The Regulation and Quality Improvement Authority

Inspection Report

04 March – 20 May 2024

Northern Health & Social Care Trust

Holywell Hospital
60 Steeple Road
Antrim
BT41 2RJ
028 9446 5211

Ross Thomson Unit
Causeway Hospital
4 New Bridge Road
Coleraine
BT52 1HS

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: Northern Health and Social Care Trust (NHSCT) **Responsible Individual:** Ms. Jennifer Welsh, Chief Executive, NHSCT	**Registered Manager:** Ms Margaret McAleese **Date registered:** Non-Registered
Person in charge at the time of inspection: Mr. Richard Bakasa Assistant Director, Acute MH & Inpatient Services / Divisional Nurse MH,LD & CW	**Number of beds:** Tobernaveen Upper: 20 Tobernaveen Lower: 20 Tobernaveen Centre; 20 Lissan 1: 6 Carrick 4: 9 Ross Thompson Unit: 20
Categories of care: Mental Health (MH) Acute Admission Psychiatric Intensive Care (PICU) Rehabilitation	**Number of patients accommodated on the date this inspection commenced:** Holywell Hospital: • Tobernaveen Upper: 21 • Tobernaveen Lower: 23 • Tobernaveen Centre: 21 • Lissan 1 (PICU): 6 • Carrick 4: 8 Causeway Hospital: • Ross Thompson Unit: 23
Brief description of the accommodation/how the service operates: The NHSCT inpatient mental health services are located at Holywell Hospital, Antrim and Causeway Hospital, Coleraine. Services at Holywell Hospital comprise three, mixed gender, acute mental health wards: Tobernaveen Upper (TNU), Tobernaveen Lower (TNL), Tobernaveen Centre (TNC), and the psychiatric inpatient care unit (PICU), Lissan 1 for male patients. These wards provide assessment and treatment for patients with acute mental health needs aged between 18 and 65 years old. Tobernaveen Centre also provides patients over 65 years with acute mental health assessment and treatment. Carrick 4 is a mixed gender ward providing a patient recovery and rehabilitation service. The Ross Thompson Unit (RTU) in Causeway Hospital is a mixed gender ward which provides assessment and treatment for patients aged between 18 and 65 years old. Patients admitted for psychiatric intensive care are detained in accordance with the Mental	

Health (Northern Ireland) Order 1986 (MHO). Patients admitted to the acute mental health wards or the patient recovery and rehabilitation service are admitted either on a voluntary basis or detained in accordance with the MHO.

2.0 Inspection summary

An unannounced inspection of the acute mental health inpatient service at Holywell and Causeway Hospitals took place between 04 March 2024 and 12 March and concluded with feedback to the Trust Senior Management Team on 20 May 2024. The inspection team comprised of four care inspectors, an assistant director, an estates inspector, estates assistant, and RQIA's sessional Consultant Psychiatrist and administrative support.

The inspection focused on ten key themes: environment, adult safeguarding (ASG) and incident management, staffing, restrictive practices, physical healthcare, patient experience, governance, patient flow, medicines management and mental health. The inspection was based on a review of intelligence received about care delivery to patients, environmental concerns, whistleblowing and receipt of Early Alerts detailing pressures of over occupancy.

The Trust commissioned an independent investigation in February 2023 into whistleblowing concerns. The recommendations were shared with RQIA in May 2024. Findings relating to staffing and morale, adult safeguarding and governance correlated with what inspectors found during this inspection in terms of good governance systems and positive morale amongst the hospital teams.

Early Alerts and updates to the Department of Health (DoH) highlighted significant pressures due to over occupancy across the service. This resulted in the use of contingency beds and day space areas in some of the wards being used to accommodate patients. At the time of inspection, contingency beds were being used in four of the six wards which included patients being accommodated in day rooms. During the inspection, the Trust advised that patients from an acute ward had also been temporarily transferred to Carrick 4. This ward provides a psychiatric inpatient service to both female and male patients and its main purpose and function is to support patient recovery and rehabilitation. The inspection team determined it was necessary to expand the scope of the inspection to include Carrick 4.

Inspectors did not visit Tobernaveen Upper ward due to a COVID outbreak but records were reviewed remotely and an online meeting took place with the ward manager.

Despite these pressures observed by inspectors, patients reported feeling safe and well cared for. Good practice was observed in the interactions between staff and patients, adult safeguarding and incident management, physical healthcare, recording of electroconvulsive treatment and governance oversight.

There were a total of seventeen AFI's from the September 2021 acute mental health inpatient wards and January 2023 Carrick 4 ward inspections. Two AFI's were not reviewed, twelve AFI's were met, two were partially met and remaining actions have been subsumed into two new AFI's. One AFI was not met and has been restated for a second time.

3.0 How we inspect

RQIA utilised its authority under the Mental Health (Northern Ireland) Order 1986 and The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland Order) 2003 to conduct this inspection. RQIA has a statutory responsibility under the Mental Health (Northern Ireland) Order 1986 to make inquiry into any case of ill-treatment, deficiency in care and treatment, improper detention and/or loss to damage or property. Care and Treatment is measured using the Quality Standards (2006) for Health and Social Care to ensure that services are safe, of high quality and up to standard.

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.

The Inspection team directly observed patient experiences, staff engagement with patients, how patients spent their day, the reaction to and management of incidents, staffing levels, senior leadership oversight and ward environments. The inspection team also reviewed patient care records, patient resettlement progress and governance documentation.

4.0 What people told us about the service

Posters and easy read leaflets were placed throughout the wards inviting staff and patients to speak with inspectors and give feedback on their views and experiences. Three completed questionnaires were received by patients. We spoke with patients, relatives and staff including nursing staff, student nurses, healthcare assistants, support staff, patient user consultant, members of the senior management team (SMT) and multi-disciplinary team (MDT).

Feedback from patient relatives was positive about care and treatment describing staff as respectful and empathetic, "wonderful", "nurses are fantastic, very patient and understanding". Suggestions where improvements could be made included: "would like more communication between different staff disciplines", "sometimes it's hard to get to speak to someone", "food could be better". Relatives told us that if they had queries or concerns, they felt comfortable in raising these directly with ward staff.

Patients reported feeling safe and well cared for. They told us they felt their mental health had improved from being in hospital.

Staff reported feeling supported by their colleagues, ward manager and senior managers and felt able to raise concerns with managers.

5.0 The inspection

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

Areas for improvement from the inspection carried out on 13-28 January 2021		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 5.1 Criteria: 5.3 (5.3.1) (f) **Stated:** First time	Carried forward from previous inspection The Northern Health and Social Care Trust shall ensure; • an immediate risk assessment on the use of PPE and plastic material is carried out. This should be completed in conjunction with the Infection Prevention Control (IPC) team in order to ensure the potential risks to patient safety are managed; and • an assurance system is introduced to monitor action and reviewing patient safety, staff practice and risk assessment.	**Met**
	Action taken as confirmed during the inspection: The Trust confirmed that this AFI was initially evidenced in July 2019 and was addressed within the action plan at that time. A risk assessment had been carried out by the Trust in conjunction with IPC. Assurance mechanisms were identified by the Trust to ensure that actions relating to patient safety and staff practice were monitored. This AFI has been met.	
Area for improvement 2 **Ref:** Standard 5.1	The Northern Health and Social Care Trust shall ensure that the Admission and Discharge to Mental Health Beds Policy is ratified and includes;	**Met**

Criteria: 5.3 (5.3.1) (f) **Stated:** First time	• a local escalation policy which clearly defines the level of bed usage and bed management strategies to manage the Trust's bed capacity; and • information on the use of leave beds within inpatient care, that is explicit on how such leave is planned and what to do if unexpected re-admission occurs.	
	Action taken as confirmed during the inspection: The Trust's Admission and Discharge to Mental Health Beds Policy was approved on 04.10.23. A bed management team and Bed Capacity Co-ordinator were responsible for co-ordinating day to day bed management issues. We saw evidence of a local escalation policy which clearly defines the level of bed usage and bed management strategies to manage the Trust's bed capacity. Within the draft Acute Mental Health Bed Management and Escalation Policy there was information on the use of leave beds within inpatient care, that is explicit on how such leave is planned and what to do if unexpected re-admission occurs. This AFI has been met.	
Area for improvement 3 **Ref**: Standard 4.1 Criteria: 4.3 (i) **Stated:** First time	In respect of managing ligature risks the Northern Health and Social Care Trust shall ensure; • each ward, accommodating patients with a mental health and/or learning disability need, has an up-to-date ligature risk assessment which accurately reflects the ligature points and control measures which is available to all staff at ward level; • relevant staff at ward level are aware of the ligature risks on their ward and the relevant mitigations; • that RQIA are furnished with an action plan detailing the anti-ligature works which require to be completed. The action plan should include timescales for the planned completion of the works.	

	Action taken as confirmed during the inspection: Five out of six ligature risk assessments were up to date but not all ligature risks identified on inspection were included. Not all relevant staff were aware of the additional ligature risks which had been identified and the relevant mitigations. Action plans for identified works had no timescales for completion and were not signed. This AFI has been subsumed into a new area for improvement.	**Partially met**
Area for improvement 4 **Ref**: Standard 4.1 Criteria: 4.3 (i) **Stated:** Second time	In relation to mitigating fire risks the Northern Health and Social Care Trust shall ensure; • each ward has an up-to-date accurate fire risk assessment; • oxygen tanks in resus bags are noted as a combustible gas in fire risk assessments; • there are sufficient numbers of staff trained as fire wardens to ensure a fire warden is scheduled for each shift; and • appropriate governance of the adherence to the fire policy in respect of completing annual fire drills or walk/talk fire drills are completed.	**Partially met**
	Action taken as confirmed during the inspection: • Fire risk assessments for all wards were up to date; • Oxygen tanks in resus bags were not noted as combustible gas in fire risk assessments; • There were sufficient numbers of staff trained as fire wardens in each shift across all wards; • There was little evidence of annual fire drills or walk/talk fire drills; • Inconsistencies in relation to adherence to fire safety regulations were noted across wards. This AFI has been partially met. Actions not met have been subsumed into a new area for improvement.	

Area for improvement 5 **Ref:** Standard 5.1 Criteria: 5.3.1 (c) **Stated:** Second time	The Northern Health and Social Care Trust shall ensure; • staff's knowledge and training in respect of safeguarding is embedded into practice; • up-to-date safeguarding policies and procedures are easily accessible for staff; • immediate protection plans are implemented for those patients for whom a safeguarding referral has been made; • there is consistency in the recording of the incident including details of the action taken following a referral; • the rationale for decision making to screen out a referral is recorded and shared with ward staff; and • ward staff are aware of what stage in the ASG process each referral is at. **Action taken as confirmed during the inspection**: ASG policy and procedures were accessible for all staff and embedded across all wards. Staff displayed knowledge of the process and were aware of any ASG referrals on their wards, their status and the protection plans in place. Staff also displayed knowledge of alternative safeguarding responses. There was evidence of clear rationale for decisions made and alternative safeguarding plans in place for patients where the threshold for adult protection was not met. See Section 5.2.2 in the body of the report for further information. This AFI has been met.	**Met**
Area for improvement 6 **Ref:** Standard 5.1 Criteria: 5.3.3 (d)	The Northern Health and Social Care Trust shall ensure: There are a sufficient number of staff trained to provide patients with support to use the ward's cardiovascular gym equipment.	**Met**

Stated: Second time	**Action taken as confirmed during the inspection**: There were a number of sufficiently trained staff to support patients use of cardiovascular gym equipment. This AFI has been met.	
Area for improvement 7 **Ref**: Standard 6.1 Criteria: 6.3.2 (g) **Stated:** Second time	The Northern Health and Social Care Trust shall ensure; • the outcomes and follow up actions taken by staff to address the issues raised at patient forum meetings are documented and recorded and reported back to patients, service user consultants/patient advocates and Senior Management Team (SMT).	**Met**
	Action taken as confirmed during the inspection: There were 'You Said, We Did' boards located in each ward with evidence of patient queries and Trust responses. Monthly patient forum meeting minutes provided evidence of patient questions/queries and efforts by staff to resolve or escalate as needed. The patient user consultant was aware of issues raised by patients and ensured their views were reported back to SMT. This AFI has been met.	
Area for improvement 8 **Ref**: Standard 5.1 Criteria: 5.3.1 (f) **Stated:** Second time	The Northern Health and Social Care Trust shall ensure; • there is a robust daily monitoring system for the cold storage of medicines; the minimum and maximum medicine refrigerator temperatures are recorded, the thermometer is reset every day and medicines are stored in accordance with the manufacturers' instructions; and • the contents of the bags are regularly inspected to take account of expired medicines and damaged packaging.	**Carried forward to the next inspection**

	This AFI was not reviewed as part of this inspection.	
Areas for improvement from the last inspection to Carrick 4 on 31 January – 08 March 2023		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 5.1 **Criteria:** 5.3.1 (f) **Stated:** First time	The Northern Trust must ensure that all fire doors are used in accordance with their installation purpose and that appropriate measures are in place to ensure that practice remains in line with fire safety regulations. **Action taken as confirmed during the inspection**: Fire doors between the foyer and male dormitory area in the temporary Inver 3 ward were wedged open in order to manage the supervision requirements for patients when in that area. The Fire Safety Officer had approved this as a temporary measure. Additional staff were in place to mitigate risks.	**Met**
Area for improvement 2 **Ref:** Standard 5.1 **Criteria**: 5.3.1 (f) **Stated:** First time	The Northern Trust must ensure that all ligature risks identified are included within the ward's ligature risk assessment with appropriately tailored control measures in place to manage each risk. **Action taken as confirmed during the inspection**: The ward's ligature risk assessment was comprehensive with appropriate measures in place to mitigate each risk identified. Due to the temporary location of the ward to Inver 3, additional staff were in place to manage risks. This AFI has been met.	**Met**
Area for improvement 3 **Ref:** Standard 5.1 **Criteria:** 5.3.3 (e)	The Northern Trust must ensure that the physical environment of the ward meets the standards as recommended by the Royal College of Psychiatrist (RCPSYCH) Standards for Inpatient Mental Health Rehabilitation Services 4th Edition, 2020.	**Carried forward to the next inspection**

Stated: First time	The Trust must have a formal record of identified actions arising from this review and clear timescales for completion.	
	Action taken as confirmed during the inspection: The refurbishment to Carrick 4 has not yet been completed, therefore, this AFI was not reviewed and is carried forward to the next inspection.	
Area for improvement 4 **Ref:** Standard 5.1 **Criteria:** 5.3.1 (f) **Stated:** First time	The Northern Trust should undertake a review and audit of incident management to ensure the appropriate recording of incidents (categories and sub-categories). The Trust should also ensure the incident contains appropriate information to determine emerging themes and patterns and support incident analysis.	**Met**
	Action taken as confirmed during the inspection: A review of incident management had been completed. Incident reports were reviewed across wards including Carrick 4 and were streamlined, consistent, categorised correctly and with good detail. From review of MDT & Directorate Governance Meeting minutes and evidence of analysis of incident trends in the Safety and Quality Booklet, we were satisfied with the level of senior management oversight This AFI has been met.	
Area for improvement 5 **Ref:** Standard 4.1 **Criteria:** 4.1.3 (m) **Stated:** First time	The Northern Trust must complete a review and update of staff training needs to ensure a focused approach to the completion of all mandatory training, including ASG, Fire Safety Awareness and Dysphagia training.	**Met**
	Action taken as confirmed during the inspection: Staff training records evidenced up to date staff training in ASG, Fire safety awareness and Dysphagia training. This AFI has been met.	

Area for improvement 6 **Ref:** Standard 5.3 **Criteria:** 5.3.1 (f) **Stated:** First time	The Northern Trust should strengthen its governance arrangements in relation to the oversight of enhanced observations to include the frequency of medical review and to ensure individual restrictions through observations continue to be necessary.	**Met**
	Action taken as confirmed during the inspection: In line with the Trust policy, 'Use of Observation and Therapeutic Engagement of Mental Health Inpatients in Holywell Hospital and Ross Thompson Unit', the Trust developed a Continuous Observation Audit tool to ensure measures were in place to review the decision making for observations and ensure consistency across inpatient services. During inspection we were advised that this review was undertaken and completed in June 2023 but had not been extended to include Carrick 4. This was discussed with the ward manager and the audit tool was implemented. This AFI has been met.	
Area for improvement 7 **Ref:** Standard 5.1 **Criteria:** 5.3.1 (a) (c) **Stated:** First time	The Northern Trust must ensure that staff have an understanding of Deprivation of Liberty Safeguards (DoLS) and where voluntary patients are subject to continuous supervision and are not free to leave that DoLS are put in place.	**Met**
	Action taken as confirmed during the inspection: Understanding of DoLS amongst relevant staff had improved. Patients who met the criteria for DoLS were subject to emergency provisions and whilst there were delays in the progression of DOLS applications, the Trust provided explanations and there was evidence of efforts to address this. The Trust advised following inspection that the application for DoLS which had been delayed had been submitted.	

Area for improvement 8 **Ref: Standard:** 4.1 **Criteria:** 4.1.3 (n) **Stated:** First time	The Northern Trust shall ensure senior management walk arounds are recorded with actions identified and shared with staff to support quality improvement for rehabilitation and recovery.	**Not met**
	Action taken as confirmed during the inspection: We were advised that there were periodic senior management walk arounds but these had not been recorded. This will be restated for a second time.	
Area for improvement 9 **Ref: Standard:** 5.3. **Criteria:** 5.3.3 (b) **Stated:** First time	The Northern Trust must revisit the resettlement options available for patients delayed in their discharge to achieve realistic and timely discharge outcomes for patients. RQIA request that a resettlement update for these patients be provided by 31 October 2023.	**Met**
	Action taken as confirmed during the inspection: The Trust had continued to pursue community placements for long term care patients. Potential placements had been identified with various providers. A Project Group consisting of MDT staff, ward staff and a senior manager were meeting weekly to discuss the resettlement needs of long term care patients. Whilst there is still work to be done on this area, this AFI has been met. A new AFI has been made to ensure a continued focus on the resettlement of long term care patients.	

5.2 Inspection findings

5.2.1 Environment

Six wards across the Holywell and Causeway Hospital sites formed part of this inspection. Although some of the ward environments were old and dated they were bright and clean. Ensuite bathroom refurbishment work within the three Tobernaveen wards was due to commence on 11

March 2024. This work was essential from an infection, prevention and control (IPC) perspective and to preserve patient safety and dignity. Completion of this work was confirmed post inspection.

Good information for patients about therapeutic activities, advocacy services and staff on duty was displayed in communal areas of the wards.

Fire Safety

Not all wards were consistent in their adherence to fire safety measures. Fire doors in three wards were wedged open. This was brought to the attention of the ward manager/nurse in charge and addressed immediately.

The fire doors in Carrick 4 between the foyer and male dormitory area were also wedged open in order to manage the supervision requirements for patients when using that space. This practice had been approved by the Fire Safety Officer as a temporary measure until the ward moved back to its original location.

Fire risk assessments were up to date but there was inconsistency across wards in the recordings of action plans and progress made. The action plan in Carrick 4 was recorded as complete but there was either limited or no progress reflected within the fire records for four wards.

Personal Emergency Evacuation Plans (PEEPS) were in place but the standard of recordings varied across wards. The completion of fire checks was not happening consistently and there was no evidence of walk/talk fire drills.

There was furniture in the fire exit corridor in TNL increasing potential risk to patients and staff in the event of a fire. This was bought to the attention of the ward manager who advised that this has been escalated to SMT and were awaiting removal by Estates.

Ligature Risk Assessments and Patient Safety

Ligature risk assessments (LRA) were up to date in five out of six wards. There were mitigations in place for identified risks but additional risks identified in Lissan 1 and the Tobernaveen wards were not included within the LRA. Action plans had not been updated or dates of completion noted consistently across wards. This is of concern as intelligence received prior to this inspection highlighted incidents of self-harm by patients using ligatures.

There was no nurse call alert system available in three wards. Patients did not have a means to summon assistance and they had to call for help or rely on other patients to do so on their behalf. Although a system had been developed to check on patients well-being there was a lack of consistency in its application and management. The Trust should review how these checks are being implemented to ensure consistency and patient safety.

A review of Serious Adverse Incidents (SAI's) noted that some incidents had occurred in between scheduled thirty-minute well-being checks. It is imperative that a more robust mechanism be put in place to enable patients to call for assistance when they need it.

Patient accommodation included single occupancy rooms and dorm style bay areas. Male and female patients were accommodated in different parts of the wards and were able to move freely around the communal areas. There were challenges for patients accommodated on a mixed

gender ward however, staff were aware and were managing this through the appropriate allocation of beds and staffing to promote safe interactions between patients.

Areas of improvement have been made in relation to the environment and patient safety.

5.2.2 Adult Safeguarding and Incident Management

Adult safeguarding (ASG) arrangements were well managed. ASG is the term used for actions which prevent harm from taking place and protects adults at risk (where harm has occurred or is likely to occur without intervention).

A Designated Adult Protection Officer (DAPO) was aligned to all wards. ASG processes and contact details for the DAPO were displayed throughout the wards and staff had good knowledge of the ASG process including what actions to take should an incident occur that met the threshold for an ASG referral. The Trust had adopted a colour coded folder and file box where relevant ASG information is contained in all the wards making this both identifiable and accessible to relevant staff. An alternative safeguarding response was developed to support the welfare of patients where the threshold for adult protection was not met. There was evidence of clear rationale for decisions made and alternative plans in place for patients. Monthly reviews of ASG referrals were managed by the DAPO and staff reported that they felt confident and comfortable when raising queries or providing updates.

Whilst staff were knowledgeable and there were robust systems in place, we could not be assured that all staff were up to date with ASG training. This is referenced further in section 5.2.3.

Inspectors reviewed 277 DATIX incidents from a six-week period (DATIX is the Trust's electronic information system for recording incidents) across the acute wards. Incident reports were streamlined, consistent across wards and provided good detail. They contained information such as the level of support provided to a patient, use of physical intervention or when a patient's risk assessment required to be updated. There was good improvement noted in the completion of DATIX reports from Carrick 4 ward following the last inspection in January 2023.

Just over half of incidents (51%) reflected patient behaviour dysregulation which is notable in the context of challenges experienced in terms of over occupancy, numbers of detained patients on the wards and high levels of acuity. It was positive to see Quality Improvement Projects underway such as 'Safe Wards'. This framework aims to support improved interactions on acute mental health wards and minimise conflict. Staff and patients spoke positively about this as a means of supporting the reduction of aggression, with greater focus on distraction techniques and patient engagement as alternatives to restrictive practices such as safety intervention and seclusion.

A considerable amount of work had been undertaken since the last acute wards inspection in relation to the improvement of ASG systems and incident management.

There was good senior management oversight of incidents and evidence of analysis of incident trends in the Safety and Quality Booklet. Incidents analysed included violence and aggression, medication issues, falls and absconding. Refer to 5.2.6 for further reference to ASG and incident management.

5.2.3 Staffing & Morale

Staffing arrangements across the wards were reviewed through analysis of the staff rota, discussion with staff, observations of staff on shift and review of the staffing model. The Trust utilised the Telford model which is a tool to assist staff in defining staffing levels based on patient acuity. The use of agency staff was minimised through sourcing of staff from within the existing staff teams and bank staff. Staffing shortages within individual wards were no longer reported on the Trust's DATIX recording system. An escalation policy was in use and shortages were recorded as part of the Joint Daily Report with managerial oversight. There were no concerns identified and staffing levels were sufficient to meet the needs of patients.

Each ward had a dedicated staff team including a ward manager, patients had a named nurse allocated and staff on duty were displayed on notice boards. There is an effective multi-disciplinary team with all necessary disciplines including Occupational Therapist (OT), activities nurse, social work and psychology staff. Despite not having a dedicated Speech and Language Therapist (SLT) onsite, inspectors were informed this does not have a negative impact for patients as referrals are actioned without delay.

Inspectors spoke with a range of staff across night and day shifts. This included, band 5 and 6 nursing staff, healthcare assistants, student nurses, domestic staff, social work staff and ward managers. Staff overall spoke very positively about feeling supported by their colleagues, managers and SMT with regular supervision and appraisals taking place. There was good communication between ward staff and managers with staff feeling listened to when any issues were raised.

Training records indicated mandatory training for staff was not up to date. Compliance rates for ASG, Fire Safety and IPC varied across wards. The system for recording of staff training was unclear. For example, training on Mental Capacity Act (Northern Ireland) 2016 and Deprivation of Liberty Safeguards (DoLS) was recorded under different headings with different dates. A clear method of recording is important given that some patients will require DoLS to be in place upon discharge and some patients have been subject to emergency provisions under the Mental Capacity Act (Northern Ireland) 2016. The Trust should have a system which is readily available and provides a clear overview of compliance rates for mandatory and other recommended training across all wards.

An area for improvement in relation to staff training has been made.

5.2.4 Patient Experience

Meal times were well organised and relaxed. Due to the layout of the Tobernaveen wards, there was limited dining room space to accommodate the number of patients on the wards. Patients queued for meals and tables were not wiped down after each use. Dining areas were used by some patients outside of meal times, as designated day space areas were allocated for the provision of contingency beds, thereby impacting on patient comfort. Dining areas within Lissan 1 and Ross Thompson Unit set excellent examples of a good dining experience, having the benefit of space with tables well presented and laid out with condiments and cutlery.

The food appeared fresh and via the Patient User Consultant, patients had reported food quality was improving with choice available. Mealtimes were co-ordinated in line with the regionally

agreed framework 'Mealtimes Matter'. Information relating to individualised SLT assessments was available for domestic and support service staff and matched information contained within patient records. This offered assurance that patients were receiving the appropriate level within the International Dysphagia Diet Standardisation Initiative (IDDSI).

Patients appeared relaxed in staff company and interactions with a range of disciplines was observed. Staff engaged with compassion and warmth evidencing therapeutic relationships. There were opportunities for patients to provide their views through the 'You Said, We did' boards which were located centrally on the wards with responses to patient queries noted. Suggestion boxes were available and monthly patient meetings were happening on all wards with evidence that staff made consistent efforts to resolve patient queries and/or escalate these to SMT.

A range of activities were available for patients, details of which were displayed on the wards but this availability did not always extend to evenings and weekends. Feedback from patients indicated there was a perception that nursing staff did not have a role in supporting patients with these activities.

'Safe Wards', a quality improvement (QI) project was being piloted on one ward to increase patient activities throughout the week including evenings and at weekends. Patients were encouraged to engage with each other and collectively choose between a range of activities such as bingo, quiz and karaoke. This example of good practice had been positively received by both staff and patients, it supports service user participation, reduces incidents of dysregulated behaviour and the use of restrictive practices.

Patients spoke positively about the care they received and believed being in hospital was helping their mental health. Patients confirmed that they were provided with information about their named nurse and Consultant Psychiatrist and information about their detention and human rights was provided on admission.

Relative feedback is a valued part of our inspection and we spoke to several relatives about their experience of the care their relatives received. There was praise for staff on their attentiveness and the care and treatment provided. However, some relatives found it difficult to speak to a member of staff about specific issues when they contacted the ward and the challenges of visiting restrictions was also raised. As part of a QI project, and in response to relative feedback, new leaflets were being developed to improve the quality of information provided for relatives.

Given the pressures of over occupancy being felt across the acute wards with day space areas being used as contingency beds, patient comfort was compromised. However, the impact on care & treatment was minimised with patients overall, reporting feeling safe & well cared for.

5.2.5 Patient Flow

All admission requests with the exception of patients admitted under the MHO are managed on a daily basis. At the time of the inspection, seven patients were waiting on admission for acute care and treatment. To support effective decision making, a 'bed priority tool' was used to prioritise patients in greatest need.

Each of the acute wards had a high number of patients detained under the MHO and were managing high levels of patient acuity. Bed pressures were evident across the wards resulting in acute patients being accommodated on contingency beds in day space areas. Patients no longer

in need of acute care were temporarily transferred to Carrick 4, the rehabilitation and recovery ward. The model of care provided in Carrick 4 ward is referenced further in 5.2.8.

Twelve patients were delayed in their discharge with some patients accommodated in acute wards for over 600 days. Discharge delays affect patient flow which impacts on bed availability for those requiring acute admission. This compromises patient comfort & safety due to potential increased risk of self-harm and dysregulated behaviours.

Patients were regularly referred for community living care packages and for some patients, multiple options had been explored without success. Inspectors were informed that the main barriers to discharge included the lack of suitable community placements.

A quality improvement project to improve admission and discharge processes was underway within the Trust. The focus of this project aims to consider different admission types: patients who are new or previously unknown to mental health services, patients who are known to mental health services who have experienced a relapse of their illness and those patients who are admitted in crisis. This information may help to support future admission practice. RTU provides patients who are due to be discharged with a 'discharge appointment card' where patients are offered a follow up appointment with community teams within seventy-two hours of discharge from hospital.

Despite the pressures and noted risks, patients reported feeling safe and well cared for.

It is RQIA's intention to share the findings from this inspection with regard to the impact over occupancy has on patient experience with the Strategic Planning and Performance Group (SPPG).

5.2.6 Governance

A review of whistleblowing notifications in 2022 and 2023 identified poor staff morale, bullying, concerns about governance and the management of adult safeguarding and incident management. Given the range of issues raised, the Trust commissioned an independent investigation in February 2023. This was completed with the recommendations shared with RQIA in May 2024. Findings relating to staffing and morale, adult safeguarding and governance correlated with what inspectors found during this inspection in terms of robust systems and a positive team morale.

Robust governance systems with effective communication mechanisms were in place to support escalation of risk, identification of themes and trends and senior management decision making.

The Trust operates a tiered process which supports escalation and theming at different levels. At ward level there was evidence of supportive and cohesive teams with good working relationships between the ward manager and staff to promote the delivery of safe and effective care Staff also spoke positively about the support provided by SMT with the presence of senior management across the Holywell site. The visibility of SMT could be improved at the Ross Thompson Unit, Causeway Hospital. The Multi-Disciplinary Team and Directorate Governance meeting minutes provided assurance through the Patient Safety Forum that themes and trends were analysed and escalated as appropriate to Divisional level.

Since the last acute ward inspection, improvement work in relation to adult safeguarding and incident management was evident with better systems in place and well-informed staff teams. Serious Adverse Incidents (SAI's) were monitored by the Trust's senior management team with identified learning following receipt of SAI recommendations being communicated to ward staff via team meetings.

Greater oversight is needed in relation to the progression of DoLS applications to ensure that patients subject to emergency provisions receive regular review. See section 5.2.9 for reference to DoLS.

5.2.7 Lissan 1

Lissan 1, the psychiatric intensive care unit, had undergone significant refurbishment over the previous twelve month period. Multi-patient dormitories had been replaced with single bedrooms which were equipped with ensuite facilities and a new seclusion room was provided. Capacity had reduced from nine to six beds. Intelligence received prior to inspection identified concerns about the lack of activities for patients and the newly refurbished environment and the impact on patient dignity. Staff also expressed concern about the lack of consultation or involvement in the design of the ward.

Upon completion of the refurbishment, ligature risks were identified in the ensuite bathrooms and on the bedroom doors. These were noted in the Ligature Risk Assessment and mitigations are in place which involves locking bedroom and ensuite bathroom doors before and after patient use. This impacts significantly on patient dignity and is also highly disruptive to patient's rest and quality of sleep at night. Additional ligature risks were also identified during the inspection and highlighted immediately to staff. The Trust must update the Ligature Risk Assessment to ensure that all identified ligature risks are included along with required actions and proposed timescales for completion. SMT were aware of the environmental concerns and advised during Feedback they were working with the Trust Estates team and contractors to address the risks identified.

Patients spoke positively about their engagement with the activities nurse and the range of activities available. The ward did not have its own laundry room and patients were reliant on their relatives and/or staff to utilise other facilities in the hospital site. The Trust advised of plans to install a laundry room within the ward.

The seclusion room was used to provide patients with a space to manage dysregulated behaviour and reduce risk to self and others. The use of seclusion is a restriction of a patient's liberty and should be used as a last resort and in line with regional operating procedures (Restrictive Practices in Health and Social Care (HSC) settings (2023). Increased use of distraction techniques, provision of a range of activities for patients and staff availability in communal areas of the ward has reduced the need for seclusion & restrictive practice. Review of seclusion records evidenced a good standard of recordings and reduced incidence of seclusion.

The seclusion room does not meet the standards outlined in Royal College of Psychiatry Standards for Psychiatric Inpatient Care Units (3rd edition)) July 2023. A number of issues were identified in relation to the design of the room which impacts on patient privacy, dignity and effective care. These were discussed during the inspection and with the Trust during feedback. The Trust acknowledged lessons learned in terms of the flaws in design of the ward and its seclusion room and the importance of involving and consulting staff who work in these areas.

Areas of improvement have been made in relation to ligature risks (see 5.2.1) and the need for staff to be consulted on all refurbishment and essential works across all wards.

5.2.8 Carrick 4 – Model of Care

Refurbishment works to Carrick 4 have been in progress for over a year resulting in patients being relocated temporarily to Inver 3 ward. The Trust envisage completion of works by the end of July 2024. The temporary relocation of patients from Carrick 4 to Inver 3 was not a suitable environment for the patients accommodated there nor was it conducive to effective rehabilitative care.

The Operational Policy for the ward was updated but remained in draft form since June 2023. There was a specific referral pathway and an assessment process to determine suitability for rehabilitation. The ward accommodated rehabilitation patients, long term resettlement patients and patients who had been temporarily transferred from one of the acute wards. The Trust's draft Bed Escalation Management Policy provided for the transfer of acute patients in situations where patients were either near the end of the acute phase of their illness, who had the potential to meet the referral criteria or, were in the process of being assessed for discharge to community placements. This information was not contained within the ward's Operational Policy and did not align with the referral pathway. A clearly defined specification for the ward is important to promote understanding of the purpose of the ward, referral criteria and support the patient's journey from acute care to rehabilitation and recovery.

The longer a patient remains in hospital, the greater the risk of institutionalisation, it reduces independence and personalisation of care. The long term resettlement patients had been living on the ward for a considerable period of time. It is recognised that there are challenges across the region in sourcing suitable community placements for patients who have complex needs and this can impact on timely and effective discharge. Weekly meetings attended by relevant MDT staff and senior management discussed the resettlement needs of patients and some progress of this was evident.

Concerns relating to the operational functioning of the ward, mixed model of care and the resettlement progress were raised with the Trust during inspection feedback.

The Trust reported further progress made to resettle long term patients and provided assurance in relation to the continued efforts to secure suitable placements with community providers. The care pathway for patients admitted to Carrick 4 has been reviewed by the Trust and a proposal submitted to the Strategic Planning and Performance Group (SPPG). This has impacted on the capacity to finalise the ward's operational policy. The Trust must continue to work with SPPG to ensure that the ward's core purpose is clearly defined.

RQIA requested the Trust provide further updates to RQIA in relation to patient resettlement and any change to the commissioning arrangements for Carrick 4. These issues will continue to be reviewed as part of inspection processes.

An area of improvement has been made in relation to patient resettlement.

5.2.9 Additional Findings

Inspectors reviewed the care provided in relation to mental health, restrictive practice, physical health and medicines management. There was good oversight of the MHO Detention forms for patients who were detained and good record keeping. Patients were provided with information about their detention and were informed of their right to be referred to The Review Tribunal and supported to attend when required. Patients who had voluntary status were aware of locked doors in place and this was reflected in their care plans. There were patients who met the criteria for DoLS with evidence of the DoLS application being progressed. There were patients who had emergency provisions in place and greater oversight is needed to ensure regular review.

Patients' physical healthcare needs were being met. Patients were appropriately assessed on admission and regularly monitored with care plans in place including risk screening and falls assessments. Patients also had access to health screening where required. Inspectors observed the Purposeful Inpatient Admission (PIPA) process where all aspects of a patient's care from admission to discharge is recorded and updated on a daily basis. Daily meetings involving the MDT were well organised with tasks agreed, prioritised and actioned to ensure patients were receiving appropriate care and treatment.

Pro Re Nata (as and when required) medications were not always consistently recorded as first, second or third line dosage in line with Trust protocol. It is recommended that the Trust ensures consistency of recordings for PRN across wards. Medication recordings (Kardex) omitted information relating to weight and height and clinical information from Kardexes was not always contained within care plans. The Trust should undertake an audit of medication recordings to ensure consistency across wards.

We reviewed records for patients in receipt of Electro-Convulsive Therapy (ECT) and found these to be very well documented with good information provided to patients prior to and post treatment. Pathways for patients who were prescribed lithium were less well evidenced. The potential for post incident review was identified to support learning about signs of a deteriorating patient and potential lithium toxicity.

An area of improvement has been made in relation to medicines management.

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	*10

* the total number of areas for improvement includes two which have been carried forward for review at the next inspection and one which has been restated for a second time.

Whilst recommendations were made during Feedback to the Trust, areas for improvement were not specifically identified at that time. 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 **Carrick 4 ward** **Carrick 4** **Ref:** Standard 4.1 Criteria: 4.1.3 (f) **Stated:** Second time **To be completed by:** 31 October 2023	The Northern Health and Social Care Trust must ensure that Senior management walk arounds are recorded with actions identified and shared with staff to support quality improvement for rehabilitation and recovery. Ref: 5.1
	Response by registered person detailing the actions taken: The NHSCT has developed the attached template to ensure that senior management walk arounds (both day and night) are recorded with actions identified and shared with staff. The template with agreed actions and updates will be shared with senior managers and discussed at ward level with staff during staff meetings. (Template for senior management walk around and staff meetings attached)
Area for improvement 2 **Carrick 4** **Ref:** Standard 5.1 **Criteria:** 5.3.3 (e) **Stated:** First time	The Northern Trust must ensure that the physical environment of the ward meets the standards as recommended by the Royal College of Psychiatrist (RCPSYCH) Standards for Inpatient Mental Health Rehabilitation Services 4th Edition, 2020. The Trust must have a formal record of identified actions arising from this review and clear timescales for completion.
	Response by registered person detailing the actions taken: The Trust anticipates the completion of works to the Carrick 4 ward by the end of July 2024. On completion the Trust will review the physical environment of the ward in accordance with the RCPSYCH standards for Inpatient Mental Health Rehabilitation Services, 4th Edition. An action plan will be devised following this review with clear times for completion. The Trust has also started the process of reviewing the ward operational policy and service provision inline with the RCPSYCH standards to ensure that all key stakeholders including patient cohort and staff are clear on what the service provision is for the ward.
Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3.1(f) **Stated:** First time **To be completed by:**	The Northern Health and Social Care Trust must ensure that the following actions are completed to effectively manage fire safety risks; • All Fire Risk Assessments have clear timescales for completion of actions; • Fire Doors are used in accordance with fire safety regulations and are not wedged open;

20 December 2024	• Information within PEEPs is suitable and sufficient to enable safe evacuation of patients in an emergency; • Corridors leading from fire exits are clutter free; • Oxygen tanks in resus bags are noted as a combustible gas in fire risk assessments. Ref: 5.2.1
	Response by registered person detailing the actions taken: The chair of the MH Fire Safety and Evacuation Planning and Sub group Trust has completed an audit and is assured that all fire risk assessments are up to date ensuring compliance with fire safety legislation and have clear timescales for completion of actions. The audit included assurances that all fire doors are used in accordance with fire safety regulations and are not wedged open and assured compliance with weekly/monthly checks and in house inspections across wards. Mitigations continue in the temporary Inver 3 ward with some fire doors being wedged open to ensure visibility across the ward. This has been approved as a temporary measure by Fire safety Advisor with a control measure of additional staff available in these areas. An audit of Personal Emergency Evacuation Plans (PEEPS) was also completed to ensure sufficient and appropriate information was included to enable the safe evacuation of patients in an emergency. The Trust has ensured that all corridors leading from fire exits are now clutter free and all excess furniture has been removed enabling a safe exit for patients and staff in the event of a fire. The Trust Senior Fire Safety Advisor has advised that the following text is inserted to the Fire Risk Assessment for each ward that has oxygen therapy within it. NOTE THERE IS OXYGEN THERAPY / RESUSCITATION EQUIPMENT LOCATED WITHIN THE WARD. WHEN NOT IN USE THE EQUIPMENT IS KEPT IN THE WARD OFFICE AND IS ONLY USED BY STAFF IN THE EVENT OF A MEDICAL EMERGENCY. APPROPRIATE SIGNAGE IS AFFIXED TO STORAGE LOCATION From the MH Fire Safety and evacuation planning subgroup a schedule of planned walk and talk fire drills is being compiled for the next 12 months.
Area for improvement 4 **Ref:** Standard 5.1 Criteria: 5.3.1 (f)	The Northern Health and Social Care Trust must ensure that • Each ward has an up to date ligature risk assessment which accurately reflects the ligature points and control measures in place;

Stated: First time **To be completed by:** 20 December 2024	• Relevant staff at ward level are aware of the ligature risks in their ward and the relevant mitigations; • All outstanding works and actions required should include timescales for completion and updated to reflect progress made. Ref: 5.2.1
	Response by registered person detailing the actions taken: The Trust has completed an audit and is assured that all wards have an up to date ligature risk assessment which accurately reflects the ligature points with mitigations in place for identified risks. Ligature risks identified and control measures in place are discussed at staff meetings as a standing agenda item to ensure that all relevant staff at ward level are aware of the ligature risks in their ward and the relevant mitigations. (Agenda for staff meetings attached) The Trust has been allocated Capital Task & Finish Scheme Monies to address outstanding anti-ligature risks across all wards in Holywell identified through ligature audits and/or RQIA recommendations. It is not anticipated that the allocated monies will be sufficient to address all outstanding ligature works and the works will therefore be prioritised to address those requirements with the highest risk rating. An action plan will be devised and updated accordingly. For all outstanding liagture risks, Ligature risk assessments will be updated including control measures to mitigate against identfied risks. These works will be in progress by December 24 and should be completed by end of 24/25 financial year.
Area for improvement 5 **Ref:** Standard 6.1 Criteria: 6.3.1(c) **Stated:** First time **To be completed by:** 20 December 2024	The Northern Health and Social Care Trust must ensure all future refurbishment works are completed in consultation with relevant staff with a record kept to ensure the environment meets the needs of patients' safety and dignity. Ref: 5.2.1
	Response by registered person detailing the actions taken: The Trust recognises the value of both staff and service user input when redesigning ward environments. There has been and continues to be extensive staff and service user involvement in the design of the new Mental health facility Birch Hill at every stage of the project to ensure that feedback from staff who work at ward level and who are familiar with ward environments is considered and integrated in the design of the ward environment across the new build to ensure it meets the needs of patients' safety and dignity. There now is an established meeting with estates that faciliatets update on works but also feedback from end user to estates.

Area for improvement 6 **Ref:** Standard 5.1 **Criteria**: 5.3.1(f) **Stated:** First time **To be completed by:** 20 August 2024	The Northern Health and Social Care Trust must implement an appropriate mechanism for patients to access assistance when required in order to maintain patient safety and dignity. The Northern Health and Social Care Trust should provide patients and relatives with information on admission about the mechanism in place to summon assistance. Ref: 5.2.1
	Response by registered person detailing the actions taken: The Trust recognise the importance of patients being able to access assistance from staff when required. Nurses carry out regular health and wellbeing checks on all the patients within their ward at regular intervals(Half hourly and more frequent depending on acuity and identified risks) and ensure patient care is provisioned on an individualised person centred approach. This person centred approach accounts for the identified needs, risk and associated management plans for each individual patient, which subsequently informs the nursing staff decision on how best to cohort patients across the wards and bedroom accommodations. A large percentage of patients in our acute admission wards are normally ambulatory and may not require the same level of physical care input. The allocation of beds is based partly on these assessments alongside the wellbeing checks that staff conduct, to ensure that any deterioration of a patient's physical or mental health is identified promptly and appropriate actions taken.The Trust are currently exploring options regarding nurse call systems and associated costings of same. Information regarding the general observations across the wards is provided verbally to all patients on admission, however an updated information leaflet is in draft awaiting patient consultation and final approval which provides same.

Area for improvement 7 **Ref:** Standard 4.1 **Criteria:** 4.3 (m) **Stated:** First time **To be completed by:** 20 December 2024	The Northern Health and Social Care Trust must ensure staff training is kept up to date and a clear record of training compliance for all wards is maintained. Ref: 5.2.3
	Response by registered person detailing the actions taken: All staff are advised of the need to remain compliant with mandatory training. A monthly table is collated across inpatient services which is forwarded to the Head of Service and nursing Services Manager for information; any training deficits are raised with the Ward Manager to address with the team. Staff training compliance is also monitored via the Governance team who issue reminders to teams regarding training updates required. Staff training compliance is also a standing item on the Senior menagerment monthly Workforce and Engagement meeting chaired by the divisional Director.The lead nurse for Nurse Education & Learning for division also drives this work ensuring compliance across all the wards with mandatory training. This post had been vacant for a period of time with the new nurse commencing post on 8 July 2024. The introduction of the new training system (LearnHSCNI) enables staff to view their training compliance and book onto relevant/mandatory training as necessary. Managers can also use this new system to view training compliance across their staff team. Staff across all wards are actively working to achieve full compliance against all mandatory training with a view to completion by the proposed deadline of 20 December, however it should be noted that some training has been temporarily stalled with a focus on Encompass training in prepartion of the Encompass system go live date on 7 November 2024 for NHSCT.
Area for improvement 8 **Ref:** Standard 5.1 **Criteria**: 5.3.1(a) **Stated:** First time **To be completed by:** 20 December 2024	The Northern Health and Social Care Trust must continue to pursue resettlement options for all patients who are delayed in their discharge to ensure suitable placements are identified in accordance with their needs. Ref: 5.2.8
	Response by registered person detailing the actions taken: The Trust remain committed to pursuing resettlement options for all patients who are delayed in their discharge to ensure suitable placements are identified in accordance with their needs. The Trust has appointed a temporary resettlement project lead whose role includes a focus on emerging pressures, delayed discharges, ECR's, High Cost placements and Resettlement options. A governance framework has been developed that ensures regular monitoring against progress on each of the aforementioned categories and timely decision making to avoid potential of any further delays. SPPG are

	invited to attend the Project Board at which progress of resettlement for patients who are delayed in discharge is discussed. The resettlement project lead liaises with both inpatient and community staff to ensure safe discharge planning and resettlement arrangements are efficiently and effectively coordinated.The Trust have recently successfully transitioned one of the long stay patients from Carrick 4 to a community setting and are actively pursuing options for the two remaining long stay patients within Carrick 4.
Area for improvement 9 **Ref:** Standard 5.1 Criteria: 5.3.1(f) **Stated:** Second time **To be completed by:** 28 December 2021	The Northern Health and Social Care Trust must ensure • There is a robust daily monitoring system for the cold storage of medicines; the minimum and maximum medicine refrigerator temperatures are recorded, the thermometer is reset every day and medicines are stored in accordance with the manufacturers' instructions; and • The contents of the bags are regularly inspected to take account of expired medicines and damaged packaging. Ref: 5.1
	Response by registered person detailing the actions taken: The Trust has completed a fridge audit across the wards to include assurances regarding compliance with the daily checking of fridge temperatures, the thermometer is reset every day and medicines are stored in accordance with the manufacturers instructions. The contents of the emergency bags on all wards are checked weekly by ward staff. The emergency equipment on the wards are checked and signed for daily (suction machine, defibrillator and oxygen cylinders). An audit regarding the contents of emergency bags is carried out monthly by the ECT team.
Area for improvement 10 **Ref:** Standard 5.1 Criteria: 5.3.1(f) **Stated:** First time **To be completed by:** 20 December 2024	In respect of medicines management, the Northern Health and Social Care Trust must undertake an audit of Kardex to ensure consistency of recordings across wards. Ref: 5.2.9
	Response by registered person detailing the actions taken: The Trust plans to undertake an audit of kardexes across the inpatient services to ensure consistency of recording across all wards with particular reference to PRN medications being recorded as first, second and third line dosage in line with Trust Protocol. This audit will also seek assurances that information relating to weight and height are recorded on kardexes and that relevant clinical information is contained within patient care plans. An audit template is currently being devised. It is anticipated with the move to Encompass which

	will include the electronic recording of medications and enable a reporting system to ensure compliance with medication management across services.

Please ensure this document is completed in full and returned via the Web Portal

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