# Mental Health and Learning Disability Inpatient Inspection Report
# 12 -13 June 2018

**Waterside 1,**
**Waterside Hospital,**
**Gransha Park,**
**Clooney Road,**
**Londonderry**
**BT47 6WH**

**Tel No: 02871 860007**

**Inspectors: Audrey McLellan and Dr Brian Fleming**
**Lay Assessor: Alan Craig**

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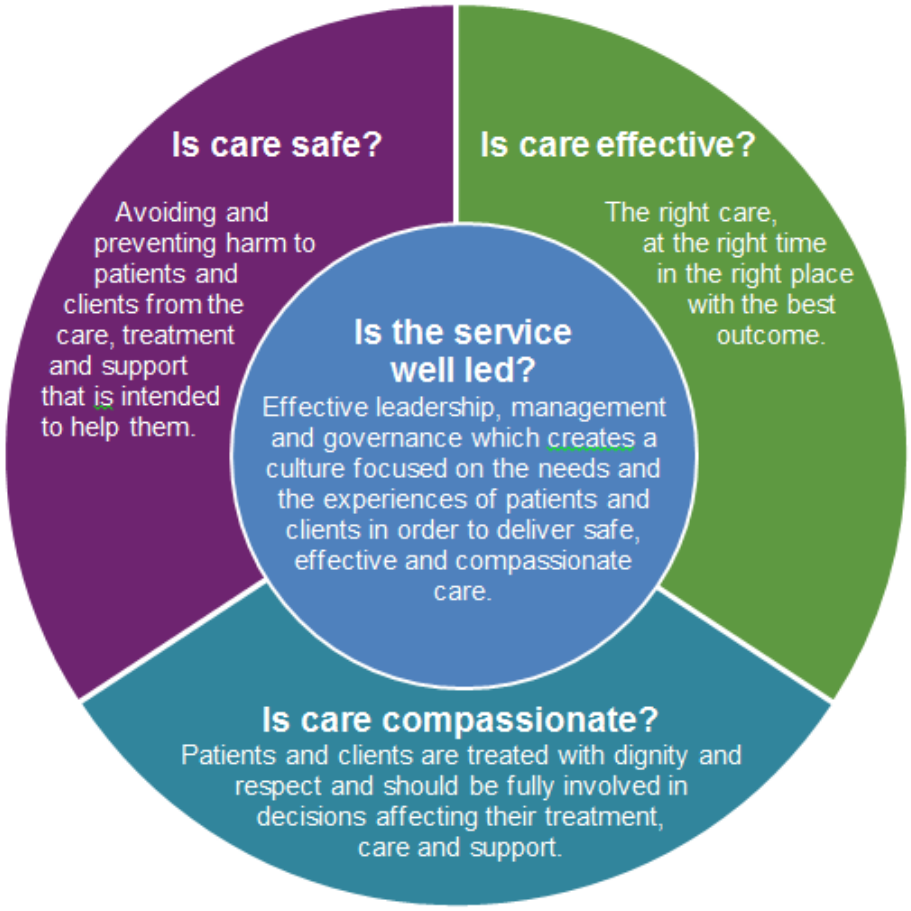
Assurance, Challenge and Improvement in Health and Social Care

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

Waterside Ward 1 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 ward manager works between Ward 1 and Ward 2 which is an adjacent ward. There is a therapeutic hub called the 'Lorem Centre' which is situated between both these wards and patients from Ward 1 and 2 can access recreational and therapeutic activities within this centre. The centre is staffed with an occupational therapist, a therapy nurse and a health care assistant.

At the time of the inspection the multidisciplinary team (MDT) consisted of a locum consultant psychiatrist, nursing staff, a clinical psychologist, an occupational therapist, a nurse therapist and health care assistants. The ward did not have a junior doctor and staff had to contact the duty doctor if they required medical support for patients. Patients had access to speech and language therapy and physiotherapy through a referral system. An independent advocacy service was also available.

On the days of the unannounced inspection there were nine patients admitted to the ward. Eight patients were on the ward and one patient was on home leave. Two patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986. There were no patients receiving enhanced one to one support from staff. There were two patients delayed in their discharge from hospital due to lack of appropriate community support.

## 3.0 Service Details

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| **Responsible person: Dr. Anne Killgallen** |
| **Ward manager: Yvette Birnie** |
| **Person in charge at the time of inspection:**<br>**12 June 2018 – Deputy ward manager Vicky Kyle**<br>**13 June 2016 – Ward manager Yvette Birnie** |

## 4.0 Inspection Summary

An unannounced inspection took place over two days on 12 and 13 June 2018.

This inspection focused on the theme of Person Centred Care. This means that patients are treated as individuals, and the care and treatment provided to them is based around their specific needs and choices.

We assessed if Ward 1 was delivering, safe, effective and compassionate care and if the service was well led.

During the inspection inspectors met with four members of the MDT. This included the occupational therapist, the nurse therapist, the deputy ward manager, and the locum consultant psychiatrist. There were no carers/relatives available to speak with the inspectors on the days of the inspection. However inspectors left questionnaires on the ward for relatives/carers to complete and forward to RQIA. None of these questionnaires were returned to RQIA.

A lay assessor Alan Craig was present during the inspection and he met with four patients and their comments are included within this report.

Evidence of good practice was found in relation to:

- The completion of patients' risk assessments.
- The completion of up to date health and safety assessments with associated action plans.
- Patients' attendance at their MDT meeting each week and their involvement in their care and treatment.
- Patients' access to the Lorem Centre to take part in activities
- The community team leader attending each MDT meeting so that the patients' keyworker in the community was kept up to date with each patients' progress.

However it was concerning to note that out of the nine areas for improvement stated at the previous inspection on 8-9 August 2017, two were fully met and one was partially met. Six areas for improvement were not met. Five areas for improvement will be restated for a second time and one will be restated for a third time in the quality improvement plan at the end of this report.

New areas requiring improvement were identified in relation to the lack of a permanent consultant psychiatrist, the lack of junior medical input, the completion of records by the medical staff and the governance arrangements in place for medical staff.

Areas of improvement were also identified in relation the lack of evidence of psychological formulations, the updating of policies and procedures, the review of patients by the medical staff, the lack of regular staff team meetings and the removal of pharmacy support from the ward.

Additional areas discussed and agreed by the ward manager included:

- Displaying the date of the patient forum meetings.
- Displaying information on the notice board regarding all members of the MDT
- Displaying information about the wards performance

The inspectors observed staff working practices and interactions with patients using a Quality of Interaction 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.

## Patients Experience:

The lay assessor spoke to four patients on the ward. Three patients made very positive comments about the ward and one patient made a negative comment regarding their care. This patient said they had received bruises from "*staff dragging"* them. The patient refused to answer any questions. The lay assessor observed a small bruise on the patient's arm. When this was discussed with the ward manager she advised that the patient may feel that she is being dragged when she has been hoisted in and out of bed. However, due to the patient's concerns the inspector requested that this information was passed onto the trust's safeguarding team to investigate. The inspector confirmed that the referral to the safeguarding team was made.

Three out of the four patients said that they felt there were enough staff on the ward and that they could talk to staff if they had any concerns. Patients stated they were updated on their care and treatment as they attended their MDT meeting each week and staff also updated them throughout the week.

## Patients Stated:

*"I'm looked after pretty good in here…. they are very kind in here…..I think the ward is well managed…..I have no complaints…..I think they are doing good here"*

*"They are very good here but I prefer to be at home……if you ask for anything they give it to you……..I haven't any complaints"*

*"I've been supported here it's always the patient first……the ward manager runs the place very well….this is my third time here. I'm going to a flat and the people here have helped me towards that…….I'm really please I've been here"*

## Relatives Views:

There were no relatives on the ward available to speak with the inspectors or the lay assessor. The inspectors left questionnaires on the ward for relatives to complete and return to the office. There were no questionnaires returned following the inspection.

## Staff Experience:

The inspectors met with four members of the MDT. Staff advised they enjoyed working on the ward and they all felt the MDT worked well together. Nursing staff and the occupational therapist confirmed that they received regular supervision in accordance to their professional guidance. Staff raised no concerns regarding patient safety and stated they felt that patients received a good quality service when on Ward 1.

In relation to improvements in the service staff felt that the Lorem Centre was a great asset to the ward but the service offered could now be improved as the full complement of staff are in place. One plan is to offer more one to one low level psychological therapies to patients when this has been identified in patient's assessment and formulation process.

**Staff Stated:**

*"This is a great ward the best I have worked on…..it is very safe there is a good ratio of staff on the ward…. It is a very good service and very effective"*

*"I have no concerns about patient safety….patients love it here and on occasions don't want to go home…more clinical psychology support on the ward would be good to assist with completing psychological formulations"*

*"The ward is busy…. but I enjoy working here"*

The findings of this report will provide the service with the necessary information to enhance practice and patient experience.

## 4.1 Inspection Outcome

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| **Total number of areas for improvement** | 21 |

Findings of the inspection were discussed with the head of service/lead nurse for older people's mental health, the medical director, the ward manager, the deputy ward manager, the community mental health team leader and the locum consultant psychiatrist as part of the inspection process and can be found in the main body of the report.

Escalation action resulted from the findings of this inspection.

The escalation policies and procedures are available on the RQIA website. https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

RQIA wrote to the medical director on 2 July 2018 to seek assurances regarding a number of concerns about the leadership and oversight of patient care by medical staff. Concerns were raised by the inspectors regarding the lack of a permanent consultant psychiatrist, the lack of junior medical input, the completion of records by medical staff and the governance arrangements in place for medical staff. A response is due from the trust by 9 July 2018.

## 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.

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- The operational policy.
- Incidents and accidents.
- Safeguarding vulnerable adults.
- Complaints.
- Health and safety assessments and associated action plans.
- Information in relation to governance, meetings, organisational management, structure and lines of accountability.
- Details of supervision and appraisal records.
- Policies and procedures.

The following records were examined during the inspection:

- Care documentation in relation to three patients
- Activity timetable
- Policies and procedures relating to the ward
- Incidents and accidents
- Complaints and compliments
- 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
- Electroconvulsive therapy (ECT) care pathway
- Medicine kardexes
- Patient forum meetings

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

The preliminary findings of the inspection were discussed at feedback to the service at the conclusion of the inspection.

## 6.0 The Inspection

## 6.1 Review of Areas for Improvement from the Most Recent Inspection dated 8-9 August 2017

The most recent inspection of Ward 1 was an unannounced type inspection. The quality improvement plan (QIP) was returned and approved by the responsible inspector. This QIP was validated by the responsible inspector during this inspection.

| Areas for Improvement | Validation of Compliance | |
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| **Number/Area 1**<br><br>**Ref**: **Standard 4.3 (i)**<br><br>**Stated:** Second 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. | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>The inspectors reviewed three sets of patient care records and there was evidence that patients and relatives/carers were involved in completing their risk assessments. Risk assessments had management plans in place and were reviewed each week by the MDT and updated with the current risk. There was evidence that risk assessments informed the patients' care plans and there was evidence in the patients' progress notes that risks were discussed with patients regarding home leave and discharge plans. | |
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| **Number/Area 2**<br><br>**Ref**: **Standard 5.3.1 (f)**<br><br>**Stated:** Second Time | The medical staff had not completed the signature sheet in the Integrated Care Pathway (ICP).<br><br>**Action taken as confirmed during the inspection**:<br><br>The inspectors reviewed the ICP signature sheet for three patients and there was no evidence that this sheet had been signed by the medical staff. | **Not Met** |
| **Number/Area 3**<br><br>**Ref**: **Standard 5.3.1 (f)**<br><br>**Stated:** First Time | The medical records did not evidence that the patients were reviewed each week by the ward doctors.<br><br>**Action taken as confirmed during the inspection**:<br><br>The inspectors reviewed three sets of care records. There was no evidence of patients' mental health being reviewed each week by the medical staff. | **Not Met** |
| **Number/Area 4**<br><br>**Ref**: Standard 5.3.1 (f)<br><br>**Stated:** First Time | The electroconvulsive therapy (ECT) care pathway documentation did not evidence that the patients were seen by the ward doctor after each ECT session.<br><br>**Action taken as confirmed during the inspection**:<br><br>The inspectors reviewed the ECT care pathway documentation and the progress notes of one patient who was currently receiving ECT. There was no evidence that this patient was reviewed by the ward doctor after each ECT session. This patient had had 12 ECT sessions. | **Not Met** |
| **Number/Area 5**<br><br>**Ref**: Standard 5.3.1 (f)<br><br>**Stated:** First 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. | **Partially Met** |

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| | **Action taken as confirmed during the inspection**:<br><br>In the three patient care records reviewed there was evidence that this section of the MDT template was still not completed in full by all who attended the MDT meeting. | |
| **Number/Area 6**<br><br>**Ref**: Standard 4.3 (a)<br><br>**Stated:** First 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. | **Not Met** |
| | **Action taken as confirmed during the inspection**:<br><br>There is currently a locum consultant psychiatrist working on the ward. They confirmed they have not had direct input into the older peoples' directorate governance meetings; therefore old age psychiatry is still not represented at these meetings. | |
| **Number/Area 7**<br><br>**Ref**: Standard 4.3 (m)<br><br>**Stated:** First Time | 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. | **Not Met** |
| | **Action taken as confirmed during the inspection**:<br><br>There continues to be deficits in staffs' mandatory training. These include:<br><br>Infection control: Four staff require training. Three staff are attending training on the 29/6/18.<br><br>Manual handling: Five staff require training. Three staff are attending training on 21/6/18. | |

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| | Fire trained: Seven staff require training. Training to be arranged in the coming weeks but no date confirmed yet.<br><br>Vulnerable adults: Four staff require training. Training arranged for 6/9/18 (no earlier dates available)<br><br>Child protection. Most of the staff on the ward require this training. Dates for this training will be available by the end June 2018. | |
| **Number/Area 8**<br><br>**Ref**: Standard 4.3 (j)<br><br>**Stated:** First Time | 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.<br><br>**Action taken as confirmed during the inspection**:<br><br>The inspectors were informed that a business case had been completed and forwarded the Health and Social Care Board (HSCB) for additional funding to improve the clinical psychology support on the ward for patients but no decision had been made yet. | **Not Met** |
| **Number/Area 9**<br><br>**Ref**: Standard 5.3.1 (f)<br><br>**Stated:** First Time | The following policy had not been reviewed and updated for staff.<br><br>• The procedure for recording fluid balance charts 2010. | **Met** |

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| | **Action taken as confirmed during the inspection**:<br><br>The policy for monitoring and recording of fluid balance in adult patients had been review and updated in June 2018. This policy was forwarded to the inspectors the day after the inspection. | |

## 7.0 Review of Findings

### 7.1 Is Care Safe?

**Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.**

**Areas of Good Practice**

There was evidence that patients and relatives/carers were involved in completing patient risk assessments. Risk assessments had management plans in place and were reviewed each week by the MDT and updated with the current risks. There was evidence that risk assessments informed the patients' care plans and there was also evidence in the patients' progress notes that risks were discussed with patients regarding their home leave and discharge plans.

The ward had a health and safety assessment completed on 28 April 2018 with no outstanding actions. This included a risk assessment of the environment.

The fire risk assessment was completed on 24/4/18 with an action plan.

The ward had seven 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 and no risks were identified however this was kept under review.

There was evidence that the MDT reviewed patients' detention under the Mental Health (NI) Order 1986 each week at the MDT meetings to ensure patients were experiencing the least restrictive option of care and treatment.

Staff who met with the inspectors stated they felt well supported on the ward and felt the MDT team worked well together. Staff understood what actions to take if they had concerns regarding the care and treatment of patients.

The ward was clean and tidy and in a good state of repair.

Patients could access two garden areas from the ward and another garden from the Lorem centre. All three gardens were well maintained with seating areas, vegetable plots and garden ornaments.

Information was available to patients in relation to their rights.

Patients who spoke to the lay assessor said they knew how to make a complaint.

Patient's regular medications were being prescribed within BNF guidelines.

**Areas for Improvement**

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.

Signatures and designation of a number of the doctors were illegible.

Kardexes were not completed correctly by medical staff and they were of a poor standard. In some cases medications had no indications documented and minimum time intervals between dosages were not recorded.

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| **Number of areas for improvement** | Three |

**7.2 Is Care Effective?**

**The right care, at the right time in the right place with the best outcome**

**Areas of Good Practice**

Comprehensive assessments were completed with patients upon their admission by nursing staff and care plans were based on each patient's assessed need.

Patients attended their MDT meeting each week and were involved in their care and treatment. Patients signed the MDT template after each meeting.

Care plans were individualised and had been completed with patients' involvement. Patients advised that they had participated in and consented to the implementation of their care plans. Care plans had been reviewed regularly.

There was evidence of family involvement in patients' care and treatment.

It was good to note that the community team leader attended each MDT meeting to ensure that the patients' keyworker in the community was kept informed of each patient's progress.

There was evidence that referrals were made to other professionals when this was identified as a need.

Discharge planning commenced for each patient on admission and discharge arrangements were discussed at MDT meetings. When Patients were nearing discharge family/carers were invited in to the ward to discuss discharge arrangements.

Deprivation of liberty (DOLs) care plans were in place which explained the rationale in relation to the locked door on the ward and the individual details around each patient's access to the keypad code.

The ward environment appeared relaxed and welcoming, patients were observed sitting in the day room and coming and going from the garden area.

There was a therapy hub called the Lorem Centre which was situated between Ward 1 and Ward 2. Patients from both wards were able to take part in activities in this centre.

**Areas for Improvement**

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.

One care record reviewed did not include a care plan for a patient who was receiving electroconvulsive therapy (ECT).

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.

Patients' mental health presentation was not reviewed by the ward consultant psychiatrist or the ward doctor on a regular basis and this included when patients had returned to the ward after receiving ECT.

Patients were not seen outside of the ward round by the consultant psychiatrist or ward doctor.

In the three care records reviewed there was no evidence of psychological formulations to underpin care planning and inform relevant models of psychological interventions.

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| **Number of areas for improvement** | Six |

## 7.3 Is Care Compassionate?

**Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.**

### Areas of Good Practice

Staff were observed assisting patients with their meals, walks around the garden and with using the telephone. All interactions were very positive. Staff were observed working at the patients' own pace and giving reassurance when necessary.

Patients attended their MDT meeting each week and were fully involved in their care and treatment.

There was evidence that patients' relatives/carers also attended meetings when requested or if a patient was nearing discharge. Meetings were also held with carers/relatives if a specific planned intervention needed to be discussed in detail.

Restricted items were included in the ward information booklet which patients received on admission.

An advocate from the Alzheimer's Society attended the ward each week and met all patients newly admitted to the ward.

Patients stated staff listened to their views and wishes.

Patients were able to come and go freely to and from the ward when this had been risk assessed and agreed by the MDT and the patient's relative/carer.

**Areas for Improvement**

No areas for improvement were identified during the inspection.

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| **Number of areas for improvement** | None |



## 7.4 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**

The ward had appropriate governance arrangements in place to identify, manage and analyse risks and incidents. (In relation to incidents of physical interventions the trust were working on updating the incident regarding system so that these incidents could be analysed)

Staff who spoke to the inspectors were aware of their role and responsibility in relation to actions they should take if they have any concerns regarding the care and treatment of patients.

Complaints and compliments were recorded on the trust's intranet staff dashboard and these were reviewed each month. There were no complaints to the ward within the last year.

Staff who spoke to the inspectors advised that they had up to date appraisals in place and received supervision in accordance with their professional guidance.

Staffing levels on the ward on the days of the inspection were appropriate to meet the needs of patients.

## Areas for Improvement

The trust reported 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 who had been in post for six months and did not plan to stay long term. There was also no junior doctor currently working on the ward and staff had to rely on the support of a duty doctor.

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.

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 analysis trends and learn from incidents. The ward manager advised that the trust is in the process of updating the DATIX system so that this information can be collated and reviewed.

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

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.

There was no longer pharmacy support on the ward to assist in reviewing prescribed medication and to complete medication reconciliation.

Patients and carers were asked to complete a survey regarding their experience of the ward when the patient was 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 had not commenced.

| **Number of areas for improvement** | Seven |
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## 8.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan. Details of the quality improvement plan were discussed at feedback, as part of the inspection process. The timescales commence from the date of inspection

The responsible person should note that failure to comply with the findings of this inspection may lead to further /escalation action being taken. It is the responsibility of the responsible person to ensure that all areas identified for improvement within the quality improvement plan are addressed within the specified timescales.

## 8.1 Actions to be taken by the Service

The quality improvement plan 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 quality improvement plan by 6 August 2018.

| Quality Improvement Plan<br>Ward 1 | |
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| **Priority 1** | |
| **The responsible person must ensure the following findings are addressed:** | |
| **Area for Improvement No. 1**<br><br>**Ref**: **Standard 5.3.1 (f)**<br><br>**Stated:** Third Time<br><br>**To be completed by:**<br>25 June 2018 | The medical staff had not completed the signature sheet in the ICP. |
| | **Response by responsible person detailing the actions taken:**<br>Additional medical input that has been job planned at Consultant and junior doctor level will facilitate more time to ensure that this is captured. This will be subject to local scrutiny and on-going audit. |
| **Area for Improvement No. 2**<br><br>**Ref**: **Standard 5.3.1 (f)**<br><br>**Stated:** Second Time<br><br>**To be completed by:**<br>25 June 2018 | The medical records did not evidence that the patients were reviewed each week by the ward doctors. |
| | **Response by responsible person detailing the actions taken:**<br>The Trust has identified a junior doctor to commence in Ward 1, Waterside Hospital, in August 2018. We fully accept the need for greater medical input and the Trust will seek recurrent funding to make this a long-term solution. We will provide job plans for the junior doctor to demonstrate enhanced input to patient care. The current consultant's job plan has been amended to provide additional clinical time on ward1. |
| **Area for Improvement No. 3**<br><br>**Ref**: Standard 5.3.1 (f)<br><br>**Stated:** Second Time<br><br>**To be completed by:**<br>25 June 2018 | The electroconvulsive therapy (ECT) care pathway documentation did not evidence that the patients were seen by the ward doctor after each ECT session. |
| | **Response by responsible person detailing the actions taken:**<br>*ECT* – increased ward time and the presence of a junior doctor on the ward will ensure that patients post ECT are reviewed and medically supervised. This will be subject to local scrutiny and on-going audit. |

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| **Area for Improvement No. 4**<br><br>**Ref**: Standard 5.3.1 (f)<br><br>**Stated:** Second Time<br><br>**To be completed by:** 25 June 2018 | Sections of the MDT template had not been completed by staff from the community team, the clinical psychologist or staff from the therapeutic hub.<br><br>**Response by responsible person detailing the actions taken:**<br>Ward Manager will ensure all professionals attending week MDT meeting will record on and sign the MDT sheet. This will be subject to scrutiny and ongoing audit. |
| **Area for Improvement No. 5**<br><br>**Ref:** Standard 5.3.1 (f)<br><br>**Stated:** First time<br><br>**To be completed by:** 25 June 2018 | Signatures and designation of a number of the doctors were illegible.<br><br>**Response by responsible person detailing the actions taken:**<br>Reference to the importance of legible handwriting will be made during Trust and ward induction for medical staff and any individual cases/examples will be brought to the attention of the Consultant to discuss on a 1-1 basis. This will be monitored by ward staff. |
| **Area for Improvement No. 6**<br><br>**Ref:** Standard 5.3.1 (f)<br><br>**Stated:** First time<br><br>**To be completed by:** 25 June 2018 | Kardexes were not completed correctly by medical staff and they were of a poor standard. In some cases medications had no indications documented and minimum time intervals between dosages were not recorded.<br><br>**Response by responsible person detailing the actions taken:**<br>The quality of medicine kardexes will be monitored weekly. This will form part of ongoing audit and with specific reference to out of hours cover these audits will involve ward staff and medical staff who do not routinely work on the ward. Consideration is being given by the Trust's Corporate Management Team (CMT) to prioritise pharmacy input a half day a week of a Band 7 Pharmacist to attend the ward round and address issues around PRN medications and best practice in medication prescribing. |
| **Area for Improvement No. 7**<br><br>**Ref:** Standard 5.3.1 (f)<br><br>**Stated:** First time<br><br>**To be completed by:** 13 July 2018 | 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.<br><br>**Response by responsible person detailing the actions taken:**<br>The ward manager will ensure all aspects of the MDT records will be completed Ward Manager will ensure all professionals attending weekly MDT meeting will record on and sign the MDT sheet. This will be subject to scrutiny and ongoing audit. |

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| **Area for Improvement No. 8**<br><br>**Ref:** Standard 5.3.1 (a)<br><br>**Stated:** First time<br><br>**To be completed by:** 25 June 2018 | One care record reviewed did not include a care plan for a patient who was receiving electroconvulsive therapy (ECT). |
| | **Response by responsible person detailing the actions taken:**<br>All patients receiving ECT will have an appropriate care plan for ECT. Compliance with this will be monitored by the Ward Manager. |
| **Area for Improvement No. 9**<br><br>**Ref:** Standard 5.3.1 (a)<br><br>**Stated:** First time<br><br>**To be completed by:** 25 June 2018 | 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. |
| | **Response by responsible person detailing the actions taken:**<br>Junior Doctors to be made aware of the necessity to keep current, accurate records. Staff will remind admitting Doctor to complete all aspects of the ICP. If this is not completed in a timely manner the ward manager will bring this to the attention of the relevant consultant. |
| **Priority 2** | |
| **Area for Improvement No. 10**<br><br>**Ref**: Standard 4.3 (a)<br><br>**Stated:** Second Time<br><br>**To be completed by:** 13 August 2018 | 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 person detailing the actions taken:**<br>*Direct Input* – the Directorate's Clinical Director attends the Directorate's Governance Committee meetings and is required to provide summary feedback with the medical team. The Directorate's Head of Older People's Mental Health Services does likewise and minutes are shared. The Directorate invites doctors to contribute to agenda items. The Trust is aiming to recruit to a team of three consultants and if this successful will appoint one of them as a specific Clinical Lead for Old Age Psychiatry. |
| **Area for Improvement No. 11** | The inspectors reviewed the wards training matrix and there were a number of deficits in staffs' mandatory training. |

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| **Ref**: Standard 4.3 (m)<br><br>**Stated:** Second Time<br><br>**To be completed by:**<br>13 September 2018 | 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. |
| | **Response by responsible person detailing the actions taken:**<br>RQIA have been supplied with dates of training since the inspection. |
| **Area for Improvement No. 12**<br><br>**Ref**: Standard 4.3 (j)<br><br>**Stated:** Second Time<br><br>**To be completed by:**<br>13 September 2018 | 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. |
| | **Response by responsible person detailing the actions taken:**<br>The current clinical psychology input is split to ensure direct and indirect interventions. It is essential that there is clinical representation at the ward rounds and that formulation/reflective practice meetings continue to ensure that staff working with those patients who are not able to engage in a direct psychological intervention still have access to a psychological formulation to underpin care planning and inform relevant models of psychological interventions. The Psychological Therapies service remains cognisant of the limited service it currently provides to the mental health wards. A business case for a permanent psychologist for both mental health wards has been completed and forwarded to the Health and Social Care Board (HSCB) for additional funding to improve the clinical psychology support to patients, carers and staff on the ward. |
| **Area for Improvement No. 13**<br><br>**Ref:** Standard 4.3 (i)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>13 September 2018 | 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. |
| | **Response by responsible person detailing the actions taken:**<br>Business case has been submitted to the Trust's Business Case Review Group for Televisions to be boxed in have recently been approved and we await completion of this work. |
| **Area for Improvement No. 14**<br><br>**Ref:** Standard 5.3.1(a) | In the three care records reviewed there was no evidence of psychological formulations to underpin care planning and inform relevant models of psychological interventions. |

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| **Stated:** First time<br><br>**To be completed by:**<br>13 September 2018 | **Response by responsible person detailing the actions taken:**<br>The Psychological Therapies service currently only has capacity to deliver three sessions per week to the ward. Only one of these sessions is for psychological formulation. Completing the psychological formulation is a substantial piece of work, which will involve working with the patient, multidisciplinary staff members and family members, where appropriate, to gather as much relevant information as is possible. Consequently only one psychological intervention can be completed at any one time. Priority for these is agreed at the multidisciplinary ward round and is based on a number of factors including complexity of presentation and date of planned discharge. A business case for a permanent psychologist for both mental health wards has been completed and forwarded to the HSCB for additional funding to improve the clinical psychology support to patients, carers and staff on the ward, including the delivery psychological formulations of all inpatients, in a timely manner. |
| **Area for Improvement No. 15**<br><br>**Ref:** Standard 4.3 (b,d,e)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>13 September 2018 | 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. |
| | **Response by responsible person detailing the actions taken:**<br>Staff meetings now scheduled monthly with a set agenda. |
| **Area for Improvement No. 16**<br><br>**Ref:** Standard 8.3 (a)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>13 September 2018 | 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. |
| | **Response by responsible person detailing the actions taken:**<br>This is now being completed fully with cooperation of the individual patients. |
| **Priority 3** | |

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| **Area for Improvement No. 17**<br><br>**Ref:** Standard 4.3 (j)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>13 December 2018 | 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.<br><br>There was also no junior doctor currently working on the ward and staff had to rely on the support of a duty doctor. |
| | **Response by responsible person detailing the actions taken:**<br>The Trust has gone out to recruit on two occasions with no applicants for the post of Consultant in Old Age Psychiatry. We have decided to wait until December to re-advertise the post when one person has indicated their willingness to apply once they are eligible in early 2019. Due to growing demand a third Consultant is also required to meet the needs of the service. A third candidate has indicated their interest to work in the service on the provision that there are two professionals already in place. This will require additional funding, however, the Trust would be confident that with corporate support this will be available. Regionally training numbers are low and therefore a regional solution will be needed to address this. |
| **Area for Improvement No. 18**<br><br>**Ref:** Standard 4.3 (l)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>13 December 2018 | 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. |
| | **Response by responsible person detailing the actions taken:**<br>The Primary Care and Older People's Services Directorate will now put in place a formal professional arrangement for the Care of the Elderly Consultant in Old Age Psychiatry to link with Adult Psychiatry. This would ensure linkages for appraisal, quality improvement, education and continuous professional development. This is currently custom and practice, with the current Care of the Elderly Consultant in Old Age Psychiatry receiving supervision from a Consultant Psychiatrist, however, will now be formalised. |
| **Area for Improvement No. 19** | 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 |

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| **Ref:** Standard 5.3.2 (a)<br><br>**Stated:** First time<br><br>**To be completed by:** 13 December 2018 | system (DATIX) so that staff can analysis trends and learn from incidents. |
| | **Response by responsible person detailing the actions taken:**<br>A MAPA template has been devised on the Datix system and is currently being trialled by Ward Managers for final feedback to risk management for implementation. |
| **Area for Improvement No. 20**<br><br>**Ref:** Standard 5.3.1 (f)<br><br>**Stated:** First time<br><br>**To be completed by:** 13 December 2018 | There were a number of policies and procedures which had not been reviewed and updated.<br><br>• Risk Management Policy - March 2014<br>• Incident Reporting - August 2014<br>• Policy on Prevention of Slips, Trips and Falls within WHSCT Facilities- February 2016<br>• Records Management Policy - November 216<br>• COSSH Policy - March 2014<br>• First Aid Policy - March 2014<br>• Fire Safety Policy - June 2014<br>• Policy for the Management of Patient Choice Related Discharge Across WHSCT Facilities- August 2014<br>• Policy for Self-Discharge Contrary to Medical Advice (CTMA)- April 2011<br>• Engagement and Supportive Observation Policy- December 2014 |
| | **Response by responsible person detailing the actions taken:**<br>Policy for the Management of Patient Choice Related Discharge has been approved at the Primary Care and Older People's Services Governance Committee in July 2018, CMT on 9th August and will now go to Trust Board on 6th September.<br><br>The Head of Service has brought the delay in the other policies listed to the attention of the Director of Primary Care & Older People's Services. This is being raised with the relevant policy owners for action and a timeframe for completing reviews will require to be agreed through the relevant Directorate's Governance Committee. |

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| **Area for Improvement No. 21**<br><br>**Ref:** Standard 4.3 (j)<br><br>**Stated:** First time<br><br>**To be completed by:** 13 December 2018 | There was no longer pharmacy support on the ward to assist in reviewing prescribed medication and to complete medication reconciliation. |
| | **Response by responsible person detailing the actions taken:**<br>Consideration is being given by CMT to prioritise pharmacy input a half day a week of a Band 7 Pharmacist to attend the ward round and address issues and promote best prescribing policy. |

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| **Name of person(s) completing the quality improvement plan** | Yvette Birnie, Pauline Casey | | |
| **Signature of person(s) completing the quality improvement plan** | Yvette Birnie | **Date completed** | 30/7/18 |
| **Name of responsible person approving the quality improvement plan** | Bob Brown | | |
| **Signature of responsible person approving the quality improvement plan** | | **Date approved** | 13/08/18 |
| **Name of RQIA inspector assessing response** | Audrey McLellan | | |
| **Signature of RQIA inspector assessing response** | Audrey McLellan | **Date approved** | 28/08/18 |

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