Unannounced Inspection Report
16 September 2018

Southern Health and Social Care Trust
Bluestone Unit

Craigavon Area Hospital
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Inspectors: Cairn Magill and Audrey McLellan

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Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service 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, psychology and pharmacy support. Patients had access to a physiotherapist and a speech and language therapy 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:** Rebecca Fearon (Acting) **Silverwood:** Angeline Magennis **Bronte:** Elaine Mc Broom **Rosebrook:** Lynsey Erskine **Willows:** Mary Donnelly **Dorsy Unit:** Geraldine Dinsmore
Category of care: Mental Health and Learning Disability	**Number of beds:** **Cloughmore** 18 **Silverwood** 18 **Bronte** 18 **Rosebrook** 10 **Willows** 20 **Dorsy Unit** 10 (9 beds available for use)
Person in charge at the time of inspection: Rebecca Fearon Acting Ward sister	

4.0 Inspection summary

An unannounced inspection took place on 16 September 2018. This inspection was undertaken out of hours on a Sunday.

This inspection was undertaken by two care inspectors.

On the day of the inspection all wards in the Bluestone unit were not at full occupancy.

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).

The inspection was undertaken due to concerns raised anonymously to RQIA in relation to staffing shortages. These concerns were similar to the findings of the recent inspection on 31 August 2018. Other concerns raised anonymously were in relation to a number of occasions where wards in the Bluestone unit were over occupied. This resulted in patients sleeping in a temporary bedroom in the extra care suite (an area that can also be used for seclusion) in Rosebrook Psychiatric Intensive Care Unit (PICU).

The Trust had previously issued an early alert notification to the Department of Health on 24 August 2018 detailing that the Bluestone unit was experiencing a greater demand for beds than they had capacity for, they had accommodated additional patient admissions by using temporary beds and they had acknowledged staffing pressures as they reported they had to rely on bank staff on a daily basis.

The following areas were examined during this inspection:

- management of over occupancy
- staffing
- staff training records
- patient care records

The previous Quality Improvement Plan (QIP) relating to this unit was also reviewed, to assess if the Trust had addressed areas of improvement identified during the most recent inspection of Bluestone Unit.

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

Areas of good practice:
Inspectors observed that staff managed and supported patients with dignity, respect and in a compassionate manner.

Inspectors were concerned that:
Restricted practices such as seclusion and physical interventions were not used in accordance with Trust policy and procedure.

Incidents which met the criteria for investigation under the HSCB, Procedure for the Reporting and Follow up of Serious Adverse Incidents, November 2016 were not reported in line with the procedure.

4.1 Inspection outcome

Total number of areas for improvement	5

There are five areas for improvement arising from this inspection, comprising of four new areas for improvement and one area for improvement which will be re-worded and stated for a second time. These are detailed in the Quality Improvement Plan (QIP).

The findings from this inspection evidenced a lack of progress in relation to the management of staffing levels since the previous inspection on 31 August 2019. RQIA continued to be concerned that the number of nursing staff available in the Bluestone unit was not sufficient enough to meet the needs of the patients admitted.

A serious concern meeting was held on 20 September 2018. At this meeting the Trust senior management team agreed to review their nursing staffing model and to share the model at a further meeting with RQIA on 12 October 2018.

Details of the QIP were discussed with Andrew Ruck, patient flow coordinator, by telephone as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

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.

Areas for improvement identified at the previous inspection were reviewed and an assessment of achievement was recorded as met, partially met or not met.

Findings of this inspection were shared with Andrew Ruck, patient flow coordinator at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection on 31 August 2018

The previous inspection of the Bluestone Unit was an unannounced inspection undertaken on 31 August 2018.

The completed QIP was returned by the Trust to RQIA and was subsequently approved by the inspector.

6.2 Review of areas for improvement from the previous inspection on 31 August 2018

Areas for improvement		Validation of compliance
Area for Improvement No. 1 **Ref**: Standard 4.3 (J) **Stated:** First time	The Trust should ensure there are sufficient numbers of band 5 staff nurses employed within each ward and across the Bluestone unit. The number of staff nurses available for duty should be in accordance to the Southern Health and Social Care Trust staffing level guidance and the presenting needs of patients.	**Not Met**
	Action taken as confirmed during the inspection: We reviewed nursing staff rotas, the numbers of patients on each ward, number of patients requiring enhanced observations and the skill mix of staff. There were insufficient registered nurses (Band 5) and nursing assistants (Band 3) across three of the six wards inspected; Silverwood, Rosebrook (PICU) and Dorsy. This area of improvement will be reworded and stated for a second time.	

6.3 Inspection findings

Management of over occupancy

Prior to this inspection, we received information that wards within the Bluestone unit were admitting patients over and above the number of commissioned places. On the day of the inspection no wards over occupied.

Prior to this inspection we were informed as a result of over occupancy patients were sleeping in the extra care suite (an area that can also be used for seclusion) in PICU. On the day of the inspection none of the wards were over occupied and the extra care suite was not used as a bedroom.

Staffing

The inspection was undertaken due to concerns raised anonymously to RQIA in relation to nursing staffing shortages. These concerns were similar to the findings of the recent inspection on 31 August 2018.

We reviewed and analysed the following information; the number of patients admitted; the number of patients requiring enhanced observations; the skill mix and numbers of nursing staff on each ward.

We found that staffing levels did not meet the needs of all patients who required enhanced observations. Staff who provided enhanced observations did not receive adequate breaks and could not be rotated with other staff in accordance with Trust policy and procedure. Enhanced observations were not always provided as staff were required to administer medication. An area for improvement will be made.

Additional findings

Restrictive practices (seclusion)

Prior to the inspection we were informed that the extra care suite in PICU (an area that can also be used for seclusion) was used during periods of over occupancy. There were no patients using the area on the day of the inspection. However as part of the inspection process we reviewed seclusion records in relation to one patient who had required seclusion previous to the inspection.

We found evidence in the patient' records that seclusion was not used in all occasions as a last resort, or proportionate to the risks presented by the patient or for the shortest time possible.

The ward manager had informed us that she had recently circulated the Seclusion policy to all staff working on the ward. However staff who spoke us indicated there remained inconsistent practices among various staff when patients are in seclusion. Some staff allowed patients out of seclusion to have a cigarette and / or a cup of tea while others strictly adhere to the SHSCT seclusion policy.

We were also concerned regarding the records maintained once a patient required seclusion. It was difficult to establish from the records when a patient was in seclusion and when seclusion had ceased. There was no evidence that the use of seclusion and associated record keeping had been audited by ward or senior trust management and all staff had not received training in the use of seclusion in accordance with Trust policy and procedure. An area of improvement will be made in relation to the governance and oversight of the use of seclusion.

Management of a serious incident

During the inspection we were informed by ward staff of a serious incident that had occurred on a ward prior to the inspection. The incident involved a patient threatening to harm staff. This resulted in the ward requiring support from the PSNI. We reviewed the records in relation to the incident and found that the incident met the criteria for reporting in accordance with the Health and Social Care Board (HSCB) Procedure for the Reporting and Follow up of Serious Adverse Incidents, November 2016.

The incident had not been reported in accordance with this procedure. In addition information recorded on the Trust's electronic incident recording system (DATIX) was brief and lacked detail. An area for improvement will be made.

Nursing staff reported to us their concern in relation to multidisciplinary team decision making on the risk management of the patient and said that their opinion was not considered. On review of the patient's records we found that the patient's risk assessment and Positive Behaviour Support Plan, had not been updated since the incident and there was no record of a difference of an opinion in relation to the management of this patients risks. An area for Improvement has been made.

Managing Aggression and Potential Aggression (MAPA) Training

During the inspection staff reported to us that they were concerned all staff were not consistently applying the most appropriate level of physical intervention (MAPA) during incidents as physical interventions were not always proportionate to the risk. On review of the records not all staff had received up to date training on MAPA. An area of improvement will be made.

Staff Views

During the inspection staff told us that currently they were concerned about managing the high risks with current staffing levels and during periods of patient over occupancy. Staff stated they had raised this with Trust senior management. Inspectors also observed the challenges staff faced in supporting patients who required high levels of enhanced observations within a ward setting.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Andrew Ruck, patient flow coordinator 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 where 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.Programmme@rqia.org.uk for assessment by the inspector by **17 December 2019.**

Quality Improvement Plan	
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:** 16 December 2018	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 taken:** 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 6.3.1(c) **Stated:** Second time **To be completed by:** 16 October 2018	The senior management team need to ensure there are 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. **Response by the Trust detailing the actions taken:** The ongoing challenge of maintaining safe staffing levels across wards needs to be set in the context of the regional position. Delivering Care Phase 5a is the DoH policy position for required staffing levels in each MH ward, however, this Phase has yet to be funded and there are insufficient RNs in the region to achieve this required level. Additionally, this work has just commenced for LD inpatients.

	The dynamic determination of what suffient staffing levels are incorporates many factors, and the senior management team along with Ward Managers assess this on a daily basis as a minimum. A bed status report is complied and circulated by the Night Coordinator. This informs the daily bed & staff management meeting chaired by the Unit's Lead Nurse. Factors considered include number of beds occupied, numbers and skill mix of staff available, levels of special oberservations and patient acuity as well as factors such as over occupancy. This is reviewed throughout the day and night if the situation changes. Staff are redeployed across the Unit in order to meet patient need and temporary staffing solutions (bank, agency, additional hours, overtime) are maximised. A senior nurse (Band 7 or above*) carries the bleep for the Unit and is therefore the senior nurse contactable for staff if they have staffing or safety concerns. *This is a new rule introduced for the Unit and we may still have on occassions a Band 6 holding the bleep, however, we are working towards ensuring that it is Band 7 and above only. In addition, a Directorate on-call rota has been introduced, ensuring staff have access to a Senior Manger, Band 8a and above, 24/7. An Escalation Flow Chart was developed to assist staff which is currently being updated to reflect the Directorate on-call arrangements. In situations where we have identified insufficient staffing levels, we have taken the position to close the Unit to external admissions, and have notified RQIA & DoH through the regional Early Alert process. In addition, the Unit has purchased the Health Roster system to ensure optimal utilisation of the available workforce and provide access to real-time staffing levels. A Health Roster Officer has been appointed to work with staff to implement, manage the system and provide reports to inform decions. Recruitment activity is ongoing with an open, rolling ad for RNs as well as specific on-site recruitment days. A recruitment day is also planned for Senior Nursing Assistants March 2020. The senior team is in the process of moving to 5WTE Band 6 per ward. This is being actioned at financial risk to the Directorate and Trust, and is a conversion of Band 5 to Band 6 posts to move towards clinical senior staff nurse cover for the majority of the 24/7 period. An IPT detailing the MDT required to deliver care across MH&LD in-patient wards is currently being developed.
Area for Improvement No. 3 **Ref:** 5.3.2 **Stated:** First time **To be completed by:** Immediately and on-going	The senior management team must ensure all incidents that meet the criteria for The Health and Social Care Board Procedure for the Reporting and Follow-up of Serious Adverse Incidents are reported in line with the procedure, November 2016.
	Response by the Trust detailing the actions taken: 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. 4 **Ref:** 5.3.1 **Stated:** First time **To be completed by:** Immediately and on-going	A comprehensive multi-disciplinary review of risk and risk management strategies must 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 taken:** 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. There are now processes in place to escalate and to alert the senior team when over occupancy occurs. Discussions between the Assistant Director and Director take place immediately on indications that the wards are approaching over occupancy. However it must be noted that in common with other Trusts in NI we have participated in the NHS Benchmarking scheme and our DTOCs and Average Length of stay is in keeping with other Trusts across the UK who are facing significant pressure. Southern Trust has on a regular basis raised the issue of running over 100% occupied (as a result of using leave beds) through the Early Alert process. Managing this level of demand within our available beds is not within our control. Benchmarks show we have fewer beds than required for the population of the Southern Trust. 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.

Area for Improvement No. 5 **Ref:** 5.3.1 **Stated:** First time **To be completed by:** 16 October 2018	The Senior management team must assure themselves 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 taken: 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.

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MHLD.Programmme@rqia.org.uk ***from the authorised email address****

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