Inspection Report

22 August 2022 – 16 September 2022

Western Health and Social Care Trust
Oak Ward and Ash Ward
Tyrone and Fermanagh Hospital
1 Donaghanie Road
Omagh
BT79 ONS
Tel No: 028 8283 3100

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Western Health and Social Care Trust (WHSCT)	**Registered Manager:** Mr. Neil Guckian Chief Executive Officer; WHSCT
Person in charge at the time of inspection: John Paul McGinley, Assistant Director, Older Persons Mental Health Services, WHSCT	**Number of registered places:** There are two wards operating within Tyrone and Fermanagh Hospital Oak ward: 10 beds Ash ward: 10 beds
Categories of care: Acute Mental Health	**Number of patients accommodated on the on the day of this inspection:** 19
Brief description of the accommodation/how the service operates: Tyrone and Fermanagh Hospital (the hospital) is a Mental Health Hospital (MH) managed by the Western Health and Social Care Trust (the Trust). Oak ward and Ash ward are situated within the Tyrone and Fermanagh Hospital site and provide inpatient care to older persons aged 65 and over in an acute psychiatric care setting. Oak Ward provides assessment and treatment to patients aged over 65 who have a functional mental illness and Ash Ward provides assessment and treatment to patients with a diagnosis of dementia. There are therapeutic hubs situated on both wards which offer patients access to recreational and therapeutic activities. Patients are admitted to Oak and Ash wards either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).	

2.0 Inspection summary

An unannounced inspection commenced on 22 August 2022 at 09:00 and concluded on 16 September 2022 with feedback to the Trust's senior management team (SMT).

The inspection focused on eight key themes including adult safeguarding (ASG) and incident management, staffing, environment, restrictive practice, care records, physical health, resettlement and discharge planning and governance/leadership.

Areas of good practice were identified. We observed staff deliver compassionate care to patients and found patient mealtimes to be well coordinated with a peaceful and relaxed ambience. Effective governance arrangements were in place with respect to adult safeguarding referrals, care records, complaints, safety huddle meetings and the use of PRN medications.

This inspection also sought to assess progress made against five areas for improvement (AFI) which were identified following the most recent inspection of Oak ward on 15 November 2017, and two AFI which were identified following the most recent inspection of Ash ward on 13 August 2018. AFI were assessed as met, partially met or not met.

Eight new AFI have been stated for the first time and are included in the Quality Improvement Plan (QIP).

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. To do this we gather and review information we hold about the service, examine a variety of relevant records, meet and talk with staff and management, observe practices throughout the inspection and engage with patients and relatives.

Our reports reflect how the service is performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

4.0 What people told us about the service

Posters were placed in both wards to inform staff, patients and relatives that an inspection had commenced and to invite them to approach the inspection team with any feedback they may have.

We gathered the views of patients, relatives and staff through questionnaires and from speaking to them.

Feedback was generally positive and all responses indicated that people were happy with the service provided.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since the last inspection?

The most recent inspection to Oak ward was undertaken on 15 November 2017 and five areas for improvement were identified. The most recent inspection of Ash ward was undertaken on 13 August 2018 and two areas for improvement were identified at this time.

A QIP was issued to both wards. Progress towards achieving compliance with the combined seven AFI identified during these inspections, was assessed. Our findings are as follows:

Areas for improvement from the last inspection of Oak on 15 November 2017		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).		**Validation of compliance**
Area for Improvement No. 1 **Ref:** Quality Standard 6.3.2 (a) **Stated:** Second time **To be completed by:** 29 May 2018	In an adjoining room to the ward which was used as an activity room the Velux window was broken (it would not open). **Action taken as confirmed during the inspection**: The Velux window had been repaired and was fully operational using a remote control. This AFI has been met.	**Met**
Area for Improvement No. 2 **Ref:** Quality Standard 6.3.2(g) **Stated:** Second time **To be completed by**: 29 December 2017	Minutes of the patient forum meetings did not evidence that action had been taken to address issues raised at the previous monthly meeting. Patients' average stay on the ward was 51 days however the patient forum meetings were held on a monthly basis. **Action taken as confirmed during the inspection**: Patient meeting records were available with action plans completed. This AFI has been met.	**Met**
Area for Improvement No. 3 **Ref:** Quality Standard 4.3(j) **Stated:** Second time **To be completed by**: 29 May 2018	The consultant psychiatrist was working on the ward as a locum. There was no permanent consultant on the ward for some time. **Action taken as confirmed during the inspection**: The consultant psychiatrist continues to work on a locum basis. However, the same psychiatrist has been in post for the last eight years therefore providing consistency and continuity of care. This AFI has been met.	**Met**

Area for Improvement No. 4 **Ref:** Quality Standard 5.3.1(a) **Stated:** First time **To be completed by**: 29 February 2018	A procedure for the completion of comprehensive risk assessments for patients admitted to the ward was not available. The procedure should identify if the acute care team or a community team is responsible.	**Met**
	Action taken as confirmed during the inspection: All patients had completed comprehensive risk assessments in their Integrated Care Pathway (ICP) which detailed the involvement of relevant MDT professionals. This AFI has been met.	
Area for Improvement No. 5 **Ref:** Quality Standard 5.3.1(a) **Stated:** First time **To be completed by**: 28 February 2018	A staff member from older people's community care team(s) did not attend the ward's weekly multi-disciplinary meeting.	**Met**
	Action taken as confirmed during the inspection: All relevant MDT professionals attended the weekly MDT meeting for their respective patients. This AFI has been met.	

Areas for improvement from the last inspection of Ash on 18 August 2018		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).		**Validation of compliance**
Area for Improvement No. 1 **Ref: 5.3.1 (a)** **Stated:** First time **To be completed by:** 15 February 2019	A number of Trust policies relevant to the ward required review. **Action taken as confirmed during the inspection**: We evidenced that a number of policies and procedures had been updated and a number were under review. The review and updating Trust policies and procedures is the responsibility of the WHSCT and not specific to directorate. We raised this with SMT at feedback to the Trust and received assurances that out of date policies were under review. This AFI has been met.	**Met**
Area for Improvement No. 2 **Ref: 5.3.1 (f)** **Stated:** First time **To be completed by:** 15 February 2019	The ward required access to Wi-Fi. **Action taken as confirmed during the inspection**: The Trust has provided Wi-Fi throughout both wards. This AFI has been met.	**Met**

5.2 Inspection findings

5.2.1 Adult Safeguarding and Incident Management

The Adult Safeguarding (ASG) arrangements for both wards were reviewed. ASG is the term used for activities which prevent harm from taking place and which protects adults at risk where harm has occurred or is likely to occur without intervention.

We found staff had good understanding/knowledge and were clear about what constituted an ASG incident. A small number of referrals made to the ASG team were completed in accordance with policy and procedure.

A review of Datix (Datix is the Trust's electronic system for recording incidents) records identified that incidents had been graded correctly, consistently and escalated to SMT when appropriate.

Staff training records in relation to ASG highlighted that training was not up to date. We were informed that a small number of middle managers had recently attended ASG training in line with their roles and responsibilities. The role of ASG champion was not identified on either ward. We recommend that the Trust expedite this training for all staff without further delay. An area for improvement has been identified.

5.2.2 Staffing

Staffing numbers should be calculated using an evidence based staffing tool. This will establish the number of staff required to ensure the safe and effective care delivery of each shift. The calculations are based on individual patient need and considers levels of support required. This contributes to the delivery of safe and effective patient care.

Staffing arrangements on Oak and Ash wards were reviewed. In the absence of a robust staffing model a determination could not be made in relation to what constitutes a safe staffing level. This matter was raised with the SMT who confirmed two staffing models were being considered at the time of the inspection. The Trust is encouraged to complete this review process with implementation of a suitable staffing model that will guide the provision of safe staffing levels for patients on the wards.

We noted staffing levels were good on both wards during the inspection and met the needs of the patients. Staffing shortages were appropriately escalated and through the Datix reporting system.

Feedback from staff indicated that the wards are staffed for the level of patient acuity and are supported by ward managers at times when they are short of staff however, it is unclear due to the lack of a staffing model, how the Trust establish safe staffing numbers.

An area for improvement has been identified in that the Trust needs to develop an evidenced based staffing model for Oak and Ash wards taking into account patient's acuity.

5.2.3 Environment

We visited each of the wards to review and assess if the environment was safe and conducive to the delivery of safe, therapeutic, compassionate care and to determine if it was suitable in meeting the assessed needs of the patients accommodated.

We found the wards were bright and spacious and patients were observed to move freely around the ward space. Décor was of an acceptable standard on both wards. Staff and patients raised concerns about the temperature of the ward being too warm. We recommend that the Trust review temperature regulation of the wards. We observed equipment was being stored inappropriately in patients sleeping areas and activity rooms. We advised staff to move this equipment to a more appropriate space. We will review the environment during our next inspection.

We observed good practice in relation to dementia friendly décor throughout Oak ward and Ash ward. Patient bedroom doors were similar to a standard front door of a house in the community. Signage for each area was displayed in written and pictorial form.

The standard of environmental cleanliness was better in Ash ward than in Oak ward. A recommendation was made to the SMT to address this deficit through provision of additional cleaning resource for Oak ward.

There was limited evidence of effective governance arrangements in relation to environmental walk arounds of the wards and staff confirmed that whilst managers visit the wards, a record of the managers' observations and any action arising was not maintained.

The patient dining experience was well coordinated and there was a peaceful and relaxed ambience. Dining room tables had a variety of condiments available for patients.

The Fire Risk Assessment (FRA) and the associated action plan were available but not all the actions had been completed within the stipulated timeframe. We recommend that the SMT review and action as appropriate. Personal Emergency Evacuation Plans (PEEPs) had been completed. During the inspection we observed fire doors were wedged open. This practice was brought to staff attention during the inspection and was dealt with promptly. We also noted not all staff had received up to date fire training, an action that was also identified on the FRA. An area for improvement has been identified in relation to fire safety.

Some of the entrance doors in Oak ward were not robust and presented as a risk to patients who could leave the ward without staff knowledge. In recognition of incidents that have occurred due to this risk, this concern was escalated with SMT. It was positive to note that the external door to the ward was altered to enable a more robust system for entry and exit to the ward. The internal doors were repaired where possible and a schedule of work was agreed with the SMT to complete the outstanding works. This matter was promptly responded to and addressed while the inspection team remained on site. An area for improvement has been identified in relation to patient safety.

Plastic bags were available in the bins throughout the ward despite visitors being asked not to bring plastic onto the wards. This was not in line with the Mental Health (MH) inpatient wards and Strategic Planning and Performance Group (SPPG) and Learning Matters Quality 2020 Issue 8, September 2018. We recommend the Trust liaise with Infection Prevention Control (IPC) team colleagues to agree on a suitable alternative that mitigates the risk associated with plastic. An area for improvement was identified in relation to accessible plastic on the wards.

The most recent Ligature Risk Assessment (LRA) raised concerns. During a walk round of the environment several ligature risks were highlighted, some of which were not noted on the ligature risk assessment. We recommend the Trust completes a further review of the LRA with view to including the additional ligature risks identified during the course of this inspection. These concerns were raised with SMT at the time of the inspection and assurances were given that action would be taken to address the concerns raised. An area for improvement has been identified in relation to ligature risk assessments.

The inspection team noted that the emergency trolley and medication trolley on Oak ward were not secured in the clinical room when not in use. This was highlighted to nursing staff and both were moved and secured in the clinical room.

We recommend communication in relation to this finding is shared with all nursing staff as a reminder to secure both trollies in accordance with Trust policy for the storage of medicines. We will review this on the next inspection.

We visited the therapeutic area of Ash ward and evidenced a 'tover tafel' available for patient use. This piece of electronic equipment helps patients with cognitive challenges engage in purposeful activity. Feedback received from staff indicated that patients enjoyed using this system.

5.2.4 Restrictive Practice

We noted that the majority of patients on Oak ward and Ash ward were detained in hospital under the provisions of the MHO. Restrictive practices identified included locked doors and bed rails. All restrictions had been assessed and were found to be proportionate to the risk and regularly reviewed at Multi-Disciplinary Team (MDT) meetings.

There were no patients on Oak ward or Ash ward that required enhanced observations at the time of the inspection.

Voluntary patients had Deprivation of Liberty safeguards (DoL's) in place and human rights considerations were documented within care plans in relation to the locked doors. Regular review arrangements were in place.

Records reviewed evidenced where appropriate bed rail assessments and care plans were in place.

On review of medication kardexes we noted that the administration of as and when required medication was used as a last resort and after all other distraction techniques had been attempted and were unsuccessful. Review of medication kardexes evidenced first line and second line medications were used appropriately.

5.2.5 Care Records

We reviewed the quality of record keeping in relation to patients' care and treatment. Each patient had an Integrated Care Pathway (ICP) booklet containing written records and also an electronic care record (PARIS). Care records were organised and completed contemporaneously. Risk assessments were up to date for the patients on the ward.

Records reviewed evidenced that patients had been seen by medical staff within six hours of admission. Individual patient records included evidence of cognitive examination and patient care plans were found to be personalised and relevant with evidence of review at weekly MDT meetings.

We noted good practice in relation to oversight of the MHO for each patient detained. A summary sheet was in place for each patient and clearly identified when review was due.

Staff displayed effective understanding and knowledge of patients' needs and demonstrated excellent skills when caring for patients. Staff were highly commended for the standard of care delivery.

5.2.6 Physical Health

The management of patients' physical health care needs was reviewed and confirmed that patients' physical health needs were being well addressed. Physical health care was monitored, reviewed and referred to Primary Health Care appropriately.

Access to medical staff was good and there were clear arrangements for patients to access the Consultant Psychiatrist. One junior doctor was also available five days per week. Weekly MDT meetings were held for each patient and ICP records completed to reflect a summary and actions agreed.

Patients had been appropriately referred and assessed by Speech and Language Therapy for eating and drinking and individualised dysphagia guidelines were in place. Patients were supported by staff to eat and drink in accordance with individualised Speech and Language Therapy assessments. We highlighted some concerns in relation to the inaccurate recorded levels on the patient menu of assessed diet levels assessed by SALT. Following discussions with nursing and catering staff we were assured that patients were receiving the appropriate level within the International Dysphagia Diet Standardisation Imitative (IDDSI).

The inspection team noted good practice in relation to pathways regarding the use of The Malnutrition Universal Screening Tool (MUST) a screening tool used to identify adults, who are malnourished, at risk of malnutrition (undernutrition).

It was positive to note that patients' fluid and nutritional needs were well addressed with the option within their SALT recommendations for levels of diet depending on their psychological and physical state. It was pleasing to observe patients being given several choices in relation to food and drinks options.

Braden scales (in relation to care of pressure areas), Suspected Deep Tissue Injury (SDTI) in relation to pressure areas, wound charts and National Early Warning Score (NEWS) a tool used for identifying acutely ill patients. Records relating to pressure area care and wound management were satisfactory and appropriate referrals were made to the Tissue Viability Nurse (TVN).

5.2.7 Resettlement/Discharge Planning

We were advised by SMT that discharge planning can be difficult due to complexity of patient need.

Patient flow data provided for inspection was inaccurate and not consistent with the profile of patients on the wards. Patients delayed in their discharge were not reflected in the data recorded by the Trust. Inspectors were unable to determine accurate information in relation to patient length of stay. The inspection concluded that governance oversight of patient flow requires improvement.

An area for improvement has been identified in relation to resettlement/discharge planning and patient flow data.

5.2.8 Governance and Leadership

Older person's psychiatry within the Trust is split between two different directorates which presents challenges in terms of resource allocation and interfaces. We were assured however that a review of this approach is underway within the Trust. Progress will be reviewed at the next inspection.

We were pleased to note that learning from a previous RQIA inspection of Waterside Ward 1 and Ward 2 had been effectively shared with Oak ward and Ash ward.

We observed a Trust wide, daily safety huddle meeting which operates as a 'call in' meeting each morning and is attended by all ward managers, nurse leads, medical staff, Head of Service and the Assistant Director. We found this to be an effective communication platform.

As previously noted in this inspection report, the inspection team were unable to evidence effective governance arrangements in relation to environmental walk arounds of the wards. Whilst staff informed the inspection team that members of the SMT were regularly visible on the wards and were very supportive to staff, we could not find formal evidence of this or assurances that the visits were focused on quality improvement audits.

We reviewed the mandatory training records and noted they were not up to date. This included ASG training for all staff, fire and other relevant training. An area for improvement has been identified in relation to mandatory training.

A process for recording complaints was evidenced to be in accordance with the Trust's policy and procedures and complaints received since the last inspection were managed in line with policy.

Staff provided the inspection team with the most recent staff meeting minutes and the agenda discussed. Staff gave assurances that the agenda items listed were discussed in length and staff were given the opportunity to contribute to the discussion.

An area for improvement has been identified to strengthen existing governance and leadership arrangements.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

	Regulations	Standards
Total number of Areas for Improvement	0	8

Areas for improvement and details of the QIP were discussed with the SMT and estates team as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)	
Area for improvement 1 **Ref:** Standard 4.1 **Criteria:** 4.3 **Stated:** First time **To be completed by:** 28 February 2023	The Western Health and Social Care Trust must implement an evidence based staffing model to determine staffing levels which must address patient acuity and the changing needs of patients. Ref: 5.2.2
	Response by registered person detailing the actions taken: The Trust is currently reviewing staffing levels through Phase 5A Delivering Value with normative staffing. SMT are liaising with regional colleagues in relation to effective acuity tools/dependency tools being used within similar service provision.
Area for improvement 2 **Ref:** Standard 5.3 Criteria 5.3.1 **Stated:** First time **To be completed by:** 30 November 2022	The Western Health and Social Care Trust must ensure that compliance with fire safety measures, are continually reviewed and assessed by the Trust's fire safety advisor(s) with assurances provided that all risks are being managed safely. Ref: 5.2.3
	Response by registered person detailing the actions taken: An updated fire risk assessment has been carried out by the Trust's Fire Safety Officer. Ward Sister will assure monthly checks within the Fire Safety Manual are maintained and any concerns are escalated and addressed in a timely manner. Ward Sister will maintain effective communication with Fire Safety Officer in relation to any identified concerns and will escalate any concerns through senior management and other avenues of escalation.
Area for improvement 3 **Ref:** Standard 5.1 **Criteria:** 5.3.1 (f) **Stated:** First time **To be completed by:** 30 November 2022	The Western Health and Social Care Trust must ensure compliance with regional guidance of the use of plastic bags in Mental Health (MH) inpatient wards and Learning Matters Quality 2020 Issue 8, September 2018. The Trust need to have robust assurance mechanisms in place to ensure compliance with the guidance in conjunction with IPC team. Ref 5.2.3

	Response by registered person detailing the actions taken: A briefing paper has been developed for PCOPS Governance Committee Meeting for approval: Control measures for implementation: A risk assessment has been carried out in all OPMHS inpatient wards and therapeutic hubs in relation to plastic bag usage. This risk has been included in the ward safety brief and discussed at handovers. This Learning Matters will be shared with all ward staff and support services staff. All staff have responsibility to ensure these control measures are implemented and adhered to. This risk has been added to the ward risk register. Alternative means to reduce access to plastic bags are being explored to enhance safety. This includes considering enclosed safety bins which prevent access to the plastic bag within the bin and which will assist with compliance with IP&C and the needs of the patients. Patient information booklet will be updated in due course (stock) and in the interim an addition to the booklet will be included relating to plastic bags, requesting patients and relatives not to bring plastic bags onto the ward and advising plastic bags are a restricted item. Paper bags are available at ward entrances to transfer personal items. Plastic bags will only be used under supervision and will be kept locked away at all times. Posters to be developed for display on the wards. Consideration to be given to a Trust Policy on use of plastic bags across service areas and compliance with same. Monitoring of this risk will be daily by all staff/Ward Sister and by SMT during assurance visits.
Area for improvement 4 **Ref:** Standard 5.1 **Criteria:** 5.3.1 **Stated:** First time **To be completed by:** 30 November 2022	The Western Health and Social Care Trust must expedite the estates work to address safety issues identified in relation to external doors. Ref 5.2.3
	Response by registered person detailing the actions taken: Immediate works were undertaken by the Estate Services Department to address the safety concerns. Functionality assessments have been carried out by both RadioContact Ltd and KCC Group - assurances given by both assessments.

Area for improvement 5 **Ref:** Standard 5.1 **Criteria:** 5.3.1 **Stated:** First time **To be completed by:** 31 December 2022	The Western Health and Social Care Trust must ensure ligature risk assessments for both wards are up to date. An action plan should include clear timescales to determine when ligature points requiring removal or replacement will be completed. Ref 5.2.3
	Response by registered person detailing the actions taken: Ward Sister has updated the ligature risk assessment and an action plan has been developed. Quarterly reviews of risk assessments will be ongoing (or earlier if deemed necessary) and actions updated as addressed/completed. Risk assessments will be standing agenda items at ward meetings for discussion and updates. Ligature risk assessments will be factored into the annual health and safety risk assessments and monitored and updated on a regular basis.
Area for improvement 6 **Ref:** Standard 8.1 Criteria: 8.3 (i) **Stated:** First time **To be completed by:** Immediately	The Western Health and Social Care Trust must ensure that the information pertaining to patient admission and discharge is accurately reflected within patient flow documentation. Ref: 5.2.7
	Response by registered person detailing the actions taken: SMT have liaised with the Trust's Information Department. A daily rolling 3 day occupancy report for OPMHS inpatient wards is provided to SMT. A monthly occupancy report is provided for OPMHS inpatient wards is provided to SMT. SMT attend a daily Delayed Transfer of Care/Patient Flow meeting to promote discharge in a timely manner where possible. Discharge guidance is being developed for OPMHS inpatient wards to ensure that discharge planning is implemented in a timely manner, with the identification of roles and responsiblities. Delayed transfer of care meetings will be held for OPMHS inpatient wards with community teams to endeavour discharge in a timely manner and promote patient flow.

Area for improvement 7 **Ref:** Standard 4.1 and 5.1 **Criteria:** 4.3, 5.3.1 **Stated:** First time **To be completed by:** 31 January 2023	The Western Health and Social Care Trust must review governance oversight arrangements of Oak ward and Ash ward in relation to the environment. SMT should make a formal record evidencing all quality assurance visits and any actions arising from the visit. This record should be available on the ward and shared with relevant staff. Ref 5.2.8
	Response by registered person detailing the actions taken: An assurance template has been developed and assurance visits will be carried out by SMT. Following these visits, action plans will be provided to Ward Sister/Nurse in Charge to action any areas for improvement and these will be available on the wards.
Area for improvement 8 **Ref:** Standard 4.1 **Criteria:** 4.3 (m) **Stated:** First time **To be completed by:** 31 January 2023	The Western Health and Social Care Trust must ensure that all staff have completed all mandatory training appropriate to their roles and responsibilities. Ref 5.2.8
	Response by registered person detailing the actions taken: The training matrix used on the wards to record mandatory and desirable training has been reviewed by Ward Sister and updated accordingly. All staff have been provided with individual records of training that require updated. All staff are currently working towards completing any outstanding mandatory training. Mandatory training updates will be a standing agenda item on the Older People's Mental Health Service Governance Meeting - held fortnightly.

Please ensure this document is completed in full and returned via the Web Portal

The Regulation and Quality Improvement Authority

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