The Regulation and Quality Improvement Authority

Inspection Report

2 May 2023

Asha Centre

Type of service: Addictions
Address: Tyrone and Fermanagh Hospital
1 Donaghanie Road
Omagh
BT79 0NS
Telephone number: 028 8283 5453

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:** Neil Guckian Chief Executive	**Registered Manager:** Imelda McNabb
Person in charge at the time of inspection: Alison Wilson, Service Manager	**Number of registered places:** 8
Categories of care: Addictions Service	**Number of patients accommodated in the ward on the day of this inspection:** 3 patients and 1 patient admission on the day of inspection.
Brief description of the accommodation/how the service operates: The Asha Centre is a regional inpatient addiction unit which can accommodate 8 patients. The service provides care and treatment to patients who have alcohol and/or drug addiction. A range of treatments including medical detoxification, and/or stabilisation for patients with complex drug and alcohol issues is provided. The average length of stay in the centre is four weeks. All patients agree to attend the centre for treatment and admissions are on a voluntary basis.	

2.0 Inspection summary

An unannounced inspection of Asha Centre took place on 2 May 2023 between 9am and 5pm. The inspection was completed by two care inspectors.

The inspection focused on ten key themes including, environment, incident management and adult safeguarding, staffing, physical health, restrictive practices, patient experience, governance, medication management, patient flow and mental health.

Care observed throughout the inspection was found to be effective and compassionate. Staff knew the patients well and were responsive to their individual needs.

Three areas for improvement (AFI) included in the Quality Improvement Plan (QIP) from the most recent inspection of Asha Centre on, 6 July 2018, were assessed. Two AFI were assessed met, and one AFI was assessed partially met and will be revised to reflect the progress that has been made. Three new AFI were identified.

Although AFI were identified, the outcome of this inspection was positive. Areas of good practice were noted in relation to patient experience, environment, patient flow, physical and mental health.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were 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.

We reviewed records in relation to patients' planned care and treatment, and observed how they spent their day. Experiences and views were gathered from staff and patients.

4.0 What people told us about the service

Posters and leaflets were placed throughout the ward inviting staff and patients to speak with inspectors and feedback on their views and experiences.

We spoke with three service users and six staff, all of whom spoke positively about the service. We received three patient questionnaires during the inspection, all of which reflected the patients were highly satisfied with the care and treatment they received. Patient experience is discussed further in Section 5.2.6.

5.0 The inspection

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

The last inspection of Asha Centre was undertaken on the 6 July 2018 by care inspectors.

Areas for improvement from the last inspection on 6 July 2018		
The responsible person must ensure the following findings are addressed:		**Validation of compliance**
Area for Improvement No. 1 **Ref:** Standard 5.3.1 (f) **Stated:** Second time **To be completed by** 6 October 2018	The operational procedure was still in draft format. **Action taken as confirmed during the inspection**: The Trust have reviewed and finalised the operational policy. This area for improvement has been met.	**Met**
Area for Improvement No. 2 **Ref:** Standard 4.3 (j) **Stated:** Second time **To be completed by**: 6 January 2019	There is no occupational therapist within the MDT. **Action taken as confirmed during the inspection**: There was evidence of adequate OT input in patient care and treatment. An OT was available through referral for individualised patient activities / therapies. The Trust have submitted a business case to secure funding for a permanent part time OT allocated to the ward. This area for improvement has been partially met and will be revised to reflect progress achieved.	**Partially met**
Area for Improvement No. 3 **Ref:** Standard 5.3.1 (f) **Stated:** First **To be completed by:** 10 August 2018	The flooring in the shower area urgently needs repaired or replaced **Action taken as confirmed during the inspection**: The flooring in the shower area has been replaced. This area for improvement has been met.	**Met**

5.2 Inspection findings

5.2.1 Environment

The ward was bright and well presented, with adequate space to meet patients' needs. The outside spaces of the ward were well maintained and inviting. The ward décor included inspirational messages, and accounts of past patient experiences. Essential oils were used to create a calm and peaceful ambience for patients.

Patient bedrooms were single occupancy, and there were communal single sex bathrooms. The floor of the main corridor leading to and in the male bathroom area was worn and requires replacement.

Patients could avail of a communal lounge area with adjoining dining space. There were three dining tables, two of which were portable. Temporary or portable furniture is not conducive to patient comfort, and more suitable and comfortable furniture should be considered. It was positive to note that new lounge furniture had been ordered.

The ward served as a therapeutic environment for patients with adequate quiet spaces that patients could avail of as they wished. Suitable visiting rooms were available and facilities for young children visiting had been considered. A pay phone was available within a private space.

Upon admission, patients could access information in relation to the ward, the care and treatment available for patients, and guidance and contact information for relevant external agencies.

The most recent ligature risk assessment (LRA), undertaken on 4 May 2023 was in place; however, the remedial actions to be managed locally had not been identified. The most recent fire risk assessment (FRA), issued on 31 March 2023 was not available for review. These issues were brought to the attention of the ward manager and rectified within two days of the inspection.

An AFI has been identified in relation to the furniture and flooring.

5.2.2 Adult Safeguarding and Incident Management

Adult safeguarding (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).

Information pertaining to the ASG policy and procedure was displayed in staff areas. Staff were knowledgeable in relation to the ASG Regional Policy. There were no ward based ASG investigations open at the time of the inspection.

The incident reports (Datix) for the last 12 months were reviewed. The majority of incidents were graded consistently. Incidents included slips, trips, and falls and evidence showed these were managed appropriately.

A small number of incidents were recorded which had originated in the community and escalated at the ward. The detail of these incidents had not been fully described in the incident reports recorded on Datix and therefore they were not appropriately reviewed and escalated. The location of the ward makes it challenging for staff should they require assistance from other wards to manage an incident. The Trust should review these incidents and ensure that staff and patients have appropriate resources and support following incidents.

5.2.3 Staffing

Staffing levels on the ward were determined using the Telford model, which is a tool to assist staff in defining staffing levels based on patient acuity. The arrangements for staffing were reviewed through the analysis of staffing duty rotas, discussions with staff, observation of staff on shift.

The ward operates a biopsychosocial model of care. This holistic approach takes into account the physical, psychological, and social factors of addiction and promotes an integrated approach to treatment by the multi-disciplinary team (MDT). The MDT consists of a consultant psychiatrist, medical registrar, social workers, nursing staff, psychology staff, and a GP available Monday to Friday. There were minimal staff vacancies within the nursing team.

Occupational therapy (OT) is provided through the referral process for individuals who are assessed as requiring this support. It was positive to note that the current OT input was adequate to meet patient needs at the time of the inspection. This arrangement is a temporary one, arranged week to week, and is not guaranteed. A business case has been submitted by the Trust to secure a permanent OT for the ward on a part time basis. This submission is timely as the ward is due to increase patient capacity in the forthcoming weeks, resulting in additional OT input being required.

The ward is supported by external agencies who provide patient activities, including yoga, arts and crafts, and creative writing amongst others activities.

On the day of inspection Asha Centre was operating at a 50% reduced patient capacity due to limited medical cover. The staffing compliment was adequate to meet the needs of the patients on that day. The Trust should consider the safe staffing levels required to meet patient needs when the ward is operating at full capacity.

The staffing rota detailed a limited number of staff on shift throughout the night. The Trust should ensure staffing levels take into consideration risk management, the potential for incidents to occur, and staff reductions during break times.

The staff training matrix was reviewed for mandatory training and e-learning. The overall training compliance for staff requires improvement. The Trust must ensure all staff have completed all mandatory training within the required timeframes and that there is effective oversight of this.

A revised AFI will be stated for the first time in relation to OT provision (see previous QIP AFI 2). An AFI has been identified in relation to mandatory training.

5.2.4 Physical Health

Patients physical health records were reviewed. Records reflected detailed recording in relation to physical health checks and follow up care.

Patients reported their physical health needs were met from the point of admission and they reflected the benefits of this for them. There was evidence of scheduled appointments, tests, and scans, some of which were arranged for dates when the patients would be discharged back into the community.

Patients completing detoxification during their care and treatment have the potential to require additional physical health support. Asha Centre is not equipped to deliver acute care, therefore, any patient who experiences a physical health need that cannot be met in Asha would be transferred to an appropriate hospital for treatment.

Smoking cessation support and advice was available to patients if they wished to avail of it.

5.2.5 Restrictive Practice

There were no restrictive practices on Asha Centre. All patients are admitted on a voluntary basis. Patients are required to sign the pre admission treatment agreement and agree to follow the 'House Rules' as part of their treatment programme.

5.2.6 Patient Experience

Assessment and treatment for patients was assessed through the observation of patient care, discussions with patients and ward staff, and from the review of patients' care documentation.

Patients sign a contract of agreement on admission, part of which is their agreement not to leave the ward unless accompanied by staff. The contract offers patients information about the ward and details the expectations for them and for staff.

Booklets and leaflets, including "The Journey Begins" booklet, were available in patient's bedrooms for each new admission.

Patients and staff described a four-week programme of care available to all patients. The four weeks are structured and take into consideration input from family and friends, and plans for discharge on the final week, including a discharge date. Patients spoke very positively about the programme and the benefits of knowing the next steps of their care.

The mealtime experience was observed to be enjoyed by patients in a relaxed atmosphere. There was a good variety of food options available, all of which appeared appetising. Staff were available should patients require assistance.

Visiting is restricted and all items brought in by visitors are checked. Patients do not have access to their mobile phones; however, they can access a telephone, located in a private space, should they wish to contact friends or relatives. Patients are asked to keep visiting to a minimum in a bid to limit disruption during structured activities.

It was positive to see former patients attending the ward, in a supportive capacity, for the patients. The former patients had opportunity to give talks about their journey and experience, and were a source of encouragement and support.

All patients spoke very highly of all staff involved in their care. They stated they were treated with respect and staff were non-judgemental in their approach. Patients expressed hope and positivity for the future which they attributed to the care and treatment they received.

5.2.7 Governance

We assessed the governance arrangements through examination of documentation and discussions with the ward manager and the service manager.

An operational policy, reflecting the aims and purpose of Asha Centre, was available for review.

A health and safety risk assessment was underway during the inspection, the report for which was available within two days following the inspection. The report did not detail dates for completion or review of actions. The Trust must ensure action completion dates are included within the health and safety risk assessment.

Senior managers had a visible presence on the ward and staff and patients were familiar with them.

Staff meetings take place monthly and give staff opportunity to raise any concerns or suggest improvements. There is a system in place for the escalation of concerns to senior management.

Audits are completed as part of a quality assurance programme. These included patient records, National Early Warning Signs (NEWS), medication administration, infection control, and hand washing.

Patient care performance reports for the Trust were also available. These included audits on environmental cleanliness, supervision, and record keeping.

One complaint was received in the last 12 months. A copy of the Trust response was available in the complaints file; however, the original complaint letter was not available. The Trust should make all complaints and their responses available to appropriate staff at ward level.

5.2.8 Patient Flow

The patient experience begins prior to admission. The majority of patients referred to Asha Centre spend time on a waiting list. Whilst waiting, patients are given an admission date and are asked to reduce or abstain from alcohol and/or drugs. The service is regional and accommodates patients from the waiting list in order of priority, regardless of patient location. The average waiting time is six to eight weeks. There were no delayed discharges.

There was evidence of risk assessment to determine which patients were in most need of admission across the region, and also the prioritisation of perinatal women. It was positive to see collaborative working between community and hospital services to provide a holistic approach to patient care.

A meeting is held weekly to discuss admissions, discharges, and patients preparing to be admitted. This meeting is attended by various members of the MDT and professionals from community services involved in the patients' care. Discussions explore in detail the patients on the waiting list, the patients who have been given a planned admission date, the patients currently on the ward and the progress they are making.

Patient records contained detailed information about the patient's journey and progress; however, these had not been updated with the patients discharge plans as discussed and agreed with the patient prior to their admission. It is recommended all patients on the ward have an up to date copy of their discharge plan available in their patient records.

As previously stated in Section 5.2.3 Asha Centre was operating at a 50% reduced bed capacity due to limited medical cover. Recent confirmation of increased medical cover will enable the Trust to increase to full capacity within a four-week period. Patients had been notified of admission dates in keeping with the planned increase in bed capacity.

5.2.9 Medicines Management

Medicines were stored in the treatment room. The room was clean, well-organised, and medications were stored appropriately, including those that required refrigeration.

The use of pro re nata (PRN) medication, which is medication that is prescribed on an as and when necessary basis, was reviewed. PRN usage for all patients was minimal and was discussed at the weekly MDT meeting.

Patients had opportunity to discuss their medication, including PRN medication, with their consultant psychiatrist and reflected on this positively. They stated it gave them a sense of ownership and involvement in their care.

Medicines for emergency use were checked. Emergency trolley audits did not accurately reflect the expiry dates of all emergency medicines and a number were noted to have expired. This was raised with senior nursing staff who remedied the situation immediately. The Trust should ensure effective oversight of emergency medication expiry dates through the audit process.

An AFI has been identified in relation to the oversight of emergency medication.

5.2.10 Mental Health

During the admission process patients are assessed by medical staff, which includes an assessment of their mental state.

Where concerns regarding a patient's mental health are identified they will be assessed and if necessary transferred to a more appropriate setting. Patients are required to agree to a pre admission treatment agreement and 'house rules'. These include compulsory attendance at AA and NA meetings and random drug/ alcohol screening. Protocols to assess and monitor patients in acute withdrawal known as "withdrawal scales" are used for alcohol and opiate withdrawal. This supports clinicians in decision making regarding the patient's treatment.

All patients had an MDT discharge plan in place, agreed prior to admission, that involved community addiction services, and in some cases community mental health services.

6.0 Quality Improvement Plan/Areas for Improvement

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

	Standards
Total number of Areas for Improvement	4

The total number of areas for improvement includes one that had been partially met and has been revised, and three which are stated for the first time.

Areas for improvement and details of the Quality Improvement Plan were discussed with the ward manager and the service manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).	
Area for improvement 1 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time	The Western Health and Social Care Trust must review the current OT arrangements to ensure that adequate permanent OT provision is available at all times to meet patients' needs; this must be considered in conjunction with bed occupancy. Ref: 5.2.3
To be completed by: 31 August 2023	**Response by registered person detailing the actions taken:** The Westeren Health and Social Care Trust Alcohol and Drugs service have not been funded for an OT. Through close working relationships with the OT Lead for Adult mental Health (AMH) when required an OT colleague from other AMH teams have attended ASHA and provided assessments. Along side this the Assistant Director continues to liaise with the commissioners regarding funding and potential sourcing of funding for this role within Alcohol and Drugs service. This has also been added to our risk register.

Area for improvement 2 **Ref:** Standard 5.1 Criteria: 5.3.1 **Stated:** First time	The Western Health and Social Care Trust must ensure that all ward furniture is robust and suitable for patient use; flooring must be maintained to an acceptable standard; the Trust must ensure that repairs are carried out in a timely manner. Ref: 5.2.1
To be completed by: 31 October 2023	**Response by registered person detailing the actions taken**: The Western Trust have recently purchased new furniture which is robust and suitable for patient use. Estate services have recently completed a site visit to ASHA to assess and cost the refurburishment of appropriate flooring within ASHA. A business case has been submitted regarding the refurbishment in ASHA and this includes the bathroom flooring
Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.2.3 **Stated:** First time	The Western Health and Social Care Trust must ensure staff complete all mandatory training, relevant to their position; and ensure suitable arrangements are in place for the effective oversight of staff training. Ref: 5.2.3
To be completed by: 31 July 2023	**Response by registered person detailing the actions taken**: With the recent recruitment of administration staff,a new training matrix has been set up using RAG rating for mandatory training,which indicates at a glance when training needs to be renewed to ensure robust monitoring. ASHA Manager has been working closely with one of the Trust Practice Educators to develop a training booklet for the inpatient Addiction Service and this will highlight further the training needs of all staff and allow for robust monitoring.

Area for improvement 4 **Ref:** Standard 5.1 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 31 May 2023	The Western Health and Social Care Trust must ensure effective oversight of emergency medication. Ref: 5.2.9
	Response by registered person detailing the actions taken: Following the inspection we have ensured and are assured that the appropriate checklist and procedures are in place on a daily and monthly basis. All staff training regarding medication management is up to date and a reminder to all staff about the importance of adhereing to this when completing these checks of emergency medications. It is agreed that with immediate effect the Service Manager will carry out unannounced checks monthly for the next six months to ensure this process is being carried out and completed to the appropriate standard

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