Unannounced Inspection Report
8 May 2019

Southern Health and Social Care Trust
Bluestone Unit

Craigavon Area Hospital
68 Lurgan Rd
Portadown
BT63 5QQ
Tel No: 028 3836 6700

Inspectors: Wendy Mc Gregor, Cairn Magill and Carmel Treacy

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 from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

The Bluestone unit comprises of six wards that provide assessment and treatment to patients with acute mental health and learning disability needs.

Cloughmore is an 18 bedded mixed gender ward. The purpose of the ward is to provide acute assessment and treatment to patients aged 18 - 65 with acute mental health needs.

Silverwood is an 18 bedded mixed gender ward. The ward provides assessment and treatment for patients aged 18 – 65 with acute mental health needs.

Bronte is a18 bedded mixed gender ward. The ward provides assessment and treatment to patients aged 18 – 65 with acute mental health needs.

Rosebrook is a 10 bedded mixed gender ward. The ward provides care to patients with acute mental health needs who require care in a psychiatric intensive care unit (PICU).

Willows is a 20 bedded mixed gender ward. The ward provides assessment and treatment to patients with acute mental illness over 65years. The ward can also accommodate four patients aged 50 - 64 years.

Dorsy is a ten bedded mixed gender ward with nine beds available for use. The ward provides assessment and treatment to patients with acute mental health needs who have a learning disability.

Patients admitted to the Bluestone Unit have access to a full multi-disciplinary team which includes psychiatry, medical, nursing, occupational therapy (OT), social work and pharmacy support. Patients had access to a physiotherapist and a speech and language therapy and psychology service by referral. A patient and carer advocacy service was also available for patients receiving care on the ward.

3.0 Service details

Responsible person: Mr Shane Devlin, Chief Executive Officer Southern Health and Social Care Trust (SHSCT)	**Ward Managers:** **Cloughmore:** Sinead Davidson **Silverwood:** Angeline Magennis **Bronte:** Christopher Higgins **Rosebrook:** Lynsey Erskine **Willows:** Mary Donnelly **Dorsy:** Geraldine Dinsmore
Category of care: Acute Mental Health & Learning Disability	**Number of beds:** **Cloughmore:** 18 **Silverwood:** 18 **Bronte:** 18 **Rosebrook:** 10 **Willows:** 20 **Dorsy:** 10 (9 currently available for use)
Person in charge at the time of inspection: Andrew Ruck, Patient Flow and Bed Management Coordinator	

4.0 Inspection summary

An unannounced inspection took place on 8 May 2019.

This inspection was undertaken by three care inspectors.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

This inspection was undertaken following information received from staff working in the Bluestone unit alerting us to a number of occasions where wards were over occupied. This has resulted in patients sleeping in non-bedroom areas such as side rooms, and lounges and voluntary patients being admitted to a PICU environment. We also reviewed the Trusts mechanism for managing nursing staff shortages, which we identified, during our previous inspections on 31 August 2018 and 16 September 2018.

Inspectors visited three of the six wards; Rosebrook, Willows, and Dorsy as these wards were reported to be mostly affected by over occupancy.

On the day of the inspection, there were 10 patients in Rosebrook ward, 18 patients in Willows ward and nine patients in Dorsy ward. A total of 24 patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986 across the three wards inspected.

While RQIA does not have formal powers to investigate complaints about health and social care services we take all concerns brought to our attention seriously.

The following areas were examined during this inspection:

- bed management
- management of over occupancy including the environment;
- management of staffing levels; and
- additional fire safety precautions required when wards are over occupied.

Inspectors visited the wards and reviewed the care and treatment processes. Inspectors evidenced the following outcomes:

Areas of good practice:

- the regional bed management policy was being adhered to;
- a daily reporting system had been introduced and implemented which informed senior management team of the staffing levels required to meet the needs of patients
- an initiative had been implemented to recruit and retain nursing staff;
- the Trust is being represented in the development of the regional bed management protocol for learning disability;

The inspectors were concerned that:

- a consistent decision making process is not applied when determining the need to use PICU beds for voluntary patients.

- fire safety officers are not informed when wards are over occupied and fire risk assessments and management plans are not updated to reflect over occupancy.

RQIA acknowledge that there are pressures on acute care mental health beds across the region in Northern Ireland. RQIA wrote to the Department of Health on 18 September 2019 in accordance with the provision of Articles 4 of the health and Personal Social Services (Quality Improvements and Regulations) (Northern Ireland) Order 2003. However we are assured during the inspection that the Southern Trust was doing everything it could to address the risks and notify the relevant people.

4.1 Inspection outcome

Total number of areas for improvement	Six

Four of the five areas for improvement from the previous inspection on the 16 September 2018 were not assessed during this inspection and will be carried forward for assessment of compliance at the next inspection.

There are two new areas for improvement arising from this inspection. These are detailed in the Quality Improvement Plan (QIP).

Details of the QIP were discussed with the Trust's mental health and learning disability senior management team. The timescales for implementation of these improvements commence from the date of this inspection.

This inspection did not result in enforcement action.

5.0 How we inspect

Prior to inspection, a range of information relevant to the service was reviewed including the following records:

- Previous inspection reports
- Serious Adverse Incident notifications
- Information on Concerns
- Information on Complaints
- Other relevant intelligence received by RQIA

Each ward is assessed using an inspection framework. The methodology underpinning our inspections include; discussion with patients and relatives, observation of practice; focus groups with staff and review of documentation. Records examined during the inspection include: nursing records, medical records, senior management and governance reports, minutes of meetings, duty rotas and training records.

Findings of this inspection were shared with the Trust's mental health and learning disability senior management team at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection on 16 September 2018

The previous inspection of the Bluestone Unit was an unannounced inspection undertaken on 16 September 2018.

Four of the five areas for improvement made during the last inspection were not assessed during this inspection. These will be carried forward to the next inspection.

6.2 Review of areas for improvement from the previous inspection on 16 September 2018

Areas for improvement		Validation of compliance
Number 1 **Ref**: 5.3.3. (d) **Stated:** First time	The senior management team need to ensure there are robust governance mechanisms in place for the use of seclusion. This should include an audit on the use of the seclusion and the records kept.	**Not assessed**
	Action taken as confirmed during the inspection: This was a focused inspection and therefore compliance with this area for improvement was not assessed and will be carried forward for review at the next inspection.	
Number 2 **Ref**: 6.3.1(c) **Stated:** Second time	The Trust must ensure that there is sufficient staffing levels across each of the wards taking into consideration the needs of the patients, enhanced observation levels and the roles and responsibilities of staff at the various grades.	**Met**
	Action taken as confirmed during the inspection: The Trust has introduced a live reporting system that records staffing numbers and patient need daily. This live system informs senior management about where to direct nursing resources to ensure patient needs are met. On the day of the inspection we reviewed the live reporting system and noted no shortages were identified for that day.	
Number 3 **Ref:** 5.3.2 **Stated:** First time	The Trust must ensure that all incidents that meet the criteria for The Health and Social Care Board Procedure for the Reporting and Follow-up of Serious Adverse Incidents, November 2016 are reported in line with the procedure.	

	Action taken as confirmed during the inspection: This was a focused inspection and therefore compliance with this area for improvement was not assessed and will be carried forward for review at the next inspection.	**Not assessed**
Number 4 **Ref:** 5.3.1 **Stated:** First time	The Trust must ensure that a comprehensive multi-disciplinary review of risk and risk management strategies be undertaken immediately following any serious incident and must consider all professional/ discipline opinions. Where there is disagreement this must be evidenced in the minutes of the meeting and a further review should be undertaken more frequently to determine if the grounds for an alternative risk management plan is evidenced.	**Not assessed**
	Action taken as confirmed during the inspection: This was a focused inspection and therefore compliance with this area for improvement was not assessed and will be carried forward for review at the next inspection.	
Number 5 **Ref:** 5.3.1 **Stated:** First time	The Trust must ensure that all staff required to use MAPA techniques have up-to-date training and that any application of a MAPA technique as an intervention with a patient is agreed amongst staff delivering care and is proportionate to the risks.	**Not assessed**
	Action taken as confirmed during the inspection: This was a focused inspection and therefore compliance with this area for improvement was not assessed and will be carried forward for review at the next inspection.	

6.3 Inspection findings

Bed management arrangements

Prior to this inspection, we received information that wards within the Bluestone unit were admitting patients over and above the number of commissioned places. This resulted in patients sleeping in non-bedroom areas such as side rooms and lounges and the admission of patients who are voluntary to PICU.

Over occupancy of wards occurs when a patient who requires an admission cannot be accommodated in an inpatient mental health facility in any other Trust area because there are no available beds. Senior staff from the Southern Trust stated they make their decision to admit additional patients to the unit based on the risks the patient is presenting. On occasions the risks involved with over occupancy is of a lesser risk than not admitting a patient. We confirmed that the rationale for admitting additional patients and using areas less suitable to accommodate patients was proportionate to the risk.

Inspectors evidenced that there are appropriate governance arrangements in place to monitor over occupancy. Senior members of the Trusts management team assured us that bed occupancy is submitted on a monthly basis to the Health and Social Care Board and discussed at the regional bed management forum.

Environment

As a result of over occupancy we were informed that patients admitted on a voluntary basis were accommodated in the Psychiatric Intensive Care Unit (PICU). We were also informed that patients were accommodated in non-bedroom areas such as ward side rooms, lounges and the low stimulus area in one ward.

On the day of the inspection the bed flow manager informed us that no wards were over occupied.

We observed the areas on the wards that were used to accommodate additional patients. These areas were not ideal, however staff stated they ensured the privacy and dignity of patients was maintained at all times. Staff reported these areas were used for the shortest time possible and the patient moved to a bedroom as soon as one became available.

It is RQIA's view that a patient, who has agreed to a voluntary admission, should only be admitted to a Psychiatric Intensive Care Unit, as a last resort. However, there are circumstances when a voluntary patient requires an admission and where no beds are available, they are admitted to PICU.

Such circumstances require careful consideration, robust decision making and appropriate and effective safeguards need to be in place. The patient flow coordinator informed us of the decision making process that took place prior to admitting voluntary patients to PICU. This decision making process was appropriate and provided a clear rationale for these admissions. We are concerned that the same decision making process may not be consistently applied by staff because it was not recorded. We recommend that the Trust evidence consistency in decision making process by a having a recorded process in place for all staff to follow.
An area for improvement will be made.

The patient flow coordinator reported that the restrictions in the PICU environment are shared with patients and their families prior to admission and patients were asked if they consented to their admission. This information was documented in the patients care records and appropriate safeguards were in place.

The ward manager stated that patients who were accommodated in the extra care suite (which is an area located off the ward) were accommodated there for the shortest time possible until an appropriate bedroom became available. Safeguards are in place, the door to the area is not locked and the patient can move freely to and from the main ward.

During this inspection one patient was using the extra care suite. This was because of their presenting needs and not due to the ward being over occupied. On review of the patient's care records and speaking to the patient this was an appropriate use of the suite.

Fire safety precautions

Prior to this inspection, we were informed of wards that were over occupied in the Bluestone Unit. We could not evidence that fire risk assessments and management plans had been updated to reflect over occupied wards. We brought this to the attention of the SHSCT senior management team and requested them to review this urgently. An area for improvement will be made.

Staffing levels

This inspection was undertaken because of our findings in relation to reduced staffing levels in the Bluestone unit during the two most recent inspections on 31 August 2018 and 16 September 2018. The findings from these inspections resulted in RQIA taking escalation action in relation to low staffing levels in Bluestone.

During this inspection we assessed progress toward addressing this issue. We evidenced that the Trust had introduced and implemented a live reporting system to inform the senior management team of staffing requirements for each ward, on a daily basis. This takes into account the number of patients on each ward and the presenting needs of every patient. We reviewed the live system in operation and noted it to be an effective system that provides the senior management team with up to date information. We were able to confirm during the inspection there was evidence that systems were in place to monitor staffing levels and patient need.

In addition, the Trust has reviewed and implemented ways for improved retention and recruitment of staff. This included appointing 12 Band 6 nurses from existing staff across all the wards. Senior management also stated that 19 pre-registration nurses had been offered posts when they qualify in August 2019.

Other inspection findings

Patient experience

We met with four patients and received questionnaire feedback from an additional four who were, overall positive about their experiences of the wards. Patients reported that they felt safe and that their experience of ward was generally good. Patients reported that staff were supportive and compassionate care was given. We observed positive interactions between staff and patients during the inspection.

Relative feedback

Two relatives returned questionnaires indicating they were satisfied with the care their relative received on the wards. Relatives said staff were excellent, professional and very caring.

Number of areas for improvement	6

7.0 Quality improvement plan

Areas for improvement identified during the inspection of 16 September 2018 are detailed in the QIP along with two new areas for improvement. Details of the QIP were discussed with SHSCT mental health and learning disability senior management team as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

The Trust should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further action. It is the responsibility of the Trust to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas for improvement

Areas for improvement have been identified and action is required to ensure compliance with The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to meet the areas for improvement identified. The Trust should confirm that these actions have been completed and return the completed QIP to MHLD.Programme@rqia.org.uk for assessment by the inspector by **17 December 2019**.

Quality Improvement Plan

This inspection is underpinned by The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

The Trust must ensure the following findings are addressed:

Area for improvement No. 1 **Ref**: Standard 5.3.3. (d) **Stated:** First time **To be completed by:** 8 September 2019	The senior management team need to ensure there are robust governance mechanisms in place for the use of seclusion. This should include an audit on the use of the seclusion and the records kept. **Response by the Trust detailing the actions given:** An audit has been completed for the episodes of Seclusion within Rosebrook Ward (PICU) from 7 January 2019 to 6 January 2020 (n=31). Following the completion of this baseline audit, processes are now in place to audit further episodes of Seclusion within Rosebrook in real time using an electronic audit form. Information relating to seclusion will be reported on at each MH Acute Governance Forum and any trends escalated to Directorate Governance for review. As a result of the initial baseline audit a number of recommendations have been identified and these recommendations will be an agenda item at the January 2020 Mental Health Acute Governance Meeting for agreement. Recommendations include a review of the Seclusion Policy and Procedure to strenghten clinical practice and documentation of continuous observations. New draft documentation has been developed in order to strenghten assurances in respect to senior nurse and medical reviews as appropriate. A seclusion audit for Dorsy will also be taken forward and will form part of an audit plan for the Unit April 2020 to March 2021. Results of the Dorsy audit will be available in February 2020.
Area for improvement No. 2 **Ref:** Standard 5.3.2 **Stated:** First time **To be completed by:** Immediately and ongoing	The Trust must ensure that all incidents that meet the criteria for The Health and Social Care Board Procedure for the Reporting and Follow-up of Serious Adverse Incidents, November 2016 are reported in line with the procedure. **Response by the Trust detailing the actions given:** Enhanced systems and processes for the management of incidents has been implemented across the Unit, which now includes a daily, high level scan by a Senior Nurse Manager (Band 8a and above). All incidents are reviewed contemporaneously and those rated at moderate and above are subject to a more detailed scrutiny. The Unit Senior Management team triage to assess if these meet SAI criteria along with the Directorate Governance Lead as well as clinicians, and initiate as appropriate. All incidents rated at moderate and above are tabled by the Directorate Governance Lead at the

	Acute Governance Forum for review.
Area for improvement No. 3 **Ref:** Standard 5.3.1 **Stated:** First time **To be completed by:** Immediately and ongoing	The Trust must ensure that a comprehensive multi-disciplinary review of risk and risk management strategies be undertaken immediately following any serious incident and must consider all professional/ discipline opinions. Where there is disagreement this must be evidenced in the minutes of the meeting and a further review should be undertaken more frequently to determine if the grounds for an alternative risk management plan is evidenced.
	Response by the Trust detailing the actions given: All Datix incidents are reviewed daily and triaged by a senior nurse. All significant risks identified across the Unit through Datix and trend analysis are entered onto the Unit Risk Register and reasonably practicable control measures agreed. These are reviewed every two months (minimum), or more frequent if any change, at the Unit Governance Fora. MH Acute Governance Forum is chaired by the Associate Medical Director and the Dorsy Governance Forum is Chaired by the Clinical Director for LD. Any risks moderate and above are entered onto the Diretorate Risk Register for escalation and discussion at the Directorate MDT Risk and Mangaement Forum chaired by the Director of MHD sevices. When a serious incident occurs an MDT risk strategy meeting is convened, which is minuted. Actions agreed are subject to ongoing review. Following identification of an SAI the Directorate Goverenance Lead works with members of the relevant MDT to identify members of an SAI group. All panels are chaired by a Consultant Psychiatrist. All discussions, contributions and recommendations are detailed in the minutes of meetingsand shared with all involved for factual accuracy before sign-off. The Trust has commisioned an SAI Masterclasses for staff acting as panel members.
Area for improvement No. 4 **Ref:** Standard 5.3.1 **Stated:** First time **To be completed by:** 8 September 2019	The Trust must ensure that all staff required to use MAPA techniques have up-to-date training and that any application of a MAPA technique as an intervention with a patient is agreed amongst staff delivering care and is proportionate to the risks.
	Response by the Trust detailing the actions given: All Bluestone substantive staff are trained to MAPA Level 4 and have yearly refresher dates monitored and recorded on the new Health Roster system. Currently 76% of the nursing workforce within the Unit are trained in MAPA Level 4 (139 trained | SIP 183WTE). Staff utilise these techniques within the scope of the Trust MOVA policy and procedures. When MAPA techniques have been used a Datix incident form is completed along with electronic RPI form (currently

	being piloted on DATIX system in Rosebrook and Silverwood, which will be subject to audit with a view to roll out across all wards). The Trust is contributing to the regional work on reduction of restrictive practices. As part of this work a baseline audit of 2018/19 and the first 3/4 of 2019/20 for Silverwood and Rosebrook has been undertaken. MAPA training for regular temporary staff has been requested and we are awaiting dates from the MAPA team.
Area for improvement No. 5 **Ref**: **Ref:** 6.1 **Stated:** First time **To be completed by:** 8 June 2019	The Trust must ensure that each of the bed managers apply the same decision making process outlining all considerations taken prior to admitting voluntary patients to the PICU.
	Response by the Trust detailing the actions given: A new, draft version of the Bed Management Policy to promote consistent decision making is currently out for consultation. A final draft of this policy is scheduled to be presented at the MH Governance Forum 29.01.2020. If an additional, undesignated bed is utilised or a voluntary patient admitted to PICU there is an escalation in place to alert the Senior Management team and RQIA.
Area for Improvement No. 6 **Ref**: Standard 4.3 (i) **Stated:** First time **To be completed by:** 8 August 2019	The Trust must ensure that environmental risk assessments are reviewed and updated to reflect when wards are over occupied.
	Response by the Trust detailing the actions given: There are now processes in place to escalate and to alert the senior team when over occupancy occurs. A daily bed state is circulated by the Unit Night Coordinator to senior managers across the Directorate. This daily bed state demonstrates by way of a traffic light system the current bed status across the Unit ie. Green = 3 or more beds available, Amber = 2 beds available and Red = 1 or less beds available. These changes will be reflected in the Bed Management Policy (due for sign-off at MH GOvernance FOrum 29.01.2020). Designated areas have been identified for use and an enviornmental and patient safety risk assessment has been completed for these designated areas. This risk has been entered onto the Bluestone Unit Risk Register which is subjected to bi-monthly review.

Name of person (s) completing the QIP	Lynn Woolsey		
Signature of person (s) completing the QIP		**Date completed**	17.01.2020
Name of person approving the QIP	Barney McNeany		
Signature of person approving the QIP		**Date approved**	17.01.2020

Name of RQIA inspector assessing response	Cairn Magill		
Signature of RQIA inspector assessing response		**Date approved**	28/07/20

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