# Mental Health and Learning Disability Inpatient Inspection Report
# 1-2 February 2017

## Asha Centre

## Addiction and Treatment
## Tyrone and Fermanagh Hospital
## 1 Donaghanie Road
## Omagh
## BT79 0NS
## Tel No: 028 82835453
## Inspector: Audrey McLellan
## Lay Assessor: Alan Craig

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

The Asha Centre is an eight bedded mixed gender regional inpatient addiction unit. The centre provides care and treatment to patients who have alcohol and drug addictions. The average length of stay on the ward is 14 days. On the days of the inspection there were six patients in the centre.

The multidisciplinary team consists of a ward manager, nursing staff, a consultant psychiatrist; the community addiction service manager (located within the same facility) and a senior social worker.

There is also a large active former service user group and alcoholics/narcotics anonymous groups which the patients meet each week. There were no patients who were detained in accordance with the Mental Health (Northern Ireland) Order 1986

## 3.0 Service Details

| |
|---|
| **Responsible person:** Elaine Way |
| **Ward manager:** Phyllis Fitzsimons |
| **Person in charge at the time of inspection:** Phyllis Fitzsimons |

## 4.0 Inspection Summary

An unannounced inspection took place over two days from 1-2 February 2017.

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 the Asha Centre was delivering, safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to the leadership on the ward, the group sessions available to patients, the involvement of patients and their families in their care and treatment and the use of ex-patients in supporting patients through their recovery.

Areas requiring improvement were identified in relation to the completion of individual environmental risk assessments and the absence of occupational therapy and within the MDT.

**Patients said:**

> "Staff are very friendly and welcoming……..they ask regularly if I am ok…..they seem to have the right balance of treating you like an adult when having to complete the programmes. I'm missing the phone but glad I'm without it……it's a small quaint family environment…it's clean, tidy, the food is lovely and there's nothing to put you down".
>
> "There's always something to keep you occupied….I was made welcome and relaxed straight away…..staff talk to you more as a friend rather than staff…..they make it feel so relaxing and they explain all the projects you have to do. They give you time to talk and ask questions….staff and patients get on well. It's more relaxing than any place I've been. It's not exactly a holiday camp, but it's not a boot camp either. The staff will go that little bit extra for you if you need it to settle you in.

"I understand it's a new facility and there's a learning curve overall it's good".

"I never get the impression of being judged…..I feel safe in here, it feels relaxed and it's a really nice place….the foods good"

"The staff do not make you feel afraid to approach them"

"There's a good level of support, the staff are attentive……the environment is nurturing and you're well fed"

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

## 4.1 Inspection Outcome

| | |
|---|---|
| **Total number of areas for improvement** | 5 |

Findings of the inspection were discussed with the ward manager and the head of primary care and specialist services as part of the inspection process and can be found in the main body of the report.

Escalation action did not result 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/

## 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 inspection we review a range of information relevant to the service. 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.

During the inspection the inspector met with six service users, two members of staff, and three members of the ex-patient advocacy group.

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

The following records were examined during the inspection:

- Care documentation in relation to three patients.
- Multidisciplinary team records
- Staff duty rota
- Training records
- Clinical room records
- Minutes of staff meetings
- 'House Rules'
- Learning needs analysis framework
- Workbook 'The journey Begins'
- Training timetable over and above mandatory training
- Patient and carer information booklet
- Patient questionnaires

During the inspection the inspector observed staff working practices and interactions with patients using a Quality of Interaction Schedule Tool (QUIS).

We reviewed the recommendations made at the last inspection. An assessment of compliance was recorded as met.

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

## 6.0 The Inspection

The most recent inspection of Asha centre was an unannounced type inspection. The QIP was returned and approved by the responsible inspector. This provider QIP was validated by the responsible inspector during this inspection.

## 6.1 Review of recommendations from the most recent inspection dated 26 May 2015

| Areas for Improvement | | Validation of Compliance |
|---|---|---|
| **Number: 1**<br><br>**Ref**: Standard 4.3 (j)<br><br>**Stated:** Second Time | It is recommended that the Trust ensures that staffing levels within the Addiction Treatment Unit are in accordance with required standards. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>The trust have recruited a number of new staff to the centre since reopening in November 2016. There is now one ward manager, two band six nurses, six band five nurses and three health care assistants. Five staff work on the day shift, the ward manager, one band six nurse, one band five nurse and two health care assistants. Two band five nurses work on the night shift. | |
| **Number: 2**<br><br>**Ref**: Standard 4.3 (l)<br><br>**Stated:** Second Time | It is recommended that the Trust risk assess lone working within the Addiction Treatment Unit. | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>This is no longer applicable. Since the centre reopened in November staff do not work on their own. | |
| **Number: 3**<br><br>**Ref**: Standard 4.3 (m)<br><br>**Stated:** Second Time | It is recommended that the Charge Nurse ensures all staff complete mandatory training in accordance with Trust policy. | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>The inspector reviewed the mandatory training records. There were a number of new staff who still had to complete some training. However, dates had been organised for this training to be completed in a timely manner.<br><br>It was good to note that a training plan had been devised and completed by all staff which included specific training for working in an addiction ward. | |

| | | |
|---|---|---|
| **Number: 4**<br><br>**Ref**: Standard 4.4 (i)<br><br>**Stated:** Second Time | It is recommended that the Trust completes a risk assessment of all potential ligature points within the ward | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>An environmental ligature risk assessment was completed on 23 January 2017. | |
| **Number: 5**<br><br>**Ref**: Standard 4.3 (i)<br><br>**Stated:** First Time | It is recommended that the Trust ensures that all actions with the environmental ligature risk assessment are completed in full prior to the opening of the new ward in September to ensure patients are provided with a safe environment. | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>The ward had completed an environmental ligature risk assessment on 23 January 2017. This detailed a number of actions required to remove all environmental ligatures throughout the ward. (some ligature points have already been removed in the bedrooms). A business plan is in place and the trust are waiting on the outcome of this before the final work can commence on the ward.<br><br>The assessment states that patients are;<br>"continually assessed on a daily basis by staff and also at the weekly multidisciplinary meeting"<br>also that;<br>"all patients are admitted onto the ward on a voluntary basis and those deemed to be at high risk of self-harm are not accepted into the inpatient programme."<br><br>A new an area of improvement has been made to ensure that risk assessments/care plans are in place to detail how risks in relation to the environmental ligature points are been managed on the ward for each patient until the ligature work is completed. | |
| **Number: 6**<br><br>**Ref**: Standard 5.3.1 (c, f) | It is recommended that where the use of exposed metal frame beds on the ward is unavoidable, the trust develops and implements a risk assessment as outlined by the Northern Ireland Adverse Incident Centre (NIAIC) – EFA/2010/006 safety | **Met** |

| | | |
|---|---|---|
| **Stated:** First Time | alert self-harm associated with profiling beds reissued on 23 December 2013 and in the letter issued to Trust Chief Executives jointly from the Public Health Agency and Health and Social are Board on 28 February 2014 | |
| | **Action taken as confirmed during the inspection**:<br><br>The ward has replaced all profiling beds with boxed in beds. If a profiling bed is required in the future an individual risk assessment will be completed for the patient using this type of bed. | |
| **Number: 7**<br><br>**Ref**: Standard 5.3.1 (f)<br><br>**Stated:** First Time | It is recommended that the Trust updates the policy and procedure for supervision in nursing | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>The policy and procedure for supervision in nursing was updated in February 2016 | |
| **Number: 8**<br><br>**Ref**: Standard 8.3 (c)<br><br>**Stated:** First Time | It is recommended that consulting rooms used by clinical staff are equipped with internet access. | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>The trust have installed Wi-Fi throughout the centre. | |
| **Number: 9**<br><br>**Ref**: Standard 6.3.2 (b)<br><br>**Stated:** First Time | It is recommended that flooring within the ward is replaced where damaged | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>The flooring throughout the ward has been replaced. However, there is still a small area outside the bathrooms that needs recovered. A new area of improvement will be made in relation to this. | |

## 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 were involved in completing their risk assessments.

An annual health and safety generic risk assessment was completed in August 2016 with an action plan.

A fire risk assessment was completed on March 2016 with an action plan.

The ward had an environmental ligature risk assessment which was completed on 23 January 2017 this detailed a number of actions required to remove all environmental ligatures throughout the ward. (some ligature points have already been removed in the bedrooms). A business plan is in place and the trust are waiting on the outcome of this before the final work can commence on the ward.

Staff knew who to raise concerns with when these were identified. There were no issues raised by staff in relation to the care and treatment of patients on the ward.

Staff confirmed they do not work beyond their role and experience.

Staff who met with the inspectors stated they felt well supported on the ward and felt the MDT team worked well together.

Patients signed up to an agreement on admission to the ward.

Information regarding the complaints procedure was displayed throughout the ward.

Patients confirmed they knew how to make a complaint and all patients said they did not have to make any complaints about the ward as the care provided was good. One patient stated they made a complaint about another patient and they were happy with how this was dealt with.

**Areas for Improvement**

Individual risk assessments were not in place to detail how environmental risks were being managed on the ward for each patient. Staff assured the inspector that there were no patients on the ward who had suicidal ideation.

| | |
|---|---|
| **Number of areas for improvement** | 1 |

## 7.2 Is Care Effective?

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

**Areas of Good Practice**

On admission the centre requests that each patient has the following documentation sent in from the community team.

- A detailed comprehensive assessment.
- An up to date risk assessment
- A signed pre- treatment agreement
- A recent routine blood results and urine screen results
- An up to date list of medication

There was evidence of comprehensive assessments completed by the ward doctor on admission. There was no assessment template for the doctor to complete this assessment however the centre have developed a draft integrated care pathway (ICP) which will be sent to the governance team for approval in the coming weeks.

Care plans had been signed by the patients and patients who met with the inspectors stated they were involved in their care and treatment.

A number of patients had commenced their 'Wellness Recovery Action Plan (WRAP) and staff had completed WRAP training.

Care records evidenced close monitoring of patients during periods of detox and during periods when patients were prescribed stabilisation medication.

There was evidence that care and treatment was planned in line with evidence based guidance and defined care pathways.

It was good to note that all professionals recorded their input in the patients' progress notes.

Patients were seen regularly by medical team.

There was evidence of good detail in each patient's care records on how they were participating in group sessions and how they were progressing in the centre.

The centre had arranged family group days each Sunday which involved patients on the ward and their families discussing various different topics in relation to supporting patients' recovery.

The ward had a comprehensive group activity timetable in place which included two group sessions for patients to attend each day. These sessions included topics such as:

- Social Consequences
- Support networks
- Coping with cravings
- Relapse prevention
- Structure and discipline
- WRAP
- Consequences of addiction- physical/psychological
- Understanding yourself
- What is addiction
- Cycle of change
- Confidence/ self-esteem building
- Family letters
- Six pictures and relapse prevention

Patients completed a workbook titled 'A journey begins' as part of their inpatient stay.

The ward manager had made links with the community to set up a choir with patients and staff.

There was evidence that appropriate referrals were made to other professionals when discussed and agreed at the MDT meeting.

The MDT template detailed the decisions agreed at the meeting and the responsible person who would complete the actions.

When patients are discharged an appointment with the GP was arranged for three days after discharge and a follow up appointment with the patients' keyworker in the community was arranged seven days after discharge

The ward was clean and tidy with ample lighting and the air quality was good. It was an open ward and patients were able to leave the ward when this was agreed by the MDT.

**Areas for Improvement**

The ward had a comprehensive information booklet for patients and patients also signed an agreement which detailed the rules of the programme. However, neither of these documents explained the level of observations the patients would have to experience whilst in the centre i.e. patients are checked every hour at night.

There was no floor covering in the hallway outside the bathrooms.

| **Number of areas for improvement** | 2 |
|---|---|

## 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

All interactions between staff and patients were observed as positive. (group and individual)

Patients confirmed that they were always treated with dignity and respect.

Patients confirmed that staff were always compassionate towards them.

There was evidence in the patients' care records and by speaking to patients that they were given the opportunity to be involved in their care and treatment.

Patients were overall very satisfied with the care and treatment provided to them.

Patients confirmed they were given the opportunity to comment on their care.

Members from the ex-patient advocacy group visit the centre to support patients on the ward and they also hold group sessions.

### Areas for Improvement

There were no areas of improvement identified.

| | |
|---|---|
| **Number of areas for improvement** | 0 |

## 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**

Staff who spoke to the inspectors demonstrated a good understanding of their roles and responsibilities if they had concerns regarding patients on the ward

Governance arrangements were in place to monitor the prescription and administration of medication.

All incidents, accidents, SAI's and whistleblowing concerns are recorded on the Datix system. These are then automatically sent to the relevant line managers, head of services, relevant professionals and the risk management team via an email to alert them to the incident. Since November 2016 when the centre reopened only one incident was recorded.

There was evidence that the ward manager cascades information from the governance meetings to the staff in the centre via the ward manager's meeting which are held monthly.

All staff who were interviewed by the inspectors stated that the MDT worked well together.

Patients complete a questionnaire on admission and on discharge.

There were no complaints received on this ward over the past year.

Staff interviewed by the inspector were aware of the organisational and management structure.

There was evidence that staff had received supervision and appraisals in accordance with their professional guidance.

There were some gaps in the staffs mandatory however the ward manager had dates booked to ensure all staff had up to date mandatory training in place.

Staff had attended a number of training sessions over and above their mandatory training.

A training needs analysis was completed for the centre staff in January 2017. This detailed the specific training needs for all staff members and a plan will be put in place to roll out this training.

There were no staff shortages on the ward. The ward had recruited a new team of staff when it was reopened in November 2016.

There were governance arrangements in place to monitor the use of bank staff.

**Areas for Improvement**

There is no occupational therapy within the MDT.

The operational procedure was still in draft format.

| | |
|---|---|
| **Number of areas for improvement** | 2 |

## 8.0 Provider Compliance Plan

Areas for improvement identified during this inspection are detailed in the provider compliance plan. Details of the provider compliance 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 provider compliance plan are addressed within the specified timescales.

## 8.1 Actions to be taken by the Service

The provider compliance 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 provider compliance plan by 30 March 2017.

| Provider Compliance Plan<br>Asha Centre | |
|---|---|
| **Priority 1** | |
| **The responsible person must ensure the following findings are addressed:** | |
| **Area for Improvement No. 1**<br><br>**Ref:** Standard 5.3.1 (a)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>2 March 2017 | Individual risk assessments were not in place to detail how environmental risks were being managed on the ward for each patient. |
| | **Response by responsible person detailing the actions taken:**<br>Individual environmental risk assessments have been introduced and are now carried out with all clients admitted to the Asha Centre. |
| **Priority 2** | |
| **Area for Improvement No. 2**<br><br>**Ref:** Standard 6.3.2 (b)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>23 March 2017 | The ward had a comprehensive information booklet for patients and patients also signed an agreement which detailed the rules of the programme. However, neither of these documents explained the level of observations the patients would have to experience whilst on the ward i.e. patients are checked every hour at night. |
| | **Response by responsible person detailing the actions taken:**<br>This information has now been added to the House Rules document which is discussed with clients prior to admission. |
| **Area for Improvement No. 3**<br><br>**Ref:** Standard 6.3.2 (a)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>2 May 2017 | There was no floor covering in the hallway outside the bathrooms. |
| | **Response by responsible person detailing the actions taken:**<br>Although this states there is no floor covering there is a covering but it is in need of replacement. This has been included in the business case for the ligature work. However this will require a more prolonged costing exercise so a Minor Capital Work application has been submitted separately for the flooring, in the hope that this can be progressed quicker and within the deadline of the 2nd May 2017. |
| **Area for Improvement No. 4**<br><br>**Ref:** Standard 5.3.1(f)<br><br>**Stated:** First time | The operational procedure was still in draft format. |
| | **Response by responsible person detailing the actions taken:**<br>The Operational Procedure is going to the next Governance meeting in April 2017 for approval. |

| | |
|---|---|
| **To be completed by:** 2 May 2017 | |
| **Priority 3** | |
| **Area for Improvement No. 5**<br><br>**Ref:** Standard 4.3 (j)<br><br>**Stated:** First time<br><br>**To be completed by:** 2 August 2017 | There is no occupational therapy within the MDT.<br><br>**Response by responsible person detailing the actions taken:**<br>There is currently no funding available for this development so the ward manager will contact the Lead OT to devise an interim plan and longer term provision. This will require a funding application which realistically may not be in place by the 2nd August 2017. In conjunction with the head of service the matter will be raised at the directorate QIP meeting which convenes on the 9th March. |

| | | | |
|---|---|---|---|
| **Name of person(s) completing the provider compliance plan** | Phyllis Fitzsimons | | |
| **Signature of person(s) completing the provider compliance plan** | | **Date completed** | 08/03/2017 |
| **Name of responsible person approving the provider compliance plan** | Trevor Millar | | |
| **Signature of responsible person approving the provider compliance plan** | | **Date approved** | 15/03/2017 |
| **Name of RQIA inspector assessing response** | Audrey McLellan | | |
| **Signature of RQIA inspector assessing response** | | **Date approved** | 23/03/17 |

The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower
5 Lanyon Place
BELFAST

BT1 3BT

**Tel** 028 9051 7500
**Fax** 028 9051 7501
**Email** info@rqia.org.uk
**Web** www.rqia.org.uk
@RQIANews