The Regulation and Quality Improvement Authority

Inspection Report

8 December 2021 – 10 January 2022

Southern Health & Social Care Trust

Bluestone Unit
Craigavon Area Hospital
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Portadown
Craigavon
BT63 5QQ
Tel No: 028 3836 6700

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: Southern Health and Social Care Trust (SHSCT)	**Responsible Individual(s):** Mr. Shane Devlin, Chief Executive Officer; SHSCT (The Trust)
Person in charge at the time of inspection: Mr. William Delaney; Assistant Service Manager (SHSCT)	**Number of commissioned beds:** This inspection included 4 wards: Cloughmore: 18; Bronte: 18; Silverwood: 18; Rosebrook PICU: 10
Categories of care: Mental Health (MH) Acute Admission; Psychiatric Intensive Care (PICU.)	**Number of beds occupied in the wards on the day of this inspection:** Cloughmore: 18 Bronte: 18 (including 2 patients on leave) Silverwood: 17 (with one planned discharge) Rosebrook PICU: 7

Brief description of the accommodation/how the service operates:

Bluestone unit comprises of five mental health wards; Cloughmore; Bronte; Silverwood; Rosebrook and Willows. Willows ward has been commissioned for 20 beds, four of which can accommodate patients between 50-65 years of age; the remaining 16 beds accommodate patients with functioning mental health from 65 years and over.

This inspection focused on three mixed gender mental health acute admission wards and one psychiatric intensive care unit (PICU) for people aged between 18 and 65 years in the Southern Health and Social Care Trust (The Trust). Cloughmore, Bronte and Silverwood wards provide assessment and treatment for people with acute mental health needs while Rosebrook is the PICU for patients who require this level of support. Patients admitted for psychiatric intensive care are detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO) and patients admitted to the acute mental health wards can be voluntary or detained. All wards consist of single occupancy bedrooms with ensuite facilities.

2.0 Inspection summary

An unannounced inspection to the mental health acute admission wards across the Trust commenced on Wednesday 8 December 2021 at 9:00am and concluded on 10 January 2022 with feedback to the senior management team (SMT).

The inspection team consisted of care and pharmacy inspectors with input from RQIA's Clinical Lead.

This inspection formed part of a series of inspections to the acute mental health inpatient services across all five Health and Social Care (HSC) Trusts in Northern Ireland. These inspections are being undertaken following a review of information and intelligence, highlighting significant pressures across three HSC Trusts as a result of ongoing bed pressures in acute mental health inpatient services in Northern Ireland. Best practice guidelines recommend that bed occupancy should be at 85%. At present demand for acute mental health inpatient beds in Northern Ireland has increased significantly and occupancy levels have escalated to over 100%. On occasions there have been no commissioned beds reported as being available across Northern Ireland, leading to decisions to admit patients to contingency beds or in some cases to support patients to sleep on settees or chairs until such times as a bed becomes available. This series of inspections aims to identify whether over occupancy is impacting the safe delivery of patient care and treatment. It also aims to share good practice between Trusts to manage over occupancy and to support regional wide improvements.

The inspection focused on eleven key themes: patient flow; environment; restrictive practices; patient comfort, care and treatment, staffing, incident management and adult safeguarding; medicines management; governance and leadership; staff engagement; and patient engagement. Each theme was assessed by inspectors to determine if over occupancy was affecting the delivery of safe care. Additionally, any areas for improvement (AFI) identified during the previous inspection undertaken on 16-29 July 2020 were also reviewed.

This inspection identified that the Trust's acute mental health inpatient wards were frequently over occupied. We determined that the over occupancy presented some challenges but had minimal impact on the ability of staff to deliver safe and effective care to patients.
We observed evidence of resilient staff teams, comprising of confident nursing staff who work well together and good multi-disciplinary team (MDT) working arrangements. Staff were observed delivering compassionate care in a timely and professional manner. Effective leadership within the wards and at senior management level has enabled the Trust to deliver a safe and compassionate service whilst embedding a least restrictive approach to supporting people with mental illness.

Staffing levels were safe and staff were routinely observed providing a high standard of care and treatment. Staff reported that there was good support from line managers, and that staffing levels had improved with proactive recruitment and opportunities for career progression.

Ward environments were clean and tidy and conducive to care and treatment. We observed good COVID-19 safety measures and signage displayed throughout the wards.

Nine previous areas for improvement (AFI) were reviewed during the course of the inspection.

Eight have been assessed as being met and one as partially met, this AFI relates to incident management and will be discussed in more detail in section 5.2.7 of this report and will be stated for a second time.

Two new AFIs were made in relation to staffing and adult safeguarding.

3.0 How we inspect

RQIA's inspections form part of the ongoing assessment of the quality of services. To do this we gather and review information we hold about the service, examine a variety of relevant records, meet and talk with staff and management, observe practices throughout the inspection and engage with patients and relatives.

The information obtained is then considered before a determination is made on whether the service is operating in accordance with the relevant legislation and quality standards. Our reports reflect how the service was performing at the time of inspection, highlighting both good practice and any AFI's. It is the responsibility of the Trust to ensure compliance with legislation, standards and best practice, and to address any deficits identified during the inspection.

4.0 What people told us about the service

Questionnaires were placed on the wards inviting patients and relatives to complete these and post them to us. Posters were placed throughout wards inviting staff to complete an electronic questionnaire.

During the inspection we spoke with several patients in each ward and we also received one patient and one relative questionnaire via post following the inspection, all indicating that patients and relatives were satisfied that the care was safe and effective, and that patients were treated with compassion within a service that was well led.

During the inspection we conducted a total of 12 staff interviews and we received three responses via the electronic survey. Staff responses indicated that they felt patient care was safe, effective, that patients were treated with compassion and that the service was well led. All staff indicated that they felt supported in their roles and that the senior management team (SMT) were visible on the wards and responsive.

5.0 The inspection

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

The last inspection to Bluestone Unit was undertaken on 16 – 29 July 2020. Nine AFIs were identified.

Areas for improvement from the last inspection on 16 – 29 July 2020		
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 4.3 (l) **Stated:** First time	The Trust must ensure that environmental risk assessments are reviewed and updated to reflect when wards are over occupied.	**Met**
	Action taken as confirmed during the inspection: Environmental risk assessments had been reviewed and updated, reflecting when the ward was over-occupied. They demonstrated evidence of consistency in decision making during periods of over-occupancy with a recorded process in place for all staff to follow.	
Area for improvement 2 **Ref**: Standard 5.3.1 (f) **Stated:** First time	The Trust must ensure all risk registers are reviewed and updated to reflect the delayed discharges in Rosebrook. Consideration should be given to Rosebrook having a specific risk register given the number of incidents of violence, aggression and abuse towards staff.	**Met**
	Action taken as confirmed during the inspection: The Trust has reviewed and improved its governance oversight and reporting process since our last inspection. The Trust has a delayed discharge spreadsheet which notes patients who are medically fit for discharge and the reasons for their delay. This is a live document which is updated weekly evidencing what efforts the Trust have made to progress their discharge and what still needs to happen. Rosebrook has its own risk register which acknowledges the risks associated with the patient profile in PICU and increased risk of violence. This also informs the unit risk register. A weekly review of incidents of violence and aggression and abuse towards staff across all settings in the directorate takes place. This is evidenced in the Mental Health weekly Governance debrief report.	

Area for improvement 3 **Ref**: Standard 5.3.3(d) **Stated:** Second time	The Trust should implement a system to ensure the equal and appropriate distribution of staff skill mix across the Bluestone unit that considers the complex needs of all patients admitted to each ward.	**Met**
	Action taken as confirmed during the inspection: The night coordinator ensures there is an appropriate distribution of staff in terms of numbers and skill mix. Every morning there is a bed management/ patient acuity meeting. At this meeting patient acuity and staffing levels are considered. If required, decisions are made to share staff across the unit as needs dictate. Following a successful recruitment drive each ward had five whole time equivalent deputy ward managers at Band 6 appointed. This has strengthened senior nurse cover on a 24/7 basis. 23 health care assistants were also appointed across Bluestone unit thus improving the skill mix.	
Area for improvement 4 **Ref**: Standard 5.3.2 (a) **Stated:** Second time	The Trust should review the high rate of incidents in Rosebrook ward using appropriate methodology to establish the reasons and put in place a clear and measurable action plan that will aim to reduce the number of incidents in Rosebrook, considering the findings of this inspection.	**Met**
	Action taken as confirmed during the inspection: The Trust complete a weekly review of all incidents that are risk rated moderate or above that occur across the directorate. This includes Rosebrook. The Trust also have a live risk register for Rosebrook which notes trends and themes and actions to be taken to mitigate risks.	

Area for improvement 5 **Ref**: Standard 5.31 (f) ; 5.32(a) **Stated:** First time	The Trust must strengthen the governance oversight of incident management to ensure: a) implementation of a programme of audit to provide assurance that the established processes are operating effectively; b) all incidents are graded appropriately;	**Partially met**
	Action taken as confirmed during the inspection: This AFI has been partially met; the inspection determined that (a) had been met. There is auditing in place to provide assurances that the processes are operating effectively. However, there were concerns identified around the appropriate grading of incidents (b) with incidents often being graded as insignificant that may warrant higher grading due to the intensity or frequency of the incident. Further details are available in section 5.2.7	
Area for improvement 6 **Ref**: Standard 5.3.1 (a) **Stated** :Second 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.	**Met**
	Action taken as confirmed during the inspection: Following a serious incident an MDT risk strategy meeting is convened, the incident is discussed and the appropriate risk assessments and management plans are updated. Meetings are recorded and minutes available for review. Any actions agreed are also subject to ongoing review. If there is any disagreement within MDT opinion, follow up meetings are scheduled more frequently and escalation to senior management initiated. In addition the Trust have invested in resources to improve staff morale and better working	

	relationships within the MDT. Interviews with staff of all grades indicated this has helped staff feel valued and respected.	
Area for improvement 7 **Ref**: Standard 5.3.1 (c) **Stated:** First time	The Trust must ensure there is an agreed policy and procedure in place for the management and oversight of the use of CCTV in the hospital. The Trust must implement assurance mechanisms to ensure CCTV is being used in line with the policy.	**Carried Forward to next inspection**
	Action taken as confirmed during the inspection: The Trust are currently reviewing the Policy for CCTV. "The Procedure on the management and use of CCTV Equipment and images within Bluestone Unit October was implemented in October 2020 and is due for review October 2023. As the policy is being reviewed we will assess this AFI on our next inspection. The Trust also implemented a pilot of body worn cameras (BWC) in one ward. The standard operating procedures for the use of BWC in Bluestone Unit was available to view during the inspection.	
Area for improvement 8 **Ref**: Standard 5.3.1(d) **Stated:** First time	The Trust must ensure that relevant safeguarding information is available and displayed for staff, patients and visitors.	**Met**
	Action taken as confirmed during the inspection: Safeguarding information and contact details for the adult safeguarding teams was displayed for patients and families in each ward. This information was also shared in the 'information packs' provided to patients on admission and sent to next of kin.	

Area for improvement 9 **Ref**: Standard 7.3 (j) **Stated:** Second time	The Trust should take appropriate action to establish the reasons for low staff morale in Rosebrook ward, and put in place a clear and measurable action plan that will address the issues. There should be clear evidence that all staff are fully involved.	**Met**
	Action taken as confirmed during the inspection: The Trust engaged support from the HSC Leadership Centre to resolve the concerns around low staff morale in Rosebrook. Focus groups for nursing staff and the wider MDT identified themes and better ways of working. Staff validated that the focus groups were beneficial and that staff morale has improved. Further details can be found in section 5.2.6 of this report.	

5.2 Inspection findings

5.2.1 Patient Flow

Patient flow is a core element of any service management process. The objective of patient flow is to enable patients to get to the right place at the right time so their care needs can be appropriately met. Good patient flow is dependent upon a number of factors, including; the delivery of a robust escalation policy, daily decision making, early escalation and the ability to respond to surges in demand, good communication and proactive management of admissions and discharges, robust and reliable information and early identification of patients expected date of discharge (EDD).

We reviewed these systems and processes to determine their effectiveness in managing the increased demands on these services.

The Trust is commissioned for 84 beds across its acute mental health inpatient services. It was evident on the days of the inspection that the Trust has been operating over the recommended 85% acute bed occupancy recommended by The Royal College of Psychiatrists. A recommendation of 85% has been set as operating a service with high levels of bed occupancy may affect patient care, as directing patients to the bed most suitable for their care is less likely to be possible.

To increase bed capacity the Trust were utilising Portland chairs, which are chairs that can be reclined into a bed. Silverwood, Bronte, Willows and Cloughmore all have capacity to accommodate one extra admission (please see section 5.2.4 entitled Patient Comfort for how this impacted patient dignity). At the time of the inspection there were two patients admitted over the commissioned number of beds and who were assigned to leave beds.

The recent recruitment of a Bed Capacity Network Coordinator to acute mental health inpatient services has been positive in establishing a more co-ordinated and collaborative approach to patient flow both within the Trust area and across the region. The role includes coordinating all bed management plans such as, the number of beds available, occupied beds, patients allocated on leave, patients on enhanced observations and patients that are identified for potential discharge. An important aspect of this role is the engagement through a regional network with other Trusts which supports the understanding and subsequent co-ordination of bed pressures across the region. In addition to the regional bed capacity coordinator, the Trust also has 1.3 full time equivalent patient flow coordinators.

The regional bed capacity network coordinator for the Trust was off on leave during this inspection; however we met with the patient flow co-ordinators, the service manager and assistant director for acute inpatients. Assurances were received that prior to admission home treatment and crisis response teams worked in collaboration with the patient flow teams to explore all options to avoid admission to hospital were possible. This approach ensures patients who can be treated at home with enhanced support are, thus avoiding an admission to hospital which ultimately reduces pressure on beds.

The Trust also has a comprehensive protocol on Bed Management which was ratified in March 2020 that aligns with the regional bed management protocol for acute psychiatric beds (Aug 2019). This regional guidance was developed by the Social Care Commissioning Lead for acute mental health in collaboration with the five Trusts in Northern Ireland. It was developed to guide the Trusts in managing psychiatric beds to ensure patients are admitted to an appropriate facility to meet their individual needs in a timely manner. The Trust's protocol stipulates that the mental health home treatment crisis response teams (HTCR) are the gatekeepers for admission to inpatient beds. This team operates 24/7.

The Trust also have a HTCR team for patients with a learning disability who act as the gate keeper for admissions although this team currently operates from 9am -1pm seven days per week. (Outside of this the mental health HTCR team will assess learning disability patients if the individual practitioner feels suitably competent to undertake the assessment)
This protocol requires review to reflect the new regional bed capacity network coordinator role.

The Trust invested in and commissioned Bed Condition Dashboards which have been installed in all wards although they still had to be linked to go live. These dashboards provide a live overview of admissions, leave beds, available beds and planned discharges across all wards. It will identify out of area admissions, Children's Acute Mental Health Service (CAMHS) patients, patients with a learning disability and those who are over 65 with dementia diagnosis.

Representatives of the SMT reported that Bluestone is the main hospital for out of area admissions and have highlighted that this has been a re-current trend over recent years. This can at times create challenges at the points of admission and discharge in relation to accessing patient information and key personnel in a timely manner. Although senior consultants reported that they are participating in regional work relating to out of area admissions and transfers. During this inspection there were four out of area patients in Bluestone Unit and three in Dorsy, the learning disability unit.

Trust patients are allocated in, as far as possible, the ward assigned to their locality so that consultant care is consistent and follows the patient prior to, during and post admission which is in line with best practice. Patient clinical records evidenced that consultants are striving to determine an estimated date for discharge as early in the admission as possible.

During this inspection there were seven patients delayed in their discharge. The Trust maintains a live spreadsheet from the point the patient has been deemed medically fit for discharge up to the point they have been discharged. The spreadsheet records key personnel involved, options considered, feasibility of options, feedback from providers, issues relating to bespoke care package needed and associated costings, staffing issues, and in-reach visits to support and prepare patients for their rehabilitation. The spreadsheet indicates the Trust are struggling to find suitable accommodation or packages of care to rehabilitate five patients into the community, one patient is on trial leave and another has a suitable plan in place which is progressing. The data on the spreadsheet evidences good governance and SMT oversight of patients delayed in their discharge and reasons why.

The Trust has quality improvement (QI) projects underway all of which will inform patient flow. The QI projects include; post discharge reviews; referral waiting lists; liaison with emergency department (ED); and the alcohol pathway.

The inspection determined that the over-occupancy occurs regularly; however, the management of patient flow is effective and there are robust measures in place to ensure patient safety during periods of over occupancy.

5.2.2 Environment

We visited each of the four wards to assess if the environment was safe and conducive to the delivery of care.

Environmental cleanliness and infection prevention control

The wards were clean, clear and clutter free. Each ward was bright and welcoming. All patient rooms are single occupancy with ensuite bathrooms and there were a number of interview rooms available to accommodate visitors. Patients also had access to well-maintained outdoor gardens.

Staff from each ward, with the exception of Rosebrook PICU, described regularly being over occupied. During periods of over occupancy, after all leave beds are used, patients sleep on Portland chairs situated in the quiet rooms. Quiet rooms promote patient recovery and are recommended by the Royal College of Psychiatrists and noted in the Standards for Inpatient Mental Health Services Third edition, 2019. When these rooms are used as sleeping areas it depletes access by other patients. The quiet rooms have no capacity to safely store patient's personal belongings.

Staff reported managing the environment during times of over-occupancy has proved more challenging in light of the Covid-19 pandemic. Ward staff described challenges at meal times when the ward is over-occupied to maintain safe social distancing. The wards alleviate this by having two-three sittings at each meal to ensure the safety of staff and patients.

Group activities with the Occupational Therapist (OT) can also be impacted during periods of over-occupancy; in an effort to accommodate as many patients as possible and ensure adherence to Covid-19 safe space guidelines, activities are staggered.

The standard of environmental cleaning of clinical and non-clinical areas throughout wards was good.

A review of a selection of documents including minutes of meetings; risk assessments; audits of the environment; staff's Infection Prevention and Control (IPC) practices; and staff training records confirmed good governance measures were in place to support staff and promote IPC in all of the wards. Covid-19 general risk assessments were completed and information to guide staff, patients and visitors on the Covid-19 safety measures to be taken was displayed in each area.

Staff were knowledgeable on IPC practices and good compliance with IPC practices was observed in relation to hand hygiene, equipment cleaning, use of personal protective equipment (PPE); and the management of linen and waste.

Ligature risks

Environmental ligature risk assessments were reviewed and evidenced that risks were properly identified and appropriate actions were taken to mitigate against any environmental risk. It was evident that the assessment was a live document. Safety checks were being undertaken routinely to identify new or emerging ligature risks. Prior to the inspection, RQIA had been informed that work to replace all windows within the wards to anti-ligature windows had been completed. This was confirmed during the inspection.

Fire risk assessments

Fire Risk Assessments (FRA) were also reviewed. Each ward had a FRA in place that noted recommendations, action plans and target dates for completion were specified. These were reviewed annually. There was no reference to over occupancy in the FRA's; on discussion with ward managers, this is mitigated by any extra patients being highlighted on handover sheets and at the ward Safety brief. The Trust has agreed to consider highlighting over-occupancy in the FRA with the Trust's Fire Officer. Fire training for staff on each ward was either up to date or scheduled for those requiring an update.
We noted there were no Personal Emergency Evacuation Plans (PEEPs) this was due to the short term length of stay of patients and patients not requiring assistance in the event of evacuation.

We determined that over occupancy does have an impact on the environment in relation to space, quiet areas and social distancing; however, there was no evidence that this was impacting the Trust's ability to provide an environment that was conducive to the delivery of effective care. No AFIs were made in respect of environment.

5.2.3 Restrictive Practices

The management of Restrictive Practices was reviewed across the four wards to determine if over occupancy was having an impact on the use of restrictive practices.

Restrictive practices in use included; locked doors; enhanced/prescribed patient observations; physical intervention; rapid tranquilisation; seclusion and prohibited items. Any restrictions in place had been risk assessed, were proportionate to the level of risk and were in keeping with best practice guidance.

Patient's care records reflected detailed recording and a plan of care for any restrictions and evidenced consideration of patient's human rights.

Deprivations of liberty care plans were in place and these were completed with the patient or their next of kin which supports collaborative care planning.

Any planned restrictions were reviewed weekly by the patient's named nurse or sooner if the level of risk had increased and agreed by the multi-disciplinary team. Increasing risks were noted, comprehensively assessed and individually managed. Minutes of MDT meetings also evidenced discussion around reducing restrictions on an individual basis following a review of patient risks and assessed need. This supports good practice guidelines where restrictive practices should be used for the shortest amount of time necessary.

Silverwood ward had a number of profiling beds to support patients with physical disabilities and post-partum mothers. Although it is not a frequent occurrence, there are occasions when profiling beds are being used for patients who don't require this type of bed. Patients admitted to these beds may be subjected to restrictive practices in the form of 1:1 enhanced observations as a means of reducing the risk of self-harm as profiling beds pose a significant ligature risk. Under such circumstances each patient is risk assessed by the MDT. This is evidenced in their case notes and minutes of meetings.

Over occupancy was observed to increase restrictive practices as additional patients admitted to wards were required to sleep on Portland chairs in undesignated sleeping areas and use communal bathroom facilities in the absence of ensuite facilities. As a result, these patients were placed on 1:1 observations due to ligature risks in the environment, including when they used the bathroom. The requirement for 1:1 observations in both areas is restrictive and impacts on privacy and dignity; however it is acknowledged that measures taken were in the interests of safety and were observed to be as least restrictive as possible.

On rare occasions at times of over occupancy some patients who did not need this level of support were placed in PICU. The SMT advised in these situations the person admitted would be a detained patient and would only be admitted for the shortest possible time. Prior to the admission/transfer staff would outline the restrictive nature of the PICU environment and seek the patients and/or next of kin's consent. This is in line with good practice.

The PICU seclusion room has been used frequently in recent months, staff informed us this was due to the acuity of the patients at present and not as a result of over occupancy; care records reviewed supported this and evidenced safe use of seclusion which was risk assessed, used for the least amount of time and proportionate to the level of risk. The policy and care pathway on the management of seclusion was available along with evidence that staff had attended relevant training.

Staff demonstrated a good awareness of restrictive practices. Staff told us that physical intervention was used as a last resort and de-escalation techniques are prioritised to support patients. It was evident that the ward managers were implementing a least restrictive ethos in the wards, and had embarked on a number of quality improvement initiative's to reduce restrictions to include use of wellness tool boxes, patient attendance at MDT meetings and a safety cross. The safety cross evidenced an endeavour to monitor and reduce the use of as and when required /Pro Re Nata(PRN) medication and physical interventions. A review of the monthly meetings with the senior management team evidenced good governance and oversight regarding the use of restrictions. We reviewed staff training records for the use of physical intervention and Management of Actual and Potential Aggression (MAPA) and found them to be up-to-date for the majority of staff.

It is evident that over occupancy impacts on restrictive practices, however, it is acknowledged that this is outside the Trusts' control and has been identified within wider over-occupancy regional issues.

5.2.4 Patient Comfort

Patient care practices were observed to determine if patient comfort had been impacted by over occupancy.

During the inspection, staff were observed treating patients with kindness and respect whilst delivering care and treatment in a committed and compassionate manner. Staff responded to patients in a timely manner and in a way they understood. There was a range of therapeutic activities on offer in the ward to include game consoles, beauty stations, CD players and some gym equipment in the outdoor garden areas. Patients were engaged in art and craft, regular walks and Christmas activities. The staff and patients spoke highly of the Occupational Therapist (OT) and the different OT therapies on offer to support patient recovery.

Silverwood had facilities to support postnatal mothers experiencing mental health issues – there was a breast feeding chair, Moses basket, cot and soft toys. The ward manager advised that the number of new mothers coming into hospital has increased recently and that she was passionate about ensuring effective care and treatment for these women.

Several of the wards had engaged in Quality Improvement Initiatives (QI) such as an 'isolation box.' The isolation box has activities for patients who are required to isolate due to COVID 19, the boxes included puzzles, colouring in books and stress relieving gadgets.

Some patients require a prescribed level of observation to maintain their safety, staff were observed affording these patients consideration by offering them space, for example, by sitting outside the patients bedroom, whilst still having sight of the patient to ensure their safety.

Patients were provided with the opportunity to select a meal of their choice from the hospital menu and staff advised that patients had access to snacks, tea and coffee throughout the day. All patients experienced protected meals times enabling a therapeutic dining experience.

Patients were provided with information on admission which included advocacy services, meal times, storing of personal property, adult safeguarding, the environment, discharge planning, how to make a complaint and consent information. All patients received a welcome pack with easy read material and a copy was also sent home to their families.

During periods of over-occupancy, the additional patient is required to use a Portland chair in the wards quiet room. This means the quiet room is unavailable for other patients. Patients who were admitted during times of over occupancy were informed of sleeping arrangements prior to their admission.

In the non-designated areas there was nowhere for the patient to store their personal belongings, and there was also a lack of privacy and dignity as windows were not obscured. Nursing staff endeavour to maintain patient privacy and dignity by using paper to cover the window panes.

It was evident that patient comfort is impacted during periods of over occupancy, however, staff where taking all necessary steps to maintain patient's dignity, privacy and comfort when wards were operating over and above their commissioned beds.

5.2.5 Care & Treatment

Patient records were reviewed to determine if over occupancy was impacting on the care and treatment of patients.

Local policies and procedures were available to guide staff on the admission and discharge of patients. Nursing staff confirmed they were familiar with the Trust's Integrated Admission and Discharge Policy (May 2017) and they were aware of the need to complete assessments and care plans in a timely manner.

Each patient had an admission assessment completed by a doctor and nurse in line with Trust policy and had comprehensive risk assessments completed and care plans in place to reflect their individual needs. The standard of documentation was good, records were contemporaneous and there was evidence of ongoing mental health assessments completed. There was evidence of medication monitoring such as Clozapine and Olanzapine monitoring, regular Electrocardiogram's (ECG's) and at the time of inspection all patients had been offered Covid 19 vaccinations.

There was evidence of MDT input, ongoing treatment plans and evidence of contact with the patients' key workers when planning for discharge and of weekly MDT meetings attended by medical and nursing staff, social worker, occupational therapist and prior to COVID 19 the home treatment team. Families were also being invited on some occasions and all patients had an opportunity to attend their multi -disciplinary team meetings. There was good evidence of patient involvement in their care. Records noted ongoing assessment of patient mental and physical wellbeing in daily progress and clinical notes, thus enabling, early indicators of decline to be monitored and actioned in a timely fashion.

Staff and patients confirmed that patients had access to a wide range of professionals to support them during their stay. We observed a high level of therapeutic engagement with patients amongst nursing and OT staff. All patients had the opportunity to have a therapeutic 1:1 with their named nurse.

Overall, it was determined that patient care and treatment was not being compromised as a result of over occupancy.

5.2.6 Staffing

Staffing levels were reviewed to determine if safe levels were being maintained when wards are over occupied.

The Trust had previously experienced pro-longed challenges to ensure safe staffing levels across the unit and over the past year the Trust successfully recruited a number of staff at various levels. Each ward had five whole time equivalent deputy ward managers at a band six appointed. This has strengthened senior nurse cover on a 24/7 basis and 23 health care assistants were also appointed across Bluestone unit thus improving the skill mix.

Whilst ward and deputy ward managers stated they were unfamiliar with the staffing model used to determine normative staffing levels on their ward, they advised that staffing levels were in the main, safe and satisfactory. We met with members of the SMT to discuss the staffing model used to determine safe levels and reported that ward and deputy ward managers felt disempowered as they were not involved in assessing staffing levels based on patient acuity. It was agreed that the SMT need to communicate with ward and deputy ward staff to ensure they have a sound understanding of the model used. An AFI has been made in relation to this.

There was an increase in staffing pressures when over occupancy occurred due to the requirement for increased patient observation levels, admissions taking place at short notice, staff absence, and the Covid-19 pandemic were identified as factors that have impacted staffing. Ward managers reported that they adhere to the escalation pathway to address staffing deficits. In recent months the Bluestone unit was particularly affected by staff absences due to an outbreak of Covid-19 and did not have the resources to maintain safe staffing levels within the unit. It was encouraging to note, staff from community services, such as community addictions and learning disability teams were temporarily re-deployed to support staff on the wards during this time. Staff highlighted that they felt well supported by their line managers and senior management who were approachable.

At times the Trust use agency staff to cover deficits in shifts. The Trust strives to keep agency staff usage to a minimum, and also make use of bank staff to cover deficits. Agency staff are block booked by the Trust which has led to positive working relationships amongst the teams.

A young staffing workforce was apparent within all wards. On discussion with the ward managers we were informed that this was due to experienced staff retiring or taking specialist posts in the community. Ward managers did not highlight any concerns regarding the skill mix indicating that senior management are very focused on upskilling the younger staff with the aim of providing a highly skilled staffing team across the unit and also to encourage the retention of staff.

The consultant psychiatrists discussed the challenges in recruiting consultant staff into substantive positions with several posts presently filled by locums. The Trust have worked with the Department of Health (DoH) and the Northern Ireland Medical and Dental Training Agency (NIMDTA) around increasing the number of psychiatry trainees to increase number of consultants. There have been challenges in attracting doctors from outside Northern Ireland due to lack of pay awards and pension issues. It was of positive note that there was a full complement of junior medical staff.

The night coordinator ensures there is an appropriate distribution of staff in terms of numbers and skill mix. Every morning there is a bed management/ patient acuity meeting where each ward is represented. Patient acuity is discussed alongside staffing levels. If required, decisions are made to share staff across the unit as requirements dictate.
Each evening when patient flow staff finish their shift (usually 5pm) until the time the night coordinator commences their shift at 8pm one of the ward managers manages admissions. This role is rotated between all wards. Members of SMT are updated regularly throughout the day on staffing levels.

A review of the staff training matrix reflected that staff were compliant with mandatory training. There was evidence of up to date supervision and appraisals in place for staff.

Multi-disciplinary staffing consisted of nursing, social work, occupational therapy, medical and psychiatry. Psychology cover for the wards was on referral basis only.

We determined that staffing was only marginally impacted during periods of over occupancy; however, the Trust had good escalation strategies and resolved the deficits quickly and effectively via the use of bank and agency staff.

5.2.7 Incident Management & Adult Safeguarding

Incidents recorded on the Trust's electronic incident recording system known as DATIX, from September to December 2021 were reviewed to determine if there was an increase in number or complexity of incidents as a result of over occupancy.

On review of these incidents within each ward, violence and aggression; self-harm and absent without official Leave (AWOL) were the highest ranking incidents reported. Incidents would be recorded in the patients progress notes and risk assessments reviewed and updated accordingly.

On examination of the incidents we noted disparity in the level of reporting, on occasions bed occupancy was being reported to RQIA and DoH in the form of Early Alerts, however, on the DATIX system, these were graded as 'insignificant.'

There was evidence that staff were using the Trust grading matrix to grade incidents, based on the inherent risk and not the outcome of the incident and did not reflect the cumulative effect of incidents involving the same patients. We reviewed the Trust's procedure for grading an incident which came into effect in January 2018 and is next due review in January 2023. The policy directs staff to grade the incident on the perceived outcome of the incident at the time. This may prohibit consideration of repeated incidents of a low risk nature being graded higher. This was discussed with SMT at feedback and it was acknowledged that this is a finding of the DATIX system regionally. However, the SMT advised that cumulative risks resulting from repeated incidents are discussed during the weekly live governance meetings. We determined that the SMT have good processes in place to review incidents which included live governance, collective leadership team and monthly governance meetings. An AFI had been identified in relation to the grading of incidents at the previous inspection in July 2020; this AFI will be stated for a second time. It was positive to note that the narrative provided in the incident reports was descriptive and informative, detailing what actions were taken to manage each situation. From our review of incident management it was determined that there was no direct correlation between increase in incidents and over occupancy.

In relation to adult safeguarding (ASG), all wards were adhering to the regional Adult Safeguarding Operational Procedures, Adults at Risk of Harm and Adults in Need of Protection, (Sept 2016) in relation to adult safeguarding referrals. Referral forms known as APP1s are completed on the Trust's electronic recording system (PARIS) and staff had a good knowledge and understanding of the safeguarding process. Details of the incident had been recorded in the patient's daily progress notes.

There were variations in each ward in relation to interim protection plans. It was observed that protection plans were focused on 'managing risk' and were aimed at managing the risk of the alleged perpetrator, rather than detailing the protection plan for the victim.

Best practice guidance would suggest more emphasis on the protection planning for the victim with risk assessments being reviewed for the perpetrator.

While there was evidence of APP1's being completed and submitted, not all adult safeguarding referrals had been reported via the DATIX system.
There was no evidence that ASG incidents were analysed at ward or unit level. This was discussed with the ASG lead and the service manager who agreed that this was an area needing further work. An AFI has been identified, recommending that the Trust collate the data to enable trend analysis and identification of themes for adult safeguarding.

There was evidence of good communication of ASG incidents between ward staff via handover sheets. There was easy read documentation available within each ward to support patients to understand the process. Each ward had displayed contact details for the Adult Safeguarding Teams for service users and their families to avail of. Contact details were also evident in the carers information pack that is sent out to the next of kin.

We determined that the deficits evidenced relating to ASG were not caused by over occupancy. The AFI relating to the grading of incidents has been stated for a second time and a new AFI has been made to analysis ASG incidents.

5.2.8 Medicines Management

Medicines management was reviewed to determine if patient medicines was effectively being managed at times of over occupancy.

There was evidence that satisfactory systems were in place for medicines management on all wards. Medicines were being managed safely and patients were being administered their medicines as prescribed.

Pharmacy support was provided on the wards Monday - Friday. Staff were complimentary of the pharmacy support provided and their contribution to the safe management of medicines. The pharmacist' s support to the wards included medicines reconciliation for newly admitted patients, ongoing review of kardexes, providing specialist advice on prescribing and managing medicines at discharge. The pharmacist aimed to review all kardexes within 24-48 hours of admission. This did not always happen due to time constraints; priority was therefore given to those patients who were prescribed clozapine, other high-risk medicines and critical medicines. The majority of the pharmacist's day was dedicated to ensuring the safe management and supply of medicines at discharge.

Nursing staff were knowledgeable regarding the medicines management processes and the medication needs of individual patients. A good standard of storage and stock control of medicines was observed across all wards. Controlled drugs were safely and securely stored and the controlled drugs registers had been appropriately maintained. Pharmacy inspectors provided some guidance on the recording of fridge temperatures, oxygen signage and in-use insulin and received assurances that this would be shared with all wards.

The Regional Rapid Tranquillisation Policy was in place and nurses were aware of its' content. Nurses advised that staff and patient debriefing took place as soon as was practical after an incident where rapid tranquillisation was needed.

A report of the use of rapid tranquillisation was made on a trust incident form. Nurses advised the frequency of use of these medicines was monitored and reviewed at the patient's MDT meeting.

Regional care pathways and appropriate arrangements were in place for both clozapine and lithium treatments including blood monitoring.

Resuscitation trolleys were readily available for staff and daily trolley audit records were observed.

There was evidence of a range of audit and quality improvement initiatives. These included: a daily check on the standard of completion of administration records; a weekly check on the controlled drug record book, and a weekly check on the appropriateness and effectiveness of the administration of as and when required (PRN) medicines that are utilised to manage agitation.

Arrangements were in place for the safe management of medicines during the patient admission and discharge processes. Details of pre-admission medicines prescribed were routinely obtained as part of the admission process. Arrangements were in place to manage medicines when patients were discharged from the wards to ensure a continuous supply of their medicines and to ensure they were given any necessary advice.

Kardexes were maintained in a satisfactory manner on each of the wards; with medicine entries, dosage regimes and the patient's allergy status appropriately recorded. The medicine administration records were generally completed to a high standard. The records indicated that patients were administered their medicines as prescribed. Staff recorded why a medicine was omitted. Staff exhibited knowledge of escalating to the prescriber in instances where patients refused medicines.

The management of medication related incidents was discussed with the pharmacist and nursing staff who advised that incidents were investigated, reported and any learning identified and changes in practice were shared with all staff to prevent a reoccurrence.

The pharmacy inspectors found that medicines management was good across the site, determining that over occupancy had no impact the safe and effective administration of medication.

5.2.9 Governance & Leadership

Governance and leadership was reviewed to ensure effective mechanisms around communication, senior decision making and escalation arrangements when wards are over occupied were in place.

The governance and leadership oversight was good at ward and directorate levels. At ward level there was evidence of cohesive teams with good working relationships between the ward manager and their staff to promote the delivery of safe and effective care. There was good multidisciplinary working across all disciplines. The SMT were aware of the bed pressures across the Trust and the impact over occupancy had on patient and ward risk. Staff at all levels confirmed that senior management are visible within the wards and that there is an 'open door' culture for staff to air any concerns.

Robust governance systems were in place to support bed management. There was a range of meetings held to support patient flow; we observed a daily huddle to discuss beds attended by the patient flow team, ward managers and ASM. There were regular MDT delayed discharge meetings to discuss individual patients that were delayed in their discharge. This enabled meaningful discussion with care managers to plan for discharge and to identify solutions such as supported living opportunities. This was identified as an example of good practice.

The Trust collates their own data in relation to length of stay, admissions, discharges, delayed discharges and out of Trust admissions. The decision to admit patients to wards when they are over occupied was considered and only agreed as a last resort when risks to patients were high and no other treatment pathway was available in the community. Arrangements were in place for reporting and escalating over occupancy within the Trust and at regional level.

Governance structures within the Trust had been reviewed and strengthened and there are clear escalation processes in place to support sharing of information through a range of meetings to include a weekly governance meetings and monthly MHLD governance group meetings. These meetings are designed for the continuous monitoring of data in relation to, absconding, monitoring of complaints, restrictive practices, ligature risks and unit risks enabling the leadership team to identify themes and trends and action any outcomes identified. The minutes also reflect updates from each professional groups including AHPs, Social work, nursing, medics and note findings on internal audits, IPC, fire safety action plans and safeguarding.

As stated in section 5.2.7 of the report the inspection identified concerns in relation to the governance oversight of adult safeguarding at ward level, with an AFI being identified. This AFI will be stated in the QIP and will be reviewed at the next inspection.

In summary the governance oversight is robust and comprehensive. The reporting and accountability structures are clear and the evidence produced during the inspection signifies that there is good collective leadership and good multi-disciplinary working relationships.

5.2.10 Staff engagement

We met with and spoke to a number of staff to seek their views regarding the impact of over occupancy on the delivery of patient care. Some staff who did not have the opportunity to speak with us on the day of the inspection completed questionnaires providing their views.

Staff reported the standard of patient care was high, patient centred and there was a culture of respect for patients and staff. Staff spoke positively about the unit and their respective wards. All staff expressed staffing shortages and a greater acuity of the patients can impact on morale and career satisfaction. Some staff also described challenges such as a disparity between the role of substantive staff and agency staff; however, felt that this was a regional issue and non-specific to the wards in Bluestone. Some staff also commented on the increase of staff assaults during periods of increased patient acuity. Staff described this as challenging but felt that the ward managers were supportive and pro-active in implementing QI improvements to reduce incidents and ensure the retention of staff.

Staff reported clear mechanisms for feedback and learning from incidents and audits via staff meetings (which could be accessed virtually), debriefs, incident review meetings, emails, minutes, clinical supervision and verbal communications. Staff reported there were weekly reflective practice sessions facilitated by psychologists and felt this was extremely helpful.

Prior to this inspection RQIA have been monitoring and managing intelligence in relation to low staff morale within Rosebrook PICU. At the previous inspection an AFI had been made in relation to this. The staff interviewed reported that the morale in Rosebrook had greatly improved and that the focus days facilitated by the HSC Leadership Centre where of great benefit as they provided them with a safe space to discuss their concerns. As a result they reported Rosebrook has now become a more positive place to work and progress has been made in the development of a more cohesive team.

RQIA's clinical lead held focus groups with the medical staff. The findings from these focus groups suggest that medical staff are working to ensure a safe service is maintained. The medical staff are cognisant of present and future challenges in relation to resources and the complex acuity of patients requiring admission. They have worked hard to implement local QI initiatives and have proactively engaged in work to improve medical workforce issues and regional issues around over-occupancy.

The service user consultant informed us that her role is to ensure that the patient voice is brought to the senior leadership forums and that any ideas or outcomes is fed back to the patients. The service user consultant also informed us that the SMT had provided an iPad so that service users could access the 'Care Opinion' website to provide their feedback on service provision.

The staff we spoke with felt they had adequate access to training, supervision and appraisal and there was a sense of compassion and dedication to the patients in their care. Staff expressed that the job can bring challenges, especially during periods of over-occupancy, however, all felt that this did not have a direct impact on patient care and treatment being delivered, and all staff advised they would be satisfied for a member of their family to be treated within Bluestone.

5.2.11 Patient engagement

We spoke with patients to determine if over occupancy was affecting the delivery of their care.

Patients told us they were treated with dignity and respect and that staff actively listened to them and attended their needs. Patients advised staff involved them in all aspects of their care and they each had opportunity to attend meetings about their care. Patients were aware of the advocacy services available to them.

Some patients would like 1:1 appointments with professionals such as the social worker to help with understanding the resettlement process; this was highlighted with the SMT during the inspection. Some patients who were on the delayed discharge list explained their frustration around waiting for a suitable placement due to constraints within the community. Other patients also suggested that the food can be repetitive at times; however, they understood how to raise a complaint about this and stated by doing so, the variety of meals had greatly improved.

Most patients reported feeling well cared for and were observed to be supported by compassionate staff. There were no patients requiring the use of Portland chairs during this inspection, the two patients over the commissioned numbers availed of leave beds. Overall the experience of patients was not affected by over occupancy.

6.0 Conclusion

It was evident that over-occupancy is a continuous challenge for the staff and SMT within the Trust. Over occupancy is having an impact on the environment, staffing and patient comfort, however, it was clear that this was not compromising the delivery of safe and effective care.

Based on the inspection findings and discussions held, we are satisfied that this service is well led and provides safe and effective care. We are also satisfied that privacy and dignity is promoted and maintained by staff who are caring and compassionate.

Four areas for improvement were identified that will support the Trust to deliver improved outcomes for patients and staff. One has been stated for a second time, one has been carried forward to review at the next inspection and two new AFIs have been identified. These are stated in the Quality Improvement Plan.

RQIA would like to take this opportunity to thank the hospital staff, patients and families for taking the time to engage with the inspection team, enabling us to deliver our findings by driving improvement for patients and a more supportive working culture for staff.

7.0 Quality Improvement Plan/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).

	Standards
Total number of Areas for Improvement	4

Four areas for improvement have been identified, which includes one area for improvement that has been stated for a second time and one that has been carried forward to the next inspection.

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

Quality Improvement Plan

Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)	
Area for improvement 1 **Ref:** Standard: 4.2, 4.3 (j) **Stated:** First time **To be completed by:** 1 April 2022	The Southern Health and Social Care Trust should ensure ward managers are informed and understand the staffing model used to determine normative staffing levels for their respective wards and be involved in this process. Ref: 5.2.6
	Response by registered person detailing the actions taken: A guidance document has been composed and shared with lead nurses and ward managers highlighting the methodology utilised in determining Normative staffing levels, i.e. Telford/Delivering Care, Discussed at weekly Ward Managers meeting, with highlight on FSL levels, comparative to Normative/Delivering care proposals for MHLD inpatients
Area for improvement 2 **Ref**: Standard 5.31 (f) ; 5.32(a) **Stated:** Second Time **To be completed by:** 1 April 2022	The Southern Health and Social Care Trust must strengthen the governance oversight of incident management to ensure: the grading of incidents reflect the cumulative effect of repeated low risk incidents involving the same patients. Ref: 5.2.7
	Response by registered person detailing the actions taken: DATIXWeb Dashboards previously included and monitored incident severity (actual harm) trend data; they now include consequence (potential harm) and the potential risk-rating trend data. Incident Reporter and Reviewer training continues regularly and this training includes and explains the difference between actual versus potential harm, including referring staff to the Guidance that is already embedded in the DATIX system Lead nurses analyse DATIXs on a daily basis, and in instances of cumulative insignificant to moderate graded incidents discuss these with the Head of Service and/or Ward managers with a subsequent, inclusive discussion and triage of each incident in regards to the need to potential regrade.

Area for improvement 3 **Ref:** Standard: 5.2, 5.3.1 (f) 5.3.2 (c) **Stated:** First time **To be completed by:** 1 April 2022	The Southern Health and Social Care Trust should collate data in relation to adult safeguarding incidents to enable trend analysis at ward and unit level, this will ensure ward managers and members of the MDT have good oversight of themes arising to identify any learning which may help in reducing reoccurrence. Ref 5.2.7
	Response by registered person detailing the actions taken: Bluestone and Dorsy have now successfully recruited a Senior Social Worker and a Lead Social Worker to strengthen the Social Work workforce within the MDT. There is a 'real time' oversight process and analysis of the Units Safeguarding Duty Desk on the Paris system. This coupled with a local Operational Protocol composed in relation to identification of learning and any relative discussion with the aspiration to reduce potential reoccurrence, this is now a standing agenda item on the Units weekly Ward Managers meeting, this attended regularly by the Lead Social worker
Area for improvement 4 **Ref**: Standard 5.3.1 (c) **Stated:** First time - Carried Forward **To be completed by:** 16 August 2020	The Trust must ensure there is an agreed policy and procedure in place for the management and oversight of the use of CCTV in the hospital. The Trust must implement assurance mechanisms to ensure CCTV is being used in line with the policy (i.e. more than one professional discipline reviewing footage of incidents). Ref 5.1
	Response by registered person detailing the actions taken: Replacement of CCTV system(s) across the Trust as a whole is being considered as part of the Trust's Violence and Aggression Committee. Version 1 of SHSCT new Policy for the Management, Operation and Use of Closed Circuit Television (CCTV) Surveillance Systems is now in draft and moving to approval via task and finish group Local process will be harmonised with the remits of the Policy Local process in the Unit now ensures that all CCTV is viewed multi-professionally

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

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