The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Oak A, Tyrone and Fermanagh Hospital

Western Trust

26 & 27 February 2015

npm national preventive mechanism

informing and improving health and social care
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Contents

1.0 General Information

Ward Name	Oak A
Trust	Western Trust
Hospital Address	Tyrone and Fermanagh Hospital 1 Donaghanie Road Omagh BT79 ONS
Ward Telephone number	82833100/82835757
Ward Manager	Nuala Burke
Email address	robert.stewart@westerntrust.hscni.net
Person in charge on day of inspection	Mary McVeigh (SEN)
Category of Care	Functional Mental Health over 65 years
Date of last inspection and inspection type	12 August 2013
Name of inspectors	Audrey McLellan Dr Shelagh Mary Rea

2.0 Ward profile

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 a team of nursing staff and health care assistants, two consultant psychiatrists, two clinical psychologists, two senior house officers, an occupational therapist and an activity coordinator.

On the days of the inspection there were seven patients on the ward. One patient was detained in accordance with the Mental Health (Northern Ireland) Order 1986. There were no patients on leave.

The ward was welcoming, calm, well lit and bright. It appeared clean and well maintained. Patients' sleeping areas consisted of two four bedded bays with one bathroom each and two single rooms with ensuite.

The nursing station was centrally positioned on the ward overlooking the patients' sleeping areas. Patients on the ward could access the garden throughout the day.

3.0 Introduction

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

3.1 Purpose and Aim of the Inspection

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

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

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

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

3.2 Methodology

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

Prior to the inspection RQIA forwarded the associated inspection documentation to the Trust, which allowed the ward the opportunity to demonstrate its ability to deliver a service against best practice indicators. This included the assessment of the Trust's performance against an RQIA Compliance Scale, as outlined in Section 6.

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

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

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

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

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

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

4.0 Review of action plans/progress

An unannounced inspection of Oak A was undertaken on 26 & 27 February 2015

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

The recommendations made following the last unannounced inspection on 12 August 2013 were evaluated. The inspector was pleased to note that nine recommendations had been fully met and compliance had been achieved in the following areas:

- Patients have access to a mobile phone on the ward to make and receive calls. A room is available for patients where patients can use the phone without being disturbed;
- Seventeen of the 18 nursing staff had received training in relation to safeguarding vulnerable adults and Deprivation of Liberty Safeguards (DOLS) – Interim Guidance. One staff member had been on long term leave and will attend training when they return to work;
- The ward manager has implemented the WHSCT patient care records audit tool which is completed on five sets of care records each month.
- Patients have access to regular therapeutic individualised and group activities in accordance to each patient's assessed needs;
- The inspectors reviewed the staff rota and staffing levels for the ward were appropriate to ensure that all aspects of care and treatment including therapeutic activities were delivered on a daily basis;
- There was evidence in the three sets of care documentation reviewed that patients had separate assessments completed by nursing staff, medical staff and the occupational therapist;
- Information relating to staff on duty was displayed in patient areas;
- The ward no longer uses a fax machine
- Staff have access to a mobile phone on the ward to make and receive calls. A room is available where staff can use the phone without being disturbed

However, despite assurances from the Trust, five recommendations had been partially met and three recommendations had not been met. Eight recommendations will require to be restated for a second time in the Quality Improvement Plan (QIP) accompanying this report.

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

There were no recommendations made following the patient experience interview inspection on 22 July 2014.

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

The recommendations made following the finance inspection on 7 January 2014 were evaluated. The inspector was pleased to note that two recommendations had been fully met and compliance had been achieved in the following areas:

- When staff are making purchases on behalf of patients, a record is maintained of the amount of money received, purchases made and change returned. All transactions were verified by two members of staff;
- The nurse in charge of the ward holds the safe key. A record is maintained of the reasons for access to the safe and this is signed by two members of staff.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection the ward manager has retired and a new ward manager is now in post. Seventeen of the 18 nursing staff have received training in relation to safeguarding vulnerable adults and Deprivation of Liberty Safeguards (DOLS) – Interim Guidance. The ward manager has implemented the WHSCT patient care records audit tool which is completed on five sets of care records each month. Patients have access to regular therapeutic individualised and group activities in accordance to each patient's assessed needs;

The following is a summary of the inspection findings in relation to the Human Rights indicator of Autonomy and represents the position on the ward on the days of the inspection.

The inspectors reviewed three set of care records. There was evidence in all three records that patients' capacity to consent to care and treatment was monitored and re-evaluated throughout their admission. Patients' progress notes and multidisciplinary team weekly case conference (MDCC) records evidenced that nursing staff reviewed patients' progress on a daily basis. The multi-disciplinary team assessed each patient's progress on a weekly basis.

There was evidence that patients' capacity was discussed at the MDCC meetings as this was evidenced in the progress notes. However, the manner of recording if patients' capacity had been assessed was very unclear as the MDCC record did not indicate the specific area of capacity that had been assessed. A recommendation has been made in relation to this.

It was good to note that records indicated patients had been asked to complete various activities such as attending to their personal hygiene and therapeutic activities. When they had refused this decision was respected by

staff. There was evidence of staff encouraging patients to complete tasks at a later time in the day and patients agreeing to complete same.

One set of care records detailed concerns regarding a patient's capacity to 'accept care and treatment' and their 'capacity to live independently in the community'. There was evidence of assessments completed in relation to the patients' capacity to manage independently. The patient's care records demonstrated that multidisciplinary team meetings had been held with the patient and their family to discuss the patient's discharge plan.

There was evidence in all three sets of care records reviewed that patients had met with the consultant and the senior house officer on a regular basis. However MDCC records were inconsistently signed by patients therefore there were occasions when there was no record to indicate if the patient had attended the meeting or if they had refused to attend. A recommendation has been made in relation to this.

Consideration of patients' Human Rights Article 8 to respect for private and family life and Article14, right to be free from discrimination was evidenced through the wards arrangements for patients to see their relatives/carers outside of the set visiting times and visiting hours were flexible on the ward. There was evidence in the patients care records of patients' relatives/carers been updated, when appropriate on patients' care and treatment. Patients' right to refuse treatment was upheld and patients had been given the choice to attend their MDCC meeting each week.

Care records reviewed by inspectors evidenced that each patient received a joint assessment, completed by nursing and medical staff, upon their admission to the ward. However these assessments were not signed by the nurse, doctor or the patient. There were also sections in the assessments that were inconsistently completed. A recommendation has been made in relation to this.

In one set of care records a care plan stated that the patient had 'thoughts of life not worth living'. Inspectors were concerned that this patient was being nursed in a profiling bed without an associated risk assessment in place. A recommendation has been made in relation to this.

It was good to note that care plans were person centred and individualised in accordance to the assessed needs of each patient. Core care plans were in place in relation to the detention process when patients had been detained in accordance to the Mental Health (Northern Ireland) Order 1986. The nursing assessment in one set of care records indicated that a care plan should be in place in relation to a patient's back pain. However, there was no care plan in place to direct the back care for this patient. Inspectors also noted that patient progress records did not reflect patients' daily contact with their named nurse. Recommendations in relation to both these issues have been made.

MDCC assessments in two sets of records reviewed indicated patients were on enhanced 1:1 observations. Each patient's progress notes recorded that

staff completed checks on the patient's progress every 15 minutes. However, there were no care plans in place in relation to this. Inspectors were unable to evidence a rationale regarding the purpose of the observation. The inspectors were also concerned to note that there was one form used to record three patients' enhanced observation checks. This is contrary to trust policy and procedures. A recommendation has been made in relation to this

In another set of care records a patient had been detained in accordance with the Mental Health (Northern Ireland) Order 1986. The patient had been reassessed and their status was changed to voluntary patient. Inspectors were concerned that the patient's care plan had not been updated to reflect this change. There were also care plans in place for two patients which stated that they were on 15 minute observations. However a MDCC meeting had been held and it was agreed that this would change to general observation and this had not been updated in the care plan. Inspectors noted that patients' care plans were not maintained in accordance to Trust policy and best practice guidance. .A recommendation has been made in relation to this

Patients' communication needs were addressed during the patient's initial assessment. Staff who met with the inspector advised that if concerns are raised regarding patients' communication needs a referral can be made to the Trust's interpreting service.

There was no evidence in the three sets of care records reviewed to indicate if patients had been involved in their care plans as none of the care plans reviewed had been signed by patients. A recommendation has been made in relation to this

Inspectors spoke to the ward's occupational therapist (OT). The OT worked part time and advised that they were supported by an activity coordinator who also worked part-time on the ward. The OT stated they and the activity co-ordinator ensured that activities were held in the morning and afternoon each day. The OT informed the inspectors that when patients are admitted onto the ward an individual OT/activity assessment is completed. This helped to inform the type of therapeutic activities organised for the patients. Inspectors were unable to evidence that individualised therapeutic/recreational care plans had been completed for each patient. A recommendation has been made in relation to this.

The OT and the activity coordinator had monitored patient's participation in activities and this was reflected in the patients' OT progress notes. Activities available included, reminisce activities, creative skills, newspaper reading, quiz, dog therapy, bingo, cooking and activities in the community. Inspectors spoke to three patients who all advised that they had attended these sessions and had enjoyed taking part.

The inspectors noted that the multidisciplinary team could refer patients to the Trust's psychological services. There was evidence in one set of care records that a patient had been assessed by a psychologist in relation to concerns regarding capacity and consent.

Inspectors reviewed the care records of one patient who had been detained to the ward in accordance with the Mental Health (Northern Ireland) Order 1986. The inspectors reviewed this patients' care documentation and there was evidence that the patient had been informed of their rights in relation to the detention process. They had also been given information on how to make a referral to the Mental Health Review Tribunal (MHRT). The patient's care documentation recorded that staff had discussed the MHRT process with the patient. However, this information was not available in a suitable format for each patient's individual communication needs. A recommendation has been made in relation to this.

Information regarding the complaints procedure and the advocacy service was displayed in several locations throughout the ward. Although, when the inspectors spoke to the patients and staff no one was sure as to which day the advocate called to the ward and how often. A recommendation has been made in relation to this

The ward's patient information booklet detailed the role of the multi-disciplinary team and provided information in relation to the locked door and patients' rights. There was also detail regarding: the ward's admission process, restrictive practices, the advocacy service, the detention process, meals, visiting times, time off the ward and discharge. Contact details in relation to the Mental Health Review Tribunal (MHRT), the Trust's complaints department and the Regulation and Quality Improvement Authority (RQIA) were also included in the booklet.

Inspectors were unable to establish if patients admitted on a voluntary basis had been advised that they could leave the ward. Inspectors were unable to identify individualised care plans in relation to how this restriction was managed for each patient. Inspectors also noted there were no individual restrictive practice care plans in place in relation to restrictions such as patients' access to personal monies, removal of restricted items which were considered harmful to the patient and the use of the locked entrance and exit. A recommendation has been made in relation to this.

However there was one restrictive practice care plan in place in relation to a patient's use of cigarettes. However the rationale around this level of restriction was unclear and there was no record of the actions to be taken by staff should the patient refuse to cooperate. A recommendation has been made in relation to this.

Two questionnaires returned from staff prior to the inspection indicated that both staff had received training in relation to restrictive practice and were aware of the Deprivation of Liberty Safeguards- (DOLS) Interim Guidance (2010). However, when the inspector reviewed the ward's nursing staff training records there were a number of deficits in relation to mandatory training. A recommendation has been made in relation to this.

Inspectors reviewed the ward's discharge procedures. Care records of one patient who was due to be discharged in the near future to a residential home evidenced that this had been discussed at the MDCC meetings. An arrangement had also been made for staff within the home to come to the ward to complete an assessment with the patient. A discharge planning meeting had been held with the patient and their family to discuss this process**.** However, the discharge records for this patient had not been completed. The discharge checklist and multidisciplinary discharge plan were not up to date. Staff who spoke with the inspectors were unable to explain the discharge planning arrangements for the patient(s). A recommendation has been made in relation to this.

Details of the above findings are included in Appendix 2.

On this occasion Oak A has achieved an overall compliance level of moving towards compliance in relation to the Human Rights inspection theme of "Autonomy".

6.0 Consultation processes

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

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

Patients

Inspectors spoke to three patients on the ward. All three patients stated they knew why they were in hospital and what they could and could not do on the ward. They informed the inspector that they had been involved in their care and treatment. One patient stated that they were going to a "new place" in the community and were looking forward to this. Two patients stated that they did not have any personal items taken from them on admission. One patient stated that the nurses had kept their cigarettes. The patient relayed that had agreed to this arrangement.

Patients stated the following comments about the overall care on the ward:

"I like the staff here"

"Nurses are very good and the food is good"

"Care is good"

Relatives/Carers

There were no relatives/carers available for interview on the days of the inspection.

Ward Staff

Inspectors spoke to the occupation therapist, the senior house officer and a nurse on the days of the inspection. The nurse advised that they enjoyed working on the ward and stated that the multidisciplinary team works well together and the consultants are very approachable. However, they stated that there have been staff shortages and the ward has used bank staff on a daily basis for a number of months. They advised the inspectors that on occasions the ward has had more bank staff on duty than the core staff members. The staff member reflected that they felt this did not provide good

continuity of care to patients. They informed the inspector that some of their mandatory training had been cancelled due to staff shortage.

The occupation therapist explained their role to the inspector and how they work closely with the activity coordinator to make sure activities are set up each day. They advised the inspector of the assessments they complete and how they set up therapeutic activities from these assessments.

The senior house officer advised that they enjoy working on the ward and have been well supported by the medical staff and colleagues. They attend the multidisciplinary ward round each week and are on the ward daily to support patients.

Other Ward Professionals

There were no other ward professionals available for interview on the days of the inspection.

Advocates

There were no advocates available for interview on the days of the inspection.

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

Questionnaires issued to	Number issued	Number returned
Ward Staff	8	2
Other Ward Professionals	2	0
Relatives/carers	10	0

Ward Staff

Two questionnaires were returned by ward staff in advance of the inspection. Both staff indicated that they had not received training in capacity to consent. However they had both received training in human rights and restrictive practices. Staff reflected that they were aware of restrictive practices on the ward.

They indicated that they had received training on meeting the needs of patients who need support with communication and that patients' communication needs are recorded in their assessment and care plan. They recorded that they were aware of alternative methods of communicating with patients.

Both staff members reported that patients had access to therapeutic and recreational activities and that these programmes meet the patients' needs**.**

Other Ward Professionals

No questionnaires were returned from ward professionals

Relatives/carers

No questionnaires were returned from ward professionals

7.0 Additional matters examined/additional concerns noted

Complaints

There were no complaints received on the ward between April 2013 and 31 March 2014.

Additional concerns

Concerns over governance arrangement on the ward

The inspector was concerned to note that on the first day of the inspection the nurse on charge of the ward was not sure if they were in charge of the ward or if it was the bank nurse. The inspector was also concerned that this nurse did not appear competent in her role of being in charge of the ward and appeared under pressure from having this responsibility. They appeared to rely heavily on the bank nurse when the inspector was asking questions about the ward. They were not able to access the computer system and therefore could not fulfil all of their duties on the ward. This was discussed with the acting service manager who assured the inspectors that they had recently met with this member of staff in relation to their role and the member of staff had not raised any concerns. However, they advised the inspectors that they would review the situation as further training may be required. A recommendation has been made in relation to this.

Concerns that the two qualified staff on the ward were not aware that three patients were receiving enhanced observations of 15 minute checks

When the inspector asked if any patients were on enhanced observations the two qualified nurses stated there were no patients on enhanced observations. However on the second day of the inspection the inspectors discovered that three patients were on 15 minute observations and had been on this level of observation on the previous day**.** This was also discussed with the acting service manager. A recommendation has been made in relation to this.

Concerns regarding the number of bank staff used on the ward on a regular basis

The inspector reviewed the wards off duty record and for the past three months there was evidence that the ward was operating with a heavy reliance on bank staff. Every day bank nurses and health care workers were on the

ward to make up the staff team. This was discussed with the acting service manager who assured the inspectors that the bank staff working on the ward are staff who are familiar with the ward. They advised that there are 17 staff members on sick leave between Oak A and another ward on the hospital site and it has been very difficult to manage the situation. However they advised that they are hopeful that some of these staff member will be returning to work shortly and this will help the situation. A recommendation has been made in relation to this.

A patient with suicidal ideation nursed in a profiling bed without a risk assessment in place and staffs lack of awareness regarding the risks associated with this practice.

The inspector reviewed one patients notes and the current care plan stated that the patient had 'thoughts of life not worth living'. However this patient was nursed in a profiling bed without a risk assessment and the staff on the ward were not aware of the risks involved with this patient continuing to be nursed in a profiling bed. This was discussed with the acting service manager who advised that they would raise this with staff and ensure a risk assessment was in place for all patients using a profiling bed. A recommendation has been made in relation to this.

Risks for patients on the ward as anti-ligature work had not been completed

When completing a ward observation the inspectors were concerned to note that there were a number of places throughout the ward which could potentially be used as a ligature point. This was discussed with the acting service manager who advised that an assessment was going to be completed the following week. However they were unsure when this work would be carried out. The inspectors were concerned to note that the acting service manager was unable to provide a timeline to the inspectors on when the risk assessment and ensuing actions to minimise risks to patients' safety would be completed. The three sets of care records reviewed by the inspectors did not have care plans/risk assessments in place to detail how this risk was being managed on the ward for each individual patient. However staff assured the inspectors that there was only one patient on the ward who had suicidal ideations and they were monitored closely by staff to ensure of their safety. A recommendation has been made in relation to this.

Deficits in mandatory training and the lack of management arrangements in relation to monitoring staff training to ensure all staff have up to date training in place

The inspector reviewed the mandatory training for staff on this ward. Records were unclear in relation to staff training on the ward or how many staff currently worked on the ward after the amalgamation of staff from other wards. The inspector reviewed this with the ward clerk and it became apparent that there were a number of deficits in staff training. Out of and 18 staff only 7 had up to date fire training and MAPA training and only 8 had up

to date moving and handling training. This was also discussed with the acting service manager. A recommendation has been made in relation to this.

An escalation meeting was held on 25 March with senior Trust representatives in relation to the above concerns and a response is due back from the Trust by 24 April 2015.

8.0 RQIA Compliance Scale Guidance

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

Appendix 1 – Follow up on Previous Recommendations

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

Appendix 2 – Inspection Findings

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

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

Appendix 1

Follow-up on recommendations made following the announced inspection on 12 August 2013

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the trust ensure a phone is made available for patients on the ward to make and receive calls privately.	Patients have access to a mobile phone on the ward to make and receive calls. A room on the ward is available for patients to speak privately on the phone.	Fully met
2	It is recommended that the ward manager ensures all staff working on the ward undertakes training in relation to Vulnerable Adults procedures.	There are 18 nursing staff working on the ward and 17 have received training in relation to safeguarding vulnerable adults. One staff member had been on long term leave and will attend training at the next available opportunity upon their return to work.	Fully met
3	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.	The inspectors reviewed three sets of patient care documentation. These records did not evidence that all care was accurate and current in keeping with revel published professional guidance. There were no care plans in place in two sets of care records in relation to restrictions such as patients' access to personal monies, restricted items and the locked door. In one set of care records care plans had not been updated to detail that the patient was no longer on enhanced observations. The records also failed to reflect that the patient was no longer detained in accordance with the Mental health (Northern Ireland) Order 1986. However, a number of care plans were noted to be based on the patient's assessed need and were individualised and person centred. This recommendation will be restated for the second time in the quality improvement plan accompanying this report.	Partially met
4	It is recommended that the ward manager introduces a system of auditing of records and record keeping to ensure defined processes are followed	The ward manager had implemented the WHSCT audit tool which was completed on five sets of case records each month. The ward manager and acting service manager complete this audit. Sections subject to audit included: admission records, treatment plans, progress notes and discharge plans. When records do not meet the standard this is raised with the named nurse to ensure	Fully met

	by relevant staff.	this is rectified	
5	It is recommended that the ward manager ensures that staff within Oak A receive awareness training on their role in relation to Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010	17 of the ward's 18 nursing staff had completed training in relation to Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010. One staff member has been on long term leave and they will attend training when they return to work. Staff who spoke to the inspectors advised that this training included training on restrictive practices and human rights legislation.	Fully met
6	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.	The inspectors reviewed three sets of patient care documentation. There was evidence in one set of records of care plans developed in relation to the use of restrictive practices and deprivation of this patients' liberty. However, the care plans did not give a clear rationale for the restrictions in place. This recommendation will be restated for a second time	Partially met
7	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 explanation of deprivation of liberty is included and relevant to the plan of care.	Inspectors reviewed three sets of care records. There was evidence that care plans had been developed in relation to actual or perceived deprivation of liberty in one set of care documentation. However, the rationale for the use of the level of restriction in terms of necessity and proportionality was unclear. In one of the three sets of care records reviewed by the inspectors a patient had been detained in accordance with the Mental Health (Northern Ireland) Order 1986. This was reviewed at MDCC and they were now a voluntary patient. The patient had also been on 15 minute enhanced observations and this had been discontinued. However, the patient's care plan had not been updated to indicate these changes. This recommendation will be restated for a second time	Not met
8	It is recommended that the Trust ensures that all patients within Oak A have access to regular therapeutic individualised and group activities on the ward that	Records in three sets of care documentation evidenced that the patients had been offered regular therapeutic individualised and group activities. Inspectors noted that the activities offered to these patients were based on each patient's assessed need. The ward's occupational therapist and activity coordinator provided activities to	Fully met

	meets assessed needs.	patients on a daily basis Monday to Friday. They worked closely together and planned activities to ensure patients could access morning and afternoon sessions. There was evidence in one set of care documentation of a patient receiving psychology input.	
9	It is recommended that the Trust ensures that the staffing for the ward is sufficiently resourced to ensure that all aspects of care and treatment including therapeutic activities can be delivered on a daily basis.	The inspectors reviewed the duty rota for a three month period. The inspectors evidenced that staffing levels on the ward had been maintained to ensure that patients' care and treatment including therapeutic activities were available on the ward. However the inspectors were concerned to note the frequent use of bank staff on the ward over this three month period. A new recommendation will be made in relation to this.	Fully met
10	It is recommended that the Trust ensures that a needs/capacity analysis is undertaken to establish need for and availability of clinical therapeutic inputs to include psychiatric, psychological, behavioural, social work and occupational therapy specialties.	There was evidence in the three sets of care documentation reviewed that patients had assessments completed by nursing staff, medical staff and the occupational therapist. There were two psychologists who were members of the multidisciplinary team and referrals could be made to these professionals in relation to behavioural and psychological interventions. Clinical and therapeutic input had been provided to patients from their assessed need. The inspectors were advised that there was no dedicated social worker attached to the ward. A new recommendation will be made in relation to this	Partially met
11	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.	The inspectors reviewed supervision records and all trained staff had received supervision which was in accordance with the Trust policies and procedures. However there were no records of untrained staff having received supervision. There was no timetable in place to ensure that staff on the ward receive regular supervision appropriate to their needs. This recommendation will be restated for the second time	Partially met

12	It is recommended that the ward manager ensures that all staff working on the ward receive an annual appraisal.	There were no records of staff having received appraisals. Staff who spoke to the inspectors advised that they did not have an appraisal completed. This recommendation will be restated for a second time.	Not met
13	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.	The inspectors spoke to the ward staff and the acting service manager regarding mandatory training requirements and bank staff. They advised the inspectors that there was no system in place to ensure that bank staff have the appropriate training and knowledge to work on the ward. This was concerning as the ward is currently using bank staff on a daily basis. This recommendation will be restated for a second time.	Not met
14	It is recommended that the ward sister ensures that information relating to staff on duty is displayed in patient areas.	There was a large notice board in the main part of the ward which displayed who was on duty each day this included the grades of staff.	Fully met
15	It is recommended that the Trust reviews the practice of sharing information with other departments via fax and ensures that all confidential information shared with other departments is in accordance with data protection legislation	The ward no longer uses a fax machine. Confidential information is now shared via password protected emails and in accordance with data protection legislation.	Fully met
16	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.	The inspectors were informed that all incidents, accidents and near misses were recorded on the Trust's Datix system and reported to the clinical and social care governance team (C&SCG). The acting service manager attends quarterly meetings with the C&SCG team to discuss all incidents. If there are any recommendations to be made in relation to staff practices this will be recorded at this meeting and will include how the recommendation will be implemented and monitored. The acting service manager meets with the ward manager each month to discuss incidents. However, there was no evidence of a system in place to inform the staff of the outcome of these meetings. There was no record of staff meetings held in the ward so that this information could be cascaded down to	Partially met

		the staff. Staff who met with the inspectors confirmed that staff meetings had not been held on the ward. This recommendation will be restated for the second time. A new recommendation in relation to informing staff of the outcome of incidents on the ward has been made. A further recommendation in relation to the ward manager ensuring staff meetings are held on a regular basis has also been made. There were no records of staff meetings held and staff could not remember when the last staff meeting had been held.	
17	It is recommended that the trust ensure that staff on the ward can take and receive information via the telephone in a private area.	Staff have access to a mobile phone on the ward to make and receive calls. A room is available on the ward for staff to make and receive confidential calls.	Fully met

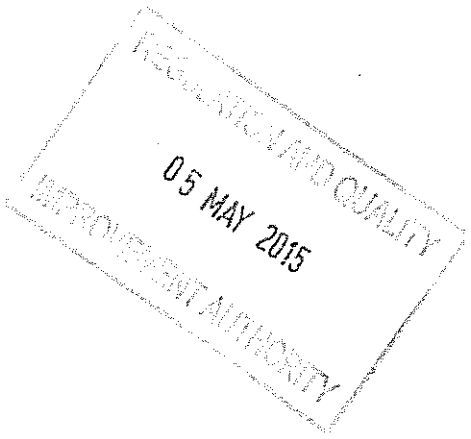
Appendix 1

Follow-up on recommendations made at the finance inspection on 7 January 2014

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager develops a system to ensure that where staff are making purchases on behalf of patients, a transparent record is maintained of the amount of money received, purchases made and change returned and verified by another staff member.	A patient cash register book is held on the ward. Records are maintained of the date transactions are made for each patient with the amount withdrawn. Receipts are maintained of all purchases made and the balance is checked and signed by two members of staff.	Fully met
2	It is recommended that the ward manager ensures that a record is of the staff member who obtains the key to the patients' safe, and the reason for access is maintained.	The nurse in charge of the ward holds the safe key. A record is maintained of the reasons for access to the safe and this is signed by two members of staff.	Fully met

Western Health
and Social Care Trust

**Directorate of Primary Care
& Older People's Services**



Your Ref: AMcL/EB

29 April 2015

Ms Audrey McLellan
Inspector
Mental Health and Learning Disability Team
Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Dear Ms McLellan

Re: UNANNOUNCED INSPECTION – OAK A, TYRONE & FERMANAGH HOSPITAL – 26 & 27 FEBRUARY 2015

I refer to your letter of 27 March 2015 to Mr James Stewart, Ward Manager, with regard to the above inspection and enclose the Quality Improvement Plan, which has been approved by the Chief Executive.

I wish to advise that Recommendations 2, 21 and 24 have been identified as not being achievable within the stated timeframe and extensions have been requested.

Please do not hesitate to contact me if you require additional information or wish to discuss this matter further.

Yours sincerely

ALAN CORRY FINN
Director of Primary Care & Older People's Services
/ Executive Director of Nursing

Trust HQs, MDEC Building, Altnagelvin Hospital Site, Glenshane Road, L'Derry, BT47 6SB
Telephone: (028) 71611247

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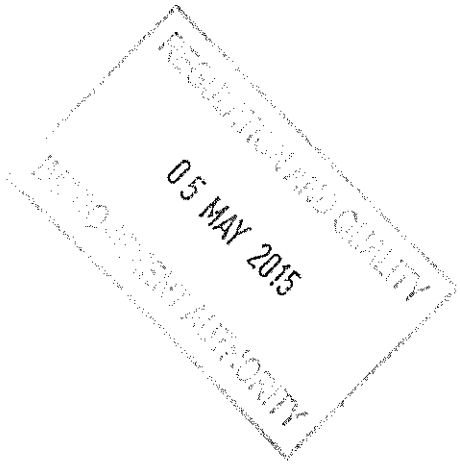
The Regulation and Quality Improvement Authority



Quality Improvement Plan

Unannounced Inspection

Oak A, Tyrone and Fermanagh Hospital

26 & 27 February 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 staff nurse in charge on the ward and with the acting service manager (over the telephone) on the day of the inspection visit.

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

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	5.3.1 (f)	It is recommended thal 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	Immediate and ongoing	All care records are audited on a monthly basis by the ward manager and validated by the Lead Nurse on a 6 monthly basis using the NIPEC audit tool. Any non-compliance by staff is addressed by the ward manager with individual staff. Record Keeping is a regular agenda item at staff meetings. All staff are required to abide by the NMC Record Keeping guidelines. The Functional Integrated Pathway is now finalised and will be implemented in the Ward over the next 2 months.
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 implemenled within Oak A.	2	15 April 2015	Deprivation of Liberty Safeguards (DOLS) interim guidelines have been developed. These will be noted at the Directorate Governance meeting in May and will be available on the Trust Intranet for reference and a hard copy available on the Ward. The Trust requires an extension to the timescale and this document is currently in draft.
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 explanation of deprivation of liberty is included and	2	15 April 2015	Deprivation of Liberty Safeguards (DOLS) included in individualised care plans and reviewed accordingly or when the patients' needs change. Individualised care plans for actual or perceived DOLS is in place.

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
		relevant to the plan of care.			
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	30 April 2015	A timetable is in place since February 2015 where all staff have dedicated dates allocated in ward diary and supervision folder maintained by ward manager.
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 reviewed staff members competency, knowledge and skills	2	30 June 2015	Annual Appraisals have commenced in March 2015 and the majority of staff have now completed same with the exception of those staff on long term absence.
6	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.	2	30 June 1015	This is being addressed at Corporate level with the intention that the banking system for mental health facilities will be incorporated into the current secondary care dedicated bank office. Systems are processed for compliance with training and will be managed centrally. A proposal of a "training passport" is being considered for bank staff. This can be produced on request by ward

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
					managers to provide assurance that training relevant to facility is up to date.
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	30 June 2015	The DATIX system is in place which provides the ward manager with information in relation to reviewing of accidents, incidents and near misses which may influence ward practices. A Trust 'Shared to Learn' newsletter is published on the Trust Intranet site and available for staff to access. The ward manager can also request specific trends analysis for their ward to review and monitor ward practices. Lessons learnt following SAI's and near misses are a standing agenda item at staff meetings and also through the ward safety brief.
8	5.3.2 (c)	It is recommended that the Trust ensure thal 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	30 June 2015	These are tabled at ward managers meetings and learning/recommendations are cascaded to team members through safety brief and staff meetings.
9	8.3 (b)	It is recommended that the ward manager ensures staff meetings are	1	Immediate	The dates are arranged for staff meetings for the calendar year 2015 and are entered into ward diary. Minutes of

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		held on a regular basis.		and ongoing	meeting are shared with all staff.
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	30 April 2015	The ward manager will ensure that patients' capacity to consent to care and treatment is clearly documented in the patients care records detailing the specific area assessed. This will include reference to care planning decisions made by, or on behalf of, the patient.
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	Immediate and ongoing	This will be audited through the NIPEC audit tool and any non-compliance addressed by the ward manager with relevant individual staff member. The full implementation of the Integrated Care Pathway (ICP) is multidisciplinary and the MDCC template will be completed at all ward rounds.
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	1	Immediate and ongoing	The ward manager will ensure that initial assessments are 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 and if they refuse this will also be recorded

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
		asked to sign their assessments and if they refuse this should also be recorded with the reason why.			with the reasons why. This will be regularly audited by ward manager and non-compliance addressed by ward manager and 6 monthly NIPEC validation audit completed by Lead Nurse.
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	Immediate and ongoing	The ward manager will ensure that all sections of the patients' assessments are completed in full. This will be audited through the NIPEC audit and random sampling done by ward manager. Non-compliance will be addressed with individuals by ward manager. The full implementation of the ICP will ensure full compliance.
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	Immediate and ongoing	The ward manager will ensure that when assessments are completed indicating a specific need/problem area, a care plan will be completed for each assessed need indicating how this will be managed and reviewed on the ward. This will be audited through the NIPEC audit and random sampling by ward manager. Non-compliance addressed with individuals by ward manager. 6 monthly validation audit completed by Lead Nurse. The full implementation of the ICP will ensure compliance.

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
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	Immediate on ongoing	The ward manager will ensure patient care plans are implemented. Care Plans will be regularly reviewed and where possible will evidence patient involvement or a reason will be recorded if patient declines to sign.
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	Immediate and ongoing	The ward manager will ensure that the Trust's Patient Observations Policy and Procedure is implemented. This will include the completion of appropriate records.
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	Immediate and ongoing	The ward manager will ensure all nursing care plans are reviewed regularly. Multidisciplinary team decisions regarding changes in care plans will be documented with the involvement of the patient or where appropriate carer/family.
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	Immediate and ongoing	The ward manager completes monthly audits of the patients' care records, the ward manager will ensure that all staff follow the same approach when recording.
19	5.3.1 (f)	It is recommended that the ward		31 March	A draft risk assessment and care plan is in place for the use

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 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.		2015	of profiling beds. This will be tabled for approval at PCOP Directorate Governance meeting prior to full implementation. Safety alerts are made available on the ward which staff have to sign that they have read and implement recommendations. Also an agenda item on staff meetings.
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 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.	1	Immediate and ongoing	The ward manager will ensure that when a patient is assessed as requiring a profiling bed a risk assessment will be completed. The risk assessment will be 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	1	31 May 2015	The ward manager will review recovery focused care planning with Head of Service and Lead Nurse for Older

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
		activity/therapeutic plan in place.			Peoples Mental Health to facilitate the implementation of this model. Dedicated ward activity co-ordinator works closely with Occupational Therapy who have in place activity / therapeutic plans for each patient. The Trust will be seeking an extension to the timescale to the 30 September 2015 to fully implement this recommendation.
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	30 June 2015	The ward manager will ensure that information with regard to patients' rights is available in an easy read format to ensure all patients' understand this process.
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	Immediate and ongoing	The ward manager will ensure that staff and patients are aware of the advocate's timetable for visiting the ward and contact details. This information will be displayed throughout the ward. Notices already displayed clearly on the ward.
24	4.3 (m)	It is recommended that the ward manager ensures that all staff have up to date mandatory training completed which includes fire training, MAPA training and moving	1	30 June 2015	The ward manager will ensure that all staff have up to date mandatory training completed which includes fire training, MAPA training and moving and handling training. However, the Trust is currently working with the Clinical Education

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
		and handling training.			Centre to facilitate additional MAPA training as capacity exceeds demand for this training. The timescale for the recommendation is not achievable and Trust will be requesting an extension to 30 September 2015.
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	Immediate and ongoing	The ward manager will ensure that all discharge records are completed in a timely manner prior to the patients' discharge. This will include a completed multidisciplinary discharge plan in accordance with Trust policy and procedure.
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	Immediate and ongoing	The ward manager will ensure that all staff are aware of the policy and procedure in relation to discharge planning arrangements.
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	1	30 June 2015	The Trust has completed a skill mixed review of the staffing arrangements on the ward which resulted in additional staffing compliment , however due to the high level of absenteeism to ensure patient safety Bank staff has had to

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
		on a regular basis.			be utilised. Absenteeism is being managed through Trust policies and recruitment process ongoing for replacement staff.
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. Details of this action plan should be forwarded to RQIA by 24 April 2015	1	24 April 2015	The Trust has completed a ligature risk assessment of the ward. Minor Capital works forms have been completed for works to be prioritised and carried out.
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	24 April 2015	The ward manager will ensure that a risk assessment /care plan is completed for each individual patient which will detail how risks are going to be managed and reviewed to ensure patient safety.
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	31 June 2015	The Trust will review 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.

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	Elaine Hay

Inspector assessment of returned QIP		Yes	No	Inspector	Date
A.	Quality Improvement Plan response assessed by inspector as acceptable		X	AMcLellan	11/5/15
B.	Further information requested from provider	X		AMcLellan	11/5/15

T/C with Paula Casey re: Recommendations 2, 21, 24, 28, E-Mail sent also to advise that QIP will need to be amended and returned to RQIA by 31/May/2015.