The Regulation and Quality Improvement Authority

Oak A

Tyrone and Fermanagh Hospital

Western Health and Social Care Trust

Unannounced Inspection Report

Date of inspection: 10 August 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(s)

- 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

Oak A is a ten bedded mixed gender ward on the Tyrone and Fermanagh Hospital site. The purpose of the ward is to provide assessment and treatment to patients over the age of 65 with a functional mental illness.

The multidisciplinary team consists of nursing staff and health care assistants, two consultant psychiatrists, two clinical psychologists, two doctors, an occupational therapist and an activity coordinator.

On the days of the inspection there were five patients on the ward. Two patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986. One patient had been transferred to the general hospital as they had become unwell. The acting deputy ward manager was in charge on the day of the inspection.

4.0 Summary

Progress in implementing the recommendations made following the previous inspections carried out on 12 August 2013 and 26 and 27 February 2015 were assessed during this inspection. There were a total of 30 recommendations made following the last inspection. Seven of these had been restated following the inspection on 12 August 2013.

It was good to note that 23 recommendations had been implemented in full.

Three recommendations had been partially met and four recommendations had not been met. One recommendation will be restated for a third time and six will be restated for a second time following this inspection. In addition to this three new recommendations have been made as a result of this inspection.

The inspector was pleased to note that improvements had been made in relation to staff training however there were still some deficits in this area. This recommendation has been restated. The ward manager had devised

deprivation of liberty care plans and had reviewed any restrictions on the ward at the multidisciplinary ward conference. DOLS care plans were in place and documented the need for a restriction. However, the DOLS care plans should be further developed to ensure that the need for a restriction is based on each patient's individual circumstances. A new recommendation has been ,made in relation to this.

It was good to note that patients' care records demonstrated that staff were assessing and recording patients consent to care and treatment. Patients were provided with an ongoing opportunity to review and sign their care plans. The inspector was concerned that the ward continued to use a high ratio of bank staff and a system had not yet been devised to ensure that all bank staff had the appropriate training skills and knowledge to work on the ward. This recommendation has been restated for a third time.

The inspector assessed the ward's physical environment using a ward observational tool and check list. The environment appeared relaxed, comfortable, clean and clutter free. Patients had access to a garden area and the ward kitchen which they could use freely throughout the day. The ward had completed an environmental ligature risk assessment. However patients did not have an individual environmental risk assessment in place to detail how risks were going to be managed until the action plan is implemented to ensure of patients' safety. The ward did not hold patient forum meetings to ensure patients were given the opportunity to voice their concerns or make suggestions on improvements to the ward. One of the patients and a patient's' relative raised issues in relation to the ward needing painted and improvements in relation to ensuring that the environment was more therapeutic. The inspector agreed with the comments made. Recommendations have been made in relation to the above concerns.

During the inspection the inspector completed a direct observation using the Quality of Interaction Schedule (QUIS) tool. The quality of interactions observed between staff and patients were positive. Staff appeared to know the patients very well and were observed providing support when this was required.

During the inspection the inspector spoke to one relative who had agreed to complete a questionnaire on behalf of the patient. Four patients agreed to complete a patient experience questionnaire however did not wish to speak with the inspector. Patients made positive comments about how they had been treated on the ward.

4.1 Implementation of Recommendations

12 recommendations which relate to the key question "**Is Care Safe**?" were made following the inspection undertaken on 12 August 2013 and 26 and 27 February 2015.

These recommendations concerned supervision records and appraisals for nursing staff and the absence of team meetings. Concerns were also raised in relation to staff training and the lack of a system in place to ensure the ward manager and nursing staff were informed of incidents and accident investigations that may influence ward practices. Recommendations were made in relation to staffs' awareness of safety alerts, the absence of risk assessments in place for patients who were using profiling beds and in relation to environmental ligature risks throughout the ward. Concerns were also raised in relation to the high level of banking staff on the ward and how the Trust ensured these staff members had completed appropriate training so they could carry out their duties.

The inspector was pleased to note that nine recommendations had been fully implemented.

- All nursing staff on the ward had received supervision and a date had been set for the next supervision session.
- Staff appraisals had been completed for nursing staff on the ward and a date had been set for the next appraisal.
- A system was in place to ensure the ward manager and nursing staff were informed of the outcomes of investigations in relation to accidents, incidents and near misses that may influence ward practices.
- Staff meetings were held on the ward with dates of the next meeting.
- Staff were aware of the safety alerts regarding the use of profiling beds/exposed mental bed frames within inpatient mental health settings.
- Patients who requiring a profiling bed had a risk assessment completed which was reviewed regularly.
- The Trust had reviewed the current staffing arrangement on the ward to ensure continuity of care for patients.
- The Trust had completed an environmental ligature risk assessment of the ward and an action plan had been sent to RQIA.

However, despite assurances from the Trust, three recommendations had not been fully implemented. The Trust did not have a system in place to ensure that bank staff had the appropriate training, skills and knowledge to work on the ward. All staff did not have up to date mandatory training in place and patients did not have individual environmental risk assessments /care plans completed in relation to the environmental ligature points throughout the ward.

13 recommendations which relate to the key question "**Is Care Effective**?" were made following the inspection undertaken on 12 August 2013 and 26 and 27 February 2015.

These recommendations concerned the completion of care records in including the Multidisciplinary Case Conference (MDCC) template. The reviewing and updating of care plans based on patients' assessed need, the recording of enhanced observations and the auditing of care records by the ward manager. Further recommendations were made in relation to the completion of discharge plans and the staffs understanding of this process. Concerns were also raised in relation to patients having access to a social worker and the absence of recovery focused activity/therapeutic care plans.

The inspector was pleased to note that nine recommendations had been fully implemented.

- Each section of the MDCC template was completed in full and included details of patients attendance/non-attendance at MDCC meetings.
- All sections of the patients' comprehensive assessments had been completed.
- When assessments had been completed indicating a specific need/problem area, a care plan had been devised for each assessed need indicating how this was going to be managed and reviewed during the patient's admission.
- Staff had completed observations of patients' in accordance with policies and procedures.
- The ward manager had completed regular audits of the patients' care records.
- Although there were no patients assessed as ready for discharge, staff were aware of the discharge pathway.
- The Trust had a mechanism in place to ensure that all patients had a social worker in the community if they required this support.

However, despite assurances from the Trust four recommendations had not been fully implemented. The 'integrated care pathway' (ICP) had been photocopied several times leaving sections on the bottom of the pages missing therefore the nurses could not sign this document. Nursing staff were reviewing patients' care plans in a number of different places within the patients' care records and care plans had have not been reviewed within the agreed timescale. Patients did not have a recovery focused activity/therapeutic plan in place.

Four recommendations which relate to the key question "**Is Care Compassionate**?" were made following the inspections undertaken on 12 August 2013 and 26 and 27 February 2015.

These recommendations concerned the completion of deprivation of liberty care plans, the reviewing of patients' capacity to consent to care and treatment and how patients had been informed of their rights. A recommendation was also made in relation informing patients of when the advocate called to the ward.

The inspector was pleased to note that all four recommendations had been fully implemented.

- Deprivation of Liberty Safeguards (DOLS) care plans were in place and documented the need for a restriction.

- Care plans in relation to actual or perceived deprivation of liberty were reviewed and an explanation of the deprivation of liberty was included in the plan of care. However a new recommendation has been made in relation to developing these care plans further to ensure that the need for a restriction is based on each patients individual circumstances.

- Patients' capacity to consent to their care and treatment had been reviewed each week at the multidisciplinary case conference (MDCC)

- Information with regard to patients' rights was available in an easy read format to ensure patients understood this process.

- Staff and patients were aware of the advocate's timetable for visiting the ward and contact details.

The detailed findings are included in Appendix 1

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

Summary

The inspector noted that there was up to date information provided in the wards information booklet which gave a detailed account of the ward. The inspector reviewed the staffing rota for the ward and noted that the ward was continuing to use a high ratio of bank staff. However when this was discussed at the conclusion of the inspection the inspector was informed that two new nurses have been recruited to work on the ward and a three staff have now returned from long term leave so this situation should improve. On the day of the inspection staffing levels were adequate to support the assessed needs of the patients. Staff were observed to be attentive and assisted patients promptly when required.

The ward environment was clean and clutter free. There was ample natural lighting, good ventilation and neutral odours. Ward furnishings were well maintained and comfortable. The ward environment promoted patients' privacy and dignity. The entrance doors to the ward were locked at all times however a number of patients were aware of the code of the door and could leave the ward if they informed the nurses. A cordless phone was available for patient access.

There were no areas of overcrowding observed on the day of the inspection; there were two communal rooms available to patients and the furniture was arranged in a way that encouraged social interaction. The inspector observed that staff were present in the main ward and available at patients' request. A well maintained garden area was noted to be open and accessible throughout the inspection. It was good to note that the ward kitchen was also available to patients to make tea and coffee or to get a cold drink.

Confidential records were stored appropriately and patient details were not displayed. Signage was available throughout the ward. There was up to date and relevant information available which included information on Human Rights, patient rights in accordance with the Mental Health (Northern Ireland) Order 1986, the right to access patient information, independent advocacy services and the right to make a complaint.

The activities arranged on the ward were displayed on the wards notice board. However patients did not have individual schedules in place from their assessed needs. Two patients raised issues in relation to the ward needing painted and could be improved in relation to ensuring that the environment was more therapeutic. Patients did not have access to a therapeutic room to complete activities such as arts and crafts. However when this was discussed at the conclusion of the inspection with a senior trust representative they advised that the occupational therapist and activity co-ordinator could access the ward adjacent and rooms were available for this work to be carried out. Recommendations have been made in relation to the above issues.

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

- Displaying information about the ward's performance e.g. information in relation to incidents, compliments and complaints.
- Displaying information on who is on duty that includes the ward doctor.
- Ensuring patients are aware of which staff member has been allocated therapeutic 1:1 time with them.
- Details of the ward round, ward doctor and other members of the multi-disciplinary team should be displayed on the notice boards.

- Staff should record when activities have been cancelled with the reason why and should ensure that there is a mechanism in place to inform patients of when activities are cancelled.

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 inspector 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 session involved observations of interactions between staff and patients. Three interactions were noted in this time period. The outcome of these interactions were as follows:

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

Overall the quality of interactions between staff and patients were positive. Nursing staff were observed interacting positively with patients throughout the day. The atmosphere was relaxed and staff appeared to know patients very well. Staff were available and prompt in assisting patients when needed.

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

7.0 Patient Experience Interviews

One patient's relative agreed to meet with the inspector to talk about their relatives care, treatment and experience as a patient. A further four patients agreed to complete a questionnaire regarding their care, treatment and experience as a patient.

The patients/relative who completed the questionnaire stated the following:

- Four patients stated they had been informed of their rights and one patient stated they had not been given enough time to understand their rights.

- Three patients stated they felt safe and secure on the ward. Two patients stated that sometimes they do not feel safe however they can talk to staff about this.

- Four patients stated they were fully informed of their care and treatment and one patient stated they are just told how this is going to be.

- Three patients said that they had been informed of the outcome of assessments and investigations and all five stated that staff continually update them on how they were progressing.

- Five patients stated that they had been offered the opportunity to be involved in activities on the ward and felt that these were helping them to recover and one patient stated that activities do not always happened on the ward.

- Three patients recorded that they felt staff were supportive and helpful on admission to the ward, one patient stated this question was not applicable and one patient stated they had been too ill to remember their admission.

- All five patients recorded they were treated with dignity and respect and that they felt staff listen to them and provided an explanation before supporting them with care and treatment.

Patients and a relative recorded the following comments:

- *"I think staff are really nice, they have the right approach when treating patients on the ward";*

- *"I think the environment could be improved ….. more therapeutic……..an art therapy room would be good"*

- *"Clean and tidy"*
- *"The ward is peaceful and quite"*
- *"The staff are all very good they do all they can for you"*
- *"Saved my life…excellent food…excellent activities"*
- *"Could be cheered up with a bit of paint"*
- *"Peaceful …. Privacy"*
- *"A water cooler would be good"*

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	**0**
Advocates	**0**

Wards staff

The inspector met with two members of nursing staff on the day of inspection. Staff members advised that they enjoyed working on the ward and felt well supported by the ward manager and colleagues. They did not express any concerns regarding the ward or patients' care and treatment

Other ward professionals

There were no ward professional available to meet with the inspector during the inspection.

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 17 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 unannounced inspection on 26 and 27 February 2015

No.	Reference.	Recommendations	No of times 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 all care documentation is accurate, current, personalised and in keeping with relevant published professional guidance documents including NMC Record keeping guidance.	2	In the three sets of care documentation reviewed by the inspector there was evidence that patients' assessments and associated care plans were comprehensively completed. Care plans were completed on the basis of the patient's assessed need and were individualised and person centred. However in one set of care records there were a number of care plans that had not been reviewed. All ten care plans had been review on 5/7/15 and only four out of ten care plans had been reviewed again on 19/7/15. It had been agreed that these care plan should be reviewed each week. Recommendation 15 states that the ward manager should ensure that care plans are regularly reviewed therefore recommendation 15 will be restated in relation to this. The multi-disciplinary case conferences (MDCC) were held weekly on the ward and MDCC records detailed the discussions and included an outcome and planned action. Progress notes reviewed by the inspector were detailed and gave a comprehensive account of each patient's progress on the ward. Assessments within the 'integrated care pathway' (ICP) had been completed in full. However the ICP documentation had been photocopied which resulted in sections on number of pages not photocopied therefore there was no section for	Met

				the nurses to sign. This was discussed with the acting head of service and lead nurse for older peoples' mental health who advised that in the coming weeks a new integrated care pathway, which has been piloted in other wards, will be implemented onto this ward which will not require to be photocopied. Recommendation 12 will be restated in relation to this as It states that the ward manager should ensures that initial assessments completed by nursing and medical staff are signed by the staff member completing the assessments with a record of their designation.	
2	5.3.1 (a)	It is recommended that the Trust ensures that Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010, is implemented within Oak A.	2	In the three sets of care documentation reviewed by the inspector there was evidence that care plans were in place in relation to restrictive practices. There was also evidence of MDCC meetings being held to discuss restrictions in place. These included personal items being removed from patients'. DOLS care plans were in place and documented the need for a restriction. However, the DOLS care plans should be further developed to ensure that the need for a restriction is based on each patients individual circumstances A new recommendation will be made in relation to ensuring that agreements made at the MDCC meetings in relation to the rationale around each restriction is clearly documented in the patients' care plans.	Met
3	5.3.1 (a)	It is recommended that the ward manager ensures that care plans in relation to actual or perceived deprivation of liberty are reviewed to ensure that an	2	In the three sets of care documentation reviewed there was evidence that care plans in relation to actual or perceived deprivation of liberty were reviewed and updated when required. However as detailed above DOLS care plans were in place and documented the need for a restriction. However, the DOLS care plans should be further developed	Met

		explanation of deprivation of liberty is included and relevant to the plan of care.		to ensure that the need for a restriction is based on each patients individual circumstances A new recommendation will be made in relation to ensuring that agreements made at the MDCC meetings in relation to the rationale around each restriction is clearly documented in the patients' care plans.	
4	4.3 (i)	It is recommended that the Trust ensures that the supervision needs for all staff working on the ward is examined and that a timetable of supervision for all staff working on the ward is developed and implemented so that staff receive regular supervision appropriate to their needs and role.	2	The inspector reviewed the records for nursing staff supervision. The inspector evidenced that all nursing staff on the ward had received supervision and a date had been set for the next supervision session. Records were noted to be in accordance to Trust and professional standards.	Met
5	4.3 (i)	It is recommended that the ward manager ensures that all staff working on the ward receive an annual appraisal. This should give the ward manager the opportunity to review staff members competency, knowledge and skills	2	The inspector reviewed the records for nursing staff appraisals. The inspector evidenced that all nursing staff on the ward had received an appraisal and a date had been set for the next appraisal.	Met
6	4.3 (m)	It is recommended that the Trust put a system in place so that the ward manager/nurse in charge	2	The inspector was advised that the Trust was developing a 'passport system' which will evidence that bank staff have up to date mandatory training in place. This system should be in place by September 2015. The inspector was also	Not met

		can ensure that bank staff have the appropriate training skills and knowledge to work on the ward.		advised that a new regional team will be set up to manage bank staff; however at present there is no system to govern bank staff training. This recommendation will be restated for a third time**.**	
7	5.3.2 (c)	It is recommended that the Trust ensures that a system to provide the ward manager with information in relation to review and outcomes of accidents, incidents and near misses that may influence ward practices is implemented.	2	The ward manager and the acting head of service and lead nurse for older peoples' mental health attend a managers meeting each month and the following issues are discussed : • incidents/accident and complaints; • the risk register; • risk management audit; • the integrated care pathway document; • Update re: RQIA inspections and QIP's; • delayed discharge resettlement; • staffing issues/management of absenteeism; • staff budgetary/over spend/ bank/agency; • NMC validation; All incidents and accidents are recorded on the Trust's Datix system and have to be reviewed by the acting head of service and lead nurse for older peoples' mental health. These incidents/accidents are discussed with the ward manager each month at the ward manager's supervision meeting. The ward manager ensures information in relation to the outcome of incidents and accidents investigations are cascaded to staff at team meetings and at daily handover meetings. The Trust also has a quarterly 'quality and safety newsletter' called 'Share to Learn' which details the outcome of a variety of incidents and accidents. This newsletter is	Met

				available on the Trust intranet.	
8	5.3.2 (c)	It is recommended that the Trust ensure that a system to provide the ward staff with information in relation to review and outcomes of accidents, incidents and near misses that may influence ward practices is implemented.	1	The ward manager attends the 'older peoples' mental health service ward managers' meeting' each month. They update staff regarding incidents and accidents at team meetings and handover meetings. The inspector reviewed minutes of a team meeting which was held in April 2015. The next meeting had been arranged for 2 September 2015 (July meeting had been cancelled due to staff on leave) Records indicate that the outcome of accidents, incidents and near misses that may influence ward practices was discussed at the meeting in April 2015. A review of incidents, accidents and near misses was also noted on the agenda for the next meeting.	Met
9	8.3 (b)	It is recommended that the ward manager ensures staff meetings are held on a regular basis.	1	There was evidence that a ward meeting had been held in April 2015 with the next meeting arranged for September 2015. A meeting had been set up for July however the ward manager took the decision to cancel the July team meeting as a number of staff were on leave. Dates have been set for the following meetings to be held every quarter.	Met
10	5.3.1 (f)	It is recommended that the ward manager ensures that patients' capacity to consent to care and treatment is clearly documented in the patients care records detailing the specific area assessed. This should include reference to care planning decisions made by, or on behalf of, the patient.	1	The inspector reviewed three sets of care records. The inspector evidenced that patients' capacity to consent to their care and treatment had been reviewed each week at multidisciplinary case conference (MDCC). All patients admitted to the ward on the day of the inspection had been assessed as having capacity in relation to understanding their care and treatment. Staff had recorded that they had sought consent prior to care delivery.	Met

11	5.3.1 (f)	It is recommended that the multi-disciplinary team ensures that each section of the MDCC template is completed in full. This should include details of patients attendance/non-attendance with the reasons why and the agreed outcomes/actions of the meeting.	1	In the three sets of care records reviewed each section of the MDCC record had been completed in full. These records detailed if the patient had attended the MDCC. Agreed actions/outcomes for each patient's care and treatment had been recorded. This included identifying the responsible professional overseeing the action/outcome. In addition to the MDCC records the consultant also records a detailed account of the MDCC meeting in the psychiatric investigation section of the ICP.	Met
12	5.3.1 (f)	It is recommended that the ward manager ensures that initial assessments completed by nursing and medical staff are signed by the staff member completing the assessments with a record of their designation. Patients should also be asked to sign their assessments and if they refuse this should also be recorded with the reason why.	1	Assessments within the 'integrated care pathway' (ICP) had been completed in full. However the ICP documentation had been photocopied a number of times and as the section for the nurses to sign was at the bottom of each page in all three records this had not been copied. Therefore there was no indication of who completed the assessment and there was no evidence that patients had signed this document. This was discussed with the acting head of service and lead nurse for older peoples' mental health. The inspector was advised that in the coming weeks a new integrated care pathway tool will be implemented. This recommendation will be restated for a second time	Not Met
13	5.3.1 (f)	It is recommended that the ward manager ensures that all sections of the patients' assessments are completed in full.	1	The inspector reviewed three sets of care records. The inspector evidenced that all sections of the patients' assessment had been completed in full and had been reviewed when required. This included: • the falls risk assessment, • moving and handling assessment,	Met

				• risk assessments of use of profiling beds, • use of bed rails, • Braden pressures ulcer risk assessment, • the MUST document, • weight record, • oral hygiene, • care plans and admission summary.	
14	5.3.1 (a)	It is recommended that the ward manager ensures that when assessments are completed indicating a specific need/problem area, a care plan is completed for each assessed need indicating how this is going to be managed and reviewed on the ward.	1	The inspector evidenced that when a patients' assessment indicated a specific need/problem area, a care plan had been devised for each assessed need detailing how these needs were going to be managed and reviewed during the patient's admission.	Met
15	5.3.1 (a)	It is recommended that the ward manager ensures that patient care plans are implemented. Care plans should be regularly reviewed and evidence patient involvement.	1	Patient care and treatment plans reviewed by the inspector had been regularly reviewed. Daily progress records detailed how staff had encouraged families to attend ward rounds and to meet privately with the doctor. Continuous records were maintained of patients' progress including their presentation and mood. However nursing staff were reviewing patients' care plans in a number of different places within the care records. Some staff had recorded this in the progress notes and others had used an 'evaluation care plan record'. The inspector was concerned that records were not consistent. Record one evidenced that the patient's care plan was reviewed in the 'evaluation of care-plan record'. This included a comprehensive record of the patient's progress.	Partially met

				The patient had signed each care plan to indicate they had agreed with the care and treatment planned. Record two evidenced that the patient signed their care plan agreement which detailed all care plans. Each care plan was evaluated in the daily progress notes not in the 'evaluation of care-plan record' Record three evidenced that the patient had ten care plans. Each care plan had been reviewed on 5/7/15. However, only four care plans had been reviewed again on 19/7/15. Care plans were in place from assessed need but had not been reviewed according to the agreed timescale. This recommendation will be restated for a second time	
16	5.3.1 (f)	It is recommended that the ward manager ensures that the Trust's patient observations policy and procedure is implemented. This should include the completion of appropriate records.	1	The inspector reviewed records of patients who had been on enhanced observations. There was evidence that this level of observation had been carried out in accordance to policies and procedures.	Met
17	5.3.3 (b)	It is recommended that the ward manager ensures all nursing care plans are reviewed regularly. Multi-disciplinary team decisions regarding changes in care plans should be documented with the involvement of the patient.	1	The inspector reviewed three sets of care records which evidenced that patients' care plans had been reviewed each week. However in one set of care records there were a number of care plans that had not been reviewed. There was evidence in the three sets of care records that decisions made during MDCC meetings had been incorporated into patients' care plans. Care plans had been signed by patients and if there was no signature a reason was recorded**.** This recommendation will be restated for a	Partially met

				second time	
18	5.3.1 (f)	It is recommended that the ward manager completes regular audits of the patients' care records to ensure that all staff follow the same approach when recording progress made in relation to each care plan.	1	The inspector reviewed documentation which evidenced that the ward manager completed monthly audits of five care records. The acting head of service and lead nurse for older peoples' mental health completed a further audit on a sample of care records every 3 months. Any issues raised as a result of the audits were discussed with nursing staff.	Met
19	5.3.1 (f)	It is recommended that the ward manager ensures that all staff are aware of the safety alerts regarding the use of profiling beds/exposed mental bed frames within inpatient mental health settings. This includes the reissue of a safety alert on 23 December 2013 by the Northern Ireland Adverse Incident Centre (NIAIC) – EFA/2010/006 safety alert self-harm associated with profiling beds.		Patients' risk assessments and care plans reviewed by the inspector included the use of profiling beds. Safety alerts are sent to the ward manager and if relevant to the ward this is discussed with senior managers and action plans are devised. The deputy ward manager advised that safety alerts are discussed at the managers' meetings each month and if relevant to the ward this is also discussed at team meetings.	Met
20	5.3.1 (c ,f)	It is recommended that the ward manager ensures that when a patient is assessed as requiring a profiling bed a risk assessment is completed. The risk assessment should be	1	In the three sets of records reviewed by the inspector there was evidence that risk assessments had been completed on each patients' admission in relation to the use of profiling beds. Risk assessments were completed with a date set to review same. All patients had a care plan in place in relation to the use of profiling beds which were reviewed regularly.	Met

		reviewed regularly in accordance with the safety alert raised on 23/12/13 by the Northern Ireland Adverse Incident Centre (NIAC) Estates Facilities Alert /2010/006 associated with profiling beds.			
21	5.3.1 (a)	It is recommended that the ward manager ensures that all patients have a recovery focused activity/therapeutic plan in place.	1	The inspector reviewed three sets of care records. There was evidence in one record that the Occupational Therapist (OT) had completed an assessment. This involved an 'occupational circumstances interview'. The outcome of the assessment included goals for the patient to work towards. However there was no review date set. The goals included the patient's participation in OT sessions, to maintain and improve the patient's concentration, to improve the patients' interest levels, to plan a kitchen assessment, to explore with the patient ways of managing their anxiety with diversional techniques and relaxation. However this was not detailed in a care plan and there was no evidence this this work had been completed or reviewed with an evaluation of the patient's progress. A second patient file recorded no evidence of the patient having a recovery focused activity/therapeutic care plan. However the patient had refused to attend any OT activities. In another record there was no evidence of an OT assessment having been completed and there was no recovery focused activity/therapeutic care plan in place**.** This recommendation will be restated for a second tim**e.**	Not met

22	6.3.2 (c)	It is recommended that the ward manager ensures that information with regard to patients' rights is available in an easy read format to ensure all patients' understand this process.	1	The inspector reviewed the care records of a patient who had been detained in accordance with the Mental Health (Northern Ireland) Order 1986. The inspector evidenced that this patient had been given information in relation to their rights. There was an easy read leaflet, 'Information for patients detained under the Mental Health (Northern Ireland) Order 1986' which detailed the detention process and patients' rights. It included information such as: • Why you are being held; • If you want to leave; • The role of the MHRT; • Your treatment if you have an queries or complaints; • RQIA details; • Carers support group detailed; • Complaints details. The inspector was informed that all patients on the ward were capable of understanding this leaflet.	Met
23	6.3.2 (b)	It is recommended that the ward manager ensures that staff and patients are aware of the advocate's timetable for visiting the ward and contact details. This information should be displayed throughout the ward	1	The notice board on the ward displayed the date when the advocate was due to visit the ward. The advocate also recorded the date of when they had visited the ward on a book held by the ward manager. There was evidence to show that the advocate visits the ward approximately every two weeks.	Met
24	4.3 (m)	It is recommended that the ward manager ensures that all staff have up to date mandatory training	1	There was evidence that progress had been made in relation to mandatory training however there were still some deficits.	Partially met

		completed which includes fire training, MAPA training and moving and handling training.		Out of the 18 nursing staff on the ward: **Fire training** 15 staff in date (three need trained) **Management of Actual or Potential Aggression (MAPA)** Eight staff in date and seven staff will be trained on 11 August 2015. The final three staff members will be trained in September 2015 **Moving and handling** Only six staff have up to date training in place (12 need to be trained **Immediate Life Support (ILS)** None of the staff on the ward had up to date ILS training in place A serious concerns meeting was held with senior trust representative on 28 July 2015 to discuss a number of concerns raised in recent inspections throughout the WHSCT. Mandatory training was one of the issues discussed at this meeting. The Trust have agreed to forward RQIA a plan in relation to governance arrangements by 28 August 2015. This recommendation will be restated for a second time.	

25	8.3. (i)	It is recommended that the ward manager ensures that all discharge records are completed in a timely manner prior to the patients' discharge. This should include a completed multidisciplinary discharge plan in accordance with Trust policy and procedure	1	The inspector was informed that there were no patients on the ward assessed as ready for discharge. However a potential date of discharge had been agreed at the MDCC. The 'Integrated Care Pathway' had a discharge planning section which was completed once a patient has been assessed as ready for discharge. Once a patient's discharge has been agreed at the MDCC meeting a discharge planning meeting is held to discuss and plan the patients' discharge.	Met
26	4.3 (n)	It is recommended that the ward manager ensures that all staff are aware of the policy and procedure in relation to discharge planning arrangements.	1	The inspector discussed the discharge process with nursing staff. Staff who met with the inspector demonstrated awareness of the discharge policy and procedure.	Met
27	4.3 (j)	It is recommended that the Trust review the current staffing arrangement on the ward to ensure continuity of care for patients thus reducing the need to use bank staff on a regular basis.	1	The acting head of service and lead nurse for older peoples' mental health services informed the inspector that the Trust had reviewed the staffing arrangements on the ward and continued to do this. The staff rota evidenced that the ward continued to use a high ratio of bank staff due to the continued high levels of core staff on long term leave. However out of the five staff who were on long term leave three had recently returned to work and two additional nurses have been recruited to the ward which should alleviate the need to use a high ratio of bank staff.	Met
28	4.3.(i)	It is recommended that the Trust complete a ligature risk assessment of the ward. This should include a subsequent action plan to address any identified risks.	1	The Trust completed an environmental ligature risk assessment of the ward on 16 March 2015. An action plan for when this work will be completed has been forwarded to RQIA. A plan was in place for this work to be completed by December 2015. However in recent correspondence from the Trust they have confirmed that they had applied for	Met

		Details of this action plan should be forwarded to RQIA by 24 April 2015		special funding from the Department of Health, Social Services and Public Safety (DHSSPS) however this has been declined as no funds are available at present. In the interim the Trust have confirmed that *'patients and the environment continue to be risk assessed and mitigating actions taken'*. RQIA will write to the DHSSPS in relation to this funding issue.	
29	4.4 (i)	It is recommended that the Trust ensures that a risk assessment /care plan is completed for each individual patient detailing how risks are going to be managed and reviewed to ensure patient safety.	1	The inspector reviewed three sets of care records. There was no evidence that patients had individual risk assessments /care plans completed detailing how environmental risks were going to be managed and reviewed to ensure patient safety. The deputy ward manager assured the inspector that this would be completed as a matter of urgency to ensure patient safety. This recommendation will be restated for a second time	Not met
30	4.4 (m)	It is recommended that the Trust reviews the social work arrangements for the ward to ensure all social work needs are met and patients are not disadvantaged by the absence of a dedicated ward social worker	1	All patients on the ward had been allocated a keyworker in the community (community psychiatric nurse or social worker). The ward manager makes a referral when social work support is requested or recommended by the multidisciplinary team.	Met

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Inspection

Oak A, Tyrone and Fermanagh Hospital

10 August 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 acting head of service and lead nurse for older peoples' 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 Trust put a system 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	30 September 2015	The management of bank and agency for Mental Health Nursing is transferring to a central system within the Trust. It is anticipated that this will be completed by end October 2015 subject to recruitment process. The validation of bank training will be completed by central system. The majority of mandatory training is coordinated and provided by the Clinical Education Centre (CEC) via a Service Level Agreement. All nursing staff, including staff that hold 'bank only' contracts can access the CEC website to request a place on a mandatory training programme. The line manager is notified by email of the staff members request to attend. The bank nurses record is then updated when attendance at the mandatory training is confirmed. These systems and processes will be applied to the mental health bank nursing staff during the next 3- 6 months as part of the plan to transfer the responsibility for these staff to the Central Nurse Bank Team. An extension is required to end of February 2016.
2	4.3 (m)	It is recommended that the ward	2	30	The ward manager will ensure that all staff have up to date

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 all staff have up to date mandatory training completed which includes fire training, MAPA training and moving and handling training.		November 2015	mandatory training completed which includes fire training, MAPA training. However Manual Handling training will not be fully addressed until Jan 2016 due to limited access to training places. Therefore the Trust requests an extension until Jan 2016 for this recommendation.
3	4.4 (i)	It is recommended that the Trust ensures that an environmental risk assessment /care plan is completed for each individual patient detailing how environmental risks are going to be managed and reviewed to ensure patient safety.	2	Immediate and ongoing	The ward manager will ensure that an environmental risk assessment /care plan is completed for each individual patient detailing how environmental risks are going to be managed and reviewed to ensure patient safety.
			Is Care Effective?		
4	5.3.1 (f)	It is recommended that the ward manager ensures that initial assessments completed by nursing and medical staff are signed by the staff member completing the assessments with a record of their designation.	2	Immediate and ongoing	The ward manager will ensure that initial assessments completed by nursing and medical staff are signed by the staff member completing the assessments with a record of their designation. Patients will also be asked to sign their assessments if appropriate and if they refuse this will also be

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
		Patients should also be asked to sign their assessments and if they refuse this should also be recorded with the reason why.			recorded with the reason why.
5	5.3.1 (a)	It is recommended that the ward manager ensures that patient care plans are implemented. Care plans should be regularly reviewed and evidence patient involvement.	2	Immediate and ongoing	The ward manager will ensure that patient care plans are implemented. Care plans will be regularly reviewed and evidence patient involvement.
6	5.3.3 (b)	It is recommended that the ward manager ensures all nursing care plans are reviewed regularly. Multi-disciplinary team decisions regarding changes in care plans should be documented with the involvement of the patient.	2	Immediate and ongoing	The ward manager will ensure all nursing care plans are reviewed regularly. Multi-disciplinary team decisions regarding changes in care plans will be documented with the involvement of the patient if appropriate.
7	5.3.1 (a)	It is recommended that the ward manager ensures that all patients have a recovery focused activity/therapeutic plan in place.	2	30 November 2015	The ward manager will ensure that all patients have a recovery focused activity/therapeutic plan in place.
8	8.3 (a)	It is recommended that the ward manager ensures that patient forum meetings are held on the ward to ensure there is a	1	Immediate and ongoing	The ward manager will ensure that patient forum meetings are held on the ward to ensure there is a mechanism for service development, improvement and patient experience. Commenced August 2015 and dates pre-planned for 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
		mechanism for service development, improvement and patient experience.			remainder of the year.
9	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. This should include painting the ward and ensuring the ward has access to a therapeutic room/area for activities to be carried out.	1	31 December 2015	The ward manager will review the ward environment to provide a more therapeutic and conducive environment that meets the therapeutic and recreational needs of the patients. Ward painting has already commenced as it was already identified through the annual environment risk assessment. The ward has access to a therapeutic room/area for activities to be carried out and this will be further developed.
		Is Care Compassionate?			
10	5.3.1 (a	It is recommendation that the ward manager ensuring that when decisions have been made at the MDCC meetings in relation to the rationale around restrictive practices this is clearly documented in the patients' deprivation of liberty care plans.	1	Immediate and ongoing	The ward manager will ensure that when decisions have been made at the MDCC meetings in relation to the rationale around restrictive practices this is clearly documented in the patients' deprivation of liberty care plans.

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	Nuala Burke
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	

	Inspector assessment of returned QIP	Yes	No	Inspector	Date
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		AM'Lellan	30/9/15
B.	Further information requested from provider		x	AM'Lellan	30/9/15