The Regulation and Quality Improvement Authority

Inspection Report

3 - 5 October 2018

Belfast Health and Social Care Trust

Adult Mental Health Acute Care Inpatient Services

Knockbracken Health Care Park
Saintfield Road, Belfast BT8 8BH
Tel: 028 9056 5656

Mater Hospital
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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: Belfast Health and Social Care Trust (BHSCT)	**Responsible Person:** Dr Cathy Jack, Chief Executive, BHSCT (The Trust)
Person in charge at the time of inspection: Assistant Director Adult Social and Primary Care Directorate.	**Number of commissioned beds:** Avoca: 8 Rathlin: 23 Ward J: 19 Ward L: 14
Categories of care: Mental Health (MH) Acute Admission Psychiatric Intensive Care	**Number of beds occupied in the wards on day one of this inspection:** Avoca: 9 Rathlin: 23 Ward J: 19 Ward L: 13

Brief description of the accommodation/how the service operates:

The Belfast Trust Mental Health Acute Care Service provides inpatient care to adults 18 years and over who have a mental health illness and require care and treatment in an acute psychiatric care setting. Patients are admitted either on a voluntary basis or in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).

All wards accommodate male and female patients. Wards J and L are based in the Mater Hospital, while Rathlin and Avoca are based in Knockbracken Health Care Park. Wards J, L and Rathlin are acute admission wards and Avoca is the Trust's psychiatric intensive care unit (PICU). Patients admitted for psychiatric intensive care are detained in accordance with the MHO.

2.0 Inspection summary

An unannounced inspection to the mental health acute admission and psychiatric intensive care wards across the Trust commenced on 3 October 2018 and concluded on 5 October 2018 with feedback to the Trust's senior management team (SMT).

The inspection was carried out by a combination of care and pharmacy inspectors with input from RQIA's clinical lead, an adept fellow, peer reviewer and lay assessor. This inspection was the first inspection RQIA conducted across a suite of inpatient mental health wards in a single HSC Trust. The methodology adopted was to assess the inpatient mental health service rather than individual wards.

At the time of this inspection a new build acute inpatient mental health unit located on the Belfast City Hospital site was under construction with a view to becoming operational in June 2019. The new unit will address the environmental concerns identified during this inspection including the use of seclusion in Avoca.

We reviewed the management of incidents in each ward and noted a high number of incidents involving violence against staff in Avoca and Ward J. To mitigate the risk to staff the Trust had implemented a number of initiatives, one of which included the introduction of a new admission framework Purposeful Inpatient Admission (PIPA), in Rathlin and Ward J. The PIPA model is considered a new approach to managing a patient's journey from admission through to discharge focusing the multidisciplinary team (MDT) on treating the patient, based on a formulation of their needs. The approach requires all members of the MDT each day to meet, review and plan action items in respect of each patient's assessed needs. The action items are noted and logged and an update is provided the following day. This model is designed to reduce the time patients remain in hospital and helps support them to leave as soon as they are well enough. We observed the PIPA model in practice and found that there was good MDT presence at the meeting, all patients were discussed, action items were agreed and progressed and an update was provided, discussion focused on all aspects of patient need including mental and physical health, social and family circumstances, capacity, voluntary or detained status, and recovery and discharge planning.

There was variation between wards regarding how incidents were managed and recorded. This variance presented a risk to the Trust's governance and oversight of incident management across their system. An area for improvement in relation to the review of incidents at ward level has been made.

The management of patient's physical health care needs requires better interface working relationships between staff in mental health services, specialist medical teams and the acute hospitals. Areas for improvement have been made regarding training mental health staff on the management of sepsis, the administration of IV antibiotics and the development of robust protocols between mental health and acute hospital inpatient services.

We identified varying practices across wards in relation to the admission, transfer and discharge of patients. In some areas we evidenced good practice in terms of patient movement but this was not reflected across the entire service. We noted that the Trust policy for the transfer and discharge of patients was not being implemented consistently. An area for improvement in relation to the review of the Trust's patient admission, transfer and discharge policy and procedures has been stated for a second time.

Compassionate and positive interactions between staff and patients were observed throughout the inspection. Incidents observed during the inspection were dealt with promptly and effectively and staff were observed treating patients with dignity and respect and responding compassionately to patients presenting with physical and/or emotional distress.

We identified two areas for improvement in relation to governance arrangements. The first relates to the timely submission and completion of SAI reports. This includes ensuring recommendations are implemented and learning is shared across the directorate in accordance with the regional HSCB procedure for the reporting and follow up of serious adverse incidents (November 2016). The second relates to ensuring ward staff make prompt adult safeguarding referrals.

This inspection resulted in 10 areas for improvement (AFI) being identified. Four AFI are new, one has been stated for the third time, four for the second time and one has been carried forward for review at the next inspection as it was not assessed during this inspection.

Since this inspection and prior to the publication of this report the new purpose built Adult Mental Health Inpatient Centre (AMHIC) opened on the Belfast City Hospital site in June 2019. All of the wards referenced in this report have been relocated to AMHIC. Each of the wards that relocated have been renamed as follows; Ward L is now Ward 1; Ward J is now Ward 2; Rathlin is now Ward 3 and Avoca is now Ward 4.

The publication of this report has been delayed by RQIA. Since the inspection we have undertaken two inspections in the new purpose built AMHIC. Ward 4 was inspected 13-20 August 2019 and wards in AMHIC were inspected 4-12 May 2021. The AFI from this inspection were followed up during the inspections in August 2019 and May 2021.

3.0 How we inspect

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

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 they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the Trust to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

4.0 What people told us about the service

Questionnaires were placed on the wards inviting patients to complete them and post them to us. Returned completed patient questionnaires were analysed following the inspection. The lay assessor also met with and spoke to a number of patients in each ward.

We also invited ward staff to complete an electronic questionnaire.

Whilst we did not receive any returned completed questionnaires from staff we held focus groups with various disciplines including, medics, nurses and allied health professionals (AHPs). The general consensus from staff was that the new PIPA model enhanced interdisciplinary working relationships as it provided accountability for actions assigned to particular members of the MDT.

5.0 The inspection

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

Avoca PICU: The most recent inspection was an unannounced inspection on 27 February 2018. There were no areas for improvement identified as a result of that inspection.

Rathlin: The most recent inspection was an unannounced inspection from 17 to 19 October 2017. Nine areas for improvement were identified as a result of that inspection. These related to record keeping, ligature risk assessment, management of incidents, environment' care plan management, and support for patients over the age of 65.

Ward J: The most recent inspection was an unannounced inspection from the 16 to 17 May 2017. 19 areas for improvement were identified as a result of that inspection. These related to care planning, management of risk, patient privacy, provision of personal protection equipment, and the need for a review of the Trust's policy and governance.

Ward L: The most recent inspection was an unannounced inspection from the 14 to 18 June 2017. Eight areas for improvement were identified as a result of this inspection. These related to, ligature risks, governance, training, environment, patients meetings, safeguarding and pharmacy support.

Areas for improvement from the last inspections		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)		**Validation of compliance**
Area for Improvement 1 **Rathlin Ward** **Ref**: Standard 5.3.1(f) **Stated:** Fourth Time	Members of the medical staff were not recording patient information on the patient electronic recording system (PARIS).	**Met**
	Action taken as confirmed during the inspection: We reviewed six sets of patient care records which evidenced that medical staff were recording patient information on the patient electronic recording system (PARIS).	

Area for Improvement 2 **Rathlin Ward** **Ref**: Standard 5.3.1(a) & 5.3.3(b) **Stated:** Second Time	The ward round template was not completed consistently each week. In a number of records minutes were not comprehensive, there was no record of each patient's progress during the week from the MDT and there was no action plan completed for the forthcoming week. Patients were not offered the opportunity to attend their weekly multi-disciplinary meeting.	**Met**
	Action taken as confirmed during the inspection: The Trust had introduced the PIPA model in Rathlin. The PIPA model included completing daily and weekly reviews of each patient's progress. Patient care records evidenced that weekly ward rounds were taking place consistently each week, minutes of the meetings were comprehensive and included a summary of the patient's progress and an action plan for the forthcoming week had been discussed and agreed. Patients were being offered the opportunity to attend the weekly ward round.	
Area for Improvement 3 **Rathlin Ward** **Ref**: Standard 5.3.1(a) & 6.3.2(b) **Stated:** Second Time	Comprehensive risk safety assessments were not completed in accordance with Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Service May 2010.	**Met**
	Action taken as confirmed during the inspection: During our review of care records we noted risk assessments were completed in accordance with Promoting Quality Care Good Practice Guidance.	

Area for Improvement 4 **Rathlin Ward** **Ref**: Standard 5.3.1(a) & 5.3.3(f) **Stated:** Second Time	In the seven sets of care records reviewed there was no evidence of staff completing psychological formulations to underpin care plans and to direct models of intervention/treatment. On review of the nursing care plans, it was evident that nursing interventions focused mainly on administration of medication, building a therapeutic relationship with patients' and one to one time. There was no evidence that nursing staff provided any other therapeutic interventions. There was no joint work by the MDT in relation to planning and delivery of either recreational or therapeutic interventions. Activities on the ward were led in the main by the occupational therapist.	**Met**
	Action taken as confirmed during the inspection: Psychological formulation meetings were held for each patient 72 hours post admission and were effective in the decision making about patients care and treatment plans. Patients mental health needs were comprehensively assessed and reviewed on an ongoing basis. Care plans were noted to be comprehensive and patient centred. The management of ward rounds was very effective. It was noted that the introduction of PIPA had a positive impact on the MDT management of patients care and treatment. There was a range of activities, including, music and group work.	

Area for Improvement 5 **Rathlin Ward** **Ref:** Standard 5.3.1 (f) **Stated:** First Time	Patients' records were stored in both paper files and on the PARIS system therefore it was difficult to review the patients' journey on the ward.	**Met**
	Action taken as confirmed during the inspection: We noted that all the wards continued to maintain dual recording systems using both paper records and the Trust's electronic patient recording system known as PARIS. The introduction of PIPA on two wards made it much easier to follow recording on PARIS. PARIS is not yet set up to store all documentation required to evidence care delivered. There will always be a need for hardcopy paper work to accompany electronic notes. The current system enables the patient journey to be reviewed.	
Area for Improvement 6 **Rathlin Ward** **Ref:** Standard 5.3.1 (a) **Stated:** First Time	Staff were using a number of different care plan templates. A number of care plans were not signed by patients and not signed and reviewed by staff. One patient had a diagnosis of type 1diabetes and there was no care plan in place to direct staff on how to manage this patient's diabetes.	**Met**
	Action taken as confirmed during the inspection: We noted improvements in patients care plans. Patients had signed their care plans, and care plans reflected each patient's needs. This is discussed further in section 5.2.2.	

Area for improvement 7 **Rathlin Ward** **Ref**: Standard 5.3.1(f) **Stated:** First Time	There was no comprehensive nursing assessment in place to assess patients' overall physical health care needs. There was evidence of nurses completing their own type of assessment with different headings to assess patients' physical health needs.	**Carried forward to the next inspection**
	Action taken as confirmed during the inspection: Compliance with this area for improvement was not assessed. This area for improvement has been carried forward to the next inspection and will remain as stated for the first time,	
Area for improvement 8 **Rathlin Ward** **Ref**: Standard 6.3.2 (a) **Stated:** First time	In a number of patients' rooms there were no curtains on the windows and the front section of the drawers on the bedside lockers had been removed and not replaced.	**No longer applicable**
	Action taken as confirmed during the inspection: Curtains were in place in patient bedrooms. We noted several front sections of drawers still missing. We were informed that the front sections of drawers were broken and replaced on a regular basis. This area for improvement has not been carried forward for review at the next inspection. At the time of the next inspection and prior to the publication of this report this ward had relocated to the newly built AMHIC. This environmental issue was not relevant in the new building.	

Area for improvement 9 **Rathlin Ward** **Ref**: Standard 5.3.1 (f) & 6.3.1 (c) **Stated:** First Time	The entrance to the ward appeared to be a very busy area as there were three main functions to this area. A seating area for patients, the nurses' office and access to the ward. We observed a number of incidents occurring in this area between patients and staff, between two patients and between a visitor and a patient which all required interventions from nursing staff to ensure patients and visitors were kept safe. This area should be reviewed in light of these issues.	**Met**
	Action taken as confirmed during the inspection: We noted that the Trust had completed significant works to the ward's entrance area. The entrance to the ward had been changed to a dedicated reception and the nursing office and seating area for patients had been relocated.	
Area for Improvement 10 **Ward J** **Ref:** Standard 5.3.1 (f) **Stated:** First Time	Staff were not completing and submitting a DATIX entry on every occasion where patients smoke on the ward or when the cigarette smoke alarms which are fitted in bathrooms and side rooms are activated.	**Met**
	Action taken as confirmed during the inspection: The ward manager confirmed that if patients smoke on the ward a DATIX is completed. DATIX records evidenced that staff were regularly recording when patients had been smoking on the ward.	

Area for Improvement 11 **Ward J** **Ref:** Standard 5.3.1(f) **Stated:** First Time	A consistent approach is needed for all care documentation, such as an agreement reached if risk assessments, care plans etc. are electronic or written record.	**Met**
	Action taken as confirmed during the inspection: All wards continued to maintain dual recording systems using both paper records and PARIS. The introduction of PIPA on two wards made it much easier to follow recording on PARIS as it had prescribed recording process. When the PIPA model is rolled out across all wards this will address the consistency aspect of this AFI. PARIS is not yet set up to store all documentation required to evidence care delivered. There will always be a need for hardcopy paper work to accompany electronic notes. The current system enables the patient journey to be reviewed.	
Area for Improvement 12 **Ward J** **Ref:** Standard 5.3.3 (a) **Stated:** First Time	The feedback from the two patients who were trialled using the Regional Mental Health Care Pathway entitled “You in Mind” was positive and the deputy nurse reported that it promoted ownership from the patient and co-production. This was not common practice for all patients.	**Met**
	Action taken as confirmed during the inspection: This area for improvement was first made in 2017. Since that date the Trust has introduced a new care pathway called PIPA. We noted that the PIPA model was having a positive impact for patients and staff. This included continued patient participation in decision making regarding their care and treatment.	

Area for Improvement 13 **Ward J** **Ref:** Standard **Stated:** First Time	The actions as detailed on the ward's ligature survey report were not implemented. This includes the boxing in of low level piping in the ensuites to side rooms 2 and 3 and the large TV room.	**Met**
	Action taken as confirmed during the inspection: The low level pipes in the ensuite to side rooms 2 and 3 and the large TV had been boxed in. A ligature risk assessment was completed on 21 March 2018. The risk assessment was reviewed and included risks that had been removed and didn't include risks that were still outstanding. Outstanding ligature points included conduit on the wall, radiators and clothes hooks. A comprehensive assessment was not in place with a management plan to address the risks. This area for improvement has not been carried forward for review at the next inspection. At the time of the next inspection and prior to the publication of this report this ward had relocated to the newly built AMHIC. During our inspection on 4-12 May 2021 we reviewed the arrangements in place for the oversight and management of ligature risk assessments and were satisfied.	

Area for Improvement 14 **Ward J** **Ref:** Standard 5.3.1 **Stated:** First Time	Updated status and any measures taken to progress action points on (a) the ward ligature risk assessment and (b) fire risk assessment action plans were not recorded on the prescribed documents to evidence that action has been taken by the appropriate responsible person/ department.	**No longer applicable**
	Action taken as confirmed during the inspection: A fire risk assessment and action plan were completed on 16 January 2018. Eight outstanding actions had not been completed. Four of these actions were to be completed 'immediately' and four should have been completed in 'the short term' according to the action plan. The importance of addressing actions detailed in the fire risk assessment was discussed with the SMT. This area for improvement has not been carried forward for review at the next inspection. At the time of the next inspection and prior to the publication of this report this ward had relocated to the newly built AMHIC. The arrangements for fire risk assessments were reviewed during the inspection of AMHIC in May 2021. Please refer to area for improvement 13 regarding the ward ligature risk assessment.	
Area for Improvement 15 **Ward J** **Ref:** Standard 5.3.1 (a) **Stated:** First Time	Patient's comprehensive safety risk assessments were not completed in full, acknowledging patient involvement and consideration of patient's human rights in the assessment. There was no recording of the contribution of the multidisciplinary team members in the assessment.	**Met**
	Action taken as confirmed during the inspection: Four sets of patient care records were examined. Risk assessments had been completed in full, acknowledging patient involvement and consideration of patient's human rights. MDT members had updated each patient's risk assessment as required.	

Area for Improvement 16 **Ward J** **Ref:** Standard 5.3.1(f) **Stated:** First Time	The review of risk assessments did not evidence who was present at the review and any changes made and the rationale for these changes.	**Met**
	Action taken as confirmed during the inspection: Patient risk assessments evidenced who had been present when the assessment had been reviewed. Records detailed any changes that had been made in relation to risk, the rationale for the changes and the members of the MDT who had been involved in the decision making.	
Area for Improvement 17 **Ward J** **Ref:** Standard 5.3.1 (f) **Stated:** First Time	The weekly or monthly checks required (e.g. door closures) did not record the job requests number against comments section to evidence that the appropriate action has been taken.	**Met**
	Action taken as confirmed during the inspection: The job request number was being recorded against the comments section to evidence appropriate action has been taken following weekly and monthly ward safety checks.	
Area for Improvement 18 **Ward J** **Ref:** Standard 5.3.1(f) **Stated:** First Time	The flooring outside the door to the ward at the top of the stairwell was ripped and needs replacement.	**Met**
	Action taken as confirmed during the inspection: The flooring at the top of the stairwell opposite the ward's entrance area had been replaced. The floor was noted to be in good condition.	
Area for Improvement 19 **Ward J** **Ref:** Standard 5.3.1 (f) **Stated:** First Time	The temperature recording of the medication fridge was not logged on a consistent daily basis.	**Met**
	Action taken as confirmed during the inspection: We reviewed the daily log used to monitor the ward's medication fridge. The log evidenced that the fridge temperature had been monitored on a daily basis in accordance to Trust guidelines.	

Area for Improvement 20 **Ward J** **Ref:** Standard 5.3.3 **Stated:** First Time	There was no evidence that care plans were evaluated.	**Not Met**
	Action taken as confirmed during the inspection: We examined four sets of patient care records and noted in three sets of records patient care plans had not been reviewed or evaluated. This area for improvement has been stated for a second time.	
Area for Improvement 21 **Ward J** **Ref:** Standard 5.3.1(f) **Stated:** First Time	Minutes of the multi-disciplinary team did not reflect the breadth of discussion on patients or the contribution of all disciplines.	**Met**
	Action taken as confirmed during the inspection: The MDT meeting had been replaced with a daily brief in accordance with the PIPA care pathway. Minutes of the daily brief evidenced that each patient's circumstances were discussed in detail by all members of the ward's MDT.	
Area for Improvement 22 **Ward J** **Ref:** Standard 4.3 (m) **Stated:** First Time	Some patients have been admitted with eating disorders and staff stated they had no specific training around the management of eating disorders such as nasal gastric (NG) feeding and administrating IV fluids.	**Part of this AFI is no longer applicable the other part is not met**
	Action taken as confirmed during the inspection: Senior Trust managers confirmed that the ward staff no longer managed patients who require an NG tube feed. If a patient requires this procedure then they will be transferred to an acute hospital. The Trust committed to ensuring that adequate numbers of staff are trained on administrating IV fluids to prevent patients transferring to the acute hospital should they require IV fluids. This area for improvement has been updated to reflect the section which has not yet been addressed and will be stated for the second time.	

Area for Improvement 23 **Ward J** **Ref:** Standard 5.3.1 (f) **Stated:** First Time	There were not enough fire wardens to have one scheduled on every shift.	**Met**
	Action taken as confirmed during the inspection: The staff duty roster and training records confirmed that there were a sufficient number of fire wardens.	
Area for Improvement 24 **Ward J** **Ref:** Standard 5.3.3 **Stated:** First Time	A comprehensive MDT care plan was not in place to direct the care and treatment of patients with eating disorders who may require a restrictive intervention for nasogastric tube feeding.	**No longer applicable**
	Action taken as confirmed during the inspection: See area for improvement 22.	
Area for Improvement 25 **Ward J** **Ref:** Standard 6.3.1 **Stated:** First time	There were not enough protective aprons available in the X-ray department.	**Met**
	Action taken as confirmed during the inspection: There were sufficient protective aprons in the X-ray department of the acute hospital if staff were required to support a mentally unwell patient to have an essential x-ray.	
Area for Improvement 26 **Ward J** **Ref:** Standard 6.3.2 **Stated:** First time	Patients' privacy and dignity was not upheld when they were being transferred from the ward to the x-ray department.	**Met**
	Action taken as confirmed during the inspection: In the returned Quality Improvement Plan the Trust confirmed that the individual patient's MDT Care Plan will provide guidance on the circumstances for transporting a patient to the x-ray department to include whether the transfer can be delayed until the patient is more cooperative. The service will also consider if there are alternative ways to access the x-ray department, which are more discreet and support the maintaining of the patient's dignity.	

Area for Improvement 27 **Ward J** **Ref:** Standard 5.3.3 **Stated:** First time	A debrief session was not held after every occasion where restraint was used.	**Met**
	Action taken as confirmed during the inspection: There had been no recent incidents of restraint being used. Ward staff, including the ward manager and Trust senior managers provided assurances that a debrief session would now be completed following any incident where restraint is used.	
Area for Improvement 28 **Ward J** **Ref:** Standard **Stated:** First time	The Trust's Policy for the Insertion and Confirmation of Position of a Nasogastric Tube in Adults, Children and Neonates 2013, had not been reviewed and updated.	**No longer Applicable**
	Action taken as confirmed during the inspection: Staff in Ward J were no longer required to insert NG tubes and as a result of the change in practice this policy was no longer relevant to Ward J. Following a change in practice this area for improvement is no longer applicable.	
Area for Improvement 29 **Ward L** **Ref:** Standard 5.3.1 (a) **Stated:** First Time	The ligature risk assessment for patients using profiling beds was not completed in all cases.	**Not Met**
	Action taken as confirmed during the inspection: Eight patients admitted to Ward L required the use of a profiling bed. We reviewed the patient's risk assessments and noted that two did not have a ligature risk assessment completed in regards to their use of a profiling bed. This area for improvement will be stated for a second time.	

Area for Improvement 30 **Ward L** **Ref:** Standard 5.3.1 (f) **Stated:** First Time	The names and designation of those in attendance at the monthly governance meeting are not recorded in the minutes.	**Met**
	Action taken as confirmed during the inspection: The minutes of monthly governance meetings recorded the names and designation of those in attendance.	
Area for Improvement 31 **Ward L** **Ref:** Standard 6.3.2 (g) **Stated:** First Time	Patient forum meetings were not occurring regularly and staff were not recording when they were offered to patients or when patients decline the opportunity to attend.	**Partially Met**
	Action taken as confirmed during the inspection: Records of patient forum meetings evidenced that a number of meetings had been held however; these were not taking place on a regular basis. This area for improvement has been stated for a second time.	
Area for Improvement 32 **Ward L** **Ref:** Standard 4.3 (m) **Stated:** First Time	There was a number of staff who required updated mandatory training as per Trust training matrix.	**Met**
	Action taken as confirmed during the inspection: We reviewed the training matrix for staff working in Ward L. The matrix detailed that staff had completed their mandatory training.	
Area for Improvement 33 **Ward L** **Ref:** Standard 5.3.1 (f) **Stated:** First Time	The male shower/toilet area was not thoroughly cleaned.	**Met**
	Action taken as confirmed during the inspection: The shower and toilet areas within Ward L were noted to be clean and appropriately maintained. Patients reported no concerns regarding the cleanliness of the toilet and shower areas.	

Area for Improvement 34 **Ward L** **Ref:** Standard 5.3.1(c) **Stated:** First Time	Staff had not followed correct procedures for an adult safeguarding referral.	**Met**
	Action taken as confirmed during the inspection: We reviewed seven safeguarding referrals. These had been completed appropriately and in accordance to regional guidelines (Adult Safeguarding: Prevention and Protection in Partnership, 2015).	
Area for improvement 35 **Ward L** **Ref**: 5.3.1(f) **Stated:** Second Time	The Trust's environmental cleanliness and mental health services admission and discharge policies required review.	**Partially Met**
	Action taken as confirmed during the inspection: The Trust's environmental cleanliness policy had been reviewed and updated. The mental health services admission and discharge policy was being completed in partnership with a number of the Trust's community teams. The review of this policy had not been completed as more time was required to engage a large number of community teams. This area for improvement has been updated to focus on the mental health services admission and discharge policy only. The relevant section of this area for improvement will be stated for the third time.	
Area for improvement 36 **Ward L** **Ref**: Standard 5.3.1 (f) **Stated:** First Time	Pharmacy presence on the ward was inconsistent.	**Met**
	Action taken as confirmed during the inspection: We noted consistent pharmacy support within Ward L. The ward was supported by a pharmacy technician and a ward pharmacist.	

5.2 Inspection findings

5.2.1 Admission/Discharge Process

The Trust's admission and discharge processes to and from mental health wards were reviewed. We noted varying practices across wards in relation to the transfer of patients between wards. In some areas we evidenced good practice in terms of patient movement but this was not reflected across the service. We noted that the Trust's policy for the admission and discharge of patients was not being implemented consistently.

We were unable to clarify how decisions regarding admission and discharge to and from wards were made and noted further work is required to standardise the decision making process.

Staff reported that due to PICU bed pressures it was sometimes necessary to source a PICU placement out of the Trust's catchment area. Delay in securing a PICU admission for a patient resulted in other mental health wards in the Trust having to manage patients who require PICU level care. During our feedback session with representatives from the Trust's SMT we were informed that this matter was also going to be explored and addressed at the forthcoming acute care planning workshop.

An area for improvement in relation to the review of Trust's patient admission, discharge and transfer policy and procedures has been stated for a third time.

5.2.2 Care and treatment

Patient records were reviewed to determine if patients were receiving the correct care and treatment at the right time.

Differences in record keeping were evident across all four wards. The introduction of the PIPA model in Rathlin and Ward J was influencing better record keeping practices.

Overall patient's mental health needs were comprehensively assessed upon admission and reviewed on an ongoing basis across all words and psychological formulations took place on the ward 72 hours post admission. Risk assessments were completed and there was evidence of patient and relative involvement in risk assessments and risk management plans. In the records reviewed, patients had signed their care plans, and care plans reflected patient's needs. Care plans were generic and improvement is required to make them more patient centred. These findings were discussed with each respective ward manager.

Concerns in relation to the management of patient's physical health care needs were identified. A lack of specialist input from colleagues within general medical care had also been highlighted as a concern during the inspection findings for Ward K in the Mater Hospital in July 2018. There were a number of patients who had specific health care conditions that required specialist input. Some patients required ongoing clinical review of their specific physical health care needs in consultation with specialist services; and although patient's records indicated that they had been reviewed by several junior medical staff, they did not have a specialist review/assessment.

Representatives from the Trust's SMT reported that work had commenced to address this issue and that there were very strong links with the community specialist service which should have been used in this instance.

A number of other concerns relating to the management/care of patient's physical health care needs were identified which included; (i) a delay of 90 minutes had occurred from the point of identifying a need for a patient to have medical input, until the doctor arrived; (ii)nursing staff on the ward were not able to administer IV antibiotics resulting in patients missing some doses of antibiotics; (iii) a lack of knowledge from staff on the emergency response required to manage patients presenting with a diagnosis of sepsis; and (iv) a lack of training in administration of IV antibiotics.

One incident, relating to the management of a patients physical health care, which met the criteria for reporting as a Serious Adverse Incident (SAI) or near miss hadn't been reported as an SAI. Therefore an opportunity to review and identify learning was missed. We discussed this particular case with members of the Trust's SMT who assured us that this would be discussed at the forthcoming acute care planning workshop and they would focus on developing protocols and procedures for the management of patients presenting with sepsis in an acute mental health ward. Staff highlighted, and we acknowledged, the challenges of managing patients who present with complex mental health needs and sepsis and the difficulty in making a diagnosis of sepsis within a mental health acute care setting.

An area for improvement has been made regarding the need for training, including the development of a care bundle, for the management of sepsis for patients admitted to Trust's acute care mental health wards. This includes nursing staff having the required knowledge and skill to administer IV antibiotics.

A further area for improvement regarding the development of robust protocols between the mental health wards and acute wards within the Trust has also been made. The improvement should include the introduction of appropriate links and protocols going forward when the mental health wards move to its new facility on the Belfast City Hospital site.

5.2.3 Management of Incidents/Accidents and adult safeguarding

A sample of adverse incidents, serious adverse incidents and safeguarding referrals across each of the four wards was reviewed.

Adverse incidents were noted to have been identified and recorded appropriately on the Trust's electronic incident system known as Datix. Each incident is graded upon entry to the Datix system as presenting with a high, medium or low risk and the likelihood of it potentially reoccurring is also assessed. Each incident is reviewed by the ward manager who approves the Datix entry including the grading of the incident. We noted incidents were assessed and graded appropriately.

We explored the arrangements for sharing learning following an incident. There was no evidence to support how learning is shared with staff in the ward where the incident occurred and staff in other MHLD inpatient wards. In one ward we noted an incident review which had been completed and closed by the ward manager, the record lacked detail regarding the actions arising from the Datix review. They were very general in nature, and did not contain specific detail or identify who was required to oversee if the action/s was/were completed.

We highlighted the importance of not only assessing and reviewing incidents at ward level, but also analysing the learning identified and then appropriately sharing this with staff. An area for improvement has been made.

We inquired how members of the SMT audited the number and frequency of assaults across the mental health directorate. Members of the SMT confirmed that they have oversight of incidents and the associated reports on a monthly basis. They assured us that these were discussed at directorate management meetings. This work should help to establish a baseline dataset and assess variations in practice within and between wards so that trends and themes can be identified and learning shared.

We identified short delays (of 2-3 days) in the completion of a small number of safeguarding referrals linked to incidents that had occurred in one ward. We noted a variation in recording of safeguarding referrals between wards with staff from some wards recording incidents on DATIX, whilst staff from other wards did not. We were concerned that this variation in practice presented a risk to the governance and oversight of incident management. This issue is further discussed in section 5.2.9 of this report.

5.2.4 Staff safety

Staff reported they had experienced higher than average episodes of violence during June and July 2018 on one of the wards which was compounded by staffing difficulties and a number of patients who presented with significant behaviours that challenged.

We met with members of the Trust's senior management team (SMT) who advised us they were aware of the situation which arose on this ward during this time. Further discussion on this matter is recorded in section 5.2.10 of this report. Since then the ward have had a change in leadership. It was positive to note that the change in leadership in the ward was perceived by ward staff as very positive; staff reported that they now felt supported.

On the first day of the inspection we were unable to clarify who was in charge in one of the wards. Later that morning we were informed that one of the band five nurses was in charge. The nurse in question reported they had not been informed of this. We raised this matter with the Trust's SMT who confirmed that they shared our concerns. The ambiguity which arose on the first day of the inspection was due to unforeseen circumstances occurring that morning which hadn't been reported to the Band 5 at the time when inspectors arrived.

5.2.5 Restrictive Practices

Avoca functions as the Trust's PICU ward. The unit does not comply with the National Association of Psychiatric Intensive Care and Low Secure National Minimum Standards for Psychiatric Intensive Care in General Adult Services, (Updated 2014).

All patients in Avoca were being cared for in the same large open space. There were no suitable safe alternative spaces or rooms which could be used to assist staff who were supporting patient(s) displaying high risk distressing behaviours and who needed a quiet, low stimulus environment in order to de-escalate behaviours and prevent incidents occurring. Staff advised that they use a room in Avoca known as the care suite, to isolate patients from the main ward area as a means of ensuring the safety of patients and staff. In this regard we determined that de-facto seclusion was happening on Avoca Ward.

We were concerned that the Trust had not implemented protocols and procedures to support patients requiring seclusion. The absence of clear protocols and the de-facto use of seclusion on the Ward placed staff in a very difficult position. Whilst the Trust had planned to have a seclusion room in the new unit, we enquired as to what interim arrangements had been made to support patients and staff prior to the ward transferring to the new facility. The SMT confirmed that they had increased nurse staffing levels and would review how Avoca would function as a PICU ward until such times as they move to the newly built AMHIC. In an effort to support staff, extra coaching support for staff on the ward had been secured and links with other Trusts have commenced.

Representatives from the Trust's SMT informed us that they reviewed and discussed the PICU environment on a regular basis and the MDT in Avoca continually work to enhance the quality of care to patients. Plans are in place for Avoca ward to be part of a collaborative project focusing on violence management, reduction and quality improvement. The Trust was gathering baseline data regarding the number, type and frequency of incidents in order to understand the current picture regarding aggression and violence on the ward.

During the building of AMHIC a new seclusion room was purpose built in line with the National Minimum Standards for Psychiatric Intensive Care in General Adult Services.

5.2.6 Medicines management

Medicines management was reviewed in all four wards. There was evidence that satisfactory systems were in place for the storage and dispensing of medication. We did not identify any specific concerns regarding the management and dispensing of medication during this inspection. Wards J and K on the Mater site had increased pharmacy input in comparison to Ward L. It was evident that Ward L did not have the same demands as the other wards, and that the Trust was managing its finite pharmacy resource. Medications on Ward L were assessed as well managed.

Concerns regarding the use of Pro Re Nata (PRN) (as and when required) medications across all wards were identified. PRN medication is prescribed as first and second line. This means a particular medication is identified which should be administered in the first instance and if that medication does not yield the desired result the second medication can then be administered. Each dose of PRN medication has maximum levels which are outlined in the British National Formulary (BNF). The BNF is a United Kingdom (UK) pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about many medicines available on the UK National Health Service (NHS).

Some staff on the Mater site were lacking in confidence in their decision making to administer prescribed PRN medication. We identified that ward staff required increased support and further training in terms of PRN procedures and processes, particularly staff that were newly qualified or new to a ward. In contrast to this, we evidenced that on Avoca first and second line PRN, medication, was being administered and recorded up to maximum doses. During discussions with members of the SMT and consultants the Trust advised that use of PRN medications will form part of a larger review in relation to violence reduction across the acute inpatient service.

There were some issues noted in Avoca in relation to the management of nebulisers and other medications required to help manage physical health care conditions.

Some prescribed medications were noted to be out of stock. During the feedback session the SMT confirmed they have also appointed additional Band 6 nurses to ensure appropriate cover on wards across all shifts. It is envisaged that this additionality will support work addressing our findings in relation to the administration of PRN medication.

An area for improvement has been made to ensure the Trust strengthens its arrangements for the management of medicines.

5.2.7 Person centred care

Staff interaction with patients was observed to assess if care was delivered in a person centred manner.

We found that when appropriate, and in accordance with each individual's presenting needs and health, patients were given the opportunity to be involved in any meetings where decisions about their care and treatment were being made.

Overall compassionate and positive interactions between staff and patients were observed throughout the inspection. Incidents that occurred on wards during the inspection were dealt with promptly and effectively. We observed staff treating patients with dignity and respect and responding compassionately to patients presenting with physical and/or emotional distress. We found that nursing staff had good knowledge and understanding of the specific needs of individual patients they were caring for.

We observed that patients were not hesitant to approach staff. Staff reassured patients and promptly attended to any queries. Staff maintained the privacy of patients at all times for example; staff knocked doors and asked permission before entering patients' rooms.

All staff described the ward MDTs as patient centred, inclusive and supportive. We noted that MDTs included the range of professionals necessary to provide the required care and treatment to patients.

5.2.8 Patient views

We spoke with patients to hear their experience of the care and treatment they received. We met with 17 patients from across each of the four wards. Patients remained relaxed and at ease throughout the inspection. Patients were generally satisfied with the care and treatment they were being provided and it was good to note that the majority of patients reported that they had felt better since being admitted. Some patients said there were not enough activities to do at the weekends.

Patients stated that when they had a concern or difficulty regarding their care they could discuss this with their named nurse. Patients told us that they knew who was involved in their care and who to talk to if they were not happy or they were upset. An independent advocacy service was available on each of the ward's we inspected and patients could access this service as required.

5.2.9 Directorate Governance Arrangements

The governance of the acute mental health service in the Trust was reviewed in order to assess how the Trust assures itself in relation to the quality of care being provided.

We found the Trust had an appropriate governance structure in place with a range of meetings where the appropriate people attended and where relevant data was being used to inform the meetings.

At the time of completing this inspection, we noted delays in the timely submission of SAI reports to RQIA in line with the regional HSCB procedure for the reporting and follow up of serious adverse incidents (November 2016). Further exploration indicated the delays were due to challenges with organising the number of multi-agency staff who were involved in the patient's care. We discussed the importance of timely submissions of SAI reports and an area for improvement has been made. Inspectors asked the Trust to ensure that the SAI reviews and subsequent reports be completed as soon as possible and shared with RQIA when completed.

We reviewed the minutes of the quarterly governance directorate meeting and enquired as to how the SMT were assured that learning outcomes from SAI reviews were being appropriately identified and actioned. Representatives from SMT reported that the SAI process was currently being audited as a means to validating and standardising reporting of the SAI information from ward level. Alongside this, the SMT has also implemented monthly walk arounds within each ward.

We also discussed our findings with representatives of the SMT in relation to delays in forwarding safeguarding referrals (see section 5.2.3) and we highlighted that this creates a risk for patient safety.

An area for improvement has been made in relation to the SMT's governance and oversight of SAI's and safeguarding referrals.

5.2.10 SMT's response to levels of violence on wards

As mentioned previously in section 5.2.4 we discussed with members of the SMT their proposed plans to manage increased incidents of violence occurring across the wards. To mitigate the risk to staff, the Trust had implemented a number of initiatives to address this issue. Work with the East London Foundation Trust as part of a violence reduction improvement collaborative had commenced and the new PIPA admission pathway was being trialled in Rathlin and Ward J. The SMT confirmed that the PIPA model was having a positive impact on patients and staff hoped it would reduce incidents of violence on the wards. The SMT will continue to collect evidence in relation to PIPA, and its effect on violence reduction.

The SMT reported that incidents of violence on wards were closely linked to issues relating to substance use/misuse which were reported as common across all wards. The SMT confirmed they received good support from the Police Service of Northern Ireland (PSNI) in relation to managing allegations of illicit substances on the wards. The PSNI have previously brought specialist sniffer dogs onto the wards to conduct searches although on all occasions the dogs have not found anything. Members of the SMT noted that they are aware of the need for a balanced approach and that they wish to avoid overuse of this approach because of its potential impact on patients. The SMT recognised that the commencement of this work needed to be aligned with the Trust's drug policy.

We commended the Trust for its planning regarding staffing levels for the new acute mental health inpatient care unit at Belfast City Hospital and it was agreed that the new environment coupled with the introduction of PIPA was a positive service development.

We were assured that work in relation to the management and reduction of violence in the wards would commence as soon as possible.

6.0 Conclusion

Based on the inspection findings ten areas for improvement were identified. Five were in relation to safe care; these included; the need for consistent nursing care plans to manage physical health care needs of patients; having a ligature risk assessment in place for patients using a profiling bed; having a care bundle and training staff on the identification and management of sepsis and the administration of IV antibiotics; the need to establish better links and protocols between mental health wards and acute general hospitals for referrals, admission and transfers and sharing the learning arising from review of Datix incidents.

One AFI was in relation to effective care; the evaluation of care plans. Another AFI was in relation to compassionate care; ensuring patient forum meetings occurred regularly and three AFIs were in relation to the service being well led; reviewing and updating the admission/discharge and transfer policy; the management of medicines and having robust governance of SAIs and adult safe guarding.

RQIA would like to take this opportunity to thank the 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	10*

*10 areas for improvement have been identified which includes; one that was carried forward from the previous inspection as it was not assessed during this inspection; one that has been stated for a third time four that have been stated for a second time and four that are new.

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 DoH (March 2006)	
The Trust must ensure the following findings are addressed:	
Area for improvement 1 **Ref**: Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 18 February 2018	The Trust must ensure there is a standardised comprehensive nursing assessment tool in place to assess patients' overall physical health care needs. **Ref: 5.1** **Response by registered person detailing the actions taken:** Trust response The physical health care pathway is in place and all patients have a nursing and medical assessment on admission.
Area for improvement 2 **Ref**: Standard 5.3.3 **Stated:** Second time **To be completed by:** 4 January 2019	The Trust must ensure care plans are regularly evaluated to evidence the effectiveness of the care delivered which will determine whether or not the care plan needs amended. **Ref: 5.1** **Response by registered person detailing the actions taken:** Trust response The professional nursing team carry out a 6 month full documentation review and action plans arise from this review. A care plan audit tool has been developed and is carried out on a monthly basis by the Deputy sisters.

Area for improvement 3 **Ref**: Standard 5.3.1 **Stated:** Second time **To be completed by:** 4 December 2018	The Trust must ensure there are ligature risk assessments in place for all patients using profiling beds. **Ref: 5.1**
	Response by registered person detailing the actions taken: Trust response Profiling beds are only used for those patients who require one, mainly those in Ward one (Pychiatry of older age ward). It is documented in the patient's comprehensive risk assessment . This is reviewed as part of the monthly care plan audit. If a patient is physically compromised and requires a profiling bed and has thoughts of life not worth living, one to one nursing observation will be prescribed.
Area for improvement 4 **Ref**: Standard 6.3.2 (g) **Stated:** Second time **To be completed by:** 4 December 2018	The Trust must ensure; • patient forum meetings occur regularly • staff record when patients decline the opportunity to attend. **Ref: 5.1**
	Response by registered person detailing the actions taken: Trust response Fortnightly patient forum meetings are held and information obtained populates are "You said , we did. There are patient experience surveys every fortnight which feeds into a monthly report. Comments are shared through the MDT and the Executive team and feedback acted upon.

Area for improvement 5 **Ref**: Standard 5.3.1 (f) **Stated:** Third time **To be completed by:** 4 April 2019	The Trust must review the mental health services admission, discharge and transfer policies. **Ref: 5.1**
	Response by registered person detailing the actions taken: Trust response An AMHIC operational policy for admisssion, discharge and transfer processes has been developed.
Area for improvement 6 **Ref**: Standard 5.3.1 (f) **Stated:** Second time **To be completed by:** 4 April 2019	The Trust must ensure that training, including the development of a care bundle, for the management of sepsis for patients admitted to the Trust's acute care mental health wards is made available for staff. This must include nursing staff having the required knowledge and skill to administer IV antibiotics. **Ref: 5.2.2**
	Response by registered person detailing the actions taken: Trust response Acute Mental Health services moved to AMHIC in June 2019, patients who require IV antibiotics are now transferred to the RVH ED for admission into the general hospital.
Area for improvement 7 **Ref**: Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 4 April 2019	The Trust must develop appropriate links and protocols between the mental health wards and general acute wards for the safe and timely admission, transfer and treatment of patients with a mental health condition. **Ref: 5.2.2**
	Response by registered person detailing the actions taken: Trust response There is a medical emergency pathway established for acutely unwell patients in AMHIC. There is an inter-specialty referral guidance available on the Hub.

Area for improvement 8 **Ref:** Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 4 January 2019	The Trust must ensure that incident management, including the records: • detail any actions that are required following a local review of the incident; • identify any learning captured from a local review of the incident; • note who has responsibility to complete those actions; and • identify who has oversight that the actions have been completed; and • shared the learning across all other relevant inpatient wards. **Ref: 5.2.3**
	Response by registered person detailing the actions taken: Trust response There is a comprehensive governance system in place. Wards carry out a weekly incident review which informs the monthly ward governance meeting, where trends and shared learning are discussed. Each ward provides an overview to the monthly Mortality and Morbidity meetings.

Area for improvement 9 **Ref:** Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 4 April 2019	The Trust must strengthen arrangements for the management of medications in the following areas: • review its use of PRN as required medication including the advice, guidance and support available for nursing staff; and • undertake a range of audits of (i) omitted doses of medicines (ii) standards and completion of administration records and (iii) effectiveness & appropriateness of administration of "when required" medicines utilised to manage agitation as part of de-escalation strategy. **Ref: 5.2.6**
	Response by registered person detailing the actions taken: Trust response Across MH, PRN medication is reviewed by a Doctor and Pharmacist on a weekly basis to continue, reduce or stop. If there are 2 PRN for the same indication, there is a clear record of first and second line choices of treatment. The medicine monthly safety thermometer audits the percentage of missed doses and includes the failure to record reason for omission. The Pharmacists audit completion of kardexes. Audits are discussed at each Ward Governance meeting which feed into Mortality and Morbidity meeting. A SQB project of reduction in prescribing of PRN medications is being rolled out across all the wards in AMHIC.

Area for improvement 10 **Ref:** Standard 5.3.1 (f) **Stated:** First time	The Trust must ensure the SMT have robust governance processes and oversight of SAI's and safeguarding referrals to ensure they are made in an appropriate and timely manner. **Ref: 5.2.9**
To be completed by: 4 January 2019	**Response by registered person detailing the actions taken:** Trust response Within the Mental Health Division there is a monthly divisional governance meeting which reviews safeguarding and incident high level data (including SAIs). On a weekly basis the Mental Health Collective Leadership Team review all new Incidents of Moderate and Above Severity and Incidents of Moderate and Above Consequence. They review all new SAIs. Safeguarding is also a standing item on the CLT agenda and new / closed data is again reviewed. Locally, within each of the areas, there are both Patient Safety and Mortality & Morbidity cases were more in-depth discussion takes place around incidents that warrant further investigation such as safeguarding or using Significant Event Audit methodology

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