Mental Health and Learning Disability
Inpatient Inspection Report
3-5 January 2017

Elm Ward and Lime Ward

Acute Admission
Tyrone and Fermanagh Hospital
1 Donaghanie Road
Omagh
BT79 0NS

Tel No: 028 82835454
Inspector: Cairn Magill, Audrey McLellan and Dr John Simpson

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

Elm and Lime are acute admission wards on the Tyrone & Fermanagh Hospital site. Elm provides assessment and treatment for female patients and Lime provides the same service for male patients. Each ward can accommodate up to 13 patients and there is also an integrated Psychiatric Intensive Care Unit (PICU) attached to the ward which accommodates four patients from the wards when this is required.

On the days of the inspection there were 12 patients on Lime ward and six patients on Elm ward. One patient from Elm was in the PICU. Three patients were appropriately detained in accordance with the Mental Health (NI) Order 1986.

The multidisciplinary team (MDT) on the ward included input from nursing, psychiatry, social work and occupational therapy. Referrals can also be made to the following teams within the community for support with patient care and treatment:

- Community Addiction Team
- Community Personality Disorder Team
- Community Forensic Team
- Eating Disorder Team

There was one ward manager in charge of both wards and the management structure included three deputy ward managers.

3.0 Service Details

Responsible person: Elaine Way
Ward manager: Jackie McCutcheon
Person in charge at the time of inspection: Jackie McCutcheon

4.0 Inspection Summary

An unannounced inspection took place over three days from 3-5 January 2017.

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

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

Evidence of good practice was found in relation to leadership in the wards, the involvement of patients in their care and treatment, the positive working relationships within the multidisciplinary team and the introduction of quality improvement projects completed by all members of the MDT.

Areas requiring improvement were identified in relation to the recording of risk management plans, the completion of actions within the fire safety audit, the updating of care plans from patients assessed need and the auditing of care records within the integrated care pathway (ICP). Only certain sections of the ICP were audited and areas that were completed stated there were no concerns or action plans. However, this was in contrast to the inspectors' assessment of these records as a number of areas for improvement were identified in relation to these audits.

One patient stated that when they were admitted a member of staff said a very unkind remark to them regarding their condition. The patient advised this was very upsetting for them and that the remark has affected their therapeutic relationship with this nurse. They stated they would like this matter discussed with the nursing team to prevent another patient experiencing this type of incident. During the Inspection, inspectors raised this matter with the Nurse in Charge who assured inspectors that the matter would be addressed to ensure no other patients who had a similar condition would experience this situation again. As it was condition specific this area of improvement is not listed in the provider compliance plan at the end of this report. Inspectors were satisfied that the Nurse in Charge would manage the situation outlined above to improve patient experience.

Patients said:

"Staff are very engaging and helpful…….good choice of food…I would like more to do at the weekends"

"Staff are friendly….I've no complaints about the staff…OT, staff and social workers are great"

"Staff are very helpful…I went to a meeting this morning about my discharge….there's good support here from other patients….meals are fantastic….staff are excellent, I got on so well with all the staff, patients and my doctor has been so attentive"

"Everyone on the ward is very good if you want you can get extra blankets at night and extra food…… nothing is a problem for the staff….I was informed of my rights the nurses explained this to me…..very good care and kind staff, they always have time for you….staff treat patients like they would treat their own family…..they work over and above their role, one nurse brought me in DVD's… they give you time on your own so there's a good balance"

"I am involved in my care and treatment everything has been explained to me…..the ward is comfortable and warm. The food is nice and the staff are lovely they are kind and treat you with so much respect……but there was one nurse who said a remark to me which I felt was unkind but I think she was using 'tough love' I did speak to another nurse about this as she said it wouldn't happen again…. the ward would need new books and board games"

"A lot of the staff want to see you get better and that comes across with how they care for you…one nurse comes in to see me every day before she leaves work, this extra touch is so nice…..they all check you at night if you have been upset during the day. I think the nurses encompass the six C's; they are caring, compassionate, competent, committed, have good communication skills and have courage. My condition has been explained to me by the nurses they gave me leaflets on my diagnosis and explained my symptoms to me. Staff have updated my family on my condition and they have attended meetings in the past with the doctor. I get on very well will my doctor I've known him a long time…. To improve the service I think it would be good to have more activities on the ward to do as the days can be long…I have made some suggestions which have been taken on board but I think the ward needs a DVD player (it's broken), stress balls and more board games for patients to play"

"I have been in and out of this ward for many years and I think the staff are great they really look after you in here. I have been out on leave and this went well so I will be getting out again….. I was really ill when I was admitted onto the ward but I'm much better now… I have done loads of stuff in here at OT. I've made a cup in arts and crafts and I've made cards for the family".

One relative said:

"Staff are very good and dedicated….X was very quickly admitted onto the ward which was good as X needed this care at the time….. there was an excellent response. X is involved in all aspects of her care and treatment and I have also met with the doctor on the ward. I requested a meeting and got all my questions answered. I know X would like more activities to do on the ward so this could be improved".

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	13

Findings of the inspection were discussed with trust representative as part of the inspection process and can be found in the main body of the report.

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

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

The inspection was underpinned by:

- The Mental Health (Northern Ireland) Order 1986.
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.
- The Human Rights Act 1998.
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

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

- The operational policy or 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 seven service users, four of staff and seven of service users' visitors/representatives.

The following records were examined during the inspection:

- Care documentation in relation to seven patients.
- Multidisciplinary team records
- Policies and procedures
- Staff duty rota
- Staff supervision templates
- Clinical room records
- Environmental risk assessments
- Health and safety assessments
- Fire audit
- Staff training records
- Minutes of ward manager meetings
- Minutes of patient forum meetings
- Staff planner record.

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

We reviewed the areas for improvements/ recommendations/ made at the last inspection. An assessment of compliance was recorded as not met, partially met and met.

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

6.0 The Inspection

6.1 Review of Areas for Improvement and Recommendations from the most recent Inspections dated 21 July 2015 Lime ward and 12-16 October 2015 in Elm Ward

The most recent inspection of the wards were unannounced type inspections. 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 of Lime Ward dated 21 July 2015

Recommendations		Validation of Compliance
Number 1 **Ref**: Standard 4.3 (m) **Stated:** Third Time	It is recommended that the ward manager ensures that all staff working on the ward undertakes mandatory manual handling training appropriate to their role.	**Met**
	Action taken as confirmed during the inspection: Inspectors confirmed that all staff had up to date manual handling training appropriate to their role. The ward manager maintained a database of mandatory training which records when training requires updating. This enables the manager to schedule training for staff in a timely fashion.	
Number 2 **Ref**: Standard 4.3 (m) **Stated:** Third Time	It is recommended that the Trust ensure that a system is put in place so that the ward manager/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. All staff who work on the ward and are on the bank duty rota have their mandatory training up to date. This is monitored by the ward manager. 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 3 **Ref**: Standard 4.3 (i) **Stated:** First Time	It is recommended that the ward manager ensures the accurate and comprehensive completion of all documentation. In addition ensure that patients who use a metal frame or profiling bed that their risk assessments reflect the frequency of review and ensures that reviews are carried out in accordance with the prescribed timescale.	**Met**
	Action taken as confirmed during the inspection: Inspectors confirmed there were no profile beds in use during the inspection. The Ward manager informed inspectors that when an individual patient assessment identifies the need for a profiling bed one is hired in from Arjo Huntley company and a ligature risk assessment is completed for the patient. One profiling bed was waiting to be collected from the company but this was stored in a locked room.	
Number 4 **Ref**: Standard 5.3.1 (a) **Stated:** First Time	It is recommended that the ward manager ensures that staff signatures are included on all necessary documentation	**Met**
	Action taken as confirmed during the inspection: Inspectors confirmed that staff signatures were included on all necessary documentation at the time of inspection.	
Number 5 **Ref**: Standard 4.3 (i) **Stated:** First Time	It is recommended that the ward manager ensures that following the identification of risk of ligature, individualised care plans are developed which reflect the management of the ligature risk.	**Not Met**
	Action taken as confirmed during the inspection: The ward environmental ligature risk assessment was completed which highlighted a number of ligature points on the ward. Although the assessment identified areas as presenting low risk there were no patient specific ligature risk assessments or care plans in place. This will be restated as an area for improvement for the second time.	
Number 6 **Ref**: Standard 4.3 (l) **Stated:** Third Time	It is recommended that the ward manager ensures that all staff working on the ward receives an annual appraisal.	**Met**
	Action taken as confirmed during the inspection: Inspectors confirmed that all staff had an annual appraisal at the time of inspection.	

Number 7 **Ref**: Standard 5.3.1 (a) **Stated:** Second Time	It is recommended that the ward manager ensures that all patients have a person centred discharge care plan that indicates the actions to support and prepare patients for discharge.	**Met**
	Action taken as confirmed during the inspection: Inspectors confirmed that there was evidence of person centred discharge care plans in place at the time of inspection.	
Number 8 **Ref**: Standard 6.3.2 (g) **Stated:** First Time	It is recommended that the ward manager ensures that agreed actions following patients' meetings are implemented and followed up at the next meeting	**Met**
	Action taken as confirmed during the inspection: Inspectors confirmed that patient meetings occur on a weekly basis and that actions identified are followed up and feedback or an update is provided at the next meeting.	
Number 9 **Ref**: Standard 4.3 (m) **Stated:** First Time	It is recommended that the Trust ensures that the nursing workforce development plan includes: • Identification of the range of high and low level evidence based psychological interventions required to meet the needs of patients who are admitted to Lime ward; • The actions which will provide the required training for staff who deliver care and treatment to patients in Lime ward, increasing the access for patients to a range of evidence based psychological interventions; • Mechanisms to maintain accurate records of staff training and development in psychological interventions; • Mechanisms to support clinical supervision for staff delivering psychological interventions.	**Partially Met**
	Action taken as confirmed during the inspection: Inspectors confirmed that the Trust has acknowledged the importance of high and low level evidence based psychological interventions required to meet the needs of patients. The ward manager had a database that recorded evidence based low level psychological training programmes offered to staff such as STORM and WRAP. The ward also has in place a pathway for psychological	

	intervention. Although not currently in operation, senior managers confirmed that a plan is in place to have clinical psychological input to the ward on a weekly basis from a qualified clinical psychologist. Mechanisms to support clinical supervision for staff delivering psychological interventions occur during their respective professional supervisions. Specific clinical psychological formal or informal supervision does not presently happen. A new area of improvement will be stated following this inspection.	
Number 10 **Ref**: Standard 6.3.2 (g) **Stated:** Second Time	It is recommended that the ward manager develops ward based therapeutic activities for patients that are also available at weekends and evenings.	**Met**
	Action taken as confirmed during the inspection: Patients who met with the inspectors advised they had access to activities during the day and in the evening and at weekends. However, a number of patients advised that this could be improved. The inspectors reviewed the activity timetable in the ward and it only included activities arranged by the OT department from Monday to Friday during the day. Although patients advised that activities were run at the weekend and evening by nursing staff there was no record of theses planned activities. A new area of improvement will be made in relation to planned evening and weekend activities	
Number 11 **Ref**: Standard 6.3.2 (g) **Stated:** Second Time	It is recommended that the Trust review the ward environment to provide a more therapeutic and conducive environment that meets the therapeutic and recreational needs of the patients.	**Met**
	Action taken as confirmed during the inspection: Inspectors noted the ward to be bright, spacious, clean, warm and welcoming. New furniture was purchased for the ward and there was a relaxed atmosphere. Patients had a number of areas to access including the gardens, TV room, quiet room, pool room, gym and dining room. A number of board games were also available for patients to use. All areas appeared to offer environmental therapeutic value to patient's recovery and mental	

	health and well-being.	
Number 12 **Ref**: Standard 6.3.2 (g) **Stated:** First Time	It is recommended that the Trust review the provision of occupational therapy on Lime ward to ensure that patients can avail of the full range of occupational therapy and recreational activities.	**Met**
	Action taken as confirmed during the inspection: There was evidence that a crisis occupational therapy pathway was in place for patients. This involved all patients being screened and assessed against a service priority checklist and from this goals are set to support each patient's recovery. Patients' participation and progress in meeting set goals were recorded in their progress notes.	
Number 13 **Ref**: Standard 6.3.1 (c) **Stated:** First Time	It is recommended that the Trust develops inpatient referral pathways for Clinical Psychology	**Met**
	Action taken as confirmed during the inspection: Inspectors confirmed that there was a referral pathway for clinical psychology.	
Number/Area 14 **Ref**: Standard 6.3.2 (b) **Stated:** Second Time	It is recommended that the Trust update the ward information leaflet to reflect all blanket and potential individual restrictions that patients may experience whilst on Lime ward.	**Met**
	Action taken as confirmed during the inspection: Inspectors received a draft copy of the revised information booklet that is waiting for approval to go to print. The booklet contains information on possible restrictions, deprivations of liberty and explains phone policy and what a patient can expect while they are an inpatient in Lime, Erne and PICU.	

6.3 Review of Areas for Improvement from Last Inspection of Elm Ward dated 12-16 October 2015

Areas for Improvement		Validation of Compliance
Number/Area: 1 **Ref**: Standard 6.3.1 (c) **Stated:** First Time	The garden area at the back of the ward was very small and was not well maintained. Cigarette debris was lying on the ground with bins overflowing. In both the back and front garden areas there were no plants or flowers and both gardens did not provide patients with a therapeutic environment.	**Met**
	Action taken as confirmed during the inspection: The inspectors reviewed the garden area and there was evidence that this area was well maintained. There was no cigarette debris on the ground and the bins had been emptied. There were bedding plants in the garden area and there were two large plant pots at the entrance to the ward which contained bedding plants and the trust confirmed these will be replanted with new plants in the spring.	
Number/Area: 2 **Ref**: Standard 5.3.1 (a) **Stated:** First Time	There was no evidence of patient/family/carer involvement in the patients' personal safety plans and no record of who contributed to the assessments. In each personal safety plan reviewed there was no management plan or contingency plans completed and two out of the three personal safety plans contained very limited information and did not focus on patients' strengths. Personal safety plans were reviewed however they did not detail an update on the current risks. Therefore they 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.	**Not Met**
	Action taken as confirmed during the inspection: There was no evidence of patient/family/carer involvement in the patients' risk assessments and no record of who contributed to the assessments. In each risk assessment reviewed there was no management plan or contingency plans completed and the assessments did not focus on patients' strengths. These assessments were reviewed	

	however they did not detail an update on the current risks. This area of improvement will be restated for the second time.	
Number/Area: 3 **Ref**: Standard 4.3 (i) **Stated:** First Time	There was no record of health care assistants having received supervision.	**Met**
	Action taken as confirmed during the inspection: There was evidence that health care assistants had received up to date supervision**.**	
Number/Area: 4 **Ref**: Standard 5.3.1 (a) **Stated:** First Time	There was evidence of low level psychological therapeutic interventions being carried out on the ward by nursing staff. However these interventions were not referenced in the patients' personal well-being plans with regard to how they would assist in patients' recovery.	**Not Met**
	Action taken as confirmed during the inspection: The inspectors reviewed six sets of care documentation and there was no evidence of psychological formulations to underpin care planning and inform relevant models of intervention. This area of improvement will be restated for the second time.	
Number/Area: 5 **Ref**: Standard 5.3.3 (b) **Stated:** First Time	Patient meetings were held however there was no clear evidence that the individual views and choices of patients had been considered	**Met**
	Action taken as confirmed during the inspection: The inspectors reviewed the minutes of the patient forum meetings. Patients' views were highlighted and there was evidence that changes were made from patients recommendations.	
Number/Area: 6 **Ref**: Standard 6.3.2 (a) **Stated:** First Time	A number of patients advised that they would like access to a locked cupboard for some of their belongings.	**Met**
	Action taken as confirmed during the inspection: All patients on the ward now have access to their	

	own safe.	
Number/Area: 7 **Ref**: Standard 4.3 (n) **Stated:** First Time	The average number of banking shifts per week was 17 shifts. **Action taken as confirmed during the inspection**: The ward is still using a high level of bank staff due to a high number of staff on sick leave this ensures that the ward is staffed at the correct level to ensure patients are cared for appropriately. This is also good to note that the trust are now using a central bank system which monitors the training of all staff who work on the bank duty rota and do not have a permanent contract on the wards to ensure their mandatory training is up to date All staff who work on the ward and are on the bank duty rota have their mandatory training up to date and this is monitored by the ward manager.	**Met**
Number/Area: 8 **Ref**: Standard 6.3.2 (b,d) **Stated:** Third Time	Patients did not have the opportunity to be involved in developing and agreeing their individual therapeutic and recreational activity programme. **Action taken as confirmed during the inspection**: There was evidence in the six care records reviewed that patients had the opportunity to be involved in developing and agreeing therapeutic and recreational activity programmes. Nursing staff met with patients each week to discuss and agree activities that could be arranged on the ward and the OT set goals for each patient to work towards their assessed need. However, each activity plan appeared to be completed when the patients had attended the activity. Therefore patients did not have a planned individual weekly therapeutic and recreational activity programme in place to assist in their recovery. A new area of improvement will be made in relation to this.	**Met**

Number/Area: 9 **Ref**: Standard 6.3.2 (b,d) **Stated:** Third Time	The range of therapeutic and recreational activities throughout the day including evenings and weekends did not incorporate the individual views and choices of patients on the ward. **Action taken as confirmed during the inspection**: Patients who met with the inspectors advised they had access to activities during the day and in the evening and at weekends. However, a number of patients advised that this could be improved especially in the evenings and at the weekend when there is no OT service. The inspectors reviewed the activity timetable in the ward and it only included activities arranged by the OT department from Monday to Friday during the day. There did not appear to be activities planned on the ward for the evenings and weekends**.** A new area of improvement will be made in relation to planned evening and weekend activities	**Met**
Number/Area: 10 **Ref**: Standard 5.3.1 (a) **Stated:** Second Time	There was no evidence of assessments completed by the occupational therapist and therefore there was no individualised therapeutic/recreational activity plans set up with goals set for each patient to work towards to support recovery. There was no record of the patients' participation and progress in meeting set goals. An action plan in relation to this area of improvement is to be forwarded to RQIA by 1st December 2015. **Action taken as confirmed during the inspection**: There was evidence that a crisis occupational therapy pathway was in place for patients. This involved all patients being screened and assessed against a service priority checklist and from this goals are set to support each patient's recovery. Patients' participation and progress in meeting set goals were recorded in their progress notes.	**Met**
Number/Area: 11 **Ref**: Standard 5.3.1 (f) **Stated:** Second Time	Patients did not have access to tea and coffee facilitates throughout the day. **Action taken as confirmed during the inspection**: A vending machine with tea and coffee was available for patients to use throughout the day.	**Met**

7.0 Review of Findings

7.1 Is Care Safe?

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

Areas of Good Practice

Staff knew who to raise concerns with when they were 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 felt well supported on the ward and that the MDT team worked well together.

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

Patients confirmed that staff explained their rights to them in relation to the detention process.

There was evidence of staff incorporating least restrictive practices.

There was information available on the detention process, patients' rights and how to make a referral to the MHRT.

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 and information regarding the complaints procedure was displayed throughout the ward.

Patients confirmed they knew how to make a complaint and all patients who met with the inspectors said they did not have to make any complaints as the care on the ward was good.

The ward had an environmental ligature risk assessment which was completed on 31 January 2016 which detailed a number of actions required to remove ligature points on Lime Ward. Senior trust representatives have advised that all these outstanding actions required will be removed in six weeks.

Areas for Improvement

An annual health and safety generic risk assessment was completed in January 2016 and included an action plan. However, there is one outstanding action with no date of completion.

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

- In all six risk assessments reviewed there was no evidence of patient/family/carer involvement or who contributed to the assessment.
- All six assessments were completed by only one professional.
- The review section of the risk assessments detailed discussions at the MDT meetings but did not record and update/change in the risks identified for each patient. Some updates did state changes in risks but this was not clear as the updates also included other plans that had been agreed at the MDT meetings. There was no evidence that risk management or contingency plans were in place.

The fire safety audit was completed on 16 November 2016. A Number of actions were identified and have not been actioned these included;

- Provide instructions and drawings at fire panel
- Commence weekly fire alarm testing
- Commence monthly checks
- Fill in Arson policy and contingency plan.
- Provide yellow nominated officer bib.

There were a number of environmental ligature points within Lime award however patients did not have an individual environmental risk assessment in place.

Number of areas for improvement	4

7.2 Is Care Effective?

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

Areas of Good Practice

It was positive to note that all professionals involved in patients' care recorded their involvement in one set of progress notes.

There was evidence that appropriate referrals were made to other professionals when discussed and agreed at the MDT meeting.

When patients are nearing discharge a discharge planning meeting is held with patients.

Deprivation of liberty (DOLS) care plans were in place when required. These detailed the restrictions in place in relation to each patient's individual needs.

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

There was evidence that patients were offered 1:1 time on a daily basis.

Patients who met with the inspectors stated they were involved in their care and treatment. Care plans had been signed by the patients. If patients disagree with their care plans this was also recorded.

Staff who spoke to the inspectors confirmed that they always had time to provide patients with 1:1 support.

It was good to note the commencement of interface meetings with the community teams to ensure continuity of care for patients when they are discharged.

The wards appeared calm and relaxed. Both wards were clean, clutter free and maintained to a good standard. The trust had purchased new furniture for the PICU which was of a high quality and suitable for the needs of patients in this unit.

It was good to note that the wards had two Occupational Therapists (OTs) who worked fulltime and provided activities for patients in a room adjacent to Lime ward. It was also goods to note that there were plans in place to develop this area into a therapeutic day centre with an extra two staff nurses being recruited to work in this facility.

Each patient had an OT assessment completed. Patients had access to a range of appropriate structured OT led therapeutic activities that included individual sessions and group work. These sessions included motivational programmes, creative classes, practical and life skill training, personal development groups, self-help awareness and social skill classes. The occupational therapy timetable was displayed on the ward and updated every week.

Medication was prescribed in accordance with the British National Formulary (BNF).

There was a social worker who worked on both wards and her role was to support patients in preparation for discharge, liaise with family members, assess housing and accommodation needs, link in with community teams, complete adult safeguarding referrals and complete carers assessments.

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

Staff who met with the inspectors demonstrated a good understanding of deprivation of liberty and it was evident that staff worked towards the least restrictive intervention.

Areas for Improvement

Patients did not have a planned individual weekly therapeutic and recreational activity programme in place to assist in their recovery. The activity timetable for the ward did not include evening and weekend activities and patients said that the ward could benefit from more board games and activities.

Patients were seen regularly by the medical team. However, the template for the zoning meetings which was held each morning and the MDT meetings which were held once a week had not been fully completed and it was not clear what had been agreed at each meeting. In a number of records there was no record of the actions agreed, the date this should be action by

and the responsible person. There was no evidence of patients' signatures or professionals' views. It was also unclear if the record was of a zoning meeting or a MDT meeting as the same template was used for each meeting.

There were sections throughout the ICP that had not been completed in a number of files.

- Screening assessments to determine if full assessments were required were not completed. These included the Malnutrition Universal Screening Tool (MUST), the manual handling screening assessment, the Braden scale assessment, a falls risk assessment and the National Early Warning Signs (NEWS) assessment. Records did not indicate if these assessments were required or not required
  - The medication on admission section had not been completed in two sets of care records
  - The section to record 'tests required' had not been fully completed. A number of tests had been identified as 'required' and there was no indication if these tests had been carried out or not.
  - In all six sets of care records the bio-psychosocial interim care plan/management plan had not been completed in full as there was no record of social management and collateral history.
  - In all six sets of care records the formulation section was not completed i.e. presenting problems, redisposing factors, precipitating factors, perpetuating factors and protective factors.
  - Out of the six sets of care records two records did not evidence that patients' needs were comprehensively assessed on admission by nursing and medical staff.
  - In two sets of care records there was no care plan in place to detail how certain areas of assessed need were going to be managed on the ward for these two patients.
  - A number of care plans reviewed by the inspectors did not detail the changes to the patients care and treatment from their assessed need. There was a record in the progress notes which detailed the changes in patients' care and treatment however each care plan had not been updated to reflect these changes.

In the six nursing care plans reviewed there was no evidence that nursing staff provided low level psychological interventions apart from 1:1 therapeutic support. Although it should be noted that when speaking with nursing staff they appeared keen to deliver these interventions however this would require some additional training and supervision. In relation to the activities on the ward these were mainly provided by the OT staff. There did not appear to be any collaborative working between the OT and nursing staff as the activity timetable only included the OT weekly timetable of activities. The inspectors reviewed six sets of care documentation and there was no evidence of psychological formulations to underpin care planning and inform relevant models of intervention.

Number of areas for improvement	4

7.3 Is Care Compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Areas of Good Practice

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

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

Patients and/or their representatives are satisfied with the care and treatment provided and the way staff treat them from admission to discharge.

Patients confirmed that they were given the opportunity to comment on their care and treatment and their wishes and views were taken into consideration.

An independent advocate from Foyle Advocate visits the ward once a week to support patients on the ward.

Patients enjoyed access to and from the ward. They were observed going out for a walk with staff, over to the OT department, going on visits to the local shops and out with family members on home leave.

Patients confirmed that they are always treated with dignity and respect.

Patients confirmed that staff were always compassionate towards them and a number of patients stated staff went over and above the call of duty.

Areas for Improvement

There were no areas for improvement identified in relation to compassionate care other than the comment made to the patient with a specific condition – see page four of this report. Inspectors received assurances that this matter would be addressed appropriately by the ward manager.

Number of areas for improvement	0

7.4 Is the Service Well Led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

Areas of Good Practice

Staff demonstrated a good understanding of their role and responsibility if they have a concern regarding patients' care and treatment.

Staff had a good understanding of the trust's policy and procedure for managing incidents and accidents.

Governance arrangements were in place to monitor the prescription and administration of medication. A pharmacy technician visits the ward weekly to determine the ward's medication needs. A pharmacist completes an audit of controlled drugs every three months and a senior trust representative confirmed that an advertisement has just gone to press for a part-time pharmacist position on the ward.

All incidents, accidents, SAI's and whistleblowing concerns were recorded on the Datix system. These are automatically sent to the relevant line managers, head of services, relevant professionals and the risk management team via an email to alert them to the incident.

Staff were involved in a number of quality improvement projects through the wards weekly micro-systems meetings such as;

- Reduce the number of aggressive incidents on the ward.
- Manage the PICU more effectively

There was evidence that all members of the MDT attended the micro-systems meetings and staff confirmed that they felt the introduction of these meetings had a positive impact on the ward. Staff confirmed that everyone in the team was given the opportunity to state their opinions and concerns in a safe environment.

The ward manager held monthly staff meetings and there was evidence that information from governance meetings was cascaded to the team.

Policies and procedures related to the ward were up to date.

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

Weekly patient forum meetings were held on the ward.

It was good to note that nursing staff including health care assistants had received supervision and appraisals.

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

A number of audits were completed by ward staff these included:

- Quarterly mattress audits
- Medication errors
- Hand hygiene
- Therapeutic engagement audits
- Patient satisfaction surveys

The ward completed a 'Daily Planner' each day to record each staff member's role and responsibility throughout their shift.

There was a defined organisational structure in place. Staff who spoke to the inspectors were aware of this structure and stated that they were well supported by management.

There were governance arrangements in place to monitor patients' length of stay on the ward and any delayed discharges.

There were no concerns raised regarding the level of staff on the ward. The ward manager confirmed that the ward is currently using a high level of bank staff due to staff on sick leave. However, all staff members on the bank rota are familiar with the ward and have the appropriate training and experience to work on the ward.

Areas for Improvement

A number of incidents have not been closed off by the ward manager in both Lime and Elm ward.

The social worker had not received regular supervision as per their professional guidance.

Audit outcomes stated that there were no concerns in relation to nursing care plans and risk assessments. No action plans arose out of the audits. However, this was in contrast to the inspectors' assessment of these records as a number of areas for improvement were identified in relation to record keeping. An audit of all sections of the ICP had not been completed.

The skills mix on the ward did not include clinical psychology. 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".*

There was no psychiatric clinical lead in place.

Number of areas for improvement	5

8.0 Provider Compliance Plan

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

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

8.1 Actions to be taken by the Service

The provider compliance plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed provider compliance plan by 2 March 2017.

Provider Compliance Plan Elm and Lime	
Priority 1	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 2 February 2017	The fire safety audit was completed on 16 November 2016. A Number of actions were identified and have not been actioned these included; • Provide instructions and drawings at fire panel • Commence weekly fire alarm testing • Commence monthly checks • Fill in Arson policy and contingency plan. • Provide yellow nominated officer bib.
	Response by responsible person detailing the actions taken: Weekly fire alarm testing commenced on Tuesday 12th January 2017, and is now established in the ward routine. Monthly fire safety checks commenced on Tuesday 12th January 2017, and is now established in the ward routine. Yellow nominated fire officer bibs are now stocked on the wards for use. The arson policy and contingency plan have been completed in the unit fire manual. Instructions and drawings are in situ at the fire panel.
Area for Improvement No. 2 **Ref:** Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 2 February 2017	There were a number of environmental ligature points within Lime however patients did not have an individual environmental risk assessment in place.
	Response by responsible person detailing the actions taken: Individual person-centred environmental risk assessments and care plans are in place for patients in Lime Ward. A capital works project under way will remove outstanding environmental ligature risks.
Area for Improvement No. 3 **Ref:** Standard 5.3.1 (f)	An annual health and safety generic risk assessment was completed in January 2016 which outlined an action plan. However, there is one outstanding action with no date of completion.

Stated: First time **To be completed by:** 2 February 2016	**Response by responsible person detailing the actions taken:** The outstanding action relates to anti-ligature remedial work in Lime Ward. A business case has been approved and the scheme of work has commenced. The anticipated date for completion of this scheme of work is 31 March 2017.
Priority 2	
Area for Improvement No. 4 **Ref:** Standard 5.3.1 (a) **Stated:** Second time **To be completed by:** 5 April 2017	Patients' risk assessments were not completed in accordance with the Promoting Quality Care – Good Practice Guidance on the Assessment of Risk and Management of Risk in Mental Health and Learning Disability Services, May 2010. • In all five risk assessments reviewed there was no evidence of patient/family/carer involvement or who contributed to the assessment. • All five assessments were completed by only one professional. • The review section of the risk assessments detailed what was discussed at the MDT meetings and did not record and update/change in the risks identified for each patient. Some updates did state changes in risks but this was not clear as the updates also included other plans that had been agreed at the MDT meeting. • There was no evidence that risk management or contingency plans were in place. •
	Response by responsible person detailing the actions taken: The Ward Sister has met the Consultant Psychiatrist with responsibility for medical training. Required standards have been reinforced with medical and nursing staff. This is subject to local review and audit. The Ward Sister is developing a guidance note and checklist for nursing staff.
Area for Improvement No. 5 **Ref:** Standard 5.3.1 (a) **Stated:** First time **To be completed by:** 6 March 2017	Patients did not have a planned individual weekly therapeutic and recreational activity programme in place to assist in their recovery. The activity timetable for the ward did not include evening and weekend activities and patients said that the ward could benefit from more board games and activities.
	Response by responsible person detailing the actions taken: Planned individual weekly therapeutic and recreational activity programmes will be in place before 6 March 2017. Additional board games and recreational materials are being sourced through

	eprocurement.
Area for Improvement No. 6 **Ref:** Standard 5.3.1(f) **Stated:** First time **To be completed by:** 6 March 2017	The template for the zoning meetings which was held each morning and the MDT meetings which were held once a week had not been fully completed. • It was not clear what had been agreed at each meeting. • There was no note of the actions agreed in a number of records. • The date this should be action by and who the responsible person was. • There was no evidence of patients' signatures or professionals' views. • It was also unclear if the record was of a zoning meeting or a MDT meeting as the same template was used for each meeting.
	Response by responsible person detailing the actions taken: Since the inspection processes have been reviewed through the local quality improvement project. Zoning meetings have been replaced with daily multidisciplinary handover meetings focusing on sharing of information. Multidisciplinary Ward Rounds determine treatment plans. Actions are recorded, identifying the responsible person and date of completion. New templates ensure that it is clearly recorded whether the information relates to Handover Meeting or Multidisciplinary Ward Round. Professionals' views are recorded. Patient signatures are completed on records of Multidisciplinary ward round.
Area for Improvement No. 7 **Ref:** Standard 5.3.1 (a) **Stated:** Second time **To be completed by:** 5 April 2017	The inspectors reviewed six sets of care documentation and there was no evidence of psychological formulations to underpin care planning and inform relevant models of intervention. There did not appear to be any collaborative working between the OT and nursing staff as the activity timetable only included the OT weekly timetable of activities.
	Response by responsible person detailing the actions taken: A workshop to review working arrangements and collaborative person

	centred therapeutic and recreational activity is scheduled for 8th March 2017. The aim of the workshop is to develop a system for activity timetabling to enable individualised programmes through multidisciplinary working and collaboration.

Area for Improvement No. 8
 	
Ref: Standard 5.3.1(f)
 	
Stated: First time
 	
To be completed by: 6 March 2017
	There were sections throughout the ICP that had not been completed in a number of files. Sections frequently incomplete were;
	
	• Screening assessments
	  • The medication on admission
	  • The section to record 'tests
	  • A number of tests had been identified as 'required' and there was no indication if these tests had been carried out or not.
	  • The bio-psychosocial interim care plan/management plan. There was no record of social management and collateral history.
	  • The formulation section i.e. presenting problems, redisposing factors, precipitating factors, perpetuating factors and protective factors.
	  • Out of the six sets of care records two records did not evidence that patients' needs were comprehensively assessed on admission by nursing and medical staff.
	  • There was no care plan in place to detail how certain areas of assessed need were going to be managed for two patients.
	  • There was a record in the progress notes which detailed the changes in patients' care and treatment however each care plan had not been updated reflect these changes.

	Response by responsible person detailing the actions taken: A multidisciplinary meeting has been organised for 8 March 2017 with nursing, medical, social work and occupational therapy staff to reinforce recording standards and associated practice requirements. The meeting will agree a programme for multidisciplinary audit of ICP documentation.
Area for Improvement No. 9 **Ref:** Standard 5.3.1 (f) **Stated:** First time **To be completed by:**	A number of incidents have not been closed off by the ward manager in both Lime and Elm ward.
	Response by responsible person detailing the actions taken: The Ward Sister and Crisis Service Manager have developed a diary schedule to review and close outstanding incidents by 5th April 2017.

5 April 2017	
Area for Improvement No. 10 **Ref:** Standard 4.3 (l) **Stated:** First time **To be completed by:** 6 March 2017	The social worker had not received regular supervision as per their professional guidance.
	Response by responsible person detailing the actions taken: The Lead Social Worker for adult mental health services is carrying out a review of supervision arrangements within the programme. A schedule of monthly supervision as per professional guidance is now in place.
Area for Improvement No. 11 **Ref:** Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 5 April 2017	Audit outcomes stated that there were no concerns in relation to nursing care plans and risk assessments. No action plans arose out of the audits. However, this was in contrast to the inspectors' assessment of these records as a number of areas for improvement were identified in relation to record keeping. An audit of all sections of the ICP had not been completed.
	Response by responsible person detailing the actions taken: The Lead Nurse and Crisis Services Manager will review audit systems and processes with the nursing team. A system of audit validation and checks will be implemented to improve rigour.
Priority 3	
Area for Improvement No. 12 **Ref:** Standard 4.3 (j) **Stated:** First time **To be completed by:** 5 July 2017	The skills mix on the wards did not 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".*
	Response by responsible person detailing the actions taken: The Clinical Lead for Psychology and Head of Crisis Services will submit a paper proposing the commissioning of dedicated clinical psychology resources to be tabled at the April 2017 Adult Mental Health Senior

	Management Team Meeting.
Area for Improvement No. 13 **Ref:** Standard 4.3 (j) **Stated:** First time **To be completed by:** 5 July 2017	There was no psychiatric clinical lead in place.
	Response by responsible person detailing the actions taken: The position of Clinical Lead for Psychiatry for the southern sector of the WHSCT is being re-advertised by Medical HR. This is being led by Divisional Clinical Director who is providing clinical leadership in the interim.

Name of person(s) completing the provider compliance plan	Jackie McCutcheon		
Signature of person(s) completing the provider compliance plan		**Date completed**	27/2/2017
Name of responsible person approving the provider compliance plan	Trevor Millar		
Signature of responsible person approving the provider compliance plan		**Date approved**	
Name of RQIA inspector assessing response	Cairn Magill		
Signature of RQIA inspector assessing response		**Date approved**	3/3/2017

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