Unannounced Follow up Inspection Report
8-9 August 2017

Waterside 1,
Waterside Hospital,
Gransha Park,
Clooney Road,
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Inspectors: Audrey McLellan and Dr Shelagh Mary Rea

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Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Ward one is a ten bedded ward. The purpose of the ward is to provide assessment and treatment to male and female patients over 65 years. The multidisciplinary team (MDT) consists of a consultant psychiatrist, a junior medical doctor, a staff grade locum doctor, nursing staff, a clinical psychologist, an occupational therapist, a consultant pharmacist and health care assistants. Patients have access to speech and language therapy and physiotherapy through a referral system. An independent advocacy service is also available.

On the days of the unannounced inspection there were 10 patients on the ward. Two of these patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986. There was one patient receiving enhanced one to one support from staff. There were no patients delayed in their discharge from hospital.

3.0 Service details

Responsible person: Dr. Anne Kilgallen	**Ward Manager:** Yvette Birnie
Category of care: Over 65 functional mental health.	**Number of beds:** 10
Person in charge at the time of inspection: Yvette Birnie	

4.0 Inspection summary

An unannounced follow-up inspection took place over two days on 8-9 August 2017.

The inspection sought to assess progress with findings for improvement raised from the most recent previous unannounced inspection 9-13 November 2015. This inspection also assessed if Ward One was well led.

Inspectors noted that the ward had made improvements from the previous inspection. The call system had been replaced and reconnected with a new system so patients were now able to call for assistance if required. The ward had set up a therapeutic hub called the 'Lorem Centre' which was staffed with a fulltime OT, therapeutic nurse and a health care assistant. These staff members provided patients on ward one and two, with therapeutic activities to take part in each day this included group and individual sessions.

Areas for improvement were identified in relation to deficits in staffs' mandatory training. The inspectors were informed that the training matrix had not been updated with all the training dates that staff had attended. Therefore inspectors requested an updated training matrix to be sent to RQIA by16 August 2017. This was received however there were still a number of staff

who required their training to be updated. RQIA have requested progress reports to ensure all staff have their mandatory training completed.

The inspectors noted that patients were asked to complete a satisfaction survey before they leave the ward. However, there was a poor return of these surveys. The ward manager has agreed to ensure staff in the Lorem Centre take on the role of assisting patients in completing this survey prior to their discharge.

Areas for improvement were also made in relation to the consultant psychiatrist's attendance at governance meeting and the absence of medical records in patients' progress notes which detailed their progress and current mental health status. There were also concerns raised regarding the completion of the MDT template by all professionals and the availability of the clinical psychologist on the ward to provide therapeutic interventions.

Views of Patients

The inspectors spoke to three patients on the ward. Patients were very complimentary about the care and treatment they were receiving. Patients confirmed they knew who to speak to if they were unhappy and that staff were always available for them to talk to. Patients stated they were involved in their care and treatment and they felt safe on the ward. They confirmed there were activities on the ward for them to take part in each day and they stated that they felt these activities were very beneficial to their recovery. They advised that staff treat them with respect and always listened to their views and took these into consideration when planning their care and treatment. They confirmed that they attend their MDT meetings each week and they stated that all professionals at these meetings listen to their views and explain any changes in their care and treatment plans. One patient stated that they would prefer a sandwich at lunchtime as it was too much having two dinners in one day. This was discussed at the conclusion of the inspection with senior trust representatives who advised they will review the meal plans with the catering staff. Patients made the following comments:

"I was crying and the nurse came over to me…to help me…. she asked if there was anything she could do for me and stayed with me talking…before she left she said if I needed her throughout the night to ring the bell and she would come…it was good she recognised that I was feeling down and came straight away…….it helped her talking to me",

"Staff are very kind, helpful and caring….. the nurses do their very best to make everyone feel comfortable…they don't talk down to you",

"Staff are caring…...doctors are good. They are straight with you….food is great",

"Meetings are warm and not daunting…staff are quick to respond to you when you need help…nurses are friendly they can't do enough for you…….they did my hair today… there is always staff about to help you",

"I would like something lighter for lunch like a sandwich".

Views of relatives

There were no relatives available to speak with the inspectors on the day of the inspection.

Views of staff

Inspectors spoke to seven members of the multi-disciplinary team. Staff confirmed that they enjoyed working on the ward and stated they felt supported by the ward manager. Staff said the ward was safe and that the care and treatment was effective. Staff stated they had up to date supervision and appraisals in place. They confirmed that since the 'Lorem Centre' opened patients have been involved in more individual and group activities on and off the ward.

The consultant psychiatrist advised that the consultant psychiatrist for Ward Two had recently left their post and they were now covering both wards. They advised that the trust has advertised this position both regionally and nationally and have not been able to recruit either a permanent or locum consultant. The consultant psychiatrist confirmed that their job plan has been reviewed and at present they are not holding any clinics in the community which will inevitably cause waiting lists to increase. An area for improvement will not be made in relation to this as the trust has done everything within their power in relation to recruiting another consultant psychiatrist to the ward and are continuing to peruse this as a priority.

In relation to governance arrangements, the consultant psychiatrist stated they do not have direct input into the older peoples' directorate governance meetings and therefore they feel that that old age psychiatry does not have a voice. An area of improvement has been made in relation to this.

The lead clinical psychologist stated they had recently completed training with all nursing staff in relation to improving staffs' knowledge of evidence based practice and in completing psychological formulations to underpin care planning. They stated they currently have three ward based sessions however two are taken up with the MDT meetings and formulation sessions/reflective practice meetings with staff. This leaves one session available to meet with patients to complete therapeutic interventions. An area of improvement has been made in relation to this.

The consultant pharmacist advised they attend the MDT meetings each week. They review patients' medicine kardexes and give advice to the doctors in relation to the prescription of medication. They stated they felt the MDT worked well together.

The findings of this report will provide the trust with the necessary information to assist them to fulfil their responsibilities, enhance practice and service user experience.

4.1 Inspection outcome

Total number of areas for improvement	9

The total number of areas for improvement comprise:

- Three restated for a second time
- Six new areas for improvement

These are detailed in the quality improvement plan (QIP).

Areas for improvement and details of the QIP were discussed with the assistant director of primary care and older peoples' services and the ward manager as part of the inspection process. The timescales for completion commenced from the date of inspection.

5.0 How we inspect

The inspection was underpinned by:

- 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.

The following areas were examined during the inspection:

- Care documentation in relation to four patients
- Ward environment
- Activity timetable
- Policies and procedures relating to the ward
- Incidents and accidents
- Complaints
- Health and Safety assessments and associated action plans
- Minutes of senior management meetings
- Supervision and appraisal records
- Staff duty rota
- Mandatory training records
- Minutes of ward manager meetings
- Medicine kardexes

During the inspection the inspectors observed staff working practices and interactions with patients using a Quality of Interactions Schedule Tool (QUIS). All interactions observed between staff and patients were noted to be positive. Staff were observed sitting talking with patients, escorting patients out to the ward garden and providing them with assistance with their mobility when required. Staff were observed serving patients their meals and offering assistant when required. During all interactions patients were treated with dignity and respect by staff.

Areas for improvements made at the previous inspections were reviewed and an assessment of compliance was recorded as met/partially met and not met.

6.0 The inspection

6.1 Review of areas for improvement from the last unannounced inspection 9-13 November 2015

The most recent inspection of Ward One was an unannounced inspection. The completed QIP was returned and approved by the responsible inspector. This QIP was validated by inspectors during this inspection.

Areas for Improvement		Validation of Compliance
Number/Area 1 **Ref**: Standard 4.3(i) **Stated:** First Time	The ward had 7 profiling beds for patients who had a clinical need for this type of bed. Patients had a risk assessment completed in relation to the use of these beds. However there was no risk management plan in place for each patient as detailed in the safety alert issued on 23/12/13 by the Northern Ireland Adverse Incident Centre (NIAC) Estates Facilities Alert /2010/006 associated with profiling beds.	**Met**
	Action taken as confirmed during the inspection: The ward had four profiling beds and three of these beds were being used by patients during the inspection. One bed was stored in a side room. The inspector reviewed the three care records of the patients who were using profiling beds and there was evidence that risk assessments were in place and had been reviewed by staff. No risks were identified regarding the use of these beds by these three patients however this was kept under review.	
Number/Area 2 **Ref**: Standard	A generic health and safety assessment had been completed on 2 March 2015 with an action plan. However there were a number of areas in the	**Met**

5.3.1(f) **Stated:** First Time	action plan which needed to be completed/updated.	
	Action taken as confirmed during the inspection: The health and safety assessment had been reviewed and updated on 30 April 2017. This assessment included the actions that had been taken by the ward to ensure patients and staff were kept safe. There were no outstanding actions.	
Number/Area 3 **Ref**: Standard 4.3(m) **Stated:** First Time	Mandatory training was up to date. However three staff required up to date training in manual handling. Dates had been set on 17/11/15 and 10/12/15 for these staff members to attend training.	**Met**
	Action taken as confirmed during the inspection: In relation to manual handling the staff who required training at the previous inspection had received their training. However, there were another three staff at the time of this inspection who required up to date training in manual handling as the trust had recruited new staff to the ward. The inspectors reviewed the ward's training matrix for staff and there were a number of deficits in staffs' mandatory training therefore a new area of improvement will be made in relation to this.	
Number/Area 4 **Ref**: Standard 5.3.1(a) **Stated**: First Time	Personal safety plans/risk assessments were not completed in accordance with the Promoting Quality Care – Good Practice Management of Risk in Mental Health and Learning Disability Services May 2010.	**Not Met**
	Action taken as confirmed during the inspection: The inspector reviewed three risk assessments (two risk screening tools and one comprehensive risk assessment)	

	In one risk screening tool the section titled "*on inpatient admission – to be completed jointly by the admitting doctor and nurse in consultation with the family/carer/others (if in attendance)* was not completed. Therefore there was no record of who completed this risk screening tool. It also stated under the section on *further action necessary* that this patient would not be discussed with the Multi-Disciplinary Team which is incorrect as this patient has been discussed and reviewed by the MDT and the outcome was that a comprehensive assessment will now be completed. Weekly reviews were completed in the review section in both risk screening tools. The comprehensive risk assessment reviewed had no management plan or contingency plan in place. There was also no record of who completed this assessment. However, there was evidence that the level of risk was reviewed each week by the MDT. This area for improvement will be restated for a second time	
Number/Area 5 **Ref**: Standard 5.3.1(f) **Stated:** First Time	A number of policies and procedures had not been reviewed and updated for staff. These included the: • Disciplinary procedure September 2007. • Trip, slips and falls 2010. • The procedure for recording fluid balance charts 2010. • The integrated admission and discharge policy 2008. • The policy on the referral to NMC 2011. • The ward's operational policy.	**Partially Met**
	Action taken as confirmed during the inspection: The following policies had been reviewed and updated: • Disciplinary procedure 3 March 2016. • Policy for the Prevention of Slips, Trips and	

	Falls for Inpatients Within Western Health and Social Care Trust February 2016. • Functional Mental Health Unit for Older People Ward 1, Waterside Hospital, Londonderry December 2015. • Policy on the referral to a NMC 2017. • The integrated admission and discharge policy, May 2017 Information regarding patients' admission and discharge into the ward was included in the wards operational policy 2015. The procedure for recording fluid balance charts 2010 had not been reviewed and updated for staff. This area for improvement will be restated for a second time. It will be reworded to include the outstanding policy that requires to be reviewed and updated.	
Number/Area 6 **Ref**: Standard 5.3.1(a) **Stated:** First Time	The call system in the bathrooms and in the patients' bedded areas/bedrooms had been disconnected and therefore patients were unable to call for assistance if required.	**Met**
	Action taken as confirmed during the inspection: The trust had replaced the call system with a new system. This was available to patients in the bathrooms, bedrooms and bedded areas.	
Number/Area 7 **Ref**: Standard 5.3.1(a) **Stated:** First Time	The psychiatric medical section of the integrated care pathway (ICP) was not fully completed.	**Met**
	Action taken as confirmed during the inspection: In the three sets of care records reviewed there was evidence that the psychiatric medical section of the integrated care pathway (ICP) had been completed in full. However, the pharmacy section was not completed in each record. This was	

	discussed at the conclusion of the inspection with the senior trust representatives who advised that this section will be removed as the ICP is still in draft format.	
Number/Area 8 **Ref**: Standard 5.3.1(f) **Stated:** First Time	The signature of the doctor on a number of care records was unclear and did not detail the designation of the doctor. The medical staff had not completed the signature sheet in the ICP.	**Partially Met**
	Action taken as confirmed during the inspection: In the three care records reviewed by the inspectors there was evidence that the signature of the doctors were clear and detailed the doctors designation. However, there was no evidence that the doctors were completing the signature sheet on the ICP. This area for improvement will be restated and reworded to reflect the outstanding area for improvement.	
Number/Area 9 **Ref**: Standard 5.3.1(a) **Stated:** First Time	There was no evidence of assessments completed by occupational therapy (OT) as the OT had resigned from their post.	**Met**
	Action taken as confirmed during the inspection: The trust had recruited a fulltime Occupation Therapist (OT) to work in both ward one and two. The inspectors reviewed four records and there was evidence that assessments had been completed by the OT.	
Number/Area 10 **Ref**: Standard 5.3.1(a) **Stated:** First Time	There were limited therapeutic/recreational activities being carried out on the ward.	**Met**
	Action taken as confirmed during the inspection: The ward had set up a therapeutic hub called the	

	Lorem Centre. This opened from 9 a.m.-5 p.m. each day to provide patients on ward one and two with therapeutic activities to take part in each day. The unit was staffed with a fulltime OT, therapeutic nurse and a health care assistant. The Centre had a timetable in place which was changed each week depending on patients' individual needs and interests. A number of group and individual sessions held with patients. The following is a reflection of some of the activities held in the centre. Exercises/Relaxation, Green Therapy/Gardening, Reminiscence, Crocheting and Craic, Movie Club, Sensory Boxes, Paula's Parlour, Music and Memories, Walk and Talk, Stress Management, Talking Therapies, Anxiety Management and Coping with Emotions.	
Number/Area 11 **Ref**: Standard 5.3.3(b) **Stated:** First Time	Patient meetings were held however there was no clear evidence that the individual views and choices of patients had been considered. **Action taken as confirmed during the inspection**: Minutes of patient meetings reviewed by the inspector evidenced that patients' views and choices had been taken into consideration.	**Met**

6.1 Is the Service Well Led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

Areas of Good Practice

All staff who spoke to the inspectors knew what actions to take if they had concerns regarding the care and treatment of patients on the ward.

Governance arrangements were in place to monitor admissions, discharge, average length of stay on the ward and occupancy.

There was a defined organisational and management structure in place. Staff who spoke to the inspectors were aware of this structure and the recent changes in senior management and the chief executive of the trust.

There were appropriate systems in place to record and report incidents, accidents and serious adverse incidents.

Staff shortages were appropriately managed and continually reviewed.

Staff from the MDT who met with the inspectors confirmed they had up to date appraisals in place and received supervision in accordance with their professional guidance.

Staff who spoke to the inspectors stated they enjoyed working on the ward and stated they were well supported by their colleagues and the ward manager.

The ward had set up a therapeutic hub called the 'Lorem Centre'. This centre was staffed with a fulltime OT, therapeutic nurse and a health care assistant who arranged therapeutic activities for patients to take part in each day.

Governance arrangements were in place to monitor the prescription and administration of medication. There was a consultant pharmacist on the ward who attended the MDT meetings each week. They gave advice to the doctors in relation to the prescription of medication, reviewing medicine kardexes and were available to speak with patients.

Medicine kardexes reviewed by inspectors evidenced that medication was prescribed within British national formulary (BNF) guidelines and there was evidence of a low use of pro re nata (PRN) medications.

The lead clinical psychologist had completed training with all nursing staff in relation to improving staffs' knowledge of evidence based practice and in completing psychological formulations to underpin care planning.

Staff held weekly patient forum meetings.

Governance arrangements were in place to monitor the use of bank and agency staff.

It was good to note the ward was working on a number of quality improvement projects:

- Reviewing observation charts
- Lithium audit (regional)
- Improvement on management of ward rounds
- Reviewing documentation sent to GPs

Areas for improvement

The inspectors reviewed the wards training matrix and there were a number of deficits in staffs' mandatory training. Progress reports on mandatory training have been requested from the trust.

The 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.

The medical records did not evidence that the patients were reviewed each week by the ward doctors.

The electroconvulsive therapy (ECT) care pathway documentation did not evidence that the patients were seen by the ward doctor after each ECT session.

Sections of the MDT template had not been completed by staff from the community team, the clinical psychologist or staff from the therapeutic hub.

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.

7.0 Quality Improvement Plan

The responsible person must ensure that all areas for improvement identified within the QIP are addressed within the specified timescales. The responsible person should note that failure to comply with the findings of this inspection may lead to escalation action being taken.

7.1 Actions to be taken by the service

The QIP should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed provider compliance plan to RQIA for assessment by the inspector. by 4 October 2017**.**

Waterside Ward 1 Quality Improvement Plan	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** Standard 5.3.1(a) **Stated:** Second Time **To be completed by:** 6 September 2017	Personal safety plans/risk assessments were not completed in accordance with the Promoting Quality Care – Good Practice Management of Risk in Mental Health and Learning Disability Services May 2010.
	Response by responsible individual detailing the actions taken: Personal safety plans/risk assessments were reviewed and completed following the inspection. Staff have been reminded by the ward manager that the above need to be completed in line with PQC guidance. These will be monitored at the MDT meeting by the ward manager
Area for Improvement No. 2 **Ref:** Standard 5.3.1(f) **Stated:** Second Time **To be completed by**: 6 September 2017	The medical staff had not completed the signature sheet in the ICP.
	Response by responsible individual detailing the actions taken: The Assistant Director and Head of Service met with the consultant and advised regarding this area of improvement. The consultant has advised the medical staff that the signature sheet in the ICP must be completed. The ward manager will monitor during completion of routine NIPEC recordkeeping audits and the Head of Service will also monitor during required validation audits of same to review progress.
Area for Improvement No. 3 **Ref:** Standard 5.3.1(f) **Stated:** First time **To be completed by:** 6 September 2017	The medical records did not evidence that the patients were reviewed each week by the ward doctors.
	Response by responsible individual detailing the actions taken: This area of improvement has been shared with the consultant who has communicated to ward doctors that patient's notes must be updated following medical review each week in addition to MDT meetings
Area for Improvement No. 4 **Ref:** Standard 5.3.1(f)	The electroconvulsive therapy (ECT) care pathway documentation did not evidence that the patients were seen by the ward doctor after each ECT session.

Stated: First time **To be completed by:** 6 September 2017	**Response by responsible individual detailing the actions taken:** This has been shared and discussed with ward consultant. The consultant has confirmed that patients will be seen by ward doctor following ECT and prior to next ECT treatment. The consultant will review and monitor compliance with this area of improvement and weekly MDT meetings.
Area for Improvement No. 5 **Ref:** Standard 5.3.1(f) **Stated:** First Time **To be completed by:** 6 September 2017	Sections of the MDT template had not been completed by staff from the community team, the clinical psychologist or staff from the therapeutic hub
	Response by responsible individual detailing the actions taken: This area of improvement was raised with the MDT and action completed. To be monitored by ward manager and HOS when completing NIPEC audits and any noncompliance to be raised to appropriate level.
Area for Improvement No. 6 **Ref:** Standard 4.3 (a) **Stated:** First Time **To be completed by:** 1 November 2017	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.
	Response by responsible individual detailing the actions taken: The Directorate's Clinical Director attends the directorate's governance meeting. Any items which the psychiatrists or any medical staff from divisions within PCOP want raised or discussed can be tabled on their behalf or can request to attend. Minutes of Directorate Governance meetings are shared with all consultants. There are also quarterly management and consultant meeting where any governance concerns can be discussed which is attended by the Assistant Director, Head of Service and consultants. The Assistant Director will further discuss with the clinical lead.
Area for Improvement No. 7 **Ref:** Standard 4.3 (m) **Stated**: First time **To be completed by:** 1 November 2017	The inspectors reviewed the wards training matrix and there were a number of deficits in staffs' mandatory training. Progress reports on mandatory training have been requested from the trust.
	Response by responsible individual detailing the actions taken: This has been supplied to the inspector following the inspection by the ward manager. Some deficits remain due to courses not yet advertised or the demand outweighing the supply. This is

	continuously reviewed by the ward manager
Area for Improvement No. 8 **Ref:** Standard 4.3 (j) **Stated:** First Time **To be completed by:** 1 November 2017	The clinical psychology 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.
	Response by responsible individual detailing the actions taken: This area of improvement requires commissioner support for additional funding. The Trust will keep this under review.
Area for improvement No. 9 **Ref**: Standard 5.3.1 (f) **Stated:** Second Time **To be completed by:** 1 November 2017	The following policies had not been reviewed and updated for staff. • The procedure for recording fluid balance charts 2010.
	Response by responsible individual detailing the actions taken: The procedure for recording fluid balance charts continues to be worked on regionally. Brian McFetridge, assistant director in acute services in Altnaglevin, is the western trust representative on the regional group. This work remains ongoing.

Name of person (s) completing the QIP	Yvette Birnie		
Signature of person (s) completing the QIP		**Date completed**	25.9.17 & 8.11.17
Name of responsible person approving the QIP	Anne Kilgallen		
Signature of responsible person approving the QIP		**Date approved**	17.10.17
Name of RQIA inspector assessing response	Audrey McLellan		
Signature of RQIA inspector assessing response		**Date approved**	10/11/17

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