The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Lime Ward, Tyrone and Fermanagh Hospital

Western Health and Social Care Trust

2 and 3 March 2015

national preventive mechanism

Contents

1.0 General Information 3
2.0 Ward Profile 3
3.0 Introduction 4
3.1 Purpose and Aim of the Inspection 4
3.2 Methodology 4
4.0 Review of action plans/progress 6
4.1 Review of action plans/progress to address outcomes from the previous announced inspection 6
4.2 Review of action plans/progress to address outcomes from the previous patient experience interview inspection 6
4.3 Review of action plans/progress to address outcomes from the previous financial inspection 6
4.4 Review of implementation of any recommendations made following the investigation of a Serious Adverse Incident 6
5.0 Inspection Summary 7
6.0 Consultation Process 13
7.0 Additional matters examined/additional concerns noted 15
8.0 RQIA Compliance Scale Guidance 19
Appendix 1 Follow up on previous recommendations 20
Appendix 2 Inspection Findings 20

1.0 General Information

Ward Name	Lime Ward
Trust	Western Health and Social Care Trust
Hospital Address	Tyrone and Fermanagh Hospital 1 Donaghanie Road Omagh BT79 0NS
Ward Telephone number	028 82835368
Ward Manager	Gloria Shaw
Email address	gloria.shaw@westerntrust.hscni.net
Person in charge on day of inspection	Day 1 – Maria Harper, Staff Nurse Day 2 – Jackie McCutcheon, Deputy Ward Manager
Category of Care	Acute Mental Health - Male
Date of last inspection and inspection type	PEI – 17 July 2014
Name of inspectors	Kieran McCormick Nichola Rooney

2.0 Ward profile

Lime is a 13 bed male acute admission ward on the Tyrone & Fermanagh Hospital site. Lime is one of two acute admission wards within the same building with the other being a 13 bed female acute admission ward (Elm). There is also an integrated psychiatric intensive care unit (PICU) attached to the ward.

The ward sleeping facilities include dormitory style accommodation with one single bedroom.

There were nine patients on the ward on the days of the inspection and five of these patients were detained under the Mental Health (NI) Order 1986. The purpose of the unit is to provide acute assessment and treatment for patients with a psychiatric illness who require care in an inpatient environment.

The multidisciplinary team on the ward consists of nursing, psychiatry, social work and occupational therapy.

The ward maintains an open door policy the main entrance to the ward was unlocked; patients could exit and enter the ward independently. Bedrooms,

sleeping areas and bathrooms were not locked on the days of the inspection. There were separate day spaces and dining areas for patients.

3.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Northern Ireland's health and social care services. RQIA was established under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to drive improvements for everyone using health and social care services. Additionally, RQIA is designated as one of the four Northern Ireland bodies that form part of the UK's National Preventive Mechanism (NPM). RQIA undertake a programme of regular visits to places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment, upholding the organisation's commitment to the United Nations Optional Protocol to the Convention Against Torture (OPCAT)**.**

3.1 Purpose and Aim of the Inspection

The purpose of the inspection was to ensure that the service was compliant with relevant legislation, minimum standards and good practice indicators and to consider whether the service provided was in accordance with the patients' assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

The aim of the inspection was to examine the policies, procedures, practices and monitoring arrangements for the provision of care and treatment, and to determine the ward's compliance with the following:

- 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.

Other published standards which guide best practice may also be referenced during the inspection process.

3.2 Methodology

RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the inspection standards.

Prior to the inspection RQIA forwarded the associated inspection documentation to the Trust, which allowed the ward the opportunity to demonstrate its ability to deliver a service against best practice indicators.

This included the assessment of the Trust's performance against an RQIA Compliance Scale, as outlined in Section 6.

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.
Specific methods/processes used in this inspection include the following:

- analysis of pre-inspection information;
- discussion with patients and/or representatives;
- discussion with multi-disciplinary staff and managers;
- examination of records;
- consultation with stakeholders;
- file audit; and
- evaluation and feedback.

Any other information received by RQIA about this service and the service delivery has also been considered by the inspector in preparing for this inspection.

The recommendations made during previous inspections were also assessed during this inspection to determine the Trust's progress towards compliance. A summary of these findings are included in section 4.0, and full details of these findings are included in Appendix 1.

An overall summary of the ward's performance against the human rights theme of Autonomy is in Section 5.0 and full details of the inspection findings are included in Appendix 2.

The inspector would like to thank the patients, staff and relatives for their cooperation throughout the inspection process.

4.0 Review of action plans/progress

An unannounced inspection of Lime was undertaken on 2 and 3 March 2015**.**

4.1 Review of action plans/progress to address outcomes from the previous announced inspection

The recommendations made following the last announced inspection on 28 August 2013 were evaluated. The inspector noted that 13 of the 21 recommendations had been fully met. However, despite assurances from the Trust, one recommendation will require to be restated for a third time and six recommendations will require to be restated for a second time, in the Quality Improvement Plan (QIP) accompanying this report. One recommendation has been removed as it is no longer applicable.

4.2 Review of action plans/progress to address outcomes from the patient experience interview inspection

The recommendations made following the patient experience interview inspection on 17 July 2014 were evaluated. The inspector noted that both recommendations had been fully met.

4.3 Review of action plans/progress to address outcomes from the previous finance inspection

The recommendations made following the finance inspection on 31 December 2013 were evaluated. The inspector noted that both recommendations had not been met. Despite assurances from the Trust, both recommendations will require to be restated for a second time in the Quality Improvement Plan (QIP) accompanying this report.

4.4 Review of implementation of any recommendations made following the investigation of a Serious Adverse Incident

A serious adverse incident had occurred on this ward on 27 February 2014. Relevant recommendations made by the review team who investigated the incident were evaluated during this inspection. It was noted that compliance had been achieved in relation to two of the five recommendations. However two recommendations were not met and one recommendation was not assessed as it was not applicable to the inspection.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection it was positive to note that a review of three patients' files evidenced that patients had been provided an opportunity to discuss their comprehensive risk assessment at the ward meeting. Patients that met with the inspector also confirmed that the choice of salads was now an option, a review of the ward menu also confirmed salads were available.

The following is a summary of the inspection findings in relation to the human rights indicator of autonomy and represents the position on the ward on the days of the inspection.

Information in relation to consent was available in a leaflet format. There was also information available for patients in relation to legal advice whilst in hospital. Staff who met with the inspector on the days of inspection explained the steps they took to ensure patients consented to care and treatment.

Care plans in each of the three patients' files reviewed were consistently signed by the patient or an explanation recorded why they had not been signed. However the inspector was not provided with any evidence that care plans had been revisited with the patients who had not signed or were unable to sign. A recommendation has been made in relation to this.

Care plans reviewed made no reference to the assessment of consent or the fact that consent had been obtained prior to care being delivered. In each of the patients' files reviewed, the care plans did not provide guidance to staff on how to obtain or assess consent or the actions to take if consent was not obtained. Patients' daily progress notes made no reference that patients were consenting or otherwise to care and treatment. A recommendation has been made in relation to this.

In two of the three patient care files reviewed the patient had a completed nursing history and initial assessment. Assessments reviewed in two of the three patients' care files identified a lack of assessment of the individual's physical and mental health needs. In the case of one of the three files reviewed the patient had no completed MUST, Braden or Falls risk assessment. In another patient's file the same assessments had not been reviewed in over six months. The care plans in the same patient's file who had been transferred to the PICU from a continuing care and rehabilitation ward, had not been updated, amended or changed since moving. The care plans did not reflect the change in the patient's needs currently in PICU. The inspector reviewed care documentation in relation to a patient with a history of complex physical, mental and social needs. The inspector noted that care plans had not been completed to reflect all the assessed needs of the patient. There was no mention of the patient's needs whilst in an acute facility or as to how the patient's needs were being monitored, met or evaluated. A recommendation has been made in relation to this. Risk assessments and care plans were not consistently reviewed and evaluated throughout each patient's admission. Reviews of care plans did not accurately reflect the change in patients' circumstances and did not provide a true reflection of the

patient's current and actual needs. A recommendation has been made in relation to this.

The inspector reviewed a specific care plan for a patient requiring care and treatment in the PICU facility. The care plan stated that the patient was receiving one to one enhanced observation. On a further date the care plan stated that the one to one observations had been discontinued. When the inspector reviewed the patient's progress notes it stated that the patient had been re-commenced on one to one enhanced observations. A cross reference with the patient's care plan and records provided no evidence of when the observations had been reinstated and a clinical explanation or rationale for this. A recommendation has been made in relation to this.

Care files for patients involved with Occupational Therapy (OT) services, evidenced initial assessment and ongoing work completed by the OT. Records evidenced an assessment of the individual with identified needs and a plan to achieve individualised set goals.

The inspector reviewed the Promoting Quality Care (PQC) documentation for three patients'. The inspector was reassured that PQC documentation was completed and regularly reviewed 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. Staff confirmed that they had access to the electronic Epex system at all times in order to obtain information on a new admission, particularly out of hours.

Patients' care files reviewed reflected contact with medical staff and a minimum of once weekly one to one consultation with the consultant psychiatrist. Patients who required review more often were facilitated and this was reflected in the medical progress notes. Care documentation made no reference to the consideration of patients' Human Rights Articles 8, respect for the right to family and private life. A recommendation has been made in relation to this.

The inspector reviewed the 24 hour nursing progress notes in three of the patients' files. In each case staff had completed a contemporaneous entry of the care delivered to the patient during the course of the 24 hour period.

The ward had two consultant psychiatrists who divide the patient cover geographically. They conduct two weekly ward meetings each on Mondays and Thursdays. Patients also had access to occupational therapy (1.0 wte OT) by referral and social work input. There is no clinical psychology on the multi-disciplinary team (MDT), with no referral pathways for inpatients. However the consultant psychiatrist had established a relationship with the Personality Disorders service and the clinical psychologist had input into the ward for advice and support. There was no access to any other specialist psychological therapists. Patients with neurological conditions, such as dementia or brain injuries were unable to access neuropsychology, other than through referral to the old age psychiatrist. A recommendation has been made in relation to this.

Lime Ward had no evidence of ward based therapeutic activities. There was no activity timetable. Therapeutic interventions were provided by OT and were aimed at addressing functional deficits. There was limited therapeutic information provided within the environment. There were a few typed A4 sheets on two walls, which included low level information on anger management and managing stress. A recommendation has been made in relation to this. An information sheet on art therapy was on view, although this was reportedly not available as the art therapist was on long term sick leave.

The 'recreation room' which was locked throughout the inspection and was not accessed by any patients, included a pool table (cues were accessible but no snooker balls) and a small coffee table with two empty board game boxes. A patient lounge with settees had a television, but no other recreational items on view. The main communal area had four seats, with no recreational items on view. A blackboard had the names of the psychiatrists and nurses on duty. Patients were able to access gym equipment, if staff were available to accompany them.

The OT room had evidence of activities and artwork. This large room was separated from the main ward space, along a long corridor, through the visiting area and through a set of doors. The room had an activity space sectioned off in the room by large plants, to provide privacy, a kitchen area and office space. During the inspection a group of female patients were participating in artwork and a male patient had joined the group. Within the OT area the inspector noted a communal toilet area with two cubicles, one for the use of males and the other for the use of females. The inspector was concerned that this facility in its current state could be compromising for staff, visitors and patients particularly due to the shared nature of the facility by both genders. A recommendation has been made in relation to this.

The OT described their specialised role on the ward. Only those patients able to engage in functional assessments and recovery work were accepted for OT input, as this was the best use of limited resources. A screening tool was used to select the most appropriate patients and the referrals were made via the ward meetings. There was little OT input into the male patients in intensive care. The OT role was described as 'core OT' focusing on addressing patients' functional deficits and reskilling patients for independent living. The OT was adamant that they should not contribute to ward based recreational activities. They reported that they should not be viewed as a member of staff whose purpose was to entertain patients. They reported that they would be willing to work with or supervise nursing activities, but felt that this service would not be valued by nursing staff.

The consultant psychiatrist was exceptionally enthusiastic about developing access to psychological therapies. They felt that this was a gap in provision for patients, compared to other Trusts and services. They had experienced very good multidisciplinary working in community services and was at a loss as to why the most ill and vulnerable patients did not have access to these services. They had established links with the Personality Disorders service, but acknowledged that this service consisted of two people and so was limited as to what could be offered. The consultant noted that the main obstacle to

developing therapeutic activities on the ward was the protection of nursing time. They stated that staff were “burnt out and demoralised” with high levels of sickness and reliance on bank staff. A recommendation has been made in relation to this.

Nursing staff reported that while there was no therapeutic group activity available, nurses did facilitate the use of gym equipment. Nursing therapeutic work was delivered during one-to-one patient time. The inspector was informed that nurses used their cognitive behavioural therapy (CBT) or counselling skills to support this work. The deputy ward manager stated that they believed that a survey of therapeutic skills was being undertaken by the Trust, but had no information about this.

Four sets of patient files were examined when reviewing therapeutic interventions. The notes reviewed did not evidence consideration of accessing specialist high intensity psychological interventions, in keeping with NICE guidance. For example, one patient experienced a family bereavement while an inpatient. This was reported as a strong supportive relationship. However, while there were notes regarding facilitating the patient buying a suit for the funeral, there was no note referencing access to bereavement support. Patients exhibiting anger management problems were not referred for anger management therapy and those with dual diagnoses or drug and alcohol addictions had no specialist interventions. A recommendation has been made in relation to this.

The inspector met with two patients individually. The first patient who was detained in accordance with the Mental Health (Northern Ireland) Order 1986 had been an inpatient for 18 weeks. The patient reported that they had a good relationship with their psychiatrist, whom they saw twice a week. The patient reported that the ward was ‘boring’, ‘there is nothing to do except lie about’. A recommendation has been made in relation to this. The second patient who was voluntarily in hospital had been an inpatient for seven months. The patient reported seeing their psychiatrist twice a week. The patient stated they had confidence in their psychiatrist. The patient reported feeling bored, as there was nothing to do. They had an interest in music but there were no facilities for music in the ward. The patient was currently residing in PICU and reported that he was ‘never asked down to the OT area’ but that the nurse had allowed him to use the treadmill in the gym area on the previous day. The patient could not describe receiving any kind of psychological intervention.

The deputy ward manager stated that trust mandatory training was available to ward staff. All other training had been put on hold due to financial pressures. Some nurses had reportedly undertaken WRAP training and some had completed some low level CBT training. There were no records of the psychological training that had been undertaken. A recommendation has been made in relation to this. The deputy ward manager stated that they had completed a module in CBT. A staff nurse who met with the inspector confirmed the lack of access to training in psychological interventions. A recommendation has been made in relation to this.

Information leaflets available for patients provided details in relation to patients' rights whilst in hospital, what a patient should expect regarding their care and treatment and the responsibilities of the ward staff. Information on how to make a complaint, the Patient and Client Council and the advocacy service was displayed on the ward.

Patient meetings are facilitated at ward level. A review of the minutes from the last meeting evidenced an agenda, those in attendance and matters arising however there was no evidence that agreed actions had been implemented. A recommendation has been made in relation to this.

In addition to the ward advocacy service, Lime ward receives a monthly visit from a legal representative from the Law Society who provides independent advice to patients.

Patients that met with the inspector were aware of their rights whilst detained and were familiar with how to access the Mental Health Review Tribunal. Patients were also aware of their right to accept and refuse treatment whilst in hospital.

Restrictions on Lime ward included the use of physical interventions, use of as and when required medication, locked recreation room, ban on sharp items and removal or certain items i.e. phone chargers. Information regarding some, but not all, of the restrictions in place was included in the ward information booklet. A recommendation has been made in relation to this.

The inspector noted in the care file for a patient subject to enhanced observations that there was a consistent review of the observations. However care documentation did not demonstrate a consistent approach to the monitoring, review and use of individualised restrictions and blanket restrictions for each individual patient. A recommendation has been made in relation to this.

Care documentation in the three patients' files reviewed made no reference to the consideration of patients' Human Rights Article 3; rights to be free from torture, inhuman or degrading treatment or punishment, Article 5; rights to liberty and security of person, Article 8; to respect the right to family, private life and Article 14; the right to be free from discrimination. A recommendation has been made in relation to this.

The inspector reviewed a Deprivation of Liberty (DoL) care plan for a patient in PICU. This care plan had been created whilst the patient was on a different ward in the hospital. The care plan had not been updated or amended to reflect the current environment the patient was in and provided no rationale or explanation with regards to the restrictions the PICU environment imposed, i.e. enhanced observations and locked door. In the other two patient care files reviewed there was no reference or guidance to the Deprivation of Liberty safeguards, this was particularly concerning given the blanket and individualised restrictive practices in use. A recommendation has been made in relation to this.

Training records examined provided reassurances that 23 of the 24 staff working on Lime had received up to date training in physical interventions.

The inspector met with the ward manager, consultant psychiatrist, social worker and OT who provided an explanation of the discharge process. The inspector was advised that the MDT met weekly. This provided an opportunity to review each patient's progress and to track those patients nearing or ready for discharge.

The ward consultant and social worker advised that preparation for discharge commences early in the admission. The MDT will review the patient's history, complete any necessary assessments and review the previous living arrangements. In preparation for discharge relevant information will be shared with the community team and where necessary they will be invited to an MDT meeting prior to the patient's discharge. Input is also sought from the patient and nearest relatives where appropriate.

On occasions it is the responsibility for the MDT to assess and plan the most suitable community placement for a patient in accordance with 'Best Interests' in mind, particularly for those patients with concerns regarding their capacity and/or lack of relative involvement.

In the three patients' files reviewed the inspector did not observe any evidence of a discharge care plan to guide staff on preparing the patient for discharge or the steps to take in monitoring a patient's progress towards discharge. A recommendation has been made in relation to this.

A patient who met with the inspector reported concerns regarding the discharge process. The patient explained that they had been fully involved in the preparation for discharge. This included viewing the new facility that they would be moving to. The patient however expressed concerns that the process was very long, they had been waiting over four months and that they were still unaware of a date for discharge to their new home. The consultant psychiatrist reported that the delay in discharge was often due to the bureaucracy around securing the accommodation.

The consultant psychiatrist stated that it can be difficult coordinating meetings with members of the community team prior to discharge particularly for those patients who are managed in accordance with Promoting Quality Care. A recommendation has been made in relation to this.

Staff who met with the inspector were familiar with individual patient needs, likes, dislikes and choices.

The inspector met with three patients during the course of the inspection; none of the patients expressed any concerns in relation to involvement in their care and treatment. Patients confirmed that they met with their consultant psychiatrist for a one to one consultation every week or more frequently if required.

Details of the above findings are included in Appendix 2.

On this occasion **Lime** has achieved an overall compliance level of **Moving towards compliance** in relation to the Human Rights inspection theme of "Autonomy".

6.0 Consultation processes

During the course of the inspection, the inspector was able to meet with:

Patients	**3**
Ward Staff	**3**
Relatives	**0**
Other Ward Professionals	**4**
Advocates	**0**

Patients

The inspector met with three patients. Patients who met with the inspector spoke positively about the ward staff. All three patients stated that it can be a long day and boring on the ward.
Patients' stated:

"My psychiatrist and the nurses are pretty good"

"Days can be long and boring with little to do"

Relatives/Carers

There were no relatives available to meet with the inspector on the days of the unannounced inspection.

Ward Staff

The inspector met with three members of nursing staff. Staff who met with the inspector stated they felt well supported. However staff who met with the inspector expressed concerns regarding inconsistent staffing levels on the ward, the increased use of bank staff, increased staff sickness and a lack of consistency with the staffing needs for the ward. Staff stated that the ward was highly stressful due to the issues with staffing. Staff also expressed concerns regarding not having received their annual appraisal. Staff also stated that there was no opportunity at present to attend training other than mandatory subjects.

Other Ward Professionals

The inspector spoke with four visiting ward professionals over the course of the two day inspection. Professionals who met with the inspector provided a detailed explanation of their role and function within the ward. Each visiting professional explained their input into patient care and their individual roles in preparing patients for discharge. Each of the visiting professionals expressed concerns regarding different aspects of ward activity. The ward social worker and OT expressed concern regarding a need for additional support and staffing resources in their respective departments. Similarly the consultant psychiatrist expressed concerns that "They had never worked anywhere where staffing levels were so low". The inspector discussed each matter of concern with the ward manager. Additional information in relation to staffing is provided later in the report.

Advocates

There were no advocates available to meet with the inspector on the days of the unannounced inspection.

Questionnaires

Questionnaires were issued to staff, relatives/carers and other ward professionals in advance of the inspection. The responses from the questionnaires were used to inform the inspection process, and are included in inspection findings.

Questionnaires issued to	Number issued	Number returned
Ward Staff	19	1
Other Ward Professionals	5	1
Relatives/carers	10	1

Ward Staff

One questionnaire was returned by ward staff.

The inspector noted that information contained within the staff questionnaire demonstrated that the member of staff was aware of the Deprivation of Liberty Safeguards (DoLS) – Interim Guidance. The staff member indicated that they had received restrictive practice training and were aware of restrictive practices on the ward. Examples of restrictive practices as reported by staff included "detention for assessment and treatment", "use of MAPA", "close observations" and smoke free environment. The staff member indicated they had not received training in the areas of Human Rights. However they had received training in relation to capacity and consent.

The staff member stated they had received training on meeting the needs of patients who require support with communication. The staff questionnaire indicated that patients' communication needs are recorded in their assessment and care plan. The staff members reported that patients had

access to therapeutic and recreational activities and that these programmes meet the individual patients' needs.

Other Ward Professionals

One questionnaire was returned by a visiting ward professional in advance of the inspection. It was noted that information contained within the professional's questionnaire demonstrated that they were aware of the DoLS – interim guidance. The visiting professional had received training in the areas of restrictive practices and human rights but had not received capacity and consent training.

The visiting professional stated they had not received training on meeting the needs of patients who require support with communication. The professional recorded that they were aware of alternative methods of communicating with patients and that these were used in the care setting.

Relatives/carers

One relative returned a questionnaire. Relative's comments included:

"The care is excellent and attention from nursing staff is outstanding"

"I feel there needs to be more therapies provided"

7.0 Additional matters examined/additional concerns noted

Complaints

Prior to the inspection RQIA requested a record of the number of complaints made between 1 April 2013 and 31 March 2014. The return from Lime ward indicated that no complaints had been made during this period. The inspector reviewed the record of complaints held on the ward in conjunction with the deputy ward manager and confirmed that there were currently no complaints outstanding regarding the ward. The inspector noted that the Trust complaints policy and procedure was created May 2011 and was due review May 2014 however this had not been completed. A recommendation has been made in relation to this.

Adult Protection Investigations

The inspector discussed with the deputy ward manager the safeguarding activity on the ward. The deputy ward manager advised that staff were familiar with the Safeguarding Vulnerable Adult policy and procedure and were making appropriate referrals in accordance with policy and procedure. The deputy ward manager advised that referrals for safeguarding investigations by ward staff were promptly completed to the safeguarding team and that protection plans were put in place.

The deputy ward manager advised that there was currently one ongoing investigation in relation to a patient who was no longer on the ward. The

inspector discussed this matter with the Crisis Service Manager who advised that the matter was awaiting closure as the patient had retracted the original allegation.

The inspector noted that the 2010 safeguarding vulnerable adults policy and procedure was due review in March 2011; there was a current draft available from October 2014 but had not been officially implemented. A recommendation has been made in relation to this.

Additional concerns noted:

Staff training

The inspector requested the staff training records for the ward. The inspector was informed that the ward did not have a completed staff training matrix. Staff training was recorded on individual staff record sheets. This did not provide a clear, accurate and robust mechanism for governing and monitoring staff training. From the current recording system the inspector was unable to be reassured that staff training needs had been maintained in accordance with mandatory requirements and the needs of the ward. The inspector requested that the ward training information is provided to the inspector on the new training matrix by 13 March 2015. The inspector received the training matrix post inspection and was concerned to note the following gaps in training for a staff team of 24:

Safeguarding Vulnerable Adults – 7 (29%) staff with no current up to date training, two with no future date booked.

Fire Safety – 13 (54%) staff with no current up to date training and no future date booked.

Only 3 of 24 staff had up to date training in Basic Life Support (CPR) or Intermediate Life Support. 21 (86%) staff with no up to date resuscitation training, 14 staff with a future date booked.

Moving and handling – no staff with current up to date moving and handling training, although all booked in for future training.

Acute patients

Prior to the inspection the inspector was aware that another ward in the hospital, Beech ward, is used as an ‘overflow facility’ for Lime. This therefore involves patients who do not have a bed on Lime to be transported via car to Beech before 11pm at night, will sleep over and then will be woken the next morning at 7.20am and transported back to Lime. The patient will then wait in Lime for a bed to become available; if this is not secured the patient is transported back to Beech ward to sleep over again. A review of previous records indicated that a patient had been transported back and forth from Lime and Beech ward on nine separate occasions between 13/08/14 – 27/08/14.

The inspector discussed with the ward manager the use of Beech ward as an ‘overflow facility’ for Lime. The ward manager, deputy ward manager and

consultant psychiatrist confirmed that this was the current practice of the hospital. All staff that spoke with the inspector expressed how they felt uncomfortable with the current arrangements but that they were adhering to Trust and regional bed management protocols. A recommendation has been made in relation to this.

Profiling and metal beds

A serious adverse incident resulting in a fatality concerning the use of a profiling bed as a ligature point occurred in 2013. In December 2013 The Health and Social Care Board requested that all HSC Trusts take appropriate actions in accordance with The Northern Ireland Adverse Incident Centre Estates and Facilities Alert EFA/2010/006. The exposed bed frame on the beds on Lime presents the same level of risk associated with ligature points as was the case when the fatality occurred.

The inspector noted that all beds on the ward were metal framed beds. One bed on the ward was a profiling bed. A review of three patients' care files provided no evidence of a risk assessment or care plan for the use of the metal framed beds. The inspector reviewed the care file for the patient residing in the profiling bed; again there was no care plan, risk assessment or rationale for the use of the bed despite the patient having a history of 'severe' suicide risk. Although the profiling bed was not plugged into the mains electric the inspector could access the remote, cables and wires beneath the bed this provided an additional ligature risk.

Staffing concerns

During discussions with the inspector nursing staff, the deputy ward manager, consultant psychiatrist and patients expressed concerns in relation to ward staffing levels. The inspector was advised of a continued high usage of bank staff, this included staff who were not permanent members of staff covering bank shifts. The inspector was also advised that on occasions the ward would run below the appropriate baseline staffing levels. The staff and patients expressed the following concerns:

"Staff can be very busy and under pressure"

"There is an increase in staff sickness"

"Heavy bank usage"

"Staffing is inconsistent"

"I never worked anywhere where staffing levels are so low"

"Staff are demoralised"

The inspector reviewed the duty rota for the fortnight prior to the inspection. A review of the duty rota evidenced a dependency on the usage of bank staff daily on the ward. Between the period of the 16 February to 1 March 2015 a total of 83 shifts required cover by bank staff. The high usage of bank staff is partially attributed to the sickness and absence of permanent members of the staff team. The deputy ward manager explained that it was always the priority

to ensure that the PICU was staffed by permanent members of staff and that bank staff are primarily used on the main ward.

The inspector noted from the rotas that on occasions permanent members of staff had worked hours additional to their full time contracts. The inspector noted that between 16 and 22 February 2015 a registered nurse had worked a total of five days out of seven. Between 23 February and 1 March 2015, the same nurse, had worked six days out of seven. From the records the inspector was unable to confirm the total amount of hours worked. Despite this continued use of such working patterns could be a concern as staff may contravene the Working Time Regulations which limits workers to a maximum 48 hour week, averaged over a 17 week period. A recommendation has been made in relation to this.

8.0 RQIA Compliance Scale Guidance

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable	Compliance with this criterion does not apply to this ward.	A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant	Compliance will not be demonstrated by the date of the inspection.	A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the inspection year.	In most situations this will result in a recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a recommendation, being made within the Inspection Report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and being made within the inspection report.

Appendix 1 – Follow up on Previous Recommendations

The details of follow up on previously made recommendations contained within this report are an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Appendix 2 – Inspection Findings

The Inspection Findings contained within this report is an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Contact Details
Telephone: 028 90517500
Email: Team.MentalHealth@rqia.org.uk

Appendix 1

Follow-up on recommendations made following the announced inspection on the 28 August 2013

No.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that information in relation to bringing illegal substances onto the ward, as outlined in the patient information booklet, should include awareness of potential sanctions.	2	The ward information leaflet clearly identified that bringing illegal substances onto the ward was a serious offence. If found this may result in the involvement of the Police Service of Northern Ireland.	**Fully met**
2	It is recommended that the ward maintains a log to record complaints that are dealt with locally.	2	The inspector reviewed the complaint records for the ward and was advised that there was no complaints log in place. However the inspector noted that local complaints or complaints received via the complaints department had been appropriately managed in accordance with the policy and procedure. The inspector met with senior management from the Trust post inspection who provided a copy of a new complaint log template.	**Fully met**
3	It is recommended that multi-disciplinary input, particularly in relation to recording in patient notes is audited.	2	The inspector reviewed the care file audit tool and noted that this did not reflect any form of auditing of MDT input.	**Not met**
4	It is recommended that the Trust ensure that the policy and procedure for staff to follow in the event procedure for staff for responding to, recording and reportingconcerns about actual or suspected adult abuse is consistent with regional guidance 'Safeguarding Vulnerable Adults – A Shared Responsibility' (2010)	1	The Trust was working with a new draft WHSCT Safeguarding Vulnerable Adults Policy and Procedure, 2014. A pathway to guide staff should a safeguarding matter arise was displayed in the staff office along with a flowchart and relevant contact telephone numbers.	**Fully met**

5	It is recommended that the ward manager ensures that all staff working on the ward undertake relevant training in relation to Safeguarding of Vulnerable Adults appropriate to their post/role.	1	The inspector attempted to review and assess the ward training records. The inspector was unable to be reassured that staff training needs had been maintained in accordance with mandatory requirements and the needs of the ward. This was largely due to the current recording system in place. The inspector requested that the ward training information is provided to the inspector on the new training matrix for 13/03/15. A review of the training matrix post inspection identified 7 (29%) staff with no current up to date training, 2 with no future date booked.	**Not met**
6	It is recommended that the ward manager introduces a system of auditing records and record keeping to ensure defined processes are followed by relevant staff.	1	The deputy ward manager undertakes a monthly nursing care plan audit and a monthly risk assessment audit. The findings from the audits are displayed for staff and visitors to read.	**Fully met**
7	It is recommended that the Trust ensures that all staff working on the ward undertake training in restraint appropriate to their role and responsibility.	1	The inspector attempted to review and assess the ward training records. The inspector was unable to be reassured that staff training needs had been maintained in accordance with mandatory requirements and the needs of the ward. This was largely due to the current recording system in place. The inspector requested that the ward training information is provider to the inspector on the new training matrix for 13/03/15. A review of the matrix post inspection identified no concerns with staff training in restraint.	**Fully met**
8	It is recommended that the Trust review the composition of and clinical specialities offered within the multidisciplinary team and the availability of psychotherapeutic	1	The inspector identified a number of concerns with the lack of psychotherapeutic interventions on the ward and the range of services available to patients. A detailed dialogue of the findings and	**Not met**

	interventions to ensure that patients on the ward have access to the full range of evidence based therapeutic interventions to meet presenting needs.		further recommendations relating to this area are included in the report and accompanying Quality Improvement Plan.	
9	It is recommended that the Trust liase with Business Services Organisation (BSO) finance auditors to clarify the role of the Trust in relation to the storage of property and valuables for patients that have been assessed as capable of managing their own affairs.	1	The inspector reviewed evidence of communication between the Trust and the BSO. The Trust was advised that current arrangements provided adequate security for all items held on behalf of patients.	**Fully met**
10	It is recommended that the Trust consider the provision of a locked facility on the ward for patients to independently securely store their valuables.	1	The ward has not provided any form of independent locked facility for patient use, this is following advice from the BSO financial auditor via email on 03/12/13, the inspector was provided a copy of the email. The email stated that it had been agreed that the current arrangements provided adequate security for all items held on behalf of patients.	**Recommendation removed**
11	It is recommended that the ward manager ensures that all staff working on the ward undertake regular mandatory training appropriate to their role.	1	The inspector attempted to review and assess the ward training records. The inspector was unable to be reassured that staff training needs had been maintained in accordance with mandatory requirements and the needs of the ward. This was largely due to the current recording system in place. The inspector requested that the ward training information is provider to the inspector on the new training matrix for 13/03/15. A review of the training matrix post inspection identified a number of mandatory subjects with concerns in level of compliance.	**Not met**

12	It is recommended that the ward manager ensures that all staff working on the ward receive an annual appraisal.	1	The deputy ward manager advised that none of the ward staff apart from her had received an appraisal.	**Not met**
13	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.	1	The ward manager, deputy ward manager and nursing staff advised that there was currently no system or way of knowing the knowledge and skills of bank staff, unless it was a member of their own team working a bank shift.	**Not met**
14	It is recommended that the ward manager develops a procedure to ensure that compliments are recorded and captured.	1	A review of the complaints and compliments folder clearly evidenced that compliments were being recorded.	**Fully met**
15	It is recommended that the ward manager develops a procedure to document locally resolved complaints.	1	A review of the complaint records clearly evidenced that local complaints had been documented and recorded.	**Fully met**
16	It is recommended that the ward manager ensures that all care documentation is in keeping with relevant published professional guidance documents including NMC Record keeping guidance.	1	The inspector reviewed three patients' files, there were no concerns identified in relation to the management of documentation in keeping with professional guidance documents on record keeping.	**Fully met**
17	It is recommended that risk assessments and care plans are discussed with the patient and if appropriate their carer. This should be evidenced within the care documentation.	1	All care plans reviewed had been signed by the respective patients. There was also evidence that patients had been provided with an opportunity to discuss their Comprehensive Risk Assessment at the ward round.	**Fully met**
18	It is recommended that the Trust undertakes a Ligature risk assessment on the ward.	1	The Ligature Risk Assessment reviewed on the day of inspection only reflected the assessment of door handles despite there being other obvious ligature risks throughout the ward. The ward manager advised that a more recent risk assessment had been completed and agreed to send this to RQIA by 13/03/15. Post inspection	**Fully met**

			the inspector received and reviewed an up to date ligature risk assessment, this clearly refected all ligature risks associated with the ward, dated November 2014.	
19	It is recommended that the ward manager ensures that the two way mirror is covered when not in use so that patients using the side room do not have their privacy or dignity compromised.	1	The two way mirror is now boarded up and painted to blend with the room.	**Fully met**
20	It is recommended that the ward manager ensures that guidance in relation to the use of the two way mirror is developed so that staff working on the ward are aware of when it should be used, how it should be used and under what circumstances it should be used.	1	The two way mirror is no longer in use as it is boarded up.	**Fully met**
21	It is recommended that the Trust ensure that the bath is repaired and that the location of the bathroom on the ward is reviewed to ensure patient privacy and dignity.	1	The bath remains in the same location since the last inspection. The inspector noted that on the day of the inspection that the bath was not in full working order due to the warm water running along the edge of the bath and onto the floor.	**Not met**

Appendix 1

Follow-up on recommendations made at the patient experience interview inspection on 17 July 2014

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the Trust review the availability of food for patients on the ward to ensure that the dietry needs and preferences for all patients on the ward to ensure that the dietry needs and preferences for all patients are catered for. Patients views regarding food choices' available should be incorporated into this review.	Patients that met with the inspector expressed no concerns regarding food. Staff and patients confirmed that salads are now on offer. A review of the ward menu also confirmed this.	**Fully met**
2	It is recommended that the Trust reviews access to gym equipment and physical activity for patients in the PIC part of the ward to ensure that all patients have the opportunity to undertake physical activity if appropriate during their admission to the ward.	Patients were able to access gym equipment, if staff were available to accompany them. Nurses facilitated the use of the gym equipment. A patient in PICU confirmed with the inspector that they had access to the gym facilities.	**Fully met**

Follow-up on recommendations made at the finance inspection on 31 December 2013

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager develops a system to ensure that where staff are making purchases on behalf of patients, a transparent record is maintained of the amount of money received, purchases made and change returned and verified by another staff member.	Ward staff do not record the purchases made by staff on a patients behalf. Instead when a member of staff obtains monies to spend on behalf of a patient, the money is recorded as signed out to the patient as opposed to the member of staff who has physically obtained the money.	**Not met**

2	It is recommended that the ward manager ensures that a record is kept of the staff member who obtains the key to the patient's safe, and the reason for access is maintained.	The key to the safe is retained throughout the day by the nurse in charge who signs for receipt of the key from the previous shift. The ward does not currently record each occasion that the safe is opened, who opened it or why it was opened.	**Not met**

Follow up on the implementation of any recommendations made following the investigation of a Serious Adverse Incident

No.	SAI No	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	SAI16-14	WHSCT Protocol for the Transmission of Confidential Information by Fax and Email should be followed at all times.	The WHSCT no longer provide facilities or allow the faxing of information. All staff that spoke with the inspector were familiar with the new protocols.	**Fully met**
2	SAI16-14	All nursing and administrative staff to be provided with Data Protection and Confidentiality Policy (November 2013) and WHSCT Protocol on Electronic Transmission of Confidential Information by Fax and Email (November 2013).	There was no evidence available on the day of inspection that the policies and procedures had been provided to all nursing and administrative staff.	**Not met**
3	SAI16-14	The protocols should be reinforced through inclusion as an agenda item at the next ward team meeting.	There was no evidence that the new protocols had been discussed at any of the ward team meetings.	**Not met**
4	SAI16-14	Ward Manager to identify training needs and facilitate training on Information Governance and Records Management.	Of the 24 staff currently working on the ward, there was evidence that 18 staff had attended record keeping, confidentiality and data protection training.	**Fully met**
5	SAI16-14	Learning from this event should be shared throughout the Trust.	N/A	**Not assessed**

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Inspection

Lime, Tyrone and Fermanagh Hospital

2 and 3 March 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with the deputy ward manager and the ward manager who joined the inspection in the afternoon of the second day.

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

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	5.3.1 (f)	It is recommended that the ward manager ensures that multi-disciplinary input, particularly in relation to recording in patient notes is audited.	3	8 May 2015	The Ward Manager has developed an audit to capture multi-disciplinary input, particularly in relation to recording in patient notes . This audit will be carried out on a monthly basis with effect from May 2015.
2	4.3 (m)	It is recommended that the ward manager ensures that all staff working on the ward undertake relevant training in relation to Safeguarding of Vulnerable Adults appropriate to their post/role.	2	8 May 2015	The Ward Manager will ensure that all staff working on the ward undertake relevant training in relation to Safeguarding of Vulnerable Adults appropriate to their post/role. All staff will be trained by 30th June 2015 to reflect available training dates. Training has occurred since inspection and at 28.04.2015 only 2 staff will be outstanding. In the interinm period all staff are aware of the Trust's adult safeguarding gateway team an their availability for consultation advice and guidance. All shifts across the 7 day 24/7 period have staff who are trained in adult safeguarding.
3	6.3 (c)	It is recommended that the Trust review the composition of and clinical specialities offered within	2	10 July 2015	Nursing staff within the ward have availed of various training in evidence-based psychotherapeutic interventions. The Trust will

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		the multidisciplinary team and the availability of psychotherapeutic interventions to ensure that patients on the ward have access to the full range of evidence based therapeutic interventions to meet presenting needs.			review the composition of and clinical specialities offered within the multidisciplinary team and develop a plan for the provision of evidence based therapeutic interventions to meet individual needs. This will involve the Professional Lead for Clinical Psychology within the adult mental health programme .
4	4.3 (m)	It is recommended that the ward manager ensures that all staff working on the ward undertake regular mandatory training appropriate to their role.	2	8 May 2015	The Ward Manager will ensure that all staff undertake regular mandatory training appropriate to their role. Mandatory training is planned on an ongoing basis using training needs analysis, appraisal and supervision precesses. The ward manager has developed a training planner to oversee and manage all the training requirements. Staff are booked into available dates as necessary.
5	4.3 (l)	It is recommended that the ward manager ensures that all staff working on the ward receive an annual appraisal.	2	10 July 2015	The Ward Manager has a programme of appraisals underway to ensure that all staff working on the ward receive an annual appraisal as per Trust policy. The process of revalidation for registered nurses is also incorporated into the

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					appraisal process.
6	4.3 (m)	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.	2	10 July 2015	This is being taken forward as a Corporate item led by the Lead Nurse in association with the Assistant Director for Nursing Workforce and Development. A project is being developed to improve professional governance arrangements around bank nursing staff across all programmes of care. The Lead Nurse will work with nurse mangers to progress this work.
7	6.3.2 (a)	It is recommended that the Trust ensures that the bath is repaired and that the location of the bathroom on the ward is reviewed to ensure patient privacy and dignity.	2	8 May 2015	The Trust will ensure that the bath is repaired as required. An estates request has been completed and will be prioritised. The Trust has also engaged with Estate services regarding remedial work to reposition the entrance to the bathroom. Minor capital works application has been completed. The Trust has also engaged with estate services for the provision of privacy screens. Minor capital works application has been completed.
8	5.3.1 (c)	It is recommended that the ward manager ensures that a record is	2	Immediate and	As explained to the inspector on the day of inspection the nurse in charge at any given time is

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		kept of the staff member who obtains the key to the patients' safe, and the reason for access is maintained.		ongoing	the keyholder of the safe. A record is maintained of the keyholder at all times. Only the keyholder accesses the safe and records any cash transactions in the the cash book and records any items/property removed or added to/ from the safe in the safe register book. This system is subject to audit by BSO.
9	5.3.1 (c)	It is recommended that the ward manager develops a system to ensure that where staff are making purchases on behalf of patients, a transparent record is maintained of the amount of money received, purchases made and change returned and verified by another staff member.	2	Immediate and ongoing	The Ward manager has developed a system to ensure that where staff are making purchases on behalf of patients, a record is maintained of the amount of money received,who received it, purchases made and change returned and verified by another staff member.
10	5.3.3 (g)	It is recommended that the Trust undertake an audit of therapeutic skills. An audit of skills should help identify any needs and gaps and support the implementation of a programme of staff development for providing effective therapeutic	1	10 July 2015	In line with the review of the composition of and clinical specialities offered within the multidisciplinary team and the availability of psychotherapeutic interventions the Trust will develop a plan for the provision of evidence based therapeutic interventions to meet individual needs.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		interventions.			
11	6.3.2 (g)	It is recommended that the ward manager develops ward based therapeutic activities for patients that are also available at weekends and evenings.	1	8 May 2015	The Ward Manager will develop therapeutic activities for patients that are also available at weekends and evenings. Staff and patients will develop a weekly therapeutic activities programme at the weekly patient meeting, based on patient choice and preferences.
12	6.3.2 (g)	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.	1	10 July 2015	The Trust will review the environment with a view to enhancement and procuring furniture and equipment to meet presenting therapeutic and recreational needs.
13	6.3.1 (a)	It is recommended that the Trust develop access to high intensity psychological interventions, in keeping with NICE guidance.	1	7 August 2015	The Head of Service and Crisis Service Manager will engage with the Profesional Lead for Clinical Psychology to develop pathways and access to high-intensity interventions
14	6.3.1 (c)	It is recommended that the Trust develops inpatient referral pathways to Clinical Psychology.	1	7 August 2015	The inpatient pathway to Clinical Psychology is by referral based on individual needs and is managed through the Integrated Elective Access Protocol (DHSSPS, 2008), and associated standards. The Head of Service and Crisis Service Manager will

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					work with the professional Lead for Clinical Psychology to develop and communicate pathways.
15	4.3 (l)	It is recommended that the Trust ensures that staff providing psychological interventions should have access to regular clinical supervision, in order to preserve and enhance their skills.	1	10 July 2015	Nursing staff on the ward engage in professional supervision for nurses as per WHST policy. The Trust will ensure that staff providing psychological interventions have access to regular clinical supervision related to the specific psychological interventions and skills, in order to preserve and enhance their skills.
16	4.3 (m)	It is recommended that the ward manager maintains records of staff training and supervision in psychological interventions.	1	10 July 2015	The Ward Manager has developed a training planner that records all training undertaken by staff including psychological interventions. Staff receiving supervision in psychological interventions will be required to provide a record of same.
17	4.3 (i)	It is recommended that the Trust urgently review the continued use of the current metal beds and profiling bed on the ward. The outcome of the review should be clearly reflected in the	1	Immediate and on-going	The Trust has reviewed the continued use of metal beds and profiling bed on the ward and updated the environmental and ligature risk assessment. The Trust plans to procure new beds to replace all existing metal bed frames. We are

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		environmental and ligature risk assessment. Patients who continue to use the beds should have a clear rationale in their care file supported by a risk assessment and care plan.			exploring appropriate replacement beds. In the interim a rationale, risk assessment and care plan will be reflected in the patient's notes.
18	8.3 (j)	It is recommended that the ward manager ensures that staff assess patients consent to daily care and treatment, this should be recorded in the patients' individual care plans and continuous nursing notes.	1	Immediate and ongoing	Where a patient is assessed not to have capacity or the abilty to consent nursing notes and records will reflect associated assessments and decision-making on a continuous basis.
19	5.3.1 (a)	It is recommended that the ward manager ensures that all patients' care plans and nursing assessments are reviewed as prescribed.	1	Immediate and ongoing	The Ward Sister has ensured that all patients' care plan reviews are completed as prescribed and are subject to a monthly audit.
20	5.3.1 (a)	It is recommended that the ward manager ensures that all patients have a person centered discharge care plan that indicates the actions to support and prepare patients for discharge.	1	8 May 2015	The Ward Manager will ensure that all patients have a person centered discharge care plan that indicates the actions to support and prepare patients for discharge.
21	5.3.1 (a)	It is recommended that the ward	1	8 May	The Ward Manager will ensure that individualised care

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		manager ensures that each patient has an individualised care plan that reflects the rationale and assessment of any individual or blanket restrictions. The care plan should incorporate the Deprivation of Liberty Safeguards and make consideration of Human Rights legislation.		2015	plans reflect the rationale and assessment of any individual or blanket restrictions. The care plan will incorporate the Deprivation of Liberty Safeguards and make consideration of Human Rights legislation.
22	5.3.1 (a)	It is recommended that the ward manager ensures that all patients have an accurate assessment of their needs. An outcome of this assessment should include detailed care plans that clearly identify the individual needs of the patient. The care plans should clearly reflect a set of goals and provide an ongoing evaluation of progress or change.	1	Immediate and ongoing	The Ward Manager will ensure that all patients have an accurate assessment of their nursing needs. An outcome of this assessment will include detailed care plans that clearly identify the individual needs of the patient. The care plans will clearly reflect a set of goals and provide an ongoing evaluation of progress or change. The Ward Manager will implement the WHSCT nursing record audit template to ensure compliance.
23	5.3.3 (b)	It is recommended that the ward manager ensures that all patients are provided with an ongoing opportunity to review their care plans as their mental state	1	Immediate and ongoing	The Ward Manager will ensure that all patients are provided with an ongoing opportunity to review their care plans with their named nurse as their mental state improves and that this is recorded and/or signed by the patient. In situations where the

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		improves and that this is recorded and/or signed by the patient.			patient refuses to sign, this will be noted in their record.
24	5.3.1 (f)	It is recommended that the Trust ensures all policies and procedures are subject to a systematic and comprehensive three yearly review.	1	7 August 2015	This matter has been raised at the Trust Adult Mental Health and Directorate Governace forums (22.04.15, and 24.04.15). The need for systematic review of policies, procedures, protocols and guidelines will be taken forward to the Trust's Quality and Safety Committee for action.
25	4.3 (m)	It is recommended that the Trust urgently review the current system and process for the collation, recording and maintenance of staff training records.	1	8 May 2015	The Ward Manager has developed a system for timely collation, recording and maintenance of staff training records.
26	4.3 (m)	It is recommended that the Trust ensures that all ward based staff are provided with training in: Human Rights, restrictive practice, capacity, consent and Deprivation of Liberty safeguards.	1	10 July 2015	A consultancy request has been forwarded to the Clinical Education Centre seeking input and support in relation to delivering this training by 10 July 2015
27	6.3.1 (a)	It is recommended that the Trust urgently review the current practice of transferring acutely unwell patients from Lime ward to	1	10 April 2015	The Trust does not transfer acutely unwell patients. No transfers have occurred since the inspection. Transfers occur in the context of

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		Beech ward. If this practice is to continue an urgent review of the sleeping area and safe staffing arrangements must be completed.			DHSSPSNI 2009 Regional Bed Management Protocol (Acute Psychiatric Beds), and individual risk assessment at the point of potential transfer. Accordingly any future transfers to Beech will continue to be based on risk assessment including environmental and support needs. Following discussion with clinicians the Head of Service has issued an interim practice note to management and staff of Lime and Beech.
28	6.3.2 (g)	It is recommended that the ward manager ensures that agreed actions following patients' meetings are implemented and followed up at the next meeting.	1	7 August 2015	The Ward Manager will ensure that agreed actions following patients' meetings are followed up by the appropriate / named person and feedback provided at the next meeting.
29	6.3.2 (b)	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.	1	8 May 2015	A review the ward information leaflet is under way. It will be updated as necessary to inform patients of all blanket and potential individual restrictions they may experience whilst on Lime ward .
30	8.3 (i)	It is recommended that the Trust review the arrangements in place to ensure the safe and timely	1	8 May 2015	The Trust will review the arrangements in place to ensure systems and processes for the safe and timely discharge of patients when the person is

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		discharge of patients when the person is deemed medically fit for discharge and an appropriate community placement has been secured.			deemed medically fit for discharge. A multidisciplinary group including hospital and community staff is being convened to develop a plan of action in relation to liaison, collaboration, and co-operation in preparation for discharge.
31	8.3 (i)	It is recommended that the Trust review the current arrangements to ensure liaison between the ward and community teams in preparation for discharge for those patients who are managed in accordance with Promoting Quality Care.	1	8 May 2015	A meeting has been convened with relevant community teams to review current arrangements and to develop a plan of action in relation to liaison and co-operation in preparation for discharge in accordance with Promoting Quality Care.
32	5.3.1 (f)	It is recommended that the Trust undertake a review of the current level of bank staff usage on Lime ward and devise a plan to manage the long term situation. Consideration of the impact on the current staffing compliment and continuity of patient care should be given.	1	10 July 2015	The Trust has filled a vacant Band 5 post in Lime Ward as of 20/4/15 and is in the process of recruiting to a second vacant band 5 post in Lime Ward. Plans are in place to recruit an additional band 6 post across the unit. The Trust and the Head of Service will continue to monitor absence and the use of bank within the ward.
33	5.3.1 (f)	It is recommended that the Trust regularly monitor the cumulative	1	10 July	Systems and processes for collating the number of bank shifts used on the ward are in place. The

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		number of hours worked by staff, and hours worked in excess of contracted hours to ensure that there is no impact on the quality and/or safety of service provision.		2015	lead nurses in adult mental health and older peoples mental health carry out audits of bank staff hours. Individual responsibilities in relation to the European Working Time Directicve and relation to the quality and safety of service has been communicated by the Lead Nurse in an email to Nurse managers/leaders on 16.03.2015 for dissemination to all staff. This will be reiterated at the Lime staff meeting on 28.04.2015, and kept under review.
34	5.3.1 (c)	It is recommended that the Trust review and reconfigure the shared toilet facilities in the Occupational Therapy area.	1	7 August 2015	The Trust has reviewed this issue and agreed that the toilet area in the OT department remains a designated female toilet and that male patients return to Lime ward to use toiliet facilities there. Signage has been changed to reflect this and all staff and patients have been informed.

NAME OF WARD MANAGER	Gloria Shaw

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

COMPLETING QIP	
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Elaine Way

Inspector assessment of returned QIP		Yes	No	Inspector	Date
A.	Quality Improvement Plan response assessed by inspector as acceptable	✓			1/5/15
B.	Further information requested from provider		✓		1/5/15