Unannounced Inspection Report
16 - 29 July 2020

Southern Health and Social Care Trust
Bluestone Unit

Craigavon Area Hospital
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Portadown
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Membership of the Inspection Team

Lynn Long	Acting Deputy Director of Improvement Regulation and Quality Improvement Authority
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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 is an acute mental health inpatient facility located within the Craigavon Area Hospital site and managed by the Southern Health and Social Services Trust (the Trust). Bluestone comprises of six inpatient wards that provide assessment and treatment to patients with acute mental health and learning disability needs

This inspection focused on Rosebrook ward, which is a 10 bedded mixed gender ward. Rosebrook ward provides care to patients with acute mental health needs who require care in a psychiatric intensive care environment (PICU). The ward was fully occupied on the day of the inspection.

Patients admitted to Rosebrook have access to a full range of multi-disciplinary services which includes; psychiatry; medical; nursing; occupational therapy; social work; and pharmacy support.

3.0 Service details

Responsible Person: Mr Shane Devlin, Chief Executive Officer Southern Health and Social Care Trust	**Ward Manager:** **Rosebrook:** Ms Lynsey Erskine
Category of care: Acute Mental Health and Learning Disability	**Number of beds:** **Rosebrook:** 10
Person in charge at the time of inspection: Mr. William Delaney, Head of Service, Bluestone. Mental Health and Learning Disability Services.	

4.0 Inspection summary

We undertook an unannounced onsite inspection to Rosebrook ward within the Bluestone unit from the 16 to 17 July 2020. The inspection concluded on 29 July 2020 following review of requested documentation provided by the Trust. This inspection was undertaken by a team of care inspectors and a medical sessional consultant and a lay assessor.

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 Department of Health (DOH) (March 2006).

This inspection was undertaken following information received by RQIA from an anonymous source that identified concerns relating to:

- aspects of ward governance which included leadership and culture, staff levels, skill mix and training and multidisciplinary team (MDT) working
- incident management
- restrictive practices
- adult safeguarding; and
- staff and patient experiences.

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

Good practice was noted across all four domains of safe, effective, compassionate and well led care and no concerns were identified in relation to patient safety during the inspection.

We did not identify any issues with culture on the ward and we evidenced that there were clear lines of accountability throughout the ward and the directorate. We also found communication between the MDT was good.

A number of areas of strength were identified, particularly in relation to staffs' knowledge and management of restrictive practices, adherence to adult safeguarding processes and the completion of patient care records. We confirmed that agency staff had been provided with up to date training and induction and nursing staff had received regular supervision and appraisals.

Areas requiring improvement were identified in relation to governance and oversight of incident management, the reviewing and updating of the Trust's risk registers, the management and oversight of closed circuit television (CCTV) and the display of adult safeguarding information.

Staff feedback was positive and staff told us, they were happy in their work, felt supported and, MDT working relationships were good. Staff did not raise any concerns about the culture on the ward and indicated that the culture was positive. We found staff morale had improved since the previous inspection undertaken in February 2020.

Patients spoke positively about their care and treatment and we observed staff deliver compassionate care to patients who were presenting as distressed and treated patients with dignity and respect.

4.1 Inspection outcome

Total number of areas for improvement	9*

Rosebrook ward had previously been inspected on 14 February 2020 as part of a wider hospital inspection of the Bluestone Unit.

*One area for improvement from the previous inspection on the 14 February 2020 was not reviewed.

Four areas for improvement identified from the previous inspection were reviewed and assessed as not met and are stated for a second time.

Four new areas for improvement were identified during this inspection against The Quality Standards for Health and Social Care DoH (March 2006) these are detailed in the Quality Improvement plan (QIP) and relate to:

- the need to review and update the Trust's risk registers
- governance and oversight of incident management
- the management and oversight of CCTV; and
- the need to display adult safeguarding information.

The area for improvement regarding the management and oversight of CCTV within the Bluestone unit was escalated to the senior management team. We received immediate assurances from senior management that this concern would be actioned as a matter of urgency. We will review this area for improvement during the next inspection of this unit.

Details of the QIP and inspection findings were discussed with senior representatives from the SHSCT's mental health and learning disability directorate at a teleconference held on 30 July 2020. The timescales for completion of these actions commence from the date of this inspection.

Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to this inspection a range of information relevant to the service was reviewed. This included the following records;

- previous inspection reports and QIPs
- serious adverse incident notifications; and
- other relevant intelligence received by RQIA.

During the inspection we reviewed the following records:

- the Trust's action plan relating to the Royal College of Psychiatrists (RCPsych) Invited Review Service Report
- Datix incident reports
- patient care records
- minutes of staff meetings at ward and management level
- complaints and compliments
- staff duty rotas; and
- staff training records.

We met and spoke with a range of staff that included: medical and nursing staff, allied health professionals (AHP) and support services staff, the Service Manager; the Head of Service; the Trust Human Resource Manager and the Clinical Coordinator/Bed Manager;

We spoke with patients, interviewed ward staff and observed staff practices. Posters informing patients, staff and visitors of our inspection were displayed while our inspection was in progress. Staff were also invited to complete an electronic questionnaire. No staff questionnaires were received following the inspection.

We provided detailed feedback to the Trust's senior management team as described in section 4.1 of this report.

6.0 The inspection

6.1 Review of areas for improvement from previous inspections dated 14 February 2020

The most recent inspection of Bluestone was an unannounced inspection undertaken on 14 February 2020. The completed QIP was returned by the Trust to RQIA and was subsequently approved by the care inspector. It should be noted the areas for improvement are not isolated to Rosebrook, a number were in relation to the Bluestone unit as a whole.

Areas for improvement from the previous inspection		
Actions required to ensure compliance with The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DoH (March 2006)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 5.3.3 (d) **Stated:** First time	The Trust 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.	**Met**
	Action taken as confirmed during the inspection: We reviewed records in relation to the use of seclusion. We found the use of seclusion was in accordance with Trust policy and procedures and best practice guidance. We also found good records were maintained. There was evidence of regular audits of the use of other restrictive practices which included seclusion.	
Area for improvement 2 **Ref**: Standard 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 (SAI), November 2016 are reported in line with the procedure.	**Met**
	Action taken as confirmed during the inspection: We reviewed the Trust's incident recording system and found any incidents that met the criteria for The Health and Social Care Board Procedure for the Reporting and Follow-up of Serious Adverse Incidents, November 2016 were reported in line with the procedure.	

Area for improvement 3 **Ref**: Standard 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 Met**
	Action taken as confirmed during the inspection: We reviewed patients' risk assessments and management plans. On review of this documentation we identified that that there was a unidisciplinery (nursing) approach to completing these records. Although we found evidence of discussions at MDT meetings regarding risk and incidents this was not detailed in the patients' risk management plan. This area for improvement has not been met and is stated for a second time.	
Area for improvement 4 **Ref**: Standard 4.3 (m) **Stated:** First time	The Trust must ensure that all staff required to use Management of Acute or Potential Aggression (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.	**Met**
	Action taken as confirmed during the inspection: We reviewed training records and found staff in Rosebrook including agency staff had received up-to-date MAPA training. We found the use of restrictive practice was being well managed in line with best practice guidance.	

Area for improvement 5 **Ref**: Standard 6.3.1 (c) **Stated:** First time	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 Psychiatric Intensive Care Unit (PICU).	**Met**
	Action taken as confirmed during the inspection: We reviewed the bed management protocol (dated March 2020) which provided guidance on the admission criteria and staff responsibilities when considering admitting a patient to the PICU. We were assured following discussion with staff, including the Clinical Coordinator/Bed manager, they were aware of the protocol. Relevant staff clearly demonstrated their knowledge of their roles and responsibilities in relation to decision making before admitting a patient to PICU. There were no voluntary patients in PICU at the time of inspection.	
Area for improvement 6 **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.	**Not Assessed**
	Action taken as confirmed during the inspection: Action required to ensure compliance with this standard was not reviewed as part of this inspection. This area for improvement has been carried forward for review during the next inspection.	

Area for improvement 7 **Ref**: Standard 5.3.3(d) **Stated:** First time	The Trust should implement a system to ensure the equal and appropriate distribution of staff skill mix across the Bluestone hospital site that considers the complex needs of all patients admitted to each ward.	**Not Met**
	Action taken as confirmed during the inspection: We did not find evidence of a system to ensure staff skill mix. We found that Rosebrook has a high proportion of junior nursing staff. Senior managers told us staff rotation was unsuccessful in the past. Senior managers told us the recruitment of experienced nurses was challenging which continues to make it difficult to ensure staff skill mix throughout the hospital. There was evidence the Trust have informed the DoH of workforce issues. This area for improvement has not been met and is stated for the second time.	
Area for improvement 8 **Standard Ref**: Standard 5.3.3 (d) **Stated:** First time	The Trust should ensure that ward management cover in Rosebrook is provided on an ongoing basis. The Trust should review and manage any additional roles placed on the Rosebrook ward management team that require them to spend less time in the ward.	**Met**
	Action taken as confirmed during the inspection: We found the ward managers dedicated ward time has improved following the appointment of a clinical coordinator/bed manager. This has reduced their time spent providing on call patient flow duties. Staff told us there is a Directorate on-call rota, which provides staff out of hours access to a senior manager.	

Area for improvement 9 **Standard Ref**: 4.3 (m) **Stated:** First time	The Trust should implement a system for the governance and oversight of agency staff training and induction. To ensure the Trust is fully assured that agency staff have been inducted to the ward environment, are familiar with patient's needs and have appropriate up to date training required to work in an inpatient mental health setting.	**Met**
	Action taken as confirmed during the inspection: Following a review of the records held relating to agency staff training and induction, we found the Trust had implemented a system to assure itself that agency staff were up to date with all required training and they had completed a comprehensive induction to allow them to work within an inpatient mental health setting.	
Area for improvement 10 **Standard Ref**:5.3.2 (a) **Stated:** First 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.	**Not Met**
	Action taken as confirmed during the inspection: We could not evidence any work having been progressed in relation to reducing incidents in Rosebrook. This area for improvement has not been met and is stated for the second time.	

Area for Improvement 11 **Standard Ref**: 7.3 (j) **Stated:** First 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.	**Not Met**
	Action taken as confirmed during the inspection: We spoke with nursing staff and other members of the MDT. We found that morale in Rosebrook had improved since our previous inspection. Nursing staff spoke highly of the ward sister and told us her leadership on the ward was supportive and visible. Senior management told us that they had established the reason for our findings relating to low staff morale on the previous inspection. We were also informed that some measures had been taken, however we were not assured that these measures were robust enough to effectively address issues with team dynamics should staff morale reduce again. We found no evidence of an action plan to address this area of concern. This area for improvement has not been met and is stated for the second time.	
Area for Improvement 12 **Standard Ref**: 6.3.2 (f) **Stated:** First time	The Trust should address the issues raised during this inspection regarding MDT working relationships, ensure all decisions made by the MDT are recorded and include the professional views expressed by all members of the MDT.	**Met**
	Action taken as confirmed during the inspection: We reviewed patient's MDT records. We found these records were comprehensive and reflected MDT input from medical staff, nursing staff and allied healthcare professionals.	

Area for Improvement 13 **Standard Ref**: 8.3 (i) **Stated:** First time	The Trust should implement a system for clearly sharing changes to patient's care and treatment plans with patients and all members of the MDT.	**Met**
	Action taken as confirmed during the inspection: We found evidence of MDT decision making recorded within patients' care records and daily handover records. The staff confirmed regular MDT meetings were in place for clearly sharing changes to patient's care and treatment plans with patients and all members of the MDT.	

6.3 Inspection findings

6.3.1 Governance, leadership and culture

During the inspection, we examined how the governance, leadership and management of the ward, assured the delivery of high quality care. We sought assurance that patients and staff are safe, secure and supported and a promotion of an open and transparent culture of learning and innovation was evident.

We found senior nursing staff were visible and approachable, and were leading effectively to support both patient and staff needs. Staff confirmed that the ward had improved under their leadership. Staff told us that senior trust management were approachable and were responsive to any suggestions or concerns raised.

We found evidence of a range of quality indicators in place to monitor, audit and review the effectiveness and quality of care delivered to patients within the ward for example hand hygiene audits and complaints.

We reviewed a sample of records and minutes of governance meetings and discussed the Bluestone Units governance arrangements and managerial oversight with a number of staff. We found evidence that the acute mental health governance group meetings regularly took place and were well attended by relevant key personnel. We found that there were systems in place to ensure the dissemination of information to staff, such as regular team meetings, daily safety briefs and multidisciplinary team meetings.

We reviewed the corporate; directorate; and hospital risk registers. We found that the Trust's corporate risk register did not reflect the potential risk relating to the high volume of incidents of aggression directed towards staff and we noted the directorate risk register had not been reviewed and updated since November 2019. We also identified the directorate risk register included delayed discharges in respect to two other Trust mental health wards. However, delayed discharges in respect of Rosebrook were not included on the register. We suggested that consideration should be given to ensuring these delayed discharges are included on the directorate risk register due to the restrictive environment these patients are accommodated in while awaiting a community placement. An area for improvement has been recommending the reviews its risk registers to include the findings from this inspection.

We found the hospital has a complaints policy in place. Staff who we spoke to demonstrated a good awareness of the processes for managing complaints. We traced the active management of two complaints associated with Rosebrook. We were assured robust arrangements were in place to ensure all complaints were managed in accordance with the Trust policy. However due to the low number of complaints recorded we suggested the senior management team review the mechanisms in place to assure themselves that all expressions of dissatisfaction are being logged as complaints.

In April 2019 the RCPsych Invited Review Service completed a review of inpatient mental health services of the Southern Health and Social Care Trust. This review was commissioned by the Trust following a number of issues identified in the Trust's inpatient mental health facilities. We found that the action plan resulting from this review was progressing slowly.

6.3.2 Multidisciplinary team working

We found evidence of good multidisciplinary working. Members of the nursing team and allied health professionals advised us that both verbal and written communication within the Rosebrook multidisciplinary team (MDT) had improved since the previous inspection in February 2020. We found evidence of MDT decision making recorded within patients' care records and daily handover records. Staff confirmed that regular MDT meetings were in place and changes to patient's care and treatment plans was discussed, agreed and shared.

Senior medical staff confirmed they participate in governance meetings however operational team meetings were not occurring, which impacted on the implementation of governance recommendations. They stated the MDT would benefit from reflective practice sessions possibly delivered by psychology and MDT involvement in debriefing following incidents. The psychologist confirmed that they are not involved in the MDT within Rosebrook ward. We suggest the Trust should consider reviewing the level of involvement of the psychology service within Rosebrook due to the high level of assaults on nursing staff.

6.3.3 Staffing levels and skill mix

We reviewed the staffing and skill mix arrangements for Rosebrook and spoke with a range of nursing staff. Following discussion with staff and a review of the duty rota we found there was an appropriate number of staff on the rota to meet the needs of the patients on the ward however we identified there was a high number of less experienced staff. We noted there was a reliance on bank and agency staff to backfill any staffing deficit across all wards, due to staff absences or unfulfilled posts. We noted a range of proactive actions taken by management to address staffing deficits. There was a continued recruitment drive and the encouragement of older staff to participate in a pre-retirement programme with a view to retaining their services post retirement on a part time basis.

There was a clear organisational structure within the ward and staff were able to describe their roles and responsibilities. The availability of the ward manger has improved since the previous inspection in February 2020 as a result of the appointment of a full time clinical coordinator /bed manager. The clinical coordinator also reviews staffing levels and skill mix daily across all wards in Bluestone and arranges temporary movement of staff to provide assistance to wards that are experiencing staff shortages. During discussions with staff we were informed they can contact the night coordinator to request additional staff if necessary. We were informed that on occasion's requests to fill shifts with qualified staff is not always possible and healthcare support workers are supplied by the nurse bank or agency.

The skill mix of staff continues to be an issue; we found a high number of less experienced staff working in Rosebrook. The senior managers informed they are experiencing difficulties recruiting experienced nurses which continues to impact on their ability to ensure staff skill mix throughout the hospital. This area for improvement is stated for the second time.

6.3.4 Staff training

We reviewed staff training and induction records. We found that all substantive and agency staff working in Rosebrook ward were up to date with the relevant training they require to carry out their role effectively.

Ward staff reported that both the corporate and department inductions were structured and comprehensive. Additionally we found a system in place to assure that agency staff have received a comprehensive induction to the ward and are familiar with patient's needs.

6.3.5 Incident management

Prior to the inspection we received information indicating that there were a high volume of incidents involving assaults on staff by patients in Rosebrook ward.

We reviewed incidents for the month of June 2020 to assess the frequency of incidents within the ward. We found that there continues to be a high volume of incidents in Rosebrook ward and approximately 50 per cent of incidents throughout June were assaults on staff. During our previous inspection, RQIA had made an area for improvement for the Trust to put in place a clear and measurable action plan that will aim to reduce the number of incidents. We did not see any evidence that the Trust had made any progress to address this area for improvement. Therefore this area of improvement is stated for a second time.

We spoke with staff, who demonstrated they were aware of the Trust policy for recording, reporting and management of incidents and had attended online training. We were informed of the mechanism for overseeing incident recording, assessment and grading. However following our review of ward incidents reported on the incident reporting system (DATIX), we identified that all incidents that occurred in June were graded as insignificant.. During discussions with senior staff we were informed that senior staff are approving incidents at ward level, based on their own knowledge of the patient rather than utilising care documentation to establish facts to complete the investigation.

We found that some incidents were inappropriately graded as the decision was based on the outcome rather than the inherent risk and likelihood of reoccurrence. We reviewed the records relating to a significant assault on several staff members by a patient. This incident was reported as a Serious Adverse Incident (SAI) and while the subsequent investigation of this incident was robust; the incident was graded as insignificant. We are concerned that incidents are being inappropriately graded and therefore under reported and not escalated to senior management for review. An area for improvement has been made in relation to incident management.

6.3.6 Restrictive practices

We reviewed the arrangements in relation to use of restrictive practices. We found the use of restrictive practices including seclusion was being well managed and in accordance with Trust policy and procedures, legislative requirements and best practice guidance. There was evidence that seclusion was used only as a last resort.

We reviewed the policies on the management of seclusion within Rosebrook and the pharmacological management of the acutely disturbed or violent behaviour (also known as rapid tranquilisation). We found them to be comprehensive and reflected best practice guidance.

Rosebrook has a purpose built seclusion room. We observed that this room can also be used as an extra care suite which provides a patient with a quiet area situated away from the main ward. The doors are not locked when the room is used for this purpose. For the duration of the inspection a patient was being supported in the extra care suite due to their assessed needs. We were therefore not able to fully review the seclusion suite. We observed that the double doors leading to the seclusion suite had a glass panel; we suggested that the glass panels should be frosted to further enhance the privacy and dignity of patients subject to seclusion.

We found the Trust had commenced a number of quality improvement initiatives in relation to restrictive practices. We noted a reducing restrictive practice management plan and the recent introduction of a restrictive practice safety cross.

The safety cross is a visual aid for staff to assess quickly the number of physical restraints, seclusions or rapid tranquilisation episodes for each individual patient.

Other quality improvement initiatives included the recent development of a number of monthly audits in relation to restrictive practices. The audits were in relation to MAPA; seclusion; continuous observation; and patients requiring a low stimulating environment. It was good to note that the use of MAPA had significantly reduced since March 2020. These audits are in the early stages of development and are primarily gathering statistical information.

We were told that a restrictive practice committee aligned to the zero suicide strategy chaired by the head of service had been established. The purpose of this committee is to review the arrangements in relation to restrictive practice and drive quality improvement. We observed that restrictive practices were reviewed at ward level by; the MDT; senior management team (SMT); and also within the directorate. We reviewed minutes of the acute mental health governance meetings between January and June 2020 and confirmed that incidents of restrictive practices and audit findings had been discussed.

We reviewed care records of patients that required a restrictive practice. We found good evidence of a clear rationale for the use of the restriction and detailed contemporaneous records were made.

We observed that staff involved in managing patients with challenging behaviour (in particular patients for whom MAPA and/or seclusion may be required) were being supported through structured debriefing and were being provided with the opportunity to discuss incidents.

Our review of care records also identified that incidences of restrictive practices were routinely discussed during MDT meetings. However, we noted that when patients overarching risk assessment was reviewed that it was primarily nursing staff that completed this. In order to ensure the assessment of risks is robust, the MDT should contribute to the overall risk assessment of patients. This area of improvement is stated for a second time.

6.3.7 Safeguarding

We reviewed arrangements for the safeguarding of children and adults in accordance with the current regional guidelines. We found policies and procedures were available in relation to safeguarding and protection of adults and children at risk of harm. We found that the Trust's policy reflected the Adult Safeguarding: Prevention and Protection in Partnership Policy (2015) and Adult Safeguarding Operational Procedures (2016). We were assured that the Trust had robust oversight and governance systems in place to provide assurance of how the hospital managed safeguarding concerns.

We spoke to nursing staff, including agency staff who demonstrated a good knowledge and understanding of adult safeguarding policies and procedures. Staff were aware of the referral procedures and their responsibilities in reporting safeguarding concerns relating to both adults and children. Staff training records reviewed evidenced that nursing staff, including agency staff had completed up to date adult safeguarding training. Staff also confirmed that they knew who to contact should they have concerns or needed to discuss a colleague's practice. Staff confirmed that they would be supported by their manager should they need to make a disclosure. Some staff mentioned reporting a safeguarding concern to the manager, while others indicated they would escalate to the ward social worker.

We reviewed a number of safeguarding referrals and we were assured the quality was good. All referrals and supporting documentation is retained at ward level. We were able to evidence the decision making process employed in relation to the screening in or out of referrals at ward level, however we found the Adult Safeguarding Team did not consistently provide an independent rationale when deciding to screen in and out referrals. There was evidence of audits of safeguarding process to identify trends and agree actions. We found evidence that safeguarding was discussed at a variety of meetings ranging from; the ward safety brief; clinical handovers; MDT meetings; ward managers meetings; and the Acute Mental Health Governance meetings.

We observed that information leaflets and posters were not available on the ward to inform patients, staff, visiting professionals or carers of adult safeguarding processes. An area for improvement has been made.

We reviewed the policy available to guide staff in the use of CCTV, we found this policy was in draft and there were no operating procedures available. There was no information in relation to the use of CCTV contained within the patients' handbook and there was a lack of signage to inform patients and the public that CCTV was in operation. Staff informed us that the reviewing of CCTV footage following potential safeguarding incidents was being completed by a single discipline. These concerns were escalated with the senior management team during the inspection. The Trust confirmed they have requested 'CCTV in operation' signage from the estates department in accordance with the policy, which will be erected as soon as it is available and action has been taken to ensure single discipline viewing of CCTV footage is discontinued. An area for improvement will be made in relation to the management and oversight of CCTV within the Bluestone unit.

6.3.8 Staff experiences/morale

Information submitted to RQIA indicated that there was low morale amongst staff in Rosebrook. During the inspection we met with; a full range of the MDT; human resource staff, support services staff, the patients' advocate and bank and agency. We also met with staff who had previously worked in Rosebrook. Staff were provided with contact details of the inspection team and an electronic questionnaire was available.

Staff were invited to complete the questionnaire and to contact the inspectors to share their experiences in relation to Rosebrook. We received two calls from staff members on completion of the inspection and there were no staff questionnaires returned following the inspection.

We found that morale in Rosebrook had improved since our previous inspection in February 2020. Nursing staff spoke highly of the ward sister and found her leadership on the ward to be supportive and visible. Staff told us that senior trust staff were also visible on the ward and were approachable. Staff responses reflected positively on Rosebrook ward and staff said they found it to be a challenging but rewarding environment to work in. Staff told us that assaults on staff continue to occur on the ward but they are supported through debriefs following incidents.

Despite the majority of staff indicating that morale in the ward had improved we continued to find some mixed responses regarding overall morale. Some staff spoke of conflict issues amongst the nursing staff team that can affect team dynamics. We note that the same concerns were identified our inspection of the ward in February 2020. While staff were aware of the Trust's Working Well Together Policy, there was no evidence of human resource involvement in trying to support better working relationships.

At our inspection in February 2020 we made an area for improvement that senior management 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 these issues. We could not find any evidence of an action plan being developed to support the staff in Rosebrook. This area for improvement is stated for a second time.

6.3.9 Patient/relative experience and feedback.

The majority of patients spoken to during the inspection were positive about their experiences. Patients confirmed they felt safe and variety of activities were provided, they were particularly complimentary about the Occupational Therapist.

Total number of areas for improvement	9

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed the Trust's senior management team during a feedback teleconference on 30 July 2020, 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 improvements required as outlined in the QIP are not taken to comply with The Quality 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 in which action is required to ensure compliance with The Quality Standards for Health and Social Care DoH (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 via Web Portal for assessment by the inspector.

Quality Improvement Plan	
This inspection is underpinned by The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DoH (March 2006)	
Area for improvement 1 **Ref**: Standard 4.3 (l) **Stated:** First time **To be completed by:** 15 September 2020	The Trust must ensure that environmental risk assessments are reviewed and updated to reflect when wards are over occupied. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.** **Ref:6.1**
	Response by the Trust detailing the actions taken: **The risk of over-occupancy situations has been reviewed, and included within the suite of Unit risk assessments, for example, ligature risk assessment, fire evacuation procedure and the health and safety general risk assessment.** **In addition, the use of undesignated beds is included in the Unit Risk Register.** **The Unit's Bed Management protocol has also been reviewed and updated to reflect the regional Bed Management protocol, which includes the requirement to seek approval from a senior manager regarding the use of an undesignated bed, completion of a Datix and a local incident review.**
Area for improvement 2 **Ref**: Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 31 October 2020	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. **Ref: 6.3.1**

	Response by the Trust detailing the actions taken: **The governance arrangements for Bluestone and Dorsy are in the process of being restructured with the aim of improving oversight, senior decision-making, MDT involvement, accountability and safety.** **The Unit has an existing Risk Register which covers all 6 wards. The specific risk identified for Rosebrook in respect of incidents of violence, aggression and abuse towards staff has been detailed specifically under the extant risk entry for 'the management of violence and agression within the Bluestone Unit'. A specific risk assessment has been commenced and was presented at the Unit Governance Forum (MH) 25 November 2020. This was also discussed at Dorsy Governance Forum 11 December 2020.** **An MDT review of incidents of violence and agression in Rosebrook will be conducted weekly and crisis plans for individual patients shall be reviewed and updated as a result. This will be subject to audit and will be a standing item on the Governance Forum agenda going forwards.** **The review of incidents is a standing item on the governance fora agendas and this issue will be discussed and monitored under that item.** **A pilot of Body Worn Cameras is scheduled to commence in Rosebrook (target date for commencement is January 2021).** **A specific entry in respect of delayed discharges, covering all Bluestone wards, is being added to the Unit Risk Register to reflect the Directorate Risk Register. This will be reviewed and updated monthly.**
Area for improvement 3 **Ref**: Standard 5.3.3(d) **Stated:** Second time **To be completed by:** 15 September 2020	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. **Ref: 6.3.1**
	Response by the Trust detailing the actions taken: **As detailed in the SHSCT response to the February 2020 inspection, a new Health Roster system went live in the Unit December 2019, with a full-time Health Roster Officer appointed to action implementation.** **Daily bed and staff management meetings continue to take place to ensure the appropriate distribution of staff, both in terms of numbers as well as skill mix. This is Chaired by the Clinical Coordinator or Head of Service, and all Ward**

	Managers or Nurse-in-Charge attend. **Overnight, the senior nurse-in-charge is a Band 7 Night Coordinator who has responsibility to ensure the appropriate distribution of staff, both in terms of numbers as well as skill mix, in line with patient acuity.** **The Staffing Escalation Tool has been updated, and reflects the new Directorate Senior Manager on-call rota.** **The Unit has recently commenced a pilot of an acuity tool, details of which will be reported through the regional MH Group Chaired by HSCB.** **The Unit has also completed successful recruitment drives for Bands 3, 5 & 6. As a result of the B6 recruitment drive, each ward will have 5wte Band 6 Senior Nurses to provide close to 24/7 Band 6 cover. This is at financial risk to the Trust. In addition, we are in the proces of agreeing start dates for 24wte Band 3 staff, again, at financial risk to the Trust. We are also planning to initiate a specific Rosebrook Band 3 recruitment drive early January 2021, as the remaining vacancies are proving difficult to fill.** **It is important to recall that the DoH requirement for safe nurse staffing levels in MH inpatient Units is as yet unfunded and indeed the supply of RMHNs within NI is insufficient to meet this required staffing level or skill mix currently. The Unit is constantly exhausting all temporary staffing solutions including bank, agency, additional hours and overtime.**
Area for improvement 4 **Ref**: Standard 5.3.2 (a) **Stated:** Second time **To be completed by:** 31 October 2020	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. **Ref: 6.3.2**
	Response by the Trust detailing the actions taken: **The governance arrangements for Bluestone and Dorsy are in the process of being reviewed, with the aim of improving oversight, senior decision-making, MDT involvement, accountability and safety.** **An MDT review of incidents of violence and agression in Rosebrook will be conducted weekly and crisis plans for individual patients shall be reviewed and updated as a result. This will be subject to audit and will be a standing item on the Governance Forum agenda going forwards. An audit tool has been drafted and circulated for comment**

	December 2020. The total number of incidents in Rosebrook shows a trend of steady reduction from June 2020 to August 2020. **Safety Crosses were introduced to Rosebrook in July 2020 as part of the Action Plan to address the issue highlighted, and were rolled out to other wards across the Unit in Setember 2020. Data for the quarter September - November 2020 demonstrates that Rosebrook had the second highest number of incidents relating to restrictive practices across the Unit, which was due to a spike of incidents in October 2020. These incidents were subject to review which directly linked the spike in incidents to the documented and reported rise in patient acuity.** **In addition, Unit staff attended and presented at the regional Restrictive Practice group in December 2020, and presented data for Rosebrook and & Silverwood for the period April 2018 to December 2019. This data demonstrated that 56% of restrictive practice incidents related to 3 specific patients. These patinets are under regular MDT review with specific medical treatment nad crisis management plans.** **Rosebrook senior nursing staff attended (virtually) an international conference focused on restrictive practice and managing acute disturbance, violence and agression. As a result, the Head of Service, Rosebrook staff and the Trust's Service Improvement Manager for Towards Zero Suicide (a strand of which is Reducing Restrictive Practices) is linking with the Nurse Consultant at Rampton Hospital, who presented on learning from incidents and implementing change, with the view of adopting this approach into Rosebrook.** **The Trust's Protect Life Coordinator is scheduling self-care sessions for PICU staff and a Forensic Social Worker has commenced reflective practice sessions with staff.** **In addition, we are linking with the Regional Trauma Network to scope and source additional training and support for staff.** **We are in the process of capturing all the above activity in an Action Plan format. This has been hampered by the impact of the global pandemic.**
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;

To be completed by: 31 October 2020	**Ref: 6.3.2**
	Response by the Trust detailing the actions taken: **All reported incidents are subject to review by an agreed approval hierarchy. Each ward within the Unit has access to a Datix Dashboard which includes data trends for all incidents and specific incident types eg. violence & aggression, falls, AWOLs etc. Senior managers also have access to the dashboard. Incident grading can be subjective (despite training) and the incident grades of all incidents are reviewed by managers and are available in trend format on the dashboard. The incident trends are available for the governance fora. In addition to trends analysis, moderate and above incidents are reviewed in detail at the Governance Group. DIF2 training sessions are being set up to assist Band 6 staff within the Unit in their review of the incidents. DIF1 (reporter) training will recommence when there is capacity in the Directorate Governance Team to do so. SHSCT is linking with WHSCT, as advised, to learn from WHSCT's approach and experience to incident management, however this has been stalled due to the impact of Covid-19.**
Area for improvement 6 **Ref**: Standard 5.3.1 (a) **Stated** :Second time **To be completed by**: 31 October 2020	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. **Ref: 6.3.3**
	Response by the Trust detailing the actions taken: **The governance arrangements for Bluestone and Dorsy are in the process of being restructured with the aim of improving oversight, senior decision-making, MDT involvement, accountability and safety.** **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 month, or more frequent if any change, at the Unit Governance Forum.** **When a serious incident occurs an MDT risk strategy meeting is convened, which is minuted. Actions agreed are subject to ongoing review. If there is disagreement, more frequent review will be scheduled and escalation to the**

	Head of Service actioned. All discussions, contributions and recommendations are shared with all involved for factual accuracy and agreement before sign-off.
Area for improvement 7 **Ref**: Standard 5.3.1 (c) **Stated:** First time **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. **Ref: 6.3.4**
	Response by the Trust detailing the actions taken: **A new CCTV Policy has been developed for Bluestone, and was tabled for approval at the Unit Governance Forum on 25th November 2020. It was agreed by members that the Information Governance considerations be aligned with the recent work undertaken for the introduction of Body Worn Cameras. This is currently being actioned and will be re-presented at Governance Forum for approval. It should be noted that the Trust CCTV Policy is not yet approved, therefore the Unit Policy will be reviewed once the Trust Policy is approved.** **CCTV signage was immediately requested post-inspection, and erected on receipt across the Unit.** **Development of a co-produced patient and carer Information Booklet has been commenced with the Lived Experience, Carers and Advocates Group.**
Area for improvement 8 **Ref**: Standard 5.3.1(d) **Stated:** First time **To be completed by:** 31 October 2020	The Trust must ensure that relevant safeguarding information is available and displayed for staff, patients and visitors. **Ref: 6.3.4**
	Response by the Trust detailing the actions taken: **Safeguarding posters and leaflets have now been erected, and re-erected, and provided in the Visitors Room in Rosebrook, and a poster on the inside of the door of the Nurses Station, where this is viewable by patients.**
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. **Ref: 6.3.5**

To be completed by: 31 October 2020	**Response by the Trust detailing the actions taken:** **This action was impeded following the previous inspection due to the impact of the global pandemic.** **Alternative methods of supporting staff and improving morale have been sourced via the Trust's HROD DIrectorate. Support has been identified using a mixed methodology approach from the HSC Leadership Centre, and has been requested for the MDT in Rosebrook. We are awaiting confirmation of availability, with early discussions considering January/February 2021. An assessment of MDT staff issues will be conducted as part of this.**

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

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