The Regulation and Quality Improvement Authority

Lime Ward

Tyrone and Fermanagh Hospital

Western Health and Social Care Trust

Unannounced Inspection Report

Date of inspection: 21 July 2015

npm national preventive mechanism

informing and improving health and social care

www.rqia.org.uk

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Our Vision, Purpose and Values

Vision

To be a driving force for improvement in the quality of health and social care in Northern Ireland

Purpose

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

Values

RQIA has a shared set of values that define our culture, and capture what we do when we are at our best:

- **Independence** - upholding our independence as a regulator
- **Inclusiveness** - promoting public involvement and building effective partnerships - internally and externally
- **Integrity** - being honest, open, fair and transparent in all our dealings with our stakeholders
- **Accountability** - being accountable and taking responsibility for our actions
- **Professionalism** - providing professional, effective and efficient services in all aspects of our work - internally and externally
- **Effectiveness** - being an effective and progressive regulator - forward-facing, outward-looking and constantly seeking to develop and improve our services

This comes together in RQIA's Culture Charter, which sets out the behaviours that are expected when employees are living our values in their everyday work.

Contents

1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

RQIA's programmes of inspection, review and monitoring of mental health legislation focus on three specific and important questions:

Is Care Safe?

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

Is Care Effective?

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

Is Care Compassionate?

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

2.0 Purpose and Aim of this Inspection

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

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

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

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

2.1 What happens on inspection

What did the inspector do:

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

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

At the end of the inspection the inspector:

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

After the inspection the ward staff will:

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

3.0 About the ward

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.

There were eight patients on the ward and two patients in PICU on the day of the inspection, four of these patients were detained in accordance with 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 ward manager was the person in charge on the day of inspection.

4.0 Summary

Progress in implementing the recommendations made following the previous inspection carried out on 2 and 3 March 2015 were assessed during this inspection. There were a total of 34 recommendations made following the last inspection.

It was noted that 20 recommendations had been implemented in full.

Two recommendations will be evaluated at the next inspection as this inspection was carried out before the date of the agreed timescale. Four recommendations had been partially met and eight recommendations had not been met. As a result a total of four recommendations will be stated for a second time and three recommendations will be restated for a third time following this inspection. In addition new and combined recommendations have been made as a result of this inspection.

The inspectors were pleased to note that improvements had been made in relation to staff training. In addition the ward manager had devised a new system for the recording and collation of training records. Staff had improved

practices for the safe handling of patients monies. Patients care records demonstrated that staff were assessing and recording patients consent to care and treatment. Patients care plans were regularly reviewed as prescribed. Patients were provided with an ongoing opportunity to review and sign their care plans as their mental state improved. The inspectors noted that two policies and procedures that had expired at the last inspection had now been updated and fully implemented. Staff demonstrated through their practice and their records an understanding and competence in relation to Human Rights, restrictive practice, capacity, consent and Deprivation of Liberty safeguards. The inspectors noted that the procedure for the transfer of patients between Beech and Lime ward had been reviewed. The inspectors identified no concerns in relation to the timely discharge of patients. A system for the review and monitoring of bank shifts used and cumulative numbers of staff hours worked was in place.

The inspectors assessed the ward's physical environment using a ward observational tool and check list. The environment appeared relaxed, comfortable, clean and clutter free. Rooms were available for patients to have quiet time on their own and there was areas in the main part of the ward for patients to spend time in the company of others. The ward had access to a garden area and surrounding grounds which were available for patients to access freely throughout the day. Staff allocated to provide therapeutic 1:1 time with patients was not displayed. In addition there was no ward activity schedule and the inspectors were concerned about the limited evidence of meaningful activities provided. These concerns were discussed with the managers at feedback and related recommendations have been made.

During the inspection the inspectors completed a direct observation using the Quality of Interaction Schedule (QUIS) tool. This assessment rated the quality of the interactions and communication that took place on the ward between patients, nursing staff and ward professionals. Overall the quality of interactions between staff and patients were positive.

During the inspection the inspectors spoke to two patients who agreed to meet with them to complete a patient experience questionnaire. This recorded their experience in relation to the care and treatment they had received on the ward. Both patients made positive comments about how they had been treated on the ward however one patient expressed concerns regarding recreation activities.

4.1 Implementation of Recommendations

12 recommendations which relate to the key question "**Is Care Safe**?" were made following the inspection undertaken on 2 and 3 March 2015.

These recommendations concerned staff training, safeguarding patients finances, management of metal/profiling beds, completion of assessments and care plans, reviewing and updating policies and procedures, transfer of

patients between wards, use of bank staff and hours worked and changes to the occupational therapy area.

The inspectors noted that nine recommendations had been fully implemented:

- There had been improvement noted with the numbers of staff with completed mandatory training.
- Safe had arrangements in place to safeguard patients' finances.
- Policies and procedures had been updated.
- The Trust had reviewed the arrangements for the transfer of patients between Lime and Beech ward.
- The Trust were monitoring the bank staff usage and amount of hours worked by staff.
- The toilet facilities in the occupational therapy area had been reconfigured for single sex use.
- Assessments and care plans had been implemented for those patients at potential risk while using a metal frame/profiling beds.

However, despite assurances from the Trust, three recommendations had not been fully implemented. This included concerns identified regarding systems for monitoring the training of bank staff and the completion of patient's assessments and care plans,

Seventeen recommendations which relate to the key question "**Is Care Effective**?" were made following the inspection undertaken on 2 and 3 March 2015.

These recommendations concerned auditing of patients' records, staff appraisals not in place, the review of patients care plans, all patients did not have a discharge care plan, timely discharge of patients, liaison with community teams in preparation for discharge and the absence of a system for the collation and recording of staff training. Recommendations also concerned the review of clinical specialities to include the availability of psychotherapeutic interventions, an audit of therapeutic skills, provision of ward based activities and improvement of the ward environment. In addition recommendations included access to high intensity psychological interventions and pathways for referral to inpatient psychology, supervision for staff who provide psychological interventions and maintaining records for this supervision. Also included was the recommendation to repair the bath on the ward.

The inspectors noted that seven recommendations had been fully implemented:

- Audits of multidisciplinary input into patients records were completed.
- Patients' care plans and nursing assessments were reviewed as prescribed.
- A training matrix which was easily accessible for the recording and monitoring of staff training had been implemented.

- There were no concerns with the timely discharge of patients and liaising with community teams to aid the discharge process.
- The bath on the ward had been repaired.

However, despite assurances from the Trust, ten recommendations had not been fully implemented. These included concerns identified regarding staff appraisals and patients did not have discharge care plans. In addition concerns were identified regarding the provision of the full range of therapeutic and recreational activities. There had been no evidence of improvement of the therapeutic skills within the ward team. Patients did not have access to the full range of psychological therapies. The date for full implementation of two of the ten recommendations was set for 7 August 2015 and had not been reached by the time of this inspection. Both recommendations will be evaluated at the next inspection.

Five recommendations which relate to the key question "**Is Care Compassionate**?" were made following the inspection undertaken on 2 and 3 March 2015.

These recommendations concerned the assessing and obtaining of patient consent, consideration of restrictive practices in terms of patients human rights and deprivation of liberty, opportunity for patients to sign their care plans and updating the ward information booklet.

The inspectors noted that four recommendations had been fully implemented:

- Staff were recording patient consent to care and treatment.
- Patients had care plans in relation to individual restrictions.
- Patients had an opportunity to sign their care plan.
- Staff demonstrated their knowledge of Human Rights, restrictive practice, capacity, consent and Deprivation of Liberty.

However, despite assurances from the Trust, one recommendation had not been fully implemented. The ward booklet had not been updated to reflect all potential individual and blanket restrictions that patients may experience.

5.0 Ward Environment

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

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

Summary

The ward had an information booklet however it had not been updated. A recommendation has been restated in relation to this. There was information displayed on the purpose of the ward and a description of the service provided. The environment was clean and clutter free. There was ample natural lighting, good ventilation and neutral odours. Ward furnishings were comfortable and well maintained. However there was a sofa in the 'quiet room' which needed replaced.

The ward environment promoted patients' privacy and dignity. Patients slept in 4 bedded bay areas with individual screens. The bathroom areas were clean and well maintained. However there was one toilet on the ward which was out of order.

Private rooms were available for patients to meet with their visitors and to make phone calls. Patients were sleeping on metal frame beds and one profiling bed however an up to date risk assessment had not been completed and regularly reviewed for each individual patient in relation to using these beds. The ward had an up to date environmental ligature risk assessment and subsequent action plan completed which identified a number of areas of work that needed completed by the Trust to ensure patient safety. However in the interim patients did not have a risk assessments/care plan in place in relation to these risks. A recommendation has been made in relation to this.

The ward's main entrance and exit door was unlocked. There were no areas of overcrowding. There were three spacious communal areas and the furniture was arranged in a way that encouraged social interaction. The majority of patients were observed sitting in the main communal area which led out onto the garden which was well maintained. Inspectors observed that staff were present in the communal areas and available at patient's request. However the ward appeared sparse with regard to furnishing. This was discussed with the ward manager who confirmed that new furnishing had been ordered for the ward.

Staffing levels appeared adequate to support the assessed needs of the patients. Staff were observed to be attentive and assisted patients promptly when required.

Confidential records were stored appropriately and patient details were not displayed. There was up to date and relevant information displayed on the wards notice board. This included information on the advocacy service and the right to make a complaint. Information in relation to the patient forum meetings convened each week was displayed on the main ward notice board.

Information on recreational and therapeutic activities was not displayed and there was no evidence in the patients care records of recreational activities having taken place. The inspectors did not observe any activities taking place on the ward. A recommendation has been restated in relation to this.

A choice of meals was available and patients were able to choose meals the day before through a new computer system. Patients could access fresh water throughout the day from the dining room. However patients were not freely able to make hot drinks. This was discussed with the ward manager who advised that they were in the process of ordering a hot drinks machine for patients to access throughout the day.

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

- Replace sofa in 'quiet room'.
- Display information for patients on which staff member has been allocated therapeutic 1:1 time with them.
- Ensure the toilet on the ward is fixed

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

6.0 Observation Session

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

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

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

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

Neutral – brief indifferent interactions

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

Summary

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

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

The quality of interactions, observed by inspectors, between staff and patients were positive. Inspectors noted that staff appeared to know the patients very well and actively sought engagement with patients. Patients were observed moving freely throughout the ward and the atmosphere was relaxed.

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

7.0 Patient Experience Interviews

Two patients agreed to meet with the inspectors to complete a questionnaire regarding their care, treatment and experience as a patient.

There were no carers/relatives available to meet with the inspectors to talk about the care and treatment on the ward.

The patients who completed the questionnaire stated the following:

- Patients recorded that they felt staff were supportive and helpful on admission to the ward and they stated they had been informed of their rights and that they were treated with dignity and respect;

- Patients stated they felt fully involved in their care and treatment and could refuse treatment. Both patients confirmed that staff listen to them and provided an explanation before supporting them with care and treatment;

- Both patients said that they had been informed of the outcome of assessments and investigations and staff continually updated them as to how they were progressing with their treatment;

- Patients sated they felt safe on the ward.

- One patient stated that there was not have enough therapeutic activities available to patients on the ward. They advised that the ward should have more recreational items and suggested for the ward to purchase a football. A recommendation has been restated in relation to this.

Patients made the following comments:

“Staff are really good here I have no complaints”

"The staff are great here they treat you with respect and dignity, I've been in a number of wards and this one is the best so far".

The detailed findings are included in Appendix 4.

8.0 Other areas examined

During the course of the inspection the inspector met with:

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

Wards staff

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

Other ward professionals

The inspection spoke to an occupational therapist on the ward that was covering the ward for a two week period. They advised the ward has a full time OT however they are currently on long term leave and an OT has been recruited on a temporary based to cover this ward and another ward on the hospital site. Therefore there is limited OT available on Lime ward. A recommendation has been made in relation to this.

The advocate

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

9.0 Next Steps

A Quality Improvement Plan (QIP) which details the areas identified for improvement has been sent to the ward. The Trust, in conjunction with ward staff, must complete the QIP detailing the actions to be taken to address the areas identified and return the QIP to RQIA by 15 September 2015.

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

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

Appendix 1 – Follow up on Previous Recommendations

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

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

Appendix 4 – Patient Experience Interview
This document can be made available on request

Appendix 1

Follow-up on recommendations made following the announced inspection on 2 and 3 March 2015

No.	Reference.	Recommendations	Number of time stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
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	The inspectors reviewed samples of two months multi-disciplinary care/treatment plan audits. The inspectors noted that the audit tool clearly assessed the multi-disciplinary input into patients' notes.	Met
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	The inspectors reviewed training records for the ward and there was evidence that 22 nursing staff had up to date training in safeguarding vulnerable adults. Two nursing staff were on long term leave and their training was out of date. However they were booked to attend training on 09/09/15.	Met
3	6.3 (c)	It is recommended that the Trust review the composition of and clinical specialities offered within 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.	2	The Head of Service and the Crisis Service Manager confirmed that any patient who requires high intensity psychological interventions in keeping with NICE guidance will be provided with an inreach service by the relevant professional. Whilst Trust staff acknowledged that the resource is limited, they are continuing to work with the Professional Lead for Clinical Psychology to further develop pathways and access to high intensity psychological interventions for inpatients. Trust representatives confirmed that there is a very limited number of ward based staff who have	Partially met

				received training in psychotherapeutic interventions. However, the Head of Service provided details of meetings held with the Lead Nurse for Workforce Planning and the Head of Specialist Services regarding the development of a nursing workforce development plan. This plan will include an audit of current skills, and highlight areas where training in effective therapeutic interventions is required. This will be set in the context of the WHSCT Learning Needs Analysis Framework, and 'Learning Together Working Together" regional framework for planning and delivery of psychological interventions. The Head of Service provided details of the next planned meeting and confirmed that the development plan, which will cover a three year period, will include details of mechanisms for provision of clinical supervision to preserve and enhance staff skills with associated record keeping. The ward manager also confirmed that the audit and the development plan will be informed by the outcomes of appraisals. This recommendation will be combined with recommendations 10, 15 & 16 and reworded to form a new recommendation.	
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	2	The inspectors reviewed the staff training records and noted an improvement across all mandatory training subjects. However the inspectors noted that staff training for manual handling was out of date for the entire team – dates were evidenced for 16 staff to be	Partially met

		role.		trained by 4 August 2015. This recommendation will be restated for a third time specific to manual handling training.	
5	4.3 (l)	It is recommended that the ward manager ensures that all staff working on the ward receive an annual appraisal.	2	Following an inspection in 2013 the trust provided assurances that appraisals would be completed for all staff by October 2013. Despite these assurances, the ward manager advised that the outstanding appraisals for 2014-2015 excluding the deputy ward manager were not completed following the last inspection. The ward manager provided evidence of three staff having received an appraisal since April 2015. Subsequent to the inspection the Head of Service confirmed that a robust plan was in place to ensure that all staff receive an appraisal and since the inspection an additional seven staff had received an appraisal.	Not met
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	The inspectors were informed by senior Trust representatives that there was no system in place to govern bank staff training or for the nurse in charge to know/validate the training skills and knowledge of bank staff working on the ward. A new regional team is currently being set up by the Trust to manage bank staff. The plan is that each staff member will have a passport of their training to bring with them when working on wards. This is due to be implemented by September 2015.	Not met
7	6.3.2 (a)	It is recommended that the	2	The bathroom remains in the same location since the	Met

		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.		last inspection. The Trust confirmed that a capital works request has been submitted to relocate the entrance to the bathroom. The Trust confirmed immediately after the inspection that the issue concerning water flowing onto the bathroom floor when the bath is being filled has been fully addressed.	
8	5.3.1 (c)	It is recommended that the ward manager ensures that a record is kept of the staff member who obtains the key to the patients' safe, and the reason for access is maintained.	2	The inspectors reviewed the finances records for the ward and noted that the safe key was signed by two nursing staff at the handover of each shift. In addition the contents of the safe were also checked daily by two nursing staff. Within each patient's finance records staff record the reason for removal of monies on each occasion. Individual patient's monies were also checked weekly and the records signed by two nursing staff.	Met
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	The inspectors reviewed the records for the management of patient finances. The inspectors observed that when staff where spending money on a patient's behalf, the money was signed out to the responsible member of staff. Records maintained evidenced the amount of money received, purchases made and change returned. Records were verified by a second member of member.	Met
10	5.3.3 (g)	It is recommended that the Trust undertake an audit of	1	An audit of therapeutic skills had not yet been undertaken by the Trust.	Not met

		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 interventions.		The Head of Service provided details of meetings held with the Lead Nurse for Workforce Planning and the Head of Specialist Services regarding the development of a nursing workforce development plan. This plan will include an audit of current skills, and highlight areas where training in effective therapeutic interventions is required. This will be in set in the context of the WHSCT Learning Needs Analysis Framework, and 'Learning Together Working Together' regional framework for planning and delivery of psychological interventions. The Head of Service provided details of the next planned meeting and confirmed that the development plan which will cover a three year period will include details of mechanisms for provision of clinical supervision to preserve and enhance staff skills with associated record keeping. The ward manager also confirmed that the audit and the development plan will be informed by the outcomes of appraisals. This recommendation will be combined with recommendations 3, 15 & 16 and reworded to form a new recommendation.	
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	There was no structured recreational activity timetable available or displayed. In the ward information booklet it states that the notice board displays up to date activities which are provided three times a day. However this was not apparent on the	Not met

				day of the inspection or evidenced in patients' care records. The inspectors reviewed the progress notes for three patients on the ward over a two week period and noted that there was no evidence of ward based therapeutic/recreational activities provided to the patients. There were no other records available on the ward to evidence same. Patients who met with the inspector expressed concerns regarding the lack of activities stating that "The day can be long and boring". Patients also stated that the activities were provided infrequently.	
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	The inspectors completed an observation of the ward environment and noted that the recreational room which had been locked on the previous inspection was now open during the day. Inspectors noted limited improvements in the environment; the ward remained sparse with regard to furnishings and did not provide patients with a therapeutic and conducive environment. However, the ward manager confirmed that a number of items to help enhance the environment had been ordered. These items are expected to be delivered to the ward within the next few weeks.	Partially met
13	6.3.1 (a)	It is recommended that the Trust develop access to high intensity psychological interventions, in keeping with NICE guidance.	1	The Head of Service and the Crisis Service Manager confirmed that any patient who requires high intensity psychological interventions in keeping with NICE guidance will be provided with an inreach service by the relevant professional. Whilst Trust staff acknowledged that the resource is limited, they are	Met

				continuing to work with the Professional Lead for Clinical Psychology to further develop pathways and access to high intensity psychological interventions for inpatients.	
14	6.3.1 (c)	It is recommended that the Trust develops inpatient referral pathways to Clinical Psychology.	1	The date for full implementation of this recommendation was set for 7 August 2015 and had not been reached by the time of this inspection. The Head of Service confirmed that he had been working in conjunction with the Professional Lead for Clinical psychology to develop formal written pathways for inpatient access to clinical psychology. This recommendation will be evaluated in full at the next inspection.	To be evaluated at the next inspection
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	There were no psychological interventions being provided by ward staff and therefore no provision of relevant clinical supervision. The Head of Service confirmed that the planned audit of staff skills in this area and the development of a workforce training plan will involve ensuring that there are mechanisms to provide clinical supervision which preserves and enhances staff skills. This recommendation will be combined with recommendations 3, 10 & 16 and reworded to form a new recommendation.	Not met
16	4.3 (m)	It is recommended that the ward manager maintains records of staff training and	1	The Trust response from the previous inspection in relation to this recommendation stated that a training plan that records all training undertaken by staff	Not met

		supervision in psychological interventions.		including psychological interventions would be developed. The Head of Service confirmed that four ward based staff had previously attended Wellness Recovery Action Plan (WRAP) training. There were no other records of staff training in psychological interventions. There were no records of supervision for these staff related to the provision of psychological interventions. The Head of Service confirmed that the planned audit of staff skills in this area and the development of a workforce training plan will involve ensuring that appropriate records of staff training and supervision are maintained. This recommendation will be combined with recommendations 3, 10 & 15 and reworded to form a new recommendation.	
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 environmental and ligature risk assessment. Patients who continue to use the beds should have a clear rationale in their care file	1	The inspectors reviewed care files for four patients and noted the following: Patient 1: A risk assessment was in place for the use of a profiling bed a relevant care plan was also in place and there was evidence that this was reviewed regularly. Patient 2: A risk assessment was in place for the use of a profiling bed. The outcome of this assessment detailed that the patient was not at risk therefore no	Met

		supported by a risk assessment and care plan.		care/management plan was in place. However this risk assessment had not been reviewed since 01/06/15 and there was no date for the next review. Patient 3: A risk assessment was in place for the use of a profiling bed. The patient was assessed and no risks were identified therefore no care/management plan was in place. However the risk assessment had not been reviewed since 04/06/15 and there was no date for the next review. Patient 4: A patient had been admitted to the ward two days prior to the inspection. During this time the risk assessment had not been completed despite the patient having a recent history of suicidal ideation/self-harm, ‘’patient will look at objects to see how he can harm himself’’. There was no care plan in place in relation to use of this bed to ensure of this patient’s safety. The Trust proposes to procure new anti-ligature beds for the ward. The inspector reviewed evidence which confirmed that plans were in place to replace all profiling/metal frame beds. However senior Trust representative were unable to confirm a date of when this will happen. The ward ligature risk assessment had been updated to reflect the use of profiling and metal beds available. A new recommendation will be made in relation to the	

				accurate and comprehensive completion of all documentation including the review of risk assessments for the use of metal/profiling beds.	
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	The inspectors reviewed the care files for four patients and noted that patients consent to daily care and treatment had been recorded in each patient's individual care records and progress notes.	Met
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	The inspectors reviewed the care files for four patients and noted the following: Patient 1: care plans and assessments were regularly reviewed in accordance with required time scales. Patient 2: care plans were regularly reviewed as required however the profiling bed risk assessment had not been reviewed since 01/06/15. Patient 3: care plans were regularly reviewed as required however the profiling bed risk assessment had not been reviewed since 04/06/15. Patient 4: patient only recently admitted to the ward. A new recommendation will be made in relation to the accurate and comprehensive completion of all documentation.	Met
20	5.3.1 (a)	It is recommended that the	1	The inspectors reviewed the care files for four	Not met

		ward manager ensures that all patients have a person centered discharge care plan that indicates the actions to support and prepare patients for discharge.		patients and noted the following: Patient 1: there was no person centred discharge care plan despite arrangements for weekend leave. Patient 2: there was no person centred discharge care plan despite agreement for trial leave. Patient 3: there was no person centred discharge care plan. Patient 4: this patient was recently admitted to the ward.	
21	5.3.1 (a)	It is recommended that the ward 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.	1	The inspectors reviewed the care files for four patients and noted that in each case individual restrictions had been clearly documented and recorded with a clear rationale and reference to consideration of patients human rights. The inspectors noted that information in relation to blanket restrictions on the ward were displayed on posters and in the ward information booklet. A further recommendation in relation to developing the information provided to include all blanket restrictions and potential individual restrictions has been made. (See recommendation 29).	Met
22	5.3.1 (a)	It is recommended that the ward manager ensures that all patients have an accurate assessment of their needs.	1	The inspectors reviewed the care files for four patients and noted that the completion of care plans was consistent in each of the four care files reviewed. Despite this it was noted that not all of the relevant	Partially met

		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.		assessments had been comprehensively completed in each case. Patient 1: An initial assessment had been completed and respective care plans were in place. There was evidence of ongoing review of the patient's care needs by both the multi-disciplinary team and the nursing staff. Patient 2: There was no evidence that a physical examination of the patient had been completed on admission. Patient 3: MUST assessment tools were not dated. Nursing staff had not fully completed the MUST tool when a risk had been identified. Patient 4: There was no evidence that a physical examination of the patient had been completed on admission Staff and patient signatures were not recorded on interim care/management plans in three of the four patient files reviewed. A new recommendation will be made in relation to the absence of staff signatures on documentation.	
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	1	The inspectors noted that in all four files reviewed there was evidence of patients being provided with the opportunity to sign their care plans as their mental state improves.	Met

		mental state improves and that this is recorded and/or signed by the patient.			
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	At the last inspection the inspectors noted two policies and procedures that had not been updated or fully implement. The inspectors reviewed the operational guidelines for safeguarding vulnerable adults and noted that the guidelines were updated in October 2014 and were now fully implemented and due review again in October 2015. The inspectors reviewed the Trust complaints policy and procedure which was devised in May 2011 and noted that this had been revised in March 2015 and was due review again in May 2017.	Met
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	The ward manager had devised and implemented a detailed training matrix which was easily accessible for the recording and monitoring of staff training.	Met
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	The inspectors noted from the review of the training matrix that four of the 24 staff had completed formal training in relation to the subjects listed. There was no evidence of arrangements to train the remaining staff team. Despite this the inspector noted that staff demonstrated through their practice and their records an understanding and competence in relation to the	Met

				subjects listed. The inspector had no concerns regarding staffs understanding in relation to same. Staff demonstrated from team meetings and patient/staff meetings that subjects listed had been considered and discussed.	
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 Beech ward. If this practice is to continue an urgent review of the sleeping area and safe staffing arrangements must be completed.	1	The inspectors were aware following the recent inspection of Beech ward that on three occasions the same patient had an overnight transfer to Beech during the month of June 2015. The inspectors discussed this with senior Trust representatives who advised that interim local practice guidance had been issued in relation to the transfer of patients between Lime and Beech ward. This details the actions staff need to take to ensure of patients' safety. This includes: Transfers only taking place in the context of a MDT risk assessment which takes into account whether the transfer is safe. The interim guidance states that the risk assessment will take into account : *"1: the environment that the patient is being transferred to include any need for ligature risk assessment of the sleeping area and general environment in the context of the patients' needs.* *2: The care and support needs of the patient*	Met

				including whether staffing levels in Beech are adequate to provide safe and effective care *Decisions to transfer should be based on the above through agreement of the respective nurses in charge and a thorough handover of the patients profile and assessed needs should occur at the point of transfer and be fully recorded. Any requirement for additional staff to support the patient must be in place at the time of transfer.* *Where a transfer from Lime to Beech is agreed consent should be sought and recorded and the patient and their family/ carers should be actively involved in the process".* In addition to this interim local practice a further review meeting has been arranged for 4 August 2015 to discuss and a formal review of this process. The Trust plan to *"develop local systems in accordance with the Regional Protocol including bed escalation systems and local standards for transfers to assure quality and safety and optimum patient experience".*	
28	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	The date for full implementation of this recommendation was set for 7 August 2015 and had not been reached by the time of this inspection. The inspectors reviewed the records for patient meetings for the past four months and could confirm that patient meetings were held monthly. However despite this the records of minutes did not provide any evidence that the actions following each meeting	To be evaluated at the next inspection

				were implemented and followed up at the next meeting. This recommendation will be evaluated in full at the next inspection.	
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	The inspectors were advised that the ward information booklet had not been updated since the last inspection and as a result there remains no reflection of all blanket and potential individual restrictions. Information missing included banned and restricted items, removal of items for safe keeping, use of physical intervention, use of as and when required medication and transfer to psychiatric intensive care unit. The Trust had planned to meet with all ward managers to agree the content of the information booklet; a date for this had not been agreed. See also recommendation 21.	Not met
30	8.3 (i)	It is recommended that the Trust review the arrangements in place to ensure the safe and timely discharge of patients when the person is deemed medically fit for discharge and an appropriate community placement has been secured.	1	The inspectors were advised by the ward manager that there were currently no delayed discharges on the ward. The inspector reviewed the care files for four patients and noted the following: Patient 1: patient was not medically fit for discharge. Patient 2: patient deemed medically fit to commence	Met

				a period of trial leave. Patient 3: patient was not medically fit for discharge. Patient 4: patient had only been admitted to the ward two days before the inspection. There was no evidence to suggest that any of the patients were delayed in their discharge from hospital. The inspectors noted that none of the patients had a person centred discharge care plan in place. A separate recommendation has been restated in relation to this. See recommendation 20.	
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	The head of crisis services and lead nurse for mental health informed the inspectors that they attend regular interface meetings with the head of service for community teams to discuss concerns and delays in admissions. The crisis service manager reports that there has been an improvement in the liaising between all community teams for the purpose of the discharge of patients. Senior managers expressed no current or ongoing concerns in relation to this matter.	Met
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	1	The inspectors were informed by senior Trust representatives that there is a system in place whereby ward managers furnish the lead nurse with the bank staff usage per week. These reports are	Met

		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.		then assessed for patterns and trends and are then forwarded to senior management. With effect from August 2015 there will be weekly meetings with ward managers to discuss, monitor and review the bank usage. This will be led by the lead nurse. The Trusts aim is that this will help to monitor ongoing themes and provide a forum for the constant scrutiny and review of bank usage.	
33	5.3.1 (f)	It is recommended that the Trust regularly monitor the cumulative 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.	1	The lead nurse issued a directive to all staff reminding them of their individual responsibility regarding total number of hours worked each week to ensure they all keep within the European Working Time Directive (EWTD) guidelines. The lead nurse had completed a random sample of staff hours worked over a 17 week period. Where there is a pattern of working over the 48 hours as set out in the EWTD senior management meet with the individual member of staff. A sample of these reviews and meetings with individual staff were provided to the inspector.	Met
34	5.3.1 (c)	It is recommended that the Trust review and reconfigure the shared toilet facilities in the Occupational Therapy area.	1	The inspector observed that the toilet facilities in the occupational therapy area had been reconfigured to reflect single sex use. The signage had been changed accordingly.	Met

R3

Quality Improvement Plan

Unannounced Inspection

Lime Ward, Tyrone and Fermanagh Hospital

21 July 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with the ward manager, crisis services manager and the head of crisis services and lead nurse for mental health on the day of the inspection visit.

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

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
Is Care Safe?					
1	4.3 (m)	It is recommended that the ward manager ensures that all staff working on the ward undertakes mandatory manual handling training appropriate to their role.	3	30 November 2015	Since July 2015 fourteen staff have received manual handling training. Ten further staff require manual handling training, two of whom are off on long term sick. Two further training sessions are booked for 22nd October and 10th November 2015 which will ensure that the remainder of available staff will be up to date by 30th November. Taking the above into account, we would seek an extension of this time scale for implementation of the plan as outlined above.
2	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.	3	31 December 2015	As per correspondence from Mr Alan Corry-Finn, WHSCT Executive Director of Nursing to Miss Theresa Nixon, RQIA on 9th September 2015 a system is being developed to centralise co-ordination and administration of bank nursing shifts and associated governance matters including

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
					supervision, appraisal, training and revalidation. The Office will be establishd by 30th October 2015, and systems in place within 3-6 months thereafter.
3	4.3 (i)	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.	1	Immediate and ongoing	The Ward Sister has reminded all staff of their responsibilities regarding accurate and comprehensive completion of all documentation at a staff meeting on 3rd Sepember 2015. The Ward Sister has developed and implemented a weekly audit of admission documentation, treatment plans and progress reports with effect from 7th September 2015 The Ward Sister has ensured that staff are aware of the need to regularly review risk assessments for patients who use exposed mental framed bed or profiling beds at the staff meeting of 3rd September 2015. All beds wil be replaced with non-liagture bed stock. A business case has been developed and is going through business case scrutiny and approval processes towards

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
					procurement at this time. The Ward Sister has developed an audit of documentation related to risk assessments for patients who use exposed mental framed or profiling beds.
4	5.3.1 (a)	It is recommended that the ward manager ensures that staff signatures are included on all necessary documentation.	1	Immediate and ongoing	At a staff meeting on 3rd September 2015 the Ward Sister reminded staff of their responsibilities in relation to record keeping to ensure that staff signatures are included in all documentation. The Ward Sister has developed a weekly audit of admission documentation, treatment plans and progress reports for implementation on the week beginning 7th September 2015. This has also been included for discussion in the regular Governance forum within Adult Mental Health & Disability Directorate.
5	4.3 (i)	It is recommended that the ward manager ensures that following the identification of risk of	1	Immediate and	The Ward Sister has ensured that following the identification of risk of ligature, individualised care plans are developed which reflect the management

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
		ligature, individualised care plans are developed which reflect the management of the ligature risk.		ongoing	of the ligature risk and is completing audits to ensure compliance.
Is Care Effective?					
6	4.3 (l)	It is recommended that the ward manager ensures that all staff working on the ward receive an annual appraisal.	3	31 December 2015	The Ward Sister will ensure that all staff working on the ward receive an annual appraisal in-line with WHSCT personal development and review policy.
7	5.3.1 (a)	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.	2	Immediate and ongoing	The Ward Sister will ensure that all actions to support and prepare patients for discharge are recorded in the patient's individual muliti-disciplinary care plan.
8	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	Immediate and ongoing	The Ward Sister has reviewed the standing agenda for patient meetings to ensure that agreed actions following patients meetings are completed and followed up at the next meeting.
9	4.3 (m)	It is recommended that the Trust ensures that the nursing	1	31 January	As per correspondence by email on 22nd July 2015 with the inspector a leaning needs and workforce

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
		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		2016	development plan for nursing staff will be developed. This will commence at a workshop planned for 28.09.15 and will include all elements described in the recommendation.

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
		clinical supervision for staff delivering psychological interventions.			
10	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.	2	30 September 2015	A programme of daytime, evening and weekend ward based therapeutic activities has been developed and implemented.
11	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.	2	30 September 2015	The ward environment has been reviewed and furniture and equipment has been procured including furniture, plants, pictures, recreational materials and television with DVD player. Orders have been made and there are some oustanding deliveries. Delivery dates are outside of the control of the Trust and may be outside of the timeframe set by the RQIA.
12	6.3.2 (g)	It is recommended that the Trust review the provision of occupational therapy on Lime	1	31 October 2015	A review workshop relating to Occupational Therapy input and therapeutic and recreational

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
		ward to ensure that patients can avail of the full range of occupational therapy and recreational activities.			activities is scheduled for 29th September 2015.
13	6.3.1 (c)	It is recommended that the Trust develops inpatient referral pathways to Clinical Psychology.	1	31 December 2015	An inpatient referral pathway to clinical psychology will be developed within this timeframe.
Is Care Compassionate?					
14	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.	2	31 October 2015	The Ward Sister is currently updating the ward information leaflet to reflect all blanket and potential individual restrictions that patients may experience whist on Lime ward. Patients are being consulted on the ward information leaflet through staff/patient meetings. We would seek extension of the timeframe until 31st October 2015 to enable completion.

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

NAME OF WARD MANAGER COMPLETING QIP	Jackie McCutcheon
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Trevor Millar

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Kieran McCormick	18/09/15
B.	Further information requested from provider		x	Kieran McCormick	18/09/15