The Regulation and Quality Improvement Authority

Inspection Report

07 June 2022 – 30 June 2022

Western Health and Social Care Trust

Mental Health and Learning Disability Hospital
Waterside Ward 1 and Ward 2
Waterside Hospital
Gransha Park
Clooney Road
Londonderry
BT47 6WH
Tel No: 028 7186 0007

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)	**Responsible Individual:** Mr. Neil Guckian, Chief Executive Officer; WHSCT
Person in charge at the time of inspection: Nicola Hayes, Acting Head of Service, Older Persons Mental Health Services, WHSCT	**Number of registered places:** There are two wards operating within Waterside Hospital Ward 1: 10 beds Ward 2: 10 beds
Categories of care: **Acute Mental Health**	**Number of patients accommodated on the wards on the date of this inspection:** 20 patients

Brief description of the accommodation/how the service operates:

Waterside Ward 1 and Ward 2 are managed by the Western Health and Social Care Trust (the Trust) and sit within the Older Persons Mental Health Directorate. Both wards provide inpatient care to older persons aged 65 and over in an acute psychiatric care setting.

Ward 1 provides assessment and treatment to patients aged over 65 who have a functional mental illness and Ward 2 provides assessment and treatment to patients with a diagnosis of dementia.

Both wards are located within Waterside hospital. The 'Lorem Centre', a therapeutic hub situated between Ward's 1 and 2, offers patients access to recreational and therapeutic activities.

Patients are admitted to ward 1 or ward 2 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 of Ward 1 and Ward 2 commenced on 7 June 2022 at 09:00 and concluded on 30 June 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, environment, staffing, care records, governance, physical health, restrictive practice and resettlement/discharge planning.

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. Patients were fully supported by staff to eat and drink. Effective governance arrangements were in place with respect to complaints, safety huddle meetings and the use of as and when required medications.

This inspection also sought to assess progress made against twenty one areas for improvement (AFI) which were identified following the most recent inspection of Ward 1 on 12-13 June 2018 and five AFI which were identified following the most recent inspection of Ward 2 on 6-7 December 2017. AFI were assessed as met, partially met or not met.

The previous inspection of ward 1 was undertaken in 2018 and ward 2 in 2017. As a result the AFI were reviewed to determine if they were still applicable. One AFI was not applicable during this inspection.

Eleven AFI of which two have been stated for the second time and three which are subsumed into a new AFI 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 provide feedback. Electronic and hard copy questionnaires were also made available on the wards to encourage patients and their relatives to complete and return these to us. Four questionnaires received from patients indicated they were generally happy with the care provided. We did not receive any completed staff questionnaires.

We spoke with six patients, three relatives' and13 staff members including medical staff. All those spoken with were generally happy with the care provided.

5.0 The inspection

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

The most recent inspection to Ward 1 was undertaken on 12-13 June 2018 and 21 areas for improvement were identified. The most recent inspection to Ward 2 was undertaken on 6-7 December 2017 and five areas for improvement were identified at this time. A QIP was issued to both wards. Progress towards achieving compliance with the 26 AFI identified during both of these inspections, was assessed. Our findings are as follows:

Areas for improvement from the last inspection to Waterside Hospital Ward 1 on 12-13 June 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**: Standard 5.3.1 (f) **Stated:** Third Time	The medical staff had not completed the signature sheet in the Integrated Care Pathway (ICP).	**Met**
	Action taken as confirmed during the inspection: Following a change in process, medical staff are no longer required to make entries in the ICP record. There was evidence to validate significant improvement in relation to medical staff signatures within the Multidisciplinary Care Records (MDT). This AFI has been met.	
Area for Improvement No. 2	The medical records did not evidence that the patients were reviewed each week by the ward doctors.	**Met**

Ref: Standard 5.3.1 (f) **Stated:** Second Time	**Action taken as confirmed during the inspection**: Weekly review records evidenced that patients were seen each week by the Consultant Psychiatrist and/or ward doctor. This AFI has been met.	
Area for Improvement No. 3 **Ref**: Standard 5.3.1 (f)**Stated:** Second Time	The electroconvulsive therapy (ECT) care pathway documentation did not evidence that the patients were seen by the ward doctor after each ECT session.	**Met**
	Action taken as confirmed during the inspection: At the time of this inspection there were no patients receiving ECT. A retrospective review of patient records confirmed that patients who had been in receipt of ECT had received a medical review before and after their ECT treatment. This AFI has been met.	
Area for Improvement No. 4 **Ref**: Standard 5.3.1 (f) **Stated:** Second Time	Sections of the MDT template had not been completed by staff from the community team, the clinical psychologist or staff from the therapeutic hub.	**Met**
	Action taken as confirmed during the inspection: The weekly MDT record was completed by all disciplines attending the meeting. This AFI has been met.	
Area for Improvement No. 5 **Ref:** Standard 5.3.1 (f) **Stated:** First time	Signatures and designation of a number of the doctors were illegible.	**Met**
	Action taken as confirmed during the inspection: The records reviewed evidenced legible signatures and designations of doctors. This AFI has been met.	
Area for Improvement No. 6	Kardexes were not completed correctly by medical staff and they were of a poor standard. In some cases medications had no	**Met**

Ref: Standard 5.3.1 (f) **Stated:** First time	indications documented and minimum time intervals between dosages were not recorded.	
	Action taken as confirmed during the inspection: Patient's medication kardexes were completed to a good standard and included indications for administration and intervals between dosages. This AFI has been met.	
Area for Improvement No. 7 **Ref:** Standard 5.3.1 (f) **Stated:** First time	The MDT records reviewed did not always detail the input of everyone who was involved in the patients' care and treatment. The person responsible for implementing each action was not always recorded and in some records the plan of care was not included.	
	Action taken as confirmed during the inspection: The MDT record contained input from each discipline attending the MDT meetings who are involved in the patients care and treatment. This AFI has been met.	**Met**
Area for Improvement No. 8 **Ref:** Standard 5.3.1 (a) **Stated:** First time	One care record reviewed did not include a care plan for a patient who was receiving electroconvulsive therapy (ECT).	
	Action taken as confirmed during the inspection: At the time of this inspection there were no patients receiving ECT. A retrospective review of patient medical and nursing records confirmed that patients who had been in receipt of ECT had a respective care plan. This AFI has been met.	**Met**
Area for Improvement No. 9 **Ref:** Standard 5.3.1 (a) **Stated:** First time	Interim care plans had not been completed in two out of the three care records reviewed. In one record the doctor had not completed the assessment until three days after the patient had been admitted and the record of this assessment was incomplete.	**Met**

	Action taken as confirmed during the inspection: Full medical assessments were completed for patients in full on admission. This AFI has been met.	
Area for Improvement No. 10 **Ref**: Standard 4.3 (a) **Stated:** Second Time	The ward consultant psychiatrist does not have direct input into the older peoples' directorate governance meetings therefore old age psychiatry is not represented at these meetings.	**Met**
	Action taken as confirmed during the inspection: Discussion with the consultant psychiatrist confirmed that the invitation to attend Older Peoples Directorate governance meetings does not extend to include the ward consultant psychiatrist. However, the consultant psychiatrist is represented at other relevant governance meetings that support improvements for patients. This AFI has been met.	
Area for Improvement No. 11 **Ref**: Standard 4.3 (m) **Stated:** Second Time	The inspectors reviewed the wards training matrix and there were a number of deficits in staffs' mandatory training. Training dates had been organised for a number of training that was out of date for staff. However this had not been completed by the time of the inspection.	**Not applicable**
	Action taken as confirmed during the inspection: This AFI was made during the last inspection in 2018 and was not applicable to this inspection due to the timeframe that had lapsed.	

	A new AFI has been made as not all staff currently working on the ward had received up to date mandatory training.	
Area for Improvement No. 12 **Ref**: Standard 4.3 (j) **Stated:** Second Time	The ward's clinical psychologist has three ward based sessions however two are taken up with the MDT meetings and formulation/reflective practice meetings. This leaves only one session per week to meet with patients to complete therapeutic interventions. This should be reviewed.	**Not met**
	Action taken as confirmed during the inspection: SMT advised that recruitment for psychologists was unsuccessful. The Trust have put in place alternative arrangements to ensure patients have therapeutic interventions. This AFI has not been met and has been subsumed into a new AFI.	
Area for Improvement No. 13 **Ref:** Standard 4.3 (i) **Stated:** First time	The two televisions in the two communal rooms require to be boxed in as they are a ligature risk. This was not recorded in the health and safety assessment.	**Met**
	Action taken as confirmed during the inspection: The televisions in the communal areas were housed in fixed wooden structures which were anti-ligature. This AFI has been met.	
Area for Improvement No. 14 **Ref:** Standard 5.3.1(a) **Stated:** First time	In the three care records reviewed there was no evidence of psychological formulations to underpin care planning and inform relevant models of psychological interventions.	**Not met**
	Action taken as confirmed during the inspection: Psychological formulations were not evident in patients care records. SMT advised that recruitment for psychologists was unsuccessful. The Trust have put in place alternative arrangements to	

	ensure patients have therapeutic interventions. This AFI has not been met and has been subsumed into a new AFI.	
Area for Improvement No. 15 **Ref:** Standard 4.3 (b,d,e) **Stated:** First time	The inspectors reviewed minutes of staff meetings held on the ward. These were held every six months and did not include a set agenda to be discussed. The ward manager did not hold regular formal monthly meetings to ensure that staff are updated on relevant information regarding the ward and to give staff the opportunity to discuss issues relating to the ward.	**Not met**
	Action taken as confirmed during the inspection: Staff meetings are infrequent and ad hoc. There was no opportunity for staff to contribute to an agenda and the meeting minutes were insufficiently detailed. This AFI has not been met and has reworded and stated for the second time in the QIP.	
Area for Improvement No. 16 **Ref:** Standard 8.3 (a) **Stated:** First time	Patients and carers were asked to complete a survey regarding their experience of the ward when they were due to be discharged. However there was a very low return of these surveys. It had been agreed informally at the previous inspection that staff in the Lorem Centre would assist patients in completing this form however this has not commenced.	**Met**
	Action taken as confirmed during the inspection: Due to visiting restrictions during Covid-19 pandemic families were unable to complete surveys. However, there was evidence to support patient and family involvement at MDT/discharge planning meetings. This AFI has been met.	

Area for Improvement No. 17 **Ref:** Standard 4.3 (j) **Stated:** First time	The Trust had significant difficulty recruiting a permanent consultant psychiatrist to work on Ward 1 and were currently reliant on locum consultants. The consultant psychiatrist currently working on Ward 1 was a locum consultant who had been in post for six months and did not plan to stay long term. Therefore there was a risk that changes in consultant staff will result in a lack of continuity of care for patients in Ward 1. There was also no junior doctor currently working on the ward and staff had to rely on the support of a duty doctor.	**Met**
	Action taken as confirmed during the inspection: There was one consultant psychiatrist and two junior doctors dedicated to the hospital. There was evidence of continuity of care at medical level for patients across the hospital. This AFI has been met.	
Area for Improvement No. 18 **Ref:** Standard 4.3 (l) **Stated:** First time	Ward 1 falls under the Primary Care and Older Peoples' Directorate (PCOP) within the Western Health and Social Care Trust. The consultant psychiatrist's clinical lead was from a general adult medical background. The consultant psychiatrist did not receive clinical supervision or peer support from colleagues in old age psychiatry.	**Met**
	Action taken as confirmed during the inspection: The consultant psychiatrist received peer support from colleagues in the Older Peoples directorate and has access to psychiatry consultants. The consultant also attends various directorate governance meetings. This AFI has been met.	
Area for Improvement No. 19 **Ref:** Standard 5.3.2 (a) **Stated:** First time	A template is completed which details when a physical intervention is used on the ward. However this information is not collated and reviewed through the incident recording system (DATIX) so that staff can analyse trends and learn from incidents.	**Met**

	Action taken as confirmed during the inspection: We evidenced DATIX incident recording by staff each time physical interventions were used for patients. The DATIX system enables theming and trend analysis of incidents involving physical intervention. We reviewed templates on both wards which staff had completed following physical interventions. These completed forms were used to identify learning in relation to patient behaviours. This AFI has been met.	
Area for Improvement No. 20 **Ref:** Standard 5.3.1 (f) **Stated:** First time	There were a number of policies and procedures which had not been reviewed and updated. • Risk Management Policy - March 2014 • Incident Reporting - August 2014 • Policy on Prevention of Slips, Trips and Falls within WHSCT Facilities- February 2016 • Records Management Policy - November 216 • COSSH Policy - March 2014 • First Aid Policy - March 2014 • Fire Safety Policy - June 2014 • Policy for the Management of Patient Choice Related Discharge Across WHSCT Facilities- August 2014 • Policy for Self-Discharge Contrary to Medical Advice (CTMA)- April 2011 • Engagement and Supportive Observation Policy- December 2014	**Met**
	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 are under review. This AFI has been met.	
Area for Improvement No. 21 **Ref:** Standard 4.3 (j) **Stated:** First time	There was no longer pharmacy support on the ward to assist in reviewing prescribed medication and to complete medication reconciliation.	**Not met**
	Action taken as confirmed during the inspection: There was no pharmacy input aligned to the wards. Staff were able to avail pharmaceutical services by request. This AFI has not been met and has been stated for the second time.	

<table>
<tr><th colspan="2">Areas for improvement from the last inspection to Waterside Hospital Ward 2 on 6-7 December 2017</th><th>Validation of compliance</th></tr>
<tr><td colspan="3">The responsible person must ensure the following findings are addressed:</td></tr>
<tr><td rowspan="2">Area for Improvement No: 1

Ref: Standard 5.3.1 (a)

Stated: First Time</td><td>It is recommended that the Trust introduces a use of a physical intervention record. This record should record reasons why the intervention was necessary, the details of the staff involved and the outcome. A copy of the record should be retained in the patient's record. A further copy should accompany the associated incident report.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
An electronic template has been developed and is being used on both wards. Review of completed records evidenced that they included the necessary information.

This AFI has been met.</td></tr>
<tr><td rowspan="2">Area for Improvement No: 2

Ref: Standard 5.3.1(a)

Stated: Third Time</td><td>Risk assessments/management plans were not completed in accordance with the Promoting Quality Care–Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
There was evidence that risk assessments and management plans were completed in accordance with Promoting Quality Care-Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010.

This AFI has been met.</td></tr>
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Area for Improvement No: 3 **Ref**: Standard 8.3 (i) **Stated:** Second Time	All staff on the ward did not have access to the Epex system. Therefore they could not update risk assessments for patients on the ward.	**Met**
	Action taken as confirmed during the inspection: The Trust electronic record system (EPEX) has been changed to the PARIS system. All staff have access to the PARIS system. This AFI has been met.	
Area for Improvement No: 4 **Ref**: Standard 5.3.1(f) Stated: Second Time	The MDT template was not fully completed to detail decisions agreed, the responsible person for implementing agreed actions and the timeframe to complete the action plan.	**Met**
	Action taken as confirmed during the inspection: The MDT record contained input from each discipline attending the MDT meetings who are involved in the patients care and treatment and included the actions agreed and the timeframes for completion of these actions. This AFI has been met. .	
Area for Improvement No: 5 **Ref**: Standard 5.3.1(f) **Stated:** Third Time	It is recommended that the Trust provides evidence that the following policies and procedures have been disseminated and implemented to ensure there is a robust and evidence based guide for staff practice: • The Procedure for Recording Fluid Balance Chart. • The Absent Without Leave Policy.	**Met**
	Action taken as confirmed during the inspection: There was evidence that staff had knowledge of and were implementing the procedure for recording fluid balance charts. Patient fluid balance charts were recorded contemporaneously and accurately with appropriate actions taken as needed.	

	The Absent Without Leave Policy was available to all staff and displayed in the ward office environment. This AFI has been met.	

5.2 Inspection findings

5.2.1 Adult Safeguarding and Incident Management

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 could not evidence full compliance with regional adult safeguarding protocols, and there was no identified ASG champion. There was no Designated Adult Protection Officer (DAPO) aligned to the ward or identified ASG champion working on the wards.

Staff at ward level were unclear regarding what constituted an ASG incident and approximately 50% of staff did not have up to date ASG training. Middle and senior managers did not have the appropriate level of ASG training for their roles and responsibilities. This should be addressed as a matter of priority.

Only one incident had been referred to the ASG team during the previous five month period and staff at ward level were not aware of this referral. Records in relation to this referral were not retained at ward level.

The inspection team reviewed 314 Datix (Datix is the Trust's electronic system for recording incidents) forms, and identified that 10% of the incidents met the threshold for ASG; however, these referrals had not been made to the ASG team in line with ASG regional protocol and appropriate ASG protection plans put in place.

Adequate governance arrangements were not in place to support the identification of trends and themes and subsequent learning to drive improvement from all incidents. Furthermore, there was no evidence of a process implemented at ward or SMT level through Datix to ensure governance oversight and escalation. Some Datix forms were inconsistently and incorrectly graded and there is a risk of incidents not being escalated appropriately.

Concerns in relation to ASG and incident management were escalated to the SMT (during the inspection and at feedback). Assurances were sought that the SMT would prioritise ASG arrangements with a view to improving the current ASG practices. The SMT also committed to undertaking a look back exercise to determine if additional opportunities have been missed in relation to making appropriate ASG referrals. An AFI in relation to ASG has been made.

5.2.2 Staffing

The staffing arrangements in both wards were reviewed through the analysis of staffing rotas, discussion with staff, review of Datix records and observation of the number of staff on shift during the inspection.

A robust staffing model was not in place and made it difficult to determine that safe staffing levels are being achieved. Datix records highlighted staffing shortfalls on multiple occasions with 1:1 observations and evening shifts highlighted as particularly difficult to cover. Staff highlighted low morale amongst the staff team linked particularly to occasions when they were unable to adequately cover shifts and manage the patient acuity. An area for improvement has been identified that the Trust needs to develop a staffing model for Ward1 and Ward 2 taking into account patient's acuity.

Nursing students were found to be contributing to the daily staffing numbers and skill mix. For the duration of their placement nursing students must remain supernumerary.

Occupational Therapists (OT) and therapeutic assistants continue to provide therapeutic interventions for patients on both wards.

There was no evidence that referrals had been made to the Trusts psychology service. Access to this service would enhance patient care and treatment by supporting the delivery of evidenced based psychological interventions to support with the management of patient's complex behaviours and support with patient's discharge.

We suggest access to the psychology service would support staff to complete patient's psychological formulations where appropriate and further support with behaviour management. An area for improvement has been identified that the Trust needs to ensure that staff can refer patients where appropriate to the relevant Trust psychology service, based on patient's assessed needs. The trust should also consider some bespoke training for ward staff.

5.2.3 Environment

Ward 1 and Ward 2 environments were observed to determine if they were safe and conducive to the delivery of safe, therapeutic, compassionate care and met the assessed needs of the patients accommodated.

Good practice in relation to creating a dementia friendly environment was observed throughout the ward, dementia friendly signage is in place to assist with orientation.

Both wards were bright and spacious and patients were observed moving freely around. Décor was mostly good however some furniture was found to be in a poor state of repair. The standard of environmental cleanliness was good and there were no malodours. Representatives of the SMT committed to removing/replacing identified furniture items that were in a poor state of repair.

The patient dining experience was well coordinated with a peaceful and relaxed ambience. Patients were supported by staff to eat and drink as defined in their Speech and Language Therapy (SALT) assessment.

The Fire Risk Assessment (FRA) and associated action plan were available. Personal Emergency Evacuation Plans (PEEPs) had not been completed. We escalated this during the inspection to SMT representatives and following the inspection we received confirmation that PEEPs had been completed without delay for all patients.

Routine fire safety checks were not consistently completed and logged within the designated FRA folders and fire doors were observed to be wedged open. An area for improvement in relation to fire safety has been made.

Plastic bags were available in the bins throughout the ward despite laundry being returned in paper bags and visitors being asked not to bring plastic bags onto the wards. Wall mounted personal protection equipment stations were found to hold rolls of plastic aprons, which are a risk to patients. We recommend the Trust liaise with Infection Prevention Control 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) had been completed in April 2022 by Older Peoples Mental Health Management Team. Not all ligature risks were recorded in the LRA and there was no action plan to address the risks that had been identified. We were aware of actions that had been taken to address risks identified following a serious incident on the ward, however some staff lacked knowledge and understanding of the LRA. These concerns were raised with senior management at the time of the inspection and assurances were given that action would be taken to address our concerns. An area for improvement has been identified in relation to ligature risk assessments.

We were unable to evidence effective governance arrangements in relation to environmental walk arounds of the wards. Staff and manager discussion with inspectors confirmed that whilst managers visit the wards, a record of the managers' observations is not maintained. See section 5.2.8

5.2.4 Restrictive Practice

We noted that the majority of patients in Ward 1 and Ward 2 were detained in hospital under the provisions of the MHO. Restrictions included locked doors, enhanced patient observations, use of rapid tranquilisation and the use of physical intervention. All restrictions had been assessed and were found to be proportionate to the risk and regularly reviewed at the weekly MDT meeting.

Enhanced observations records reviewed highlighted that medical staff did not review all patients daily as directed by the Trust policy and not all patients had an enhanced observation care plan in place. We recommend that the Trust strengthen its governance arrangements in relation to the oversight of enhanced observations which includes the frequency of medical review. To ensure this restriction continues to be necessary and also to support with arranging required staffing levels.

We noted that 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.

We observed the use of specialist seating with a lap belt. This belt was applied to ensure patient safety when being moved/transported to another part of the ward. There was no care plan or direction for the use of the lap belt. This was highlighted with ward staff who agreed to put a care plan in place.

We noted the administration of as and when required medication was used a last report 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. We found that each patient had an ICP booklet containing written records and also an electronic care record (PARIS). We noted care records were organised and completed contemporaneously. Risk assessments were found to be up to date for patients on the ward.

There was evidence that patients had been seen by medical staff within 6 hours of admission or prior to transfer. Individual patient records included evidence of cognitive examination and patient care plans were found to be personalised and relevant with evidence of review at 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.

5.2.6 Physical Health

The management of patients' physical health care needs was reviewed. RQIA found that patient's 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. Two junior doctors were 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.

The inspection team noted good practice in relation to the use of The Malnutrition Universal Screening Tool (MUST) a screening tool used to identify adults, who are malnourished, at risk of malnutrition (undernutrition), Braden Scales (in relation to care of pressure areas), falls and National Early Warning Score (NEWS) a tool used for identifying acutely ill patients. Care plans were in place to address any risks identified in accordance with MUST, pressure area care and falls etc.

5.2.7 Resettlement/Discharge Planning

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

We reviewed the data provided to the inspection team on the day of the inspection and found patient flow information to be inaccurate. Patients delayed in their discharge were not reflected in the data recorded by the Trust. Inspectors were therefore unable to determine accurate information relating to patient length of stay. The inspection team 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

Old age psychiatry within the WHSCT 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.

Learning from inspection findings at neighbouring inpatient facilities within the Gransha site had not been effectively shared with the Older People's Mental Health directorate. This indicates there is a lack of effective communication at senior levels and across directorates within the Trust. This was addressed with SMT at Trust feedback and will be monitored through future inspections of inpatient mental health facilities in the WHSCT.

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, HOS 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 nor were we assured that the visits were focused on quality assurance audits.

The long term absence of the ward manager resulted in there being no on site managerial oversight on a day to day basis. We therefore recommend the Trust review the managerial cover at ward level to ensure adequate and sustainable arrangements are put in place.

We reviewed the records provided in relation to staff mandatory training and found they were not up to date. An area for improvement has been identified in relation to mandatory training.

A lack of oversight of incident management at SMT level raises concern in relation to shortfalls regarding incident analysis, identification of trends and theming. It was also identified that all queries relating to DATIX records had been made directly via an electronic incident management system, to an absent member of staff who had been selected by others as the incident handler. SMT representatives confirmed they were not aware of this deficit.

Adult safeguarding concerns identified during the course of the inspection were not known by the Trust's senior management representatives. This was escalated to the SMT during the inspection. We recommend that a look back exercise be completed to identify incidents of a safeguarding nature that should have been escalated and reported in accordance with regional safeguarding procedures. A copy of the findings from this look back exercise should be submitted to RQIA. All staff including SMT should complete ASG training as a matter of priority. An area for improvement has been identified. See section 5.2.1.

Audits of clinical records were undertaken infrequently. We recommend that clinical records audit processes be performed regularly to highlight improvement areas and should be coordinated and reviewed by management to achieve optimal results, with the aim of continuously improving patient care.

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.

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 Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

	Regulations	Standards
Total number of Areas for Improvement	0	11*

*The total number of AFI's includes two that have been stated for a second time and two that have been subsumed into new AFI.

Areas for improvement and details of the Quality Improvement Plan were discussed with the ward manager and SMT 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 Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006)

Area for improvement 1 **Ref:** Standard 4.3 (b,d,e) **Stated:** Second time **To be completed by:** Immediate and ongoing	The Western Health and Social Care Trust must ensure formal monthly staff meetings are convened to ensure staff are provided regular updates and are offered opportunity to raise and discuss matters in relation to day to day practice. Records should be retained on the ward for staff reference and for future inspection.
	Response by registered person detailing the actions taken: Ward Sister has developed a monthly schedule for staff meetings. The schedule has been shared with all staff. An agenda will be provided for every meeting and staff will be given the opportunity to add to every agenda. Minutes of every meeting will be taken, shared with staff and these will be kept on the ward for reference by staff/Senior Management/RQIA Inspection Team/other relevant personnel.

Area for Improvement 2 **Ref:** Standard 4.3 (j) **Stated:** Second time **To be completed by:** 28 February 2023	The Western Health and Social Care Trust must determine the requirement to have pharmacy support on Wards 1 and 2. This review should consider any impact on patient outcomes.
	Response by registered person detailing the actions taken: In consultation with the Consultant Pharmacist (Older People) an IPT is being developed to secure a Pharmacist and a Pharmacy Technician (WTE 1.25) across both Ward 1 & 2.
Area for Improvement 3 **Ref:** Standard 4.3 (j) **Stated:** First time **To be completed by:** 31 January 2023	The Western Health and Social Care Trust should ensure where appropriate staff can refer patients to the relevant Trust psychology service, based on patient's assessed needs. The trust should also consider some bespoke training for ward staff in relation to psychological formulating and care planning. Ref 5.2.2
	Response by registered person detailing the actions taken: Currently there is no commissioned Psychology resource within the older people's mental health inpatient wards. There is no access to psychological interventions for inpatients or their families. Referrals can only be made to Psychological Therapies upon discharge from the ward. There will continue to be no access to psychological formulation training or psychological formulations on the ward unless inpatient psychology is commissioned. Reconfiguration of the community Psychological Therapies service to provide permanent inpatient Psychologists using exisiting funding has not been approved by the senior management team. This will be raised for consideration once again. A recommendation regarding inpatient Psychology services has been raised for the third time. No inpatient Psychology provision can be made unless permanent funding for inpatient psychology is made available. When Psychology is commissioned back into the wards, formulation was be recommenced and formulation and care planning training in this area will be provided to staff.
Area for Improvement 4 **Ref:** Standard 4.3 **Criteria** 4.3 (m)	The Western Health and Social Care Trust must ensure that all staff currently working on the ward have received up to date mandatory training. Ref 5.2.8

Stated: First time **To be completed by:** 31 January 2023	**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 the 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.
Area for Improvement 5 **Ref:** Standard 5.3 **Criteria** 5.3.1 **Stated:** First time **To be completed by:** Immediate and ongoing	The Western Health and Social Care Trust must ensure that any increase in fire risk, is continuously reviewed and assessed by the Trust's fire safety advisor(s) with assurances provided that risk is 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 and NIFRS. Ward Sister will assure that 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 6 **Ref:** Standard 5.1 **Criteria**: 5.3.1(f) **Stated:** First time **To be completed by:** Immediately	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 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 that these control measures are implemented and adhered to. This risk has been added to the ward risk registers. 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 WHSCT 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 7 **Ref:** Standard 5.3 **Criteria:** 5.3.1 **Stated:** First time **To be completed by:** 30 November 2022l	The Western Health and Social Care Trust must ensure the ligature risk assessments for Waterside Ward 1 and Ward 2 are disseminated to all staff and includes an action plan. The Trust must also ensure that all staff have a working knowledge of the ligature risks and management. 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. Quaterly 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 8 **Ref:** Standard 5.3 Criteria: 5.3.1 **Stated**: First time **To be completed by:** 31 January 2023	The Western Health and Social Care Trust must: 1. Implement effective governance arrangements for adult safeguarding arrangements to ensure compliance with regional Adult Safeguarding guidance and addresses the following AFI: a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations; b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively; c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care; d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding are improved; e) ensure regular of adult safeguarding referrals and incidents; 2. Implement an effective governance process for oversight and escalation of matters relating to adult safeguarding in Wards 1 and Ward 2.

	3. Implement effective mechanisms to evidence and assure compliance with good practice in respect of Adult Safeguarding in the hospital. 4. Ensure that all staff including SMT have completed the appropriate level of ASG training for their roles and responsibilities. Ref: 5.2.1
	Response by registered person detailing the actions taken: The following has been developed to address this AFI: All staff have either been trained in Adult Safeguarding training or will be trained by early February 2023 (new staff have come into post since inspection). SMT will all have training completed by early February 2023. An Adult Safeguarding Flowchart has been devised and shared with all staff. Adult Safeguarding Champions for both wards have been identified and shared with all staff. All staff are aware of the process for accessing advice and resolution from ASGPT and/or the process for completion of APP1's. Protection plans are implemented following any identified concerns. All APP1's are screened by SMT prior to referring onto ASGPT. A guidance sheet has been provided to staff on the completion of Datix's. All DATIX's are discussed at MDT ward meetings. All DATIX's are reported through the morning huddles and any adult safeguarding concerns can be discussed at this forum. All staff are aware of their roles and responsibilies in relation to the adult safeguarding processs and in relation to commencement/continuation of protection plans. Initial protection plans accompany APP1 referrals. An Adult Safeguarding audit template has been developed in conjunction with CMHTOP DAPO. This audit template will be completed monthly by SMT and quarterly by CMHTOP DAPO. An Adult Safeguarding database has been developed and maintained on Sharepoint site, which will provide the status of each referral at any given point in time. A DATIX audit is completed monthly by SMT which will also provide assurances in relation to adult safeguarding concerns and referrals. Staff are provided with an audit summary which will identify trends and shared learning to prevent similar safeguarding concerns occurring. Adult Safeguarding is considered during assurance visits to the inpatient wards.

	Adult safeguarding is a standing agenda item at fortnightly OPMHS Governance meetings.
Area for improvement 9 **Ref:** Standard 4.1 **Criteria**: 4.3 **Stated:** First time **To be completed by:** 31 January 2023	The Western Health and Social Care Trust must implement a staffing model to determine staffing levels which must address patient acuity and the changing needs of patients. The Trust must also ensure nursing students are rostered as supernumerary while on ward placements. 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 liaison with regional colleagues in relation to effective acuity tools/dependency tools being used within similar service provision.
Area for Improvement 10 **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 Ward 1 and Ward 2 in relation environments. 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 all 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 11 **Ref:** Standard 8.1 **Criteria:** 8.3 **Stated:** First Time	The Western Health and Social Care Trust must ensure there are robust procedures in place for the safe and efficient discharge of patients from hospital care and patient flow within the ward. Ref: 5.2.7

To be completed by: Immediately	**Response by registered person detailing the actions taken:** SMT have liaised with the Trust's Informance 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.

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The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care