&

Elm and Lime Wards
Tyrone and Fermanagh Hospital, 1 Donaghanie Road, Omagh
BT79 0NS

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Assurance, Challenge and Improvement in Health and Social Care

Membership of the Inspection Team

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Fionnuala Breslin	Inspector, Mental Health and Learning Disability Team Regulation and Quality Improvement Authority
Carmel Tracey	Inspector, Mental Health and Learning Disability Team Regulation and Quality Improvement Authority
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Dr Leanne Morgan	Clinical Leadership Fellow Regulation and Quality Improvement Authority
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Anne Simpson	Lay Assessor
Robert Mercer	Inspection Coordinator Regulation and Quality Improvement Authority
Hayley Barrett	Administrative Support Regulation and Quality Improvement Authority

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 from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Within the Western Health and Social Care Trust (the Trust), there are four acute mental health admission wards for people aged between 18 and 65. These wards provide assessment and treatment for patients with acute mental health needs. Patients are admitted either on a voluntary basis or in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).

Carrick and Evish wards are situated in Grangewood Hospital, within Gransha Park, Londonderry. Carrick is a 15 bedded male ward and Evish is a 15 bedded female ward. Bedrooms in both wards are single rooms with en-suite bathrooms. The design of the building lends itself to increasing the number of female or male beds whilst keeping the wards gender specific. A Psychiatric Intensive Care Unit (PICU) with the capacity to accommodate up to three patients can also be created between the two wards.

Elm and Lime wards are situated in Tyrone and Fermanagh (T&F) Hospital, Omagh. Elm is a 13 bedded female ward and Lime is a 13 bedded male ward. Both wards have single and double bedroom and three and four bedded dorm rooms. Between the two wards, there is an adjoining PICU, which can accommodate four patients.

Patients in both hospitals have access to a multi-disciplinary team that includes; consultant psychiatrists; doctors; nurses; occupational therapists and social workers. A pharmacist/pharmacy technician visits the wards every week. Patients can access a physiotherapy and a clinical psychology therapy service by referral. A patient and carer advocacy service was also available for patients receiving care on the wards.

The Trust's mental health inpatient units operate as part of a single-system mental-health crisis response service. This includes a crisis response home treatment team and an acute day hospital service.

3.0 Service details

Responsible person: Dr Anne Kilgallen, Chief Executive Officer Western Health and Social Care Trust (The Trust)	**Ward Managers:** **Carrick and Evish (Grangewood):** Mr Tony Simmons **Elm and Lime (Tyrone and Fermanagh):** Ms Jackie McCutcheon
Category of care: Mental Health Acute Care	**Number of beds:** Carrick: 15 Evish: 15 Elm: 13 Lime: 13
Persons in charge at the time of inspection: Mr. Tony Simmons, Grangewood Hospital Ms Jackie McCutcheon, Tyrone and Fermanagh Hospital	

4.0 Inspection summary

We undertook an unannounced inspection to the Carrick and Evish wards (Grangewood) and Elm and Lime ward (T&F) over three days commencing on Monday 3 June 2019 and concluding on Wednesday 5 June 2019. On Tuesday 4 June 2019 we commenced the inspection at 07:30 hours to observe the nursing handover from staff going off night duty to day staff coming on duty and speak to night staff.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DoH (March 2006).

This inspection was undertaken as part of RQIA's planned programme of inspection activity.

We employed a multidisciplinary inspection methodology during this inspection. The multidisciplinary inspection team examined a number of aspects of both hospitals from front line care and practices, to governance management and oversight of the service. We met with various staff members, patients, reviewed care practices; relevant documentation; and reviewed the organisational governance and assurance systems.

We found good practice in relation to three of the four domains; is care safe, effective and compassionate. We observed compassionate care delivered to patients and observed staff use effective de-escalation techniques with patients displaying challenging behaviours. We found low use of restrictive practices, good multidisciplinary working and an effective advocacy service. We also identified a number of quality improvement initiatives were being developed.

We found evidence of service development in the T&F hospital site with the recent establishment of a step-up/step-down service and early indications suggest this service was preventing admissions and assisting with early discharges.

We identified a number of concerns during the inspection relating to; organisational governance and quality assurance; adult safeguarding; infection prevention, environmental risks; finances, audits, medicine management; physical health care; emergency equipment; and therapeutic engagement.

We also found that the PICU model of care in operation on both sites was not clear and the provision of PICU was not in accordance with the NAPICU, National Minimum Standards for Psychiatric Intensive Care Adult Service, (September, 2014). We noted that the PICU model in place was impacting on arrangements to plan and provide safe staffing levels for the wards. We escalated our concerns relating the PICU operating model of care in accordance with our escalation policy and procedures and senior Trust representatives attended a serious concerns meeting held in RQIA on 10 July 2019.

We identified a number of serious issues in relation to incident management. These issues resulted in the issuing of an Improvement Notice; IN000002 in accordance with our escalation policy.

4.1 Inspection outcome

Total number of areas for improvement	17*

*Seventeen areas for improvement were identified against The Quality Standards for Health and Social Care DoH (March 2006); these include one area for improvement not assessed during this inspection; one area for improvement assessed as partially met and two areas for improvement assessed as not met and 13 new areas for improvement.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with senior members of the Trust management team as part of the inspection process. The time scales for implementation of these improvements commence from the date of this inspection.

Enforcement action resulted from the findings of this inspection. An Improvement Notice; IN000002 was served to the Trust on 22 July 2019 which detailed the actions the Trust are required to take to strengthen their system for identifying and managing adverse incidents and near misses. The date by which compliance must be achieved is 22 October 2019. Further information can be found in section 4.2 of this report.

The enforcement policies and procedures are available on the RQIA website. https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Improvement Notices for Trusts are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

4.2 Enforcement action taken following this inspection

In response to concerns identified during this inspection we invited Dr Anne Kilgallen, Chief Executive of the Trust and Responsible Individual and representatives of the Adult Mental Health and Disability Directorate to attend a serious concerns meeting in RQIA on 10 July 2019. During this meeting we highlighted the following five serious concerns; the safe management of hospital environments; organisational governance; incident management; patient physical health needs; and the Psychiatric Intensive Care Unit (PICU) model. Senior Trust representatives agreed to forward us an updated action plan outlining the actions they proposed to in relation to the above serious concerns by 24 July 2029.

Following this meeting, we received additional intelligence about the Adult Mental Health and Disability Directorate's governance and management of serious adverse incidents (SAI), incidents and near misses.

On the 17 July 2019, RQIA senior representatives held a meeting in RQIA to discuss the areas of concern identified during the inspection and the additional intelligence received following the inspection. Following a review of all intelligence and the findings from the inspection we issued the Trust with an Improvement Notice. On 18 July 2020 Dr Anne Kilgallen, Chief Executive of the Trust was informed of our decision to issue an Improvement Notice.

On 22 July 2019 we issued Improvement Notice IN000002 to the Chief Executive of the Trust. The Improvement Notice was issued as a result of the Trust failing to ensure it had a robust system in place for the recognition and management of adverse incidents and near misses across the Directorate of Adult Mental Health and Learning Disability Services.

The Trust were to ensure the following actions were completed in order to comply with the Improvement Notice:

- undertake an urgent review of information recorded in the Trust's Datix system, to ensure that they understand the nature and extent of risks captured in the system as it operates across the Trust's Directorate of Adult Mental Health & Disability Services;

- take action to address and mitigate specific patient safety risks (individual, themes and/or trends) identified as part of the above review and ensure these risks are appropriately addressed in a timely manner;

- assure themselves that staff across the Directorate of Adult Mental Health & Disability Services have sufficient knowledge, awareness and understanding of adverse incidents and near misses, so that they (incidents and/or near misses) are appropriately recognised and accurately recorded in the Trust's Datix system. The grading of adverse incidents and near misses must be based on the risk inherent in each event and not on the outcome reported for the event in question;

- ensure that there are appropriate structures in place to review, approve, and escalate all incidents, adverse incidents and near misses captured in the Trust's Datix system as it operates across the Directorate of Adult Mental Health & Disability Services and demonstrate that mechanisms for assuring this dynamic process are sufficiently robust; and

- design and implement processes to ensure that i) they are regularly updated on the spectrum of adverse incidents and near misses occurring across the Directorate of Adult Mental Health & Disability Services, ii) all incidents and near misses are graded on inherent risk, iii) appropriate mitigating actions have been identified and progressed in relation to risks identified, iv) learning arising from incidents and near misses has been identified and shared with all relevant staff, and v) they and Trust Board receive appropriate assurance(s) regarding the operation of these processes.

The date for the Trust to achieve compliance with the Improvement Notice was 22 October 2019.

On 22 July 2019 we issued correspondence to the Chief Social Work Officer in the Department of Health (DoH) in accordance with the provision of Articles 4 and 35 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inform him of our decision to issue the improvement notice.

5.0 How we inspect

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

- previous inspection reports;
- Serious Adverse Incident (SAIs) notifications and final reports;
- information on concerns;
- information on complaints; and
- other intelligence received by RQIA.

Each ward was assessed using an inspection framework. The methodology underpinning our inspections included; discussion with patients and relatives, observation of practice; and focus groups with staff and review of relevant documentation.

Records examined during the inspection included; patients care and treatment records; governance information; ward operational records; training records; complaints and compliments; incident and accident and adult safeguarding records; medicine kardexes; patient's property and finances records; Trust policies and procedures; a range of audits; and environmental risk assessments.
Nine areas for improvement identified at the previous inspection were reviewed and an assessment of achievement was recorded as met, partially met or not met. Further information can be found in section 6.2 of this report.

During our inspection, our Lay Assessor spoke with patients in Grangewood and our inspection team spoke to patients in T&F. Questionnaires were also distributed to patients on both sites and analysed following the inspection. We also invited staff to complete an electronic questionnaire. No staff questionnaires were received by RQIA.

Findings of this inspection were shared with senior members of the Trust management team, Ms Jackie, McCutcheon Ward Manager of Elm and Lime (T&F Hospital) and Mr Anthony Simmons Ward Manager of Carrick and Evish (Grangewood Hospital) at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection of Carrick ward dated 13 March 2019 and Tyrone and Fermanagh (T&F) dated 24-25 October 2017

The previous inspection of Carrick ward (Grangewood) was an unannounced inspection undertaken on 13 March 2019 and the previous inspection of T&F was an unannounced inspection undertaken between the 24 and 25 October 2017.

The completed QIP of the T&F was returned by the Trust to RQIA and was subsequently approved by the inspector. The report of the Grangewood inspection completed on 13 March 2019 was not issued before this inspection. However, the areas for improvement from that inspection were discussed with the Trust senior management team in detail at the end of the inspection and during the serious concern meetings held in RQIA on 10 July 2019.

6.2 Review of areas for improvement from last inspection of Carrick ward dated 13 March 2019

<table>
<tr><th colspan="3">Areas for improvement from the last inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Quality Standards for Health and Social Care DoH (March 2006)</th><th>Validation of compliance</th></tr>
<tr><th colspan="3">Risk Assessment</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 5.3.1 (a)

Stated: First Time</td><td>The WHSCT senior management team shall address the following matters with respect to Risk Assessments:
ensure that comprehensive risk assessments completed by other mental health services are received prior to patients admission to the wards; and
ensure that these are maintained and updated while the patient remains on the ward.</td><td rowspan="2">Not Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
We confirmed that no current patients had been admitted from other mental services (outside of the Trust) during this inspection. However, we saw evidence of patients being transferred to Grangewood and we noted that the patient’s care documentation notes had not transferred with them.</td></tr>
</table>

	We spoke with the patient flow manager who told us that every effort is made to ensure all assessments are received prior to a patient being admitted from another Trust; and whilst this has improved there continues to be an issue with the time taken to receive notes. This area for improvement has not been met and has been stated for the second time.	
Serious Adverse Incidents (SAIs)		
Area for improvement 2 **Ref:** Standard 5.3.2 **Stated:** First Time	The WHSCT senior management team shall address the following matters with respect to Serious Adverse Incidents (SAIs): • ensure the recommendations and action plan must adhere to the Guidance on Minimum Standards for Action Plans as outlined in Appendix 8 of the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents; • ensure that all SAI's are reported in accordance with the HSCB guidance document entitled ' Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016); and • ensure that an update of action items listed in the recommendations should be reviewed through the Directorate's Governing systems.	**Not Met**
	Action taken as confirmed during the inspection: This area for improvement has not been met and has been subsumed into the Improvement Notice. Additional information can be found in section 4.2 of this report.	
Incident Management		
Area for improvement 3 **Ref:** Standard 5.3.1 (f**)** **Stated:** Second Time	The WHSCT senior management team shall address the following matters with respect to incident management: • the WHSCT incident management policy and procedure dated 2014 should be updated to fully reflect the Health and Social Care Board (HSCB) guidance document entitled 'HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents, (November 2016)'; • the updated policy should be shared with	

	staff; • appropriate staff should complete training with regard to recording incidents on the Datix system; and • incidents recorded on Datix should be audited to ensure all incidents that meet the threshold for reporting as a SAI in accordance with HSCB guidance have been reported.	**Not Met**
	Action taken as confirmed during the inspection: This area for improvement has not been met and has been subsumed into an Improvement Notice. Additional information can be found in section 6.5.5 of this report.	
Area for improvement 4 **Ref:** Standard 5.3.2 **Stated:** First Time	The WHSCT senior management team shall address the following matters with respect to incident debrief: • a local incident debrief policy and procedure should be developed and implemented; • the policy should be shared with staff; • a record must be maintained for all incident debrief sessions undertaken; and • any learning identified as a result of incident debrief sessions must be shared with staff and actioned. Senior members of the WHSCT should ensure there are localised formal incident debrief sessions following adverse incidents. These should be recorded at ward level for reference and learning.	**Not Met**
	Action taken as confirmed during the inspection: We found limited evidence during the inspection of any formal incident debriefs. We noted a SAI had occurred on Carrick the day prior to our inspection and we found no evidence of a debrief having occurred by the time our inspection concluded. Additional information can be found in section 6.5.6 of this report. This area for improvement has not been met and has been stated for the second time.	

<table>
<tr><th colspan="3">Fire Safety</th></tr>
<tr><td rowspan="2">Area for improvement 5

Ref: Standard 5.3.1

Stated: First Time</td><td>The WHSCT senior management team shall address the following matters with respect to ignition sources:
a local policy and procedure to manage and mitigate the risks associated with patients accessing ignition sources must be developed and implemented; and
the policy must be shared with staff.</td><td rowspan="2">Partially Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Following the inspection to Carrick and Evish during March 2019 the Trust submitted an action plan to RQIA with respect to ignition sources. We note that although work has commenced to address this area for improvement it has not been fully met. Representatives from the Trust outlined their plan to mitigate this risk. This area for improvement has not been met and has been stated for the second time.</td></tr>
<tr><th colspan="3">Medicines Management</th></tr>
<tr><td rowspan="2">Area for improvement 6

Ref: Standard 5.3.1.(f)

Stated: Third Time</td><td>The WHSCT senior management team shall address the following matters with respect to Pro Re Nata (PRN) medication:
medicine kardexes must record the indication for PRN medication and whether prescribed PRN medicines are to be administered as first or second line medications;
medicine kardexes must include minimum time intervals between the administration of the first and second line medications;
following administration of PRN medications the outcome for the patient must be documented; and
a rolling audit programme must be developed to provide assurance that the medicine kardexes are being fully completed and that staff are adhering to the PRN prescription, consideration should be given to involving the ward pharmacist in the audit programme.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
This area for improvement has been met. Further details on this area can be found in section 6.5.6 of this report.</td></tr>
</table>

6.3 Review of areas for improvement from last inspection of Elm and Lime Wards dated 24 - 25 October 2017

<table>
<tr><th colspan="3">Areas for improvement from the last inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Quality Standards for Health and Social Care DoH (March 2006)</th><th>Validation of compliance</th></tr>
<tr><th colspan="3">Completion of Care Documentation</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Quality Standard 5.3.1(f)

Stated: Second Time</td><td>The WHSCT senior management team shall ensure the screening assessment and the bio-psychosocial interim care plan/management plan section of the ICP are completed in full.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
We reviewed a random sample of patients care records across both sites and found that the screening assessment and the bio-psychosocial interim care/management plans in the ICP had been completed in full.

This area for improvement has been assessed as met.</td></tr>
<tr><th colspan="3">Clinical Psychology Input to Multi-disciplinary Team</th></tr>
<tr><td rowspan="2">Number/Area 2

Ref: Quality Standard 4.3(j)

Stated: Second time</td><td>The WHSCT senior management team shall address the skills mix on the wards to include a clinical psychologist.
AIMS: CCQI Accreditation For Inpatient Mental Health Services (Standards for Acute Inpatient Services for Working-Age Adults – 5th Edition, 2014) states the following under the standard of care planning:
U20.5 “The team has the capacity to offer service users a psychological assessment and formulation delivered by a psychologist, based on clinical need”, and;
U20.6 “Staff members liaise with the patient’s community-based therapist to co-ordinate their psychological treatment”.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

This area for improvement has been assessed as met. Further information can be found in section 6.5.1 of this report.</td></tr>
</table>

Governance Audit Tool		
Number/Area 3 **Ref**: Quality Standard 5.3.1 (f) **Stated:** First time	The WHSCT senior management team shall ensure the audit tool for the Integrated Care Pathway (ICP) and the Comprehensive Risk Assessment (CRA) are completed in full. **Action taken as confirmed during the inspection**: Compliance with this area for improvement was partially assessed during this inspection. We identified issues in relation to how the Trust undertakes audits. This area for improvement has been subsumed into a new area for improvement to further strengthen the arrangements in respect of audits. This new area for improvement will be stated for a first time. Additional information in this regard can be found in section 6.8.3 of this report.	**Not Met**
Nurse Training on Psychological Formulation		
Number 4 **Ref**: Quality Standard 4.3 (m) **Stated:** First time	The WHSCT senior management team shall address the following matters with respect to developing a training programme to ensure staff have the skills and knowledge to complete care plans which were based on psychological formulations. **Action taken as confirmed during the inspection**: Compliance with this area for improvement was not assessed. This area for improvement has been carried forward to the next inspection.	**Carried forward to the next inspection**

6.4 Inspection findings

6.5 Is care safe?

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

6.5.1 Staffing

We reviewed the staffing arrangements in both hospitals and spoke to members of the multidisciplinary team (MDT).

We noted a stable and core group of nursing staff and a multidisciplinary team that worked well together in both hospitals. Staff told us that members of the senior management team were approachable.

However, we observed the continued use of the PICU in both hospitals had an impact on staffing levels. This is discussed further in section 6.8.2.
We also identified a number of vacancies within the medical team, however we were informed this was not having an impact on the delivery of care.

A ward based psychology service is not available, the Trust acknowledges there is a need for this service and informed us that finances have been secured to fund the service. However, despite all efforts the Trust has been unable to recruit ward based clinical psychologists. We acknowledge there is a shortage of clinical psychologists across the region. We were informed the Trust are exploring other alternatives, accessing psychology services from the voluntary and community sectors. We were however told that inpatients can access the wider Trusts clinical psychology service by referral.

We spoke with the principal occupational therapist (OT) who told us there are a number of vacant OT posts in the Trust, which were having an impact on the provision of OT services in the acute mental health inpatient wards. They informed us the Trust intends to advertise for additional OT positions for a third time. Presently hospital OT provision is 9-5pm Monday to Friday. Quality improvement work to expand the service outside the 9-5 office hours is in its planning stages.

We spoke to support staff across both sites and we identified there was an inconsistent approach to the communication of risk to support staff across both hospitals. It was evident that the communication of risk to support staff in Grangewood was good; however we found improvements are required in T&F in this area. We highlighted the importance of a consistent approach to communicating risk to all staff working on the wards with ward staff and the Trust senior management team.

6.5.2 Staff Training

We reviewed the mandatory training records of nursing staff. We noted that a number of staff were not up to date with mandatory training. Staff told us that due to the staffing shortages it is difficult to be released from the ward to attend training as providing safe staffing levels take priority. An area for improvement has been made.

6.5.3 The Mental Health (Northern Ireland) Order 1986

We reviewed the arrangements in respect of detention in accordance with The Mental Health (Northern Ireland) Order 1986 (The Order). We found no concerns and observed that patients were detained appropriately. There was evidence that patients were made aware of their rights and appropriate care plans were in place.

6.5.4 Adult Safeguarding

We reviewed the arrangements in relation to adult safeguarding and spoke to staff. During our review of incidents recorded on Datix (the trusts electronic incident recording system) we found incidents requiring an adult safeguarding referral had not been referred onward to the adult safeguarding team. We also found from speaking to staff that there was a lack of understanding on the threshold for making a safeguarding referral.

We identified issues across both hospitals regarding the knowledge and understanding of staff in relation to adult safeguarding procedures and we were concerned that some staff were not familiar with the Protocol for the Joint Investigation of Adult Safeguarding. We were also concerned that and some staff did not understand the value of making safeguarding referrals. We believe this presents as a significant risk to patient safety. We highlighted this concern at the serious concerns meeting held on 10 July 2019 and the Trust agreed to submit an action plan to us by 24 July 2019 to address this matter. An area for improvement has been made.

6.5.5 Restrictive Practices

We found the use of restrictive practices was low and we observed when used the restriction was proportionate to the risk and used as a last resort. We noted for a period of time during the inspection that access and exit to Elm was controlled by staff due to risks on the ward. We found this to be an appropriate response however we found no governance mechanisms around this restriction. We recommend that the Trust should consider keeping a record to note the dates, duration and rationale for locking the doors.

6.5.6 Management of incidents and risks

We reviewed the arrangements in place for the reporting and recording incidents and assessing risk and we identified concerns. We noted that the grading of incidents on the Trust Datix system was based on the outcome of the incident and not on the inherent risk, resulting in a significant number of incidents being graded to low. We were informed that incidents graded as low do not always result in learning being identified and subsequent actions taken to prevent and reduce the likelihood of incidents reoccurring.

We were further concerned that the inappropriate grading of incidents was not identified when reviewed by hospital senior management staff. Due to the inappropriate low grading of incidents, risks that should have been escalated to the Trust senior management team were not, they were therefore not being investigated further and therefore no actions were put in place to mitigate any risks.

We reviewed the mechanism in place for sharing safety issues on the wards with staff. We were concerned that some incidents / risks were not shared with relevant staff and the MDT. The record made for sharing the information did not provide context to some of the items recorded and did not allow collation or analysis of data over a period of time to evident reoccurring themes or trends. We also found very limited evidence of formal debriefs following incidents.

In T&F we noted that while the daily shift handover was comprehensive, focused and well-led, however we found any safety issues including but not limited to the fire safety risk assessment and fire safety plan were not discussed.

In addition we also identified that appropriate actions were not taken following incidents involving patients who attempted self-harm / suicide using a ligature. We found the Trusts ligature risk assessment was not updated to highlight the risk associated with the ligature point that was used. Significant improvements are required in the management of ligature risk assessment.

We highlighted these concerns at the serious concerns meeting held on 10 July 2019 and the Trust agreed to submit an action plan on 24 July 2019 to address this matter. However, we received further intelligence in relation to incident management between the 10 July and 24 July 2019. This resulted in further enforcement action being taken in relation to incident management. Further details relating to incident management are found in section 6.8.7 and the details of the Improvement Notice issued as a result of our serious concerns are found in section 4.2 of this report.

An area for improvement has been made in relation to the management of the ligature risk assessment.

6.5.7 Management of Medicines

We reviewed the arrangements in relation to medicine management. Across both hospitals we found personal medication records/kardexes were well maintained. We also found good adherence to Trust policies and procedures in relation control drug management and we were told that issues identified through the controlled audit process were discussed with individual staff and at training sessions. We also found robust medicine discharge arrangements were in place for patients and also for patients going on temporary leave from the ward.

We found inconsistencies in relation to other aspects of medicine management across both hospitals. We found evidence of satisfactory systems in place in T&F hospital. However, we identified the need for improvements in Grangewood in relation to; the storage and stock control of medicines (including the cold storage of medicines); disposal of medicines; infection prevention and the recording and administration of first and second line treatments. The ward pharmacist told us the most recent medicines management audit had identified these issues and these were being addressed through staff training and further audits.

We were assured that the Trust had appropriate assurance mechanisms in place around the prescribing and administration of first and second line medications and in this regard we are therefore satisfied that this area for improvement made at previous inspection has been met.

We also identified an inconsistent approach to the provision of pharmacy services across both hospitals. There was one part time pharmacist in Grangewood and no pharmacist in the T&F. Throughout the inspection, it was evident from discussions with the MDT, that ward-based pharmacist support was considered fundamental to the care of patients. We did however identify the positive impact of having a pharmacy technician to support medicines management in T&F and found the standard of storage and stock control of medicines was good. We suggest the support of a pharmacist technician to support Grangewood would also be beneficial. An area of improvement has been made in this regard.

Across both hospitals we identified an inconsistent approach to the reporting and recording of medicine incidents. We also found there was no mechanism in place for the collation, review, trend analysis of medicine incidents or sharing of learning with relevant staff. The governance of medicines is discussed in section 6.8.2 of this report.

6.5.8 Resuscitation and management of medical emergencies

We reviewed the arrangements with respect to resuscitation and the management of medical emergencies in both hospitals. We identified concerns with the accessibility of resuscitation trolleys due to clutter and the means of opening the door of the treatment rooms in T&F. We escalated these issues with the ward manager, who immediately took steps to clear the clutter and reposition the resuscitation trolley so that it could be accessed without obstruction in the event of an emergency. We were concerned that staff would find it difficult to access emergency equipment in a timely manner as would be required in an emergency. We recommend that the Trust's resuscitation officers should review this area of concern. An area for improvement has been made.

6.5.9 Infection prevention control and decontamination procedures

We reviewed the arrangements in relation to infection prevention and control and decontamination procedures by undertaking a tour of the premises, speaking with staff and reviewing relevant documentation. We found that that the standard of cleanliness particularly in relation to sanitary wear required improving and we were informed that support staff cover for across both hospitals was limited. We were also told that ward staff do not have access to the cleaning store when support staff are not available. We found this caused issues when a patient was discharged and nursing staff were required to clean the bedroom in preparation for an out of hour's admission.

In T&F we observed considerable wear and tear to the internal environment which impacted on the ability to effectively clean surfaces. We identified improvements were required in relation to the cleaning of high and low horizontal surfaces. We observed items were stored at floor level which also caused difficulty with cleaning and areas in T&F to be particularly cluttered and disorganised, most notably within equipment and linen storage areas.

We were concerned to find used linen and patient clothing was stored alongside clean linen in the wards linen store in Elm ward. This practice presents a risk of contamination to the clean linen.

We found the cleaning of patient equipment throughout all wards was generally of a good standard. However improvements are required in relation to the cleaning and storage of domestic cleaning equipment.

We found issues with the disposal and management of sharps waste across both hospitals and we observed variations between wards in staff member's knowledge and application of hand hygiene practices, the use of personal protective equipment and adherence to the Trusts uniform policy.

All areas of concern we raised with ward managers and highlighted at the serious concerns meeting held on 10 July 2019. The Trust agreed to submit an action plan on 24 July 2019 to address these concerns. An area for improvement has been made.

6.5.10 Environment

Overall we found very clear distinctions between the ward environments located in the both hospitals. Grangewood provides a modern ward environment which appeared well kept and maintained in contrast to the T&F environment.

Grangewood

We reviewed a fire risk assessment and action plan which was completed in Grangewood on 19 January 2019. We noted a number of management controls were not recorded as completed; however, we received confirmation from the Trust's fire officer following the inspection that the actions required to mitigate risks had been completed.

The bedroom door closures were removed as they were ligature points. The fire risk assessor has confirmed that the removal of self-closer devices from bedroom doors has been evaluated and appropriate management controls have been implemented to maintain fire safety in the facility.

We reviewed the risk assessment and water hygiene survey report dated 16 July 2015 and we were concerned that results showed a high risk evaluation and there was no evidence that a further survey had been undertaken since. We escalated this to representatives from the Trust's estates department and received confirmation that a further water sampling had been undertaken following this inspection and the bacteriological analysis completed on 24 July 2019, indicated a negative result for the presence of legionella bacteria. We were informed a further review of the risk assessment & water hygiene survey report is to be completed by 11 October 2019 to provide assurance to the effectiveness of the water hygiene control measures.

Tyrone and Fermanagh

We met with nursing staff on Elm ward who reported safety concerns in relation to the PICU environment. We were concerned that these safety issues where the cause of a serious adverse incident 2 years previously and had not been addressed at the time of the inspection and risks to patient and staff safety remained. We were informed that work is planned to enhance the security and safety of PICU.

Nurses also reported concerns about the lack of medicines storage in the clinical room in PICU which delays the administration of rapid tranquilization and we observed other than the provision of hand sanitiser there was no other means for staff to effectively wash and decontaminate their hands.

We observed the interior and exterior environment and found fixtures & fittings across the T&F have deteriorated for example light fittings were loose and wall surfaces and floor coverings were damaged. Outdoor spaces were observed as non-therapeutic.

We were concerned about the safe storage of an oxygen cylinder in the treatment room we also identified issues with security and privacy due to the location of the treatment room.

The risk assessment and water hygiene survey report dated 22 September 2016 was evaluated as high and it is noted that the action plan was not updated to evidence if action was taken to address the recommendations within it. We escalated this to representatives from the Trust's estates department and received confirmation the action plan had been completed.

The fire risk assessment action plan recommendations were not validated as completed by a competent person. The risk to life was evaluated as `tolerable` even though the action plan recommendations were listed a high priority. Representatives from the Trust informed us that the proposed improvement works were to be completed during October 2019. However, we were informed following the inspection by the Trust that the action plan has been amended as a result of completing a new fire risk assessment.

We highlighted our environmental findings from both hospitals at the serious concerns meeting held on 10 July 2019 and the Trust agreed to submit an action plan on 24 July 2019 to address this matter. An area for improvement has been made.

6.5.11 Management of Patient's Property and Finances

We reviewed the arrangements in place to manage of patient's property and finances by reviewing a sample of patient finance records and talking to staff.

We found a number of discrepancies across both hospitals in relation to transactions undertaken on behalf patients such as; inaccurate recording of amounts withdrawn; dates of purchases; legibility of records; and patient specific financial risk assessments and care plans.

We did not find any evidence of any assurance mechanisms to monitor staff practices at ward level in relation to the management of patient's property and finances.

An area for improvement which relates to both hospitals has been made in relation to the management of patient property and finances

Areas of good practice – Is care safe?

There were examples of good practice found in relation to; each site having a stable core group of nursing staff; the low use of restrictive practices; patients detained under the Mental Health NI Order 1986 were informed of their rights and posters were positioned around the wards informing them of how to appeal their detention.

Areas for improvement – Is care safe?

Areas for improvement were identified in relation to; mandatory training; appropriate management of ligature risks; medicine management; resuscitation equipment and management of medical emergencies; infection prevention control; the environment and managing patient property and finances.

Number of areas for improvement	8

6.6 Is care effective?

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

6.6.1 Care pathway

We reviewed a random sample of patients care and treatment records across both hospitals and found each patient had an individualised MDT Integrated Care Pathway (ICP) in place. We found assessments and care plans reflected the assessed needs of each patient and there was evidence that patients were involved their care plans. However, we found inconsistencies across the two hospitals regarding the review of patient care documentation; reviews were regular in T&F but this was not the case for Grangewood. We highlighted the need for more regular reviews of patients care and treatment with the ward manager in Grangewood.

We were concerned to learn that patients who were no longer assessed as requiring a psychiatric intensive care environment in T&F could not transfer back to the open wards due to no available bed. However, patients were informed of this reason and had consented to remain in PICU until a bed became available and could access the open wards during the day.

6.6.2 Physical Health Care

We observed the National Early Warning Score (NEWS) system was in place for each patient. This is a system for scoring the physiological measurements that can detect and respond to clinical deterioration and is a key element of patient safety.

We noted that appropriate screening tools and care plans were in place for those patients who required interventions around skin care and malnutrition and appropriate referrals had been made for patients who required specialist services. In particular, we noted the persistence of staff in the T&F hospital for making re-referrals to acute general hospitals for investigations, which led to positive outcomes for patients and resulted in an early diagnosis and appropriate and timely interventions in relation to medical conditions.

Across both hospitals, we were concerned about the management of patients with hyponatraemia (a low sodium concentration in the blood). Although regular blood monitoring was undertaken and medical staff were reviewing the patients regularly, there was no management of fluid intake as fluid balance recording was not taking place.

Junior doctors highlighted the need for specialist input for patients with eating disorders as the specialist input to the wards was one day per month and this did not adequately address the needs of patients with this diagnosis.

We highlighted these concerns at the serious concerns meeting held on 10 July 2019 and Trust agreed to submit an action plan on 24 July 2019 to address this matter. An area for improvement has been made.

6.6.3 Records management

We reviewed the arrangements in place for the management of patient's records across both hospitals. We observed a pilot had commenced for the use of PARIS, an electronic patient record system in the T&F. This had not been rolled out to Grangewood at the time of this inspection. We found two systems (paper and electronic) in place for the management of care records in Grangewood and we found it difficult to locate patient information and trace the patient journey. In Grangewood we also noted a number of concerns as to how patient documents were being maintained and secured. We also found different templates were used across both sites. We were informed the Trust intends to implement PARIS across both hospitals following the completion of the pilot in T&F and we acknowledge the implementation of PARIS will address the issues highlighted above.

6.6.4 Therapeutic Engagement

We observed the availability of therapeutic activities available for patients and spoke to staff and patients. Patients told us that the opportunity to engage in therapeutic activities and one to one time with staff was limited due to reduced staffing levels and this added to their frustration. Patients across both sites told us there were no activities scheduled for evenings or weekends and the opportunity to engage in therapeutic activity on the wards was determined by the availability of nursing staff. We have included these issues into the area for improvement in relation to therapeutic engagement. As highlighted in section 6.7.3.

6.6.5 Discharge planning

We reviewed patient's notes across both hospitals and found evidence that discharge planning arrangements were good and there was good interface arrangements with the Home Treatment Crisis Response service in planning post discharge contact and review were place.

We identified a number of patients who were delayed in their discharge due to the lack of suitable community placements with one patient who was delayed in their discharge for over 12 months. We were informed that the Trust were trying to source placements that appropriately met the needs of patients on a continuous basis.

Areas of good practice – Is care effective?

There were examples of good practice found in relation to; the delivery of patient centred care; the appropriateness of individualised care plans; the involvement of patients in the delivery of their care; appropriate onward referrals for patients who require specialist services and good working relationships with representatives from advocacy services.

Areas for improvement – Is care effective?

Areas area for improvement was identified in relation to managing the physical health care needs of patients and enhancing therapeutic activities.

Number of areas for improvement	2

6.7 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.

6.7.1 Person centred care

We reviewed patient care records and observed patient and staff interactions, and found evidence that care was person centred. We observed staff across both hospitals responding to patients in a respectful, warm and compassionate manner. Visiting professionals such as advocates were complementary about the care delivered to patients. We observed staff employ good de-escalation skills when supporting patients who were distressed or upset. This was completed in calm, confident manner, demonstrating respect towards the patient.

Patients told us staff were kind, considerate and helpful. However, in the T&F patients said there was limited private space for them to relax in. We also received some reports that the safe to hold personal belongings was not working properly. This was brought to the attention of the ward manager during the inspection.

6.7.2 Consent/capacity

From discussions with patients and representatives from the advocacy services and the review of care documentation, we did not identify any concerns in relation to capacity and consent. We saw patients were given the opportunity to consent to interventions in the delivery of their care. Where patients declined certain interventions such as medication or withheld their consent for staff to consult with family members their opinion was respected.

6.7.3 Patient engagement

We reviewed the arrangements in place for supporting patient engagement. We found information in relation to the ward was contained in the ward information pack given to patients on admission and there was information available directing patients how to make a complaint. Patients also confirmed they knew how to raise any concerns they had. We identified that improvements are required in relation to meaningful patient engagement to drive service improvement. We found patient / staff meetings occurred on an irregular basis and actions points arising from these meetings were not always addressed or followed up. We also observed the system for patient's to provide comments of their ward experience was ineffective. We observed the return box for patients to post their comments contained feedback dating as far back as 2015 in the T&F hospital. Staff we spoke to were unclear about how this information lends itself to service improvements, improved patient experiences and could further enhance therapeutic engagement.

We have included these issues into the area for improvement in relation to therapeutic engagement. As highlighted in section 6.6.4

Areas of good practice – Is care compassionate?

There were examples of good practice found in relation to; informed consent to treatment; good de-escalation techniques being used in a calm, confident manner to good effect; observed interactions with patients which were noted to be warm, relaxed and calm and staff honoured patient's choice.

Areas for improvement – Is care compassionate?

No additional areas for improvement were identified in relation to the delivery of compassionate care.

Number of areas for improvement	0

6.8 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.

6.8.1 Organisational governance and Quality Assurance

We reviewed the organisational governance and quality assurance systems in place across the directorate. During our inspection we found there was no overarching quality assurance framework to govern services provided; to identify risks; and to evidence the quality of care delivered across the Directorate of Adult Mental Health & Disability Services. We found no evidence of key performance indicators or analysis and trending of data to inform approaches to reducing risks and delivering high quality, safe care across the directorate. A disconnect across the governance structures of the directorate was also identified.

Throughout the inspection we could clearly identify that both hospitals are operating quite differently to each other. Staff expressed their frustrations with the differences, and indicated there is a need for consistent practices and operational procedures across both hospitals. We were unclear how quality improvement work undertaken in one hospital was being shared and we identified how implementing quality improvement initiatives could be challenging due to both hospitals operating quite differently.

We would encourage the Trust to complete a rapid review of the operating models and assure standardisation and alignment across the two sectors.

From our observations and discussions with key members of staff we found a multiplicity of meetings and groups in place. Staff were making every effort to attend all of the meetings however we found there was no evidence of linking or alignment between the groups and staff were unclear about the purpose of some meetings / groups. We suggest the Trust undertakes a review of this system, this review should look at the purpose, function and necessity of all of the meetings / groups and how they link and feed into the organisational governance structure.

We also requested trend data from incidents, SAIs and complaints. We identified that information relating to individual incidents, SAIs and complaints was available and we found these were reviewed and reacted to in isolation. We found no evidence that the Trust were analysing and triangulating all of the data to establish trends and patterns. This means that the senior management team were not being informed of emerging risks over time in the directorate.

We highlighted these concerns at the serious concerns meeting held on 10 July 2019 and Trust agreed to submit an action plan on 24 July 2019 to address this matter. An area for improvement has been made.

6.8.2 Incident Management

We reviewed the arrangements in place to manage risks. We identified serious concerns with regard to recognition and management of adverse incidents and near misses. We identified incidents that had been incorrectly categorised on Datix. We were concerned there was an over reliance on the Datix system to escalate risks. We identified the incorrect categorising of incidents has led to under reporting, limited escalation and did not afford the Trust opportunities to identify, action and share learning to prevent or reduce the likelihood of similar incidents occurring and improve the safety and quality of care delivered.

We are also concerned that there was a reactive approach to the management of incidents rather than a measured proactive approach and the actions taken were as a response to the incident outcome rather than the inherent risk. There was no evidence of a review of the course of events, previous incidents or the recent history of a patient(s) that led up to an incident. We noted several incidents of the same nature involving the same patient(s) reoccur. There was no evidence of any proactive planning to reduce the likelihood of incidents reoccurring and no measures put in place to mitigate against risks.

In relation to medication incidents, staff and the pharmacist informed us that all medicine related incidents were reported to the Medicines Governance Committee, which met on a monthly basis and reviewed incidents. However we were unsure of the process to identify trends in medicines related incidents or how learning was shared following the audit.

We are also concerned the governance arrangements in place to ensure any recommendations made and actions required following a serious adverse incident investigation were not robust. We were told that no one person is assigned responsibility to ensure recommendations are seen through to completion; no timeframes are set against recommendations; and no audit is completed to oversee the progression of action plans arising out of SAI investigations.

Furthermore, we are concerned that there was no live weekly safety brief across the directorate to inform senior management of emerging risks or trends across the admission wards.

We discussed our concerns with Trust representatives at a serious concerns meeting held in RQIA on 10 July 2019. We received limited assurance regarding the actions in progress by the Trust with respect to recognition and management of adverse incidents and near misses.

We escalated this matter to serious concerns and held a serious concerns meeting with senior Trust representatives on 10 July 2019. We requested the Trust submit an action plan to us to address our concerns by 24 July 2020.

Following the serious concerns meeting on 10 July 2019 we received further information that suggested a number of additional adverse incidents had been incorrectly categorised on Datix and thus may not have been appropriately managed or escalated within the Trust's governance structures.

Following receipt of this information we determined the system for identifying and managing adverse incidents and near misses currently in operation across the Directorate of Adult Mental Health & Disability Services in the Trust is not sufficiently robust. As a result of our findings, we issued the Trust with an Improvement Notice IN000002 on 22 July 2020. The detail of the improvement notice specified the actions the Trust are required to take to improve their governance and management of risk, adverse incidents and near misses. These are noted in section 4.2 of this report. The date for the Trust to achieve compliance with the Improvement Notice is 22 October 2019.

6.8.3 PICU operating Model

We reviewed the PICU operating model across both hospitals. We are concerned that the PICU was not operating in accordance with the NAPICU National Minimum Standards for Psychiatric Intensive Care Adult Services, (September, 2014). We found both hospitals operate a model whereby a separate PICU is established, from the existing bed numbers, to accommodate the changing needs of patients. When patients do not require a PICU bed, the beds revert back to acute mental health in-patient beds provided in an open ward environment. We noted that this was not the case across both sites and were informed by staff that a separate PICU had been in operation in Grangewood on a continuous basis for approximately 18 months and in T&F hospital for many years. This indicates that that both PICUs are operating on a permanent basis rather than the flexible model the Trust had intended it to be. Challenges arise with there is a need to staff the PICU wards, as there was no dedicated PICU team. We found this impacted on the availability of nursing staff on the other wards. The staffing compliment across both hospitals does not include the additional numbers of staff required to accommodate a permanent PICU ward. We identified this creates increased pressure on ward/deputy managers who have to ensure safe staffing levels on all wards as well as sufficient staff to provide the enhanced care required by patients in PICU. As highlighted above in section 6.5.9 we also identified issues with environmental safety in PICU in T&F.

We also identified issues with patient flow between PICU and the acute mental health inpatient wards and staff at the Grangewood site reported one occasion when the ward could not be operated as a separate PICU overnight due to lack of available staff for night duty. This increases the risk to patient and staff safety.

We are concerned that the current operating model and environments are not appropriate to meet the needs of the service and do not meet the NAPICU, National Minimum Standards for Psychiatric Intensive Care Adult Service, (September, 2014).

We escalated this matter to serious concerns and held a serious concerns meeting with senior Trust representatives on 10 July 2019. We requested the Trust submit an action plan to us to address our concerns by 24 July 2020. An area for improvement has been made.

6.8.4 Audits

We reviewed a number of audits in relation to; record keeping; care practices; infection prevention control, environment; therapeutic engagement; patient experience; medication; and staff appraisal and supervision. Although audits were being carried out, few were displayed to inform patient or relatives.

We were concerned to note a number of these audits did not reflect our findings from this inspection for example the environmental cleanliness and therapeutic engagement audits did not pick up on our findings.

Several audits were undertaken in relation to medicines management. We identified the controlled drugs audit and the recent audit of first and second line medicines was effective and changes and improvements were implemented. However we could not identify any improvements or changes made following the omitted dose audit. We also noted this audit did not identify the reason for the omitted dose or the impact to the patient.

The audit arrangements needs to be reviewed and strengthened across all levels of the Adult Mental Health and Disability Directorate to ensure data captured reflects what is happening at ward level and escalated to appropriate managers.
The Trust should consider revisiting roles and responsibilities of all levels and disciplines of staff and the escalation pathway for each audit so that it can be, where necessary, discussed at the appropriate governance meeting. An area for improvement has been made.

6.8.5 Medical governance

We met with junior medical staff in Grangewood who raised a number of concerns. We were concerned that the medical governance structure was not sufficiently robust to reflect, capture and mitigate the concerns from junior doctors. Junior medical staff told us that they had a number of concerns in relation to patient and personal safety when conducting out of hours admissions. They also told us that learning from SAI reports was not shared with them and they were not part of the daily handovers which informed staff of emerging patient risks. They informed us it was difficult to raise these concerns and affect change due to the lack of permanent medical staff in Grangewood and this was having an impact on their morale. Following the inspection these issues were shared with the relevant consultant responsible for clinical education, who agreed to address these concerns.

Medical staff in Grangewood told us of interface issues between the primary health and acute directorate and mental health and learning disability directorate. These included the lack of a psychiatric liaison doctor in Altnagelvin hospital. At present Grangewood psychiatry staff are providing this service as an informal arrangement and this is not sustainable. We raised this issue with the senior representative from the Trust at the end of the inspection who said they were aware of this arrangement and were planning to address it and acknowledged the need to improve the interface between acute and mental health hospitals.

Areas of good practice – Is the service well led?

A good range of audits were completed.

Areas for improvement – Is the service well led?

Areas for improvement were identified in relation to: strengthening organisational governance; and the PICU operational model.

Number of areas for improvement	3

6.9 Patient and staff views

Eight patients submitted responses to RQIA questionnaires. Most patients indicated that they felt their care was safe and effective, that they were treated with compassion and that the service was well led. However, one patient did make comments on the lack of; therapeutic activities; one to one time with their named nurse and indicated that more staff was needed as they considered "staff were overworked". One patient believed they did not receive adequate information about the plan for their future care and another patient from Elm had suggested a tuck shop would be beneficial. One patient noted that the temperature of the ward was very warm and stuffy and this had affected their breathing at night-time (they had a breathing condition). Patient feedback was given to staff at the end of the inspection.

Overall nurses reported that care on the ward was compassionate, effective and well-led though they acknowledged that the wards are not the most appropriate environment for patients who are delayed in their discharge. Staff on both sites reported that low staffing levels were impacting the safe delivery of care.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mr Tony Simmons, Ms Jackie McCutcheon and senior members of the Trust management team as part of the inspection process. The timescales commence from the date of inspection.

The Trust senior management team should note that if the actions outlined in the QIP are not taken to comply with standards this may lead to further action. It is the responsibility of the Trust senior management team to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas for improvement

Areas for improvement have been identified and action is required to ensure compliance with The Quality Standards for Health and Social Care DoH (March 2006).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to meet the areas for improvement identified. The Responsible Person should confirm that these actions have been completed and return the completed quality improvement plan to BSU.admin@rqia.org.uk for assessment by the inspector by 3 Spetember 2020.

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">Carried forward from previous inspection of Carrick dated 13 March 2019</td></tr>
<tr><td colspan="2">Action is required to ensure compliance with The Quality Standards for Health and Social Care DoH (March 2006)</td></tr>
<tr><td colspan="2">Risk Assessments</td></tr>
<tr><td rowspan="2">Area for Improvement 1

Ref: Standard 5.3.1 (a)

Stated: Second time

To be completed by:
7 November 2019</td><td>The Trust senior management team shall address the following matters with respect to Risk Assessments:
• ensure that comprehensive risk assessments completed by other mental health services are received prior to patients admission to the wards; and
• ensure that these are maintained and updated while the patient remains on the ward.

Ref: 6.2</td></tr>
<tr><td>Response by the Trust detailing the actions taken:

The Trust Senior Management team ensures that comprehensive risk assessments, completed by other mental health services are received prior to patients admission to the admission wards.

Senior Trust managers attend the regional bed management meetings were this protocol has been discussed and agreed. The bed manager adheres to the WHSCT bed management flow chart that guides them to the safe transfer of relevant information that pertains to the patient.

These are maintained and updated while the patient remains on the ward. We continue to endeavour to obtain patient notes in an acceptable timeframe before their admission to our wards.</td></tr>
</table>

Incident Debrief	
Area for improvement 2 **Ref**: Standard 5.3.1 **Stated:** Second time **To be completed by:** 7 November 2019	The Trust senior management team shall address the following matters with respect to incident debrief: • a local incident debrief policy and procedure should be developed and implemented; • the policy should be shared with staff; • a record must be maintained for all incident debrief sessions undertaken; and • any learning identified as a result of incident debrief sessions must be shared with staff and actioned. **Ref: 6.2**
	Response by the Trust detailing the actions taken: The Trust Senior Management team have developed a local incident debrief procedure. This procedure is read in conjunction with the (Risk management policy August 2019). This is in the process of being shared with staff. Records are kept of all incident debrief sessions undertaken and any learning identified is shared with staff and actioned.
Fire Safety	
Area for improvement No. 3 **Ref:** Standard 5.3.2 **Stated:** Second time **To be completed by:** 7 November 2019	The Trust senior management team shall address the following matters with respect to ignition sources: • develop a local policy and procedure to manage and mitigate the risks associated with patients accessing ignition sources; and • ensure the policy is shared with staff. **Ref: 6.2**
	Response by the Trust detailing the actions taken: The Trust Senior management team have developed a new procedure for managing hazards which could cause harm to self/others or the environment. This has been co-produced with Service User and Carer input. This procedure should be read in conjunction with the (Regional Guidelines for the Search of Patients, their Belongings and the Environment of Care within Adult Mental Health/Learning Disability Inpatient Settings September 2013, Risk Management Policy August 2019 and Fire Policy March 2018). This procedure, and associated resources are in the process of being shared with all staff.

Carried forward from previous Elm and Lime inspection dated 24-25 October 2017	
Area for Improvement No. 4 **Ref**: Standard 4.3 (m) **Stated:** First time **To be completed by:** 7 November 2019	The Trust senior management team shall develop a training programme to ensure staff have the skills and knowledge to complete care plans which are based on psychological formulations. **Ref: 6.2**
	Response by the Trust detailing the actions taken: The Trust senior management team have employed two psychologists 8B and 8C . We have provisional start dates of 5th October 2020. These professionals will lead on the development of knowledge and skills regarding psychological formulations and interventions across the multidisciplinary team.
Areas for improvement arising from this inspection	
Staffing: Mandatory Training	
Area for improvement 5 **Ref**: Standard 5.3.1 **Stated:** First time **To be completed by:** 7 November 2019	The Trust senior management team shall develop an action plan to address deficits in staff mandatory training. **Ref: 6.5.2**
	Response by the Trust detailing the actions taken: The Trust senior management team have developed a training matrix which captures mandatory training needs for all staff. This has been developed for both hospital sites. The Nursing support officer oversees this and populates when training is complete and alerts staff and ward managers when training is due.

Adult safeguarding	
Area for improvement 6 **Ref**: Standard 5.3.1 **Stated:** First time **To be completed by:** 7 November 2019	The Trust senior management team shall develop an action plan to address deficits in staff adult safeguarding training. The action plan shall also include the development and implementation of a rolling audit programme that provides the Trust with an assurance mechanism that all staff are competent and are adhering to the Trust's regional safeguarding policies. **Ref 6.5.4**
	Response by the Trust detailing the actions taken: The Trust Senior Management team have developed a robust training programme that addresses the deficits in staff adult safeguarding training. This is a rolling programme that staff complete every three years. The Trust has completed a safeguarding audit and plan to continue this as a rolling programme also . We have adapted our Datix database to capture information on Adult safeguarding that will inform the audit process. Our Handover documentation also captures Safeguarding Information.
Management of incidents and risk	
Area for improvement 7 **Ref**: Standard 5.3.1 **Stated:** First time **To be completed by:** 7 November 2019	Senior members of the Trust should review the ligature risk assessments for each ward and ensure that any action plans generated as a result of the risk assessments are actioned in a timely manner. The environmental ligature risk assessment should be a live document and not solely conducted on an annual basis. Areas identified for action must be regularly reviewed and should be updated when they are completed. **Ref: 6.5.6**
	Response by the Trust detailing the actions taken: The Senior members of the Trust review the ligature risk assessment for each ward and ensure action plans generated as a result of the risk assessments are actioned in a timely manner. The environmental ligature risk assessment is a live document and is updated when required. Areas identified for action are regularly reviewed and are updated when they are completed.

Management of Medicines	
Area for improvement 8 **Ref**: Standard 5.3.1 **Stated:** First time **To be completed by:** 7 November 2019	The Trust senior management shall address the following issues in relation to medicine management; • ensure there is a robust system in place with regard to stock control of medicines; • there are no expired medicines or medicine prescribed to patients that have been discharged retained in ward stock; • all discontinued or unwanted ward/patient medicines should be returned to the pharmacy/patient as applicable and in a timely manner; • ensure stocks of the same medicine are stored in the same place in the stock cupboards; • ensure all medicines are stored in their original packaging or pharmacy containers; • ensure a copy of the record for the disposal of medicines, sent to the hospital pharmacy, is retained on the ward; and • should review and consider enhancing pharmacy support in both hospitals. **Ref: 6.5.7**
	Response by the Trust detailing the actions taken: The Trust senior management team has addressed the issues as listed above in relation to medicine management. There is a proposal recently developed regarding enhancement of pharmacy support accross the in-patient wards.
Resuscitation and management of medical emergencies	
Area for improvement 9 **Ref**: Standard5.3.1 **Stated:** First time **To be completed by:** 7 July 2019	The Trust resuscitation officers should audit access to resuscitation trolleys across all wards and ensure that all relevant staff can assess this equipment in an emergency. **Ref: 6.5.8**
	Response by the Trust detailing the actions taken: There is a daily check of the defibrillation and suction equipment on each resuscitation trolley. There are monthly checks of the whole trolley. If the trolley is used or seal broken, there is a full reset check by the trust resuscitation team. There is an annual audit of the trolley and checks as above by the trust resuscitation team. The trolleys are more physically available on each ward for staff to access in an emergency. The improvement works in T&F wards is ongoing and will further improve physical access to the trolleys.

Infection Prevention Control	
Area for improvement 10 **Ref**: Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 7 July 2019	The Trust shall address the following matters in relation to infection prevention and control: • improve the standard of ward cleanliness; paying particular attention to ward sanitary wear and equipment storage areas; • commence a programme of decluttering and reorganisation of storage areas; • take action and provide assurance that staff are managing linen and waste in line with the Trust's policy; • improve the cleaning and organisation of domestic cleaning equipment and stores. Robust monitoring of these areas should be in place to provide continued assurance; and • take action to improve staff adherence to the Trust's policies on hand hygiene, use of personal protective equipment and uniform and dress. Robust monitoring should be in place to provide continued assurance. **Ref: 6.5.9**
	Response by the Trust detailing the actions taken: The Trust has improved the standard of ward cleanliness paying particular attention to ward sanitary wear and equipment storage areas. Sanitary bags has been sourced to improve safe disposal of sanitary products. The wards have decluttered and reorganised storage areas. The Trust has taken action and can provide assurances that staff are managing linen and waste in line with the trust policy. We have improved the cleaning and organisation of domestic cleaning equipment and stores monitoring of these areas are in place. The Trust has improved staff adherence to the Trust's policies on hand hygiene PPE, uniform and dress.

Environment	
Area for improvement 11 **Ref**: Standards 4.3 and 5.3.1 **Stated:** First time **To be completed by:** 31 March 2020	In respect of T&F the Trust shall address the following matters in relation to the environment: • undertake a survey of the interior fabric of the wards and generate an action plan to repair or replace any issues identified. Particular attention should be paid to floors; walls; lightening and ceilings; review the water safety/legionella risk assessment for the facility and implement any recommended improvements/control measures to reduce the potential risk of legionella bacteria in the water system; • submit to RQIA a suitable and sufficient fire risk assessment for the wards, any recommended action plan items must be noted with a completion date. RQIA must be informed of the completion or delay of any works action plan items, as works proceed; • ensure that oxygen cylinders are stored away from direct sunlight and undertake a risk assessment regarding the exterior glass door in the clinical room of Lime; • ensure the environment and furniture in the psychiatric intensive care unit (PICU) shared between Elm and Lime meet the required safety standard for a PICU; paying particular attention to glazing; install a clinical hand washing basin in the clinical room of PICU; and • remedial works should be undertaken to ensure a therapeutic outdoor environment for patients. In respect of Grangewood the Trust shall submit the following documentation to RQIA upon return of this quality improvement plan (QIP): • an updated fire risk assessment, an action plan generated as a result of this risk assessment. A progress report detailing the actions taken to address actions identified in the action plan to include timeframes; and • an updated risk assessment and water hygiene survey report following 11 October 2019 assessment. **Ref: 6.5.10**
	Response by the Trust detailing the actions taken: The T&F have undertaken substantial refurbishment of Elm ward and PICU. Lime is currently in the process of phase three of these works. These works had been delayed because of Covid-19. All remedial works have been addressed. The trust has reviewed the water safety/Legionella risk assessment for the facility and improvements has been implemented. A fire risk assessment has been completed and will be submitted to RQIA.

	The oxygen cyclinder are stored away from direct sunlight. The exterior glass door in clinical room in Lime has now been removed as part of phase three of the current works. All furniture in the PICU has been updated to meet the required safety standards for PICU. All glazing in PICU has been replaced as part of phase one remedial works. T&F no longer has a clinical room in PICU. Remedial works have been undertaken to ensure a therapeutic oudoor environment for patients.
Management of Patient's Property and Finances	
Area for Improvement 12 **Ref**: Standard 5.3.1 **Stated:** First time **To be completed by: 7 November 2019**	The Trust shall ensure that all relevant staff are familiar with the policy and procedure for securing and managing patient's property and finances with particular regard to; • recording patient items against the correct patient; • accurate entries are made in patient finance records; and adherence to the policy and procedure for amending errors. The Trust shall: • update and complete regular financial audits at ward level to assure themselves that the Trust's policy in relation to the Management of Patient's Property and Finances is being adhered to; and • ensure the audit identifies when and who areas of concern should be escalated to, if applicable. **Ref: 6.5.11**
	Response by the Trust detailing the actions taken: The Trust ensures that all relevant staff are familiar with the policy and procedure for securing and managing patient property and finances. The ward managers will undertake monthly financial and property audits, commencing September 2020. Areas of concern will be escalated to the Service Managers and trust finance department.

Physical Health Care	
Area for improvement 13 **Ref**: Standard 5.3.3 **Stated:** First time **To be completed by:** 7 July 2019	The Trust shall address the following matters in relation to physical health care needs: • undertake a review of specialist consultant input for patients with an eating disorder; and • review the system for monitoring patients who are subject to fluid restriction to ensure that all patients with hyponatraemia are being managed in accordance with NICE Clinical Guidance CG174. **Ref: 6.6.2**
	Response by the Trust detailing the actions taken: The trust has secured funding for Consultant input to the Eating Disorder team on a sessional basis. This is being developed along with Mental health liaison services and other regional resources. The Trust has reviewed the system for monitoring patients who are subject to fluid restriction to ensure that all patients with hyponatraemia are being managed in accordance with NICE clinical guidance CG174. There is a rolling training program for staff that identifies and shows the management and treatment of patients with hyponatraemia. Physical health care is audited on a monthly basis at ward level and the Crisis service manager audits fluid management every two months. This is recorded on the Trust dash board.

Therapeutic Activity	
Area for improvement 14 **Ref**: Standards 5.3.3 6.3.1 6.3.2 **Stated:** First time **To be completed by:** 7 November 2019	The Trust shall review and enhance patient engagement in relation to therapeutic activities and patient engagement with particular regard to: • reviewing the provision of therapeutic activities; to include evenings, weekends and bank holidays. The review should consider the type of activities and how and where it is delivered; • ensure the results of patient experience questionnaires are shared with staff. An action plan should be generated to improve service delivery; and • ensure that patient experience feedback is considered, measure, monitored and informs pieces of quality improvement work. • Ward managers should ensure patient/staff meetings occur on a regular and consistent basis. The minutes of meetings should refer back to items discussed at the previous meeting and note any follow-up taken to address issues discussed. **Ref: 6.6.4 & 6.7.3**
	Response by the Trust detailing the actions taken: The Trust will endeavour to provide therapeutic activities and encourage patient engagement through individual therapeutic planners to include weekends/evening and bank holidays. The Trust service user experience consultant has co-produced a patient experience questionnaire that captures feedback from patients which is considered, measured and monitored and will inform quality improvement. This was commenced on the 01/09/2020. Findings will be shared at staff meetings and at governance meetings. Ward managers ensure that patient/staff meetings occur on a weekly basis. Actions from previous meetings are captured and discussed. This is evidenced through the minutes of each meeting.

Organisational Governance	
Area for improvement 15 **Ref**: Standard 4.3 **Stated:** First time **To be completed by:** 7 November 2019	The Trust shall address the following matters with respect to the governance arrangements across the Mental Health and Disability Directorate: • undertake a rapid review of the Trusts governance structures to determine what committees/forums and meetings are required in order to assure best practice; • the role and responsibilities of each committee need to be clearly delineated to ensure there is no ambiguity with respect to who has overall responsibility for clinical governance, operational management and any other relevant roles within the directorate. All roles need to be clearly defined and specified; • governance structures within the directorate should be shared with staff; and • Grangewood and T&F governance structures should be closely aligned to ensure equity in relation to patient flow and care pathways; and that quality improvement initiatives are integrated across the directorate. **Ref: 6.8.1**
	Response by the Trust detailing the actions taken: The trust Mental Health and Disability Directorate Governance structures have been reviewed and a proposal established and submitted for funding approval. This includes: • Band 8C Assistant Director Governance Nurse Lead • Band 8C Assistant Director Governance Social Work Lead • 3 x Band 8a Governance Lead, including service improvement Recurrent funding for 2 x 8a governance posts is already established. In mid July, the Trust submitted Mental Health Demography IPT to secure permanent funding for the 2 x 8c and 1 x 8a posts. The Directorate has also been re-configured to improve Operational management and lines of accountabilty, with a single Assistant Director/Divisional Clinical Director now responsible for In-patient and Crisis Services, with an aligned single head of Service(8b) and Service Managers (8a) on each site. The Business team has been developed with recruitment of a Reform and Modernisation Manager and a Systems manager. They are able to support the governance arrangements of the Directorate as required. The following Committees / forums / meetings support the governance agenda: • Trust Governance meeting • Rapid Review Group • Monthly Directorate governance meeting • Divisional governance meetings – across Learning Disability, Mental Health and Physical and Sensory Disability

PICU Operating Model	
Area for improvement 16 **Ref**: Standard 4.3 **Stated:** First time **To be completed by:** 7 November 2019	The Trust shall review the arrangements in respect of the psychiatric intensive care units (PICUs). The review should consider the NAPICU, National Minimum Standards for Psychiatric Intensive Care Adult Service, (September, 2014) and include: • bed occupancy, patient need, staffing, levels of observation and ability to respond to emergencies and out of hours admissions; • identification of normative nursing staffing levels for each inpatient ward to include nursing capacity to undertake joint medical and nursing assessments for admissions; and • a review of the E-rostering system ensuring that bank shifts are easily identified and the system is user friendly. **Ref: 6.8.3**
	Response by the Trust detailing the actions taken: Following subsequent inspections RQIA requested "The trust will undertake a review of the current flexible model of care in PICU which will address the core question of whether the current model is the most appropriate model for PICU provision in the trust going forward; • The trust will include independent expertise in the panel who will undertake the above review (two independent experts); and • This review will take account of the needs of the population across the Trust and will be fully completed by July 2020." This timeline has been challenged by Covid pressures, and an extension approved by RQIA. The prelminary (virtual) meeting of the trust senior managers with the 2 identified independent experts is 04/09/2020. The e-roster system has been reviewed and easily identifies bank shifts. It is user friendly. The bank list has been recently validated and updated.

Audits	
Area for improvement 17 **Ref**: Standard 4.3 **Stated:** First time **To be completed by:** 7 November 2019	The Trust shall address the following matters with respect to audits: • undertake a review of the rolling audit programme to ensure it provides the Trust with the necessary assurances in relation to the standard of care; • undertake a review of audit tools to ensure they are user friendly and in accordance with best practice guidance and evidence base; • ensure a consistent approach to audits is undertaken across the northern and southern areas within the directorate; • ensure that robust arrangements are established to escalate issues identified during the audit process through the directorates governance structures; and • consideration must be given to how audit findings are analysed for trends/comparative data, and how audit findings are shared with relevant governance committees; staff and patients. **Ref: 6.8.4**
	Response by the Trust detailing the actions taken: The Trust has addressed the following matters with the respect to audits. Both service managers have met with lead nurse for Governance and reviewed and updated the audit schedule and audit tools to ensure a robust audit process which is user friendly and inaccordance with best practice guidance and evidence base. Both service managers work in partnership to ensure a consistent approach which involves validating the audits in Northern and Southern areas within the directorate. The service managers lead on monthly team health checks and produce trend analysis/comparative data which is displayed on each ward. This is desiminated to ward teams through their staff meetings. This is also shared with senior managers through governance meetings. Mental health inpatient wards across the Northern and Southern sector has adapted a new process (ALAMAC) which provides the teams with the opportunity to collect data. This data includes staffing levels,sickness/attendance/incidents/ patient behaviors ect. This information will inform practice moving forward and provides us with an evidence base.

Please ensure this document is completed in full and returned via email to;
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