Inspection Report

16-17 January 2024

Southern Health and Social Care Trust

Willows Ward & Gillis Ward
Bluestone Unit
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Telephone number: 028 3836 6780

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Southern Health and Social Care Trust (SHSCT)	**Registered Manager:** Dr Maria O'Kane Chief Executive SHSCT
Person in charge at the time of inspection: Willows – Mary Donnelly Gillis Ward – Mark Christie	**Number of registered places:** Willows – Ten Gillis Ward – Ten
Categories of care: Dementia Care Mental Health Acute Admission for persons over 65 years	**Number of patients accommodated in the ward on the day of this inspection:** Willows – Eight Gillis - 13
Brief description of the accommodation/how the service operates: Willows ward provides inpatient care to men and women aged 65 years and over who require assessment and treatment in an acute psychiatric care setting. Gillis Ward provides assessment, care and treatment to male and female patients with dementia. The wards are situated within the Bluestone Unit which is located on the grounds of Craigavon Area Hospital. Patients are admitted either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO). In May 2022 Willows ward reduced its capacity to admit patients over the age of 65 with a functional mental illness from 20 beds to10. This change was to make provision for 10 dementia care beds following the closure of Gillis Ward which was situated on St Luke's Hospital site in Armagh.	

2.0 Inspection summary

An unannounced inspection took place on 16 January 2024 at 09:00 and concluded on 17 January with feedback to the SHSCT senior management team (SMT). The inspection team comprised of three care inspectors.

Following a public consultation by the SHSCT on dementia services entitled 'Future Dementia In-patient Service' which concluded in December 2022, a decision was made for Gillis Ward to remain on the Bluestone site with the longer term aim to develop a new facility for Gillis Ward at Bluestone. As an interim measure plans have been prepared for some refurbishment of Willows ward to create additional lounge and dining room space. The SHSCT confirmed post inspection that these improvement works commenced on 30 January 2024.

This inspection reviewed the arrangements in place to accommodate both groups of patients who were admitted and who share the same environment. This review focused on; assessing if sharing the environment was having an impact on patient outcomes and patient experience; and to monitor progress with the proposed interim measures. See section 5.2.5.

Information received by RQIA prior to the inspection indicated concerns with communication between the Adult Safeguarding team, Trust Senior Management Team, Nurse Bank Management Team and Human Resources. The management of these concerns was reviewed during this inspection with further details in section 5.2.2.

This was a follow up inspection to assess progress against areas for improvement (AFI) identified in the Quality Improvement Plan (QIP) following the inspections of Willows Ward, 25 July 2022, and Gillis Ward, 03 November 2022. The inspection also focussed on the following seven key themes; environment, adult safeguarding (ASG) and incident management, restrictive practice, patient experience, governance, patient flow and medicines management.

Good practice was identified in relation to care documentation audits, mealtime experience, staff/patient interactions and activity provision.

A total of 14 AFI's were reviewed from the most recent inspections of Willows and Gillis wards. Seven were assessed as met, three were partially met, four were not met. The three AFI's that were partially met and the four AFI's not met have been re-worded and subsumed into four AFI's which will be stated for a second time along with one new AFI that was identified at this inspection. These are included in the QIP.

3.0 How we inspect

RQIA has a statutory responsibility under the Mental Health (Northern Ireland) Order 1986 to make inquiry into any case of ill-treatment, deficiency in care and treatment, improper detention, and/or loss or damage to property. Care and Treatment is measured using the Quality Standards (2006) for Health and Social Care to ensure that services are safe, of high quality, and up to standard.

RQIA's inspections form part of our ongoing assessment of the quality of services. 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 service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

The inspection team directly observed patient experiences; staff engagement with patients; how patients spent their day; staffing levels; senior leadership oversight; and ward environments. The inspection team also reviewed patient care records; patient discharge progress; and governance documentation.

Experiences and views were gathered from staff, patients, and their families.

4.0 What people told us about the service

Posters and easy read leaflets were provided inviting staff and patients to speak with inspectors and give feedback on their views and experiences.

We spoke with a number of patients, relatives and staff. We received four questionnaires from relatives by the end of the inspection on 17 January 2024.

Overall comments were very positive regarding the care patients received; two respondents described the care as 'excellent'. However, a number of patients highlighted the negative impact the shared environment was having. Relatives described staff as attentive, and caring who 'strive to do the best for each patient' and were reassured that they could raise concerns and were confident that these were addressed. Some relatives were happy with communication while others indicated there was a need for improved communication.

Staff reported they were well supported by their ward managers.

5.0 The inspection

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

The last inspection of Willows ward was undertaken 25 July 2022 and Gillis ward was undertaken on 03 November 2022. Seven AFIs were identified for each ward and were included in the review of the QIP below.

<table>
<tr><th colspan="3">Areas for improvement from the last inspection to Willows ward on 25 July 2022</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 5.3.1

Stated: Reworded and stated a second time

To be completed by:
30 November 2022</td><td>The Southern Health and Social Care Trust must ensure that meaningful activities are offered to individual patients and that records maintained include information to describe the activity offered, levels of participation and presentation throughout the activity.

Ref: 5.1</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

An Occupational Therapist supported by care staff provides a range of occupational and recreational activities for patients. Records are maintained on the electronic care record</td></tr>
</table>

	included activity offered, levels of participation and presentation throughout the activity. Further detail is included in section 5.2.4. This AFI has been met.	
Area for improvement 2 **Ref:** Standard 6.3.2 **Stated:** Reworded and stated a second time **To be completed by:** 30 November 2022	The Southern Health and Social Care Trust shall ensure that all patients and relatives are given information regarding their right to complain. Ref: 5.1	**Met**
	Action taken as confirmed during the inspection: Information regarding the right to complain was available on the notice board and information is provided to patients and relatives on admission. This AFI has been met.	
Area for Improvement 3 **Ref:** Standard 5.3.1 **Stated:** First time **To be completed by:** 30 November 2022	The Southern Health and Social Care Trust must ensure that staff are supported to make direct referrals to the ASG team. This practice is consistent with Regional Adult Safeguarding Policy and will mitigate against unnecessary delays in protection planning for patients. Ref: 5.2.1	**Met**
	Action taken as confirmed during the inspection: Compliance with this AFI has been achieved. Staff confirmed that direct referrals are now made to the ASG team without deferring to the ward manager prior to their submission. Incidents reviewed on DATIX confirmed referrals were made in a timely manner. This AFI has been met.	

Area for improvement 4 **Ref:** Standard 8.3 **Stated:** First time **To be completed by:** 30 November 2022	The Southern Health and Social Care Trust must ensure that whilst communal spaces continue to be shared between patient groups, regular meetings between staff teams are facilitated to support effective communication, enhance co-operative working arrangements and improve patient opportunities to access ward based activities. Ref: 5.2.3	**Partially met**
	Action taken as confirmed during the inspection: Informal meetings take place between both ward managers, and a daily safety brief is available for staff. There are no formal arrangements for both staff teams to meet to discuss any operational issues. This AFI was assessed as partially met and will be subsumed into a new AFI and will be stated for a second time.	
Area for improvement 5 **Ref: Standard 5.3.1** **Stated:** First time **To be completed by:** 30 November 2022	The Southern Health and Social Care Trust shall review the impact of the current shared spaces on patient experience within Willows and Gillis wards. Ref: 5.2.2	**Met**
	Action taken as confirmed during the inspection: The Trust fully acknowledged the challenges the impact this shared space has on both groups of patients. Since the last inspection the Trust has made some environmental changes which were observed to have improved patient experience. Further Estates work is planned to enhance the environment to improve the patient experience. This AFI has been met.	

Area for improvement 6 **Ref: Standard 5.3.1** **Stated:** First time **To be completed by:** 30 November 2022	The Southern Health and Social Care Trust must ensure that the ward environment, ligature risks and fire safety risks are regularly reviewed to provide assurance that identified and emerging risks in all areas are being managed safely. Records should reflect the change to patient profile and consider the impact of the environment of patient safety and well-being. Ref: 5.2.2	**Not met**
	Action taken as confirmed during the inspection: The Fire Risk Assessment (FRA) and Ligature Risk Assessments (LRA) were reviewed. It was established that the FRA is overdue for review. This was discussed with the ward manager and highlighted to senior management. The LRA, although in date, there was no evidence that actions identified have been reviewed. This AFI was assessed as not met and will be reworded and combined into one AFI and stated for a second time in the QIP for both wards.	
Area for improvement 7 **Ref: Standard 5.3.1** **Stated:** First time **To be completed by:** 30 November 2022	The Southern Health and Social Care Trust must ensure that all staff receive appropriate up to date mandatory training. Ref: 5.2.3	**Not met**
	Action taken as confirmed during the inspection: Review of training records identified that not all mandatory and statutory training were up to date. This AFI was assessed as not met and is stated for a second time.	

<table>
<tr><th colspan="3">Areas for improvement from the last inspection to Gillis ward on 03 November 2022</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for Improvement 1

Ref: Standard 5.3.3 (f)

Stated: Second time

To be completed by:
Immediate and ongoing</td><td>The Southern Health and Social Care Trust must develop and implement a system of governance and oversight for patient care records to ensure records are maintained to the required standards.

Ref: 5.1 and 5.2.4</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

The ward had developed an audit tool for care records. The ward manager advised that these are used with staff during supervision to promote learning and improve standard of documentation.

This AFI has been met.</td></tr>
<tr><td rowspan="2">Area for Improvement 2

Ref: Standard 5.3.3 (g)

Stated: First time

To be completed by:
31 January 2023</td><td>The Southern Health and Social Care Trust must apply a robust audit approach to incident analysis that supports the identification of emerging trends and themes.

Ref: 5.2.1</td><td rowspan="2">Partially Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

Records reviewed evidenced that the SHSCT had developed a robust approach for the analysis of incidents. All incidents are reviewed by SMT and Governance team to identify trends and take steps to mitigate risk. A number of incidents did not take account of the cumulative effect of repeated incidents or the potential impact or risk likelihood of incidents.

Further details are recorded in section 5.2.1 and 5.2.8.

This AFI will be reworded and subsumed into a new AFI.</td></tr>
</table>

Area for Improvement 3 **Ref:** Standard 6.3.2 (g) **Stated:** First time **To be completed by:** 31 January 2023	The Southern Health and Social Care Trust must review the dining arrangements for both groups of patients with view to improving the coordination and management of patients' dining experience. Ref: 5.2.2	**Met**
	Action taken as confirmed during the inspection: The dining arrangements and experience were observed. Meal time matters had been implemented and a planned refurbishment to create another dining room was due to commence. Further details will be discussed in section 5.2.1 and 5.2.4. This AFI has been met.	
Area for improvement 4 **Ref:** Regulation 5.3.2 **Stated:** First time **To be completed by:** 31 January 2023	The Southern Health and Social Care Trust should monitor the ward environment to assess any impact on patient experience relating to the mixed model of care, noise levels, overcrowding of communal spaces and over-occupancy. Ref: 5.2.2	**Met**
	Action taken as confirmed during the inspection: The Trust fully acknowledged the challenges the impact this shared space has on both groups of patients. Since the last inspection the Trust has made some environmental changes which were observed to have improved patient experience. Further Estates work is planned to enhance the environment to improve the patient experience. This AFI has been met.	

Area for improvement 5 **Ref:** Regulation 8.3 **Stated:** First time **To be completed by:** 31 January 2023	The Southern Health and Social Care Trust shall review the communication arrangements between Gillis and Willows to ensure all staff have adequate understanding of patient risk issues in order to be able to intervene appropriately and provide effective support should a need arise. Ref: 5.2.8	**Not met**
	Action taken as confirmed during the inspection: It was observed that staff work well together to support patients. However, there are no formal arrangements for both staff teams to meet to discuss any operational issues. This was verified by staff during the inspection. This AFI has not been met.	
Area for improvement 6 **Ref:** Standard 5.3.1 **Stated:** First time **To be completed by:** Immediate and ongoing	The Southern Health and Social Care Trust must assure itself that the practice of propping fire doors open is not common practice and all patients who require assistance in an emergency have an up to date Personal Emergency Evacuation Plan. Ref: 5.2.2	**Partially met**
	Action taken as confirmed during the inspection: Personal Emergency Evacuation Plans (PEEPS) were in place with evidence that review had taken place. We observed a number of bedroom doors propped open with furniture. These were brought to the attention of the ward manager. This was an observation on the last inspection and the mechanism in place for monitoring fire safety had not been effective. This AFI was partially met and will be re-worded and stated for a second time.	

Area for improvement 7 **Ref:** Standard 5.3.1 **Stated:** First time **To be completed by:** 31 January 2023	The Southern Health and Social Care Trust shall ensure that the ligature risk assessment is kept under review and identified risks are managed to eliminate or reduce the level of risk. Ref: 5.2.2	**Not Met**
	Action taken as confirmed during the inspection: The ligature risk assessment (LRA) has been amalgamated with Willows. The LRA is in date although there was no evidence that previous actions have been reviewed in line with their review date. This AFI has not been met.	

5.2 Inspection findings

5.2.1 Environment

Willows and Gillis wards were inspected to review and assess if the environment was conducive to the delivery of safe, therapeutic and compassionate care. The Trust fully acknowledged the challenges the impact this shared space has on both groups of patients. Since the last inspection the Trust has made some environmental changes which were observed to have improved patient experience. Further Estates work is planned to enhance the environment for patient experience.

Improvements had been noted since the last inspection and the ward environment was observed to be calmer, more organised and noise levels had significantly reduced.

The wards presented as bright spaces with lots of natural light. Overall cleanliness on both wards were of an acceptable standard with evidence of environmental audits being completed. A number of wheelchairs stored outside a disabled access toilet could pose a trip hazard. The SMT were advised during feedback and the SHSCT should review the storage of wheelchairs to minimise any risks to patients, visitors and staff.

Willows and Gillis wards share a lounge and dining room. It was observed during the inspection these areas were used mostly used by patients from Gillis ward. Staff reported that patients on Willows ward tended to spend more time in the activities room and their bedroom. These arrangements were not conducive to therapeutic care, which the SHSCT acknowledged. It was positive to note that refurbishment plans were in place to create a dining room and lounge for patients on Willows ward. SMT informed inspectors that this work would be completed by the end of March 2024.

During the inspection the music room and a small lounge were being utilised as bedrooms due to over occupancy issues. Whilst these arrangements are not ideal, staff had made efforts to maintain patient's dignity although the SHSCT should review the window coverings in the music room to maintain patient's privacy.

There was evidence of use of appropriate signage to help orientate patients to their surroundings although were no handrails to promote patient mobility.

An information board at the entrance to the ward held details of advocacy organisations, how to complain, what constitutes adult safeguarding how to report a concern and information on health promotion.

The Fire Risk Assessment (FRA) and action plan were examined. There was no evidence of a current review of the FRA, and a number of actions remain outstanding. These were raised and discussed with the ward manager who advised this had been escalated to the Estates Officer. Up to date Personal Emergency Evacuation Plans PEEPS were in place for patients.

A number of bedroom doors were propped open with furniture. These were brought to the attention of the ward manager. This was an observation on the last inspection and the mechanism in place for monitoring fire safety had not been effective.

There was one combined Ligature Risk Assessment (LRA) for both wards. The LRA was due for review at the time of the inspection. The assessment did not identify the risks observed such as the handrails in the patients en-suite bathrooms. The SHSCT should review the ligature risk assessment and ensure that all risks are identified and appropriate mitigations put in place to minimise the risk.

The previously stated AFI's for the FRA and LRA have been amalgamated and reworded in a new AFI which will be stated for a second time.

5.2.2 Adult Safeguarding and Incident Management

Adult Safeguarding (ASG) arrangements were reviewed. ASG is the term used for activities which prevent harm from taking place and which protects adults at risk where harm has occurred or is likely to occur without intervention.

There is a Designated Adult Protection Officer (DAPO) aligned to the wards within the SHSCT. There was a system in place that included management oversight to ensure compliance with ASG policies and procedures. ASG processes and contact details for the DAPO were clearly displayed within the staff meeting room. It would be beneficial if this information was also available in the nurse's office.

Ward staff demonstrated a good knowledge and understanding of what constituted an ASG incident. A number of ASG incidents were reviewed and these had been reported in accordance with ASG policy and procedure. Protection plans were implemented and available for staff.

Information received prior to the inspection identified a concern regarding the communication and implementation of protection plans between the Adult Safeguarding team, Trust Senior Management Team, Nurse Bank Management Team and Human Resources. This had the potential to increase the risk to patients. The SMT must review how protection plans are communicated and information shared to ensure a consistent approach to minimise risk to patients.

An area for improvement has been made.

Staff in Willows no longer waited for approval prior to making an ASG referral therefore eliminating any delay in the implementation of a protection plan to minimise risk of harm to patients. On reviewing ASG referral information and cross referencing with the DATIX incidents, it was noted these were recorded and appropriately graded.

ASG training in both wards was not up to date. This will be discussed further in section 5.2.8.

A review of the SHSCT's electronic system for recording incidents (Datix) for the previous six months were sampled. The use of physical interventions were graded as insignificant or minor and did not fully reflect the intervention or outcome. This may result in significant incidents not being highlighted to senior management for governance oversight of physical interventions.

There was no evidence the potential impact or risk likelihood of any single incident was considered, which may result in potentially serious incidents not being escalated to senior management.

A number of repeated incidents were not graded correctly to reflect the cumulative impact. This has the potential to expose patients and staff to repeated risk. The SHSCT should review the current arrangements for reporting and recording incidents to provide assurance that risks are being identified and managed.

An area for improvement in relation to incident management has been made.

5.2.3 Restrictive Practice

Restrictive practices in use included locked doors, enhanced observations, the use of bed rails, sensor mats and physical intervention. It was positive to note the use of assistive technology, such as sensor mats, was in place to reduce the use of more restrictive options.

There was weekly Multi-Disciplinary Team (MDT) reviews of restrictions and evidence of Human Rights considerations within patient care plans. Risk assessments identified restrictions which were proportionate to the risk, the least restrictive option and used as a last resort.

Staff demonstrated a good knowledge of restrictive practices. Care plans were in place for locked doors for voluntary patients who may request to leave and who were deemed safe to do so. This is good practice.

Staff had limited knowledge of the Regional Policy on the Use of Restrictive Practices in Health and Social Care Settings and Regional Operational Procedure for the Use of Seclusion Northern Ireland March 2023. We recommend that SMT address this as matter of urgency.

5.2.4 Staffing

Staffing levels on the wards were determined by the use of the Telford Model which is a tool to assist staff in ensuring appropriate staffing levels based on patient acuity.

The arrangements for staffing were reviewed and safe staffing levels were evidenced through staff discussion, daily safety brief, analysis of staff duty rotas and observation of staff on shift.

Patients from respective wards have a dedicated nursing staff team including individual ward managers. An escalation policy provides staff with guidance regarding the management of staff absence /shortages. There were sufficient staff on duty with agency staff being utilised to cover shortfalls. Staff expressed concern that agency staff were not always block booked in advance which impacted on the continuity of care due to a lack of regular agency staff covering shifts.

Staffing shortfalls were not consistently recorded on Datix. The SHSCT should review the recording of staffing shortages to support effective governance oversight.

Staff morale appeared to be good and staff from both wards confirmed they were well supported by their manager. Staff confirmed that they all work well together and support each other, notwithstanding there were no joint formal meetings between the staff groups. This would enhance relationships, team building and sharing of information.

Concerns regarding the ward environment continue to be expressed. These included challenges experienced of sharing facilities. This was not shared by some medical staff who spoke of the benefits for patients due to improved accessibility of services at Craigavon Area Hospital.

An Occupational Therapist (OT) and activities staff are employed to provide a range of occupational and therapeutic activities for patients, this includes one to one work with patients in preparation for discharge. At present the OT post for Gillis is vacant and has been advertised.

5.2.5 Patient Experience

The current arrangement of Willows and Gillis sharing the ward environment continues to impact adversely on patients. Patients from Willows expressed dissatisfaction about not having access to a TV lounge and having to spend long periods in their rooms. It is positive to note that plans are underway to develop the ward and create additional day/dining space for patients on Willows ward. SMT informed us this work would be completed by end March 2024.

Staff interactions with patients were observed to be caring, compassionate and respectful. Staff spoken with were knowledgeable regarding the patients care needs and treatment.

Relatives spoke highly of the staff and the care their relatives experienced. A number of relatives described the care provided as excellent. Two relatives spoke of communication concerns between staff although these had been addressed.

Patient questionnaires and feedback from Care Opinion, an online platform which allow patients and relatives to share their experiences of health services, was reviewed. These identified a high level of satisfaction.

The dining experience was observed and noted to be well managed. There was a good choice of menu and the atmosphere was relaxed with staff providing care and support in a sensitive compassionate manner.

Mealtime co-ordinators oversee mealtimes in line with the regionally agreed framework 'Mealtimes Matter'. Information relating to individual patient's dietary needs was consistent with care plan information and available for all staff involved in serving patient meals, including support service staff. Audits of mealtimes were completed to provide assurance that practice was consistent with the agreed standards.

Patients were appropriately referred and assessed by Speech and Language Therapy (SLT) and individualised dysphagia guidelines were in place where required. These were consistent with the International Dysphagia Diet Standardisation Initiative (IDDSI) and available to all staff.

5.2.6 Patient Flow

During the inspection Gillis ward was operating at 120% bed occupancy. This reduced the capacity of Willows to admit patients over 65 years of age and limits Gillis wards' ability to admit patients with dementia in need of acute care and assessment. At the time of inspection three Willows patients were receiving care and treatment in under 65 acute wards.

Gillis ward patients' length of stay ranged from 15 weeks to 2.5 years. Inspectors were informed that barriers to discharge included the lack of suitable community placements that would meet the complex needs of the patients. Staff reported that there were no delayed discharges for patients on Willows ward.

We evidenced records of discharge planning meetings which were held weekly to review and plan for discharge. There was evidence that patient's next of kin were invited to these meetings.

It is recommended the SHSCT considers a review to determine if the shared environment is impacting on patient flow outcomes for patients in Willows and Gillis wards.

5.2.7 Medicines Management

Gillis and Willows share a clinical room where all medications are stored and dispensed. Willows ward dispense from a medicine trolley and Gillis medications are stored and dispensed from a cupboard.

Staff told us that the clinical room can be over crowded at times as all medication rounds take place at the same times. It is recommended the Trust review the current arrangements for use of the clinical room by Willows and Gillis staff during medication rounds.

One nurse was observed to be wearing a red tabard with 'do not disturb'. This is good practice and RQIA recommend that all nurses administering medication adopt this practice to minimise any risk of medication errors.

5.2.8 Governance

There was evidence of some good governance oversight arrangements in place, with Governance data being collated and presented to the Senior Management Team on a weekly basis, and the Governance Group bi-monthly. This information is used to identify themes and trends and any learning to improve patient care and experience.

There was evidence of a range of audits being completed to ensure that standards were being met. These included National Quality Improvement (NQI) audits. These audited medication compliance, nutrition, falls management, physical interventions and rapid tranquillisation. We found these audits consistently achieved 80 -100% compliance. Care plan audits were completed and discussed as part of staff supervision which provides an opportunity for reflection on practice and promotes learning and continuous improvement.

The ward managers attended hospital wide meetings and information was shared with staff following these. There was evidence of patient and staff meetings taking place. Staff used daily handover meetings and safety briefs to provide an effective method of communication between shifts. However, there are no formal arrangements for both staff teams to meet to discuss any operational issues.

The SHSCT should review communication arrangements between Willows and Gillis wards to ensure all staff have the opportunity to discuss operational matters including any risks.

An AFI has been reworded and stated for a second time.

The staff training matrix was reviewed for both mandatory training and e-learning. It was noted that not all staff were compliant with training requirements, including ASG, Fire Safety, Dysphagia/Swallow Awareness and other relevant training, although it was noted that Willows ward had a higher level of compliance. This was discussed with the ward managers and records were being updated to reflect training that had not been recorded.

The SHSCT should review the management oversight process to ensure staff who were in need of training updates are identified in a timely manner. The previous AFI has been re-worded and included in the new QIP.

Complaints received since the last inspection were managed in line with SHSCT policy.
The SHSCT had updated their operational policy which was detailed and comprehensive.

6.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	0	5

* the total number of areas for improvement includes four that have been stated for a second time.

Feedback was provided to the SMT at the end of the inspection on day two, however specific AFI's were not discussed as time was required to review the evidence and deliberate on the findings.

Quality Improvement Plan	
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)	
Area for improvement 1 **Ref:** Standard 5.3.1 **Stated:** Second time **To be completed by:** 30 April 2024	The Southern Health and Social Care Trust must ensure that the ligature risks and fire safety risks are regularly reviewed to provide assurance that identified and emerging risks in all areas are being managed safely. This includes ensuring that a system is developed to ensure fire doors are not propped open. Ref: 5.2.1
	Response by registered person detailing the actions taken: Guidance will be recirculated to ensure managers are aware of their responsibility to follow up on actions identified during yearly Ligature and Fire Risk Assesments. In addition, Lead Nurses will arrange quarterly oversight meetings to ensure actions have been progressed and are reflected on the Risk Assessment. This will also apply to actions identified as part of Fire Risk Assessment. Due to mobility issues, some patients are unable to open bedroom doors. This will be reflected in MDT meetings, individual Care plans, the ward will ensure this is agreed by Next of kin and the situation will be reviewed regularly. This issue will also be discussed with the Fire Officer to see if there are any alternative options, to reduce the need for higher levels of observation if not clinically required.

Area for improvement 2 **Ref:** Standard 5.3.1 **Stated:** First time **To be completed by:** 30 April 2024	The Southern Health and Social Care Trust must ensure that where protection plans are subject to change these are discussed and agreed with all relevant parties and ensure that there is effective communication with managers responsible for the oversight of the protection plans. Ref:5.2.2
	Response by registered person detailing the actions taken: Roles and responsibilities will be clearly identified when protection plans are in place involving staff employed by Nurse Bank to ensure consistent communication and update of changes
Area for improvement 3 **Ref:** Standard 5.3.1 **Stated:** Second time **To be completed by:** 30 April 2024	The Southern Health and Social Care Trust must ensure that all incidents recorded take account of the HSC Regional Risk Matrix and the actual and potential impact of incidents along with the risk likelihood are considered and recorded. 5.2.2
	Response by registered person detailing the actions taken: All incidents recorded do take account of the HSC Regional Risk Matrix. The Regional Impact Table is also accessible via the DATIX DIF1 (reporter) form to assist reporters in their grading of the incident. Staff reporting an incident record the "actual" harm. The incident reviewer/approver then reviews the actual harm grading submitted by the reporter and also enters a "potential" harm grading using the Risk Matrix (calculating likelihood x consequence) in the DIF2 form. Both actual and potential harm gradings are included in Datix Dashboards and monitored over time. The Trust demonstrated this to the inspector via a Teams call. Within Bluestone there is a weekly review of all Datixs, undertaken by the Directorates systems assurance manager, lead nurses, head of service and assistant director. All Datixs are then reviewed and discussed at the Directorate weekly collective leadership governance debrief. These reviews are inclusive of assessing and reviewing the cumulative effect of incidents, something that has allowed Bluestone to establish a number of improvements to mitigate frequency and reoccurrence. Willows and Gillis Wards will establish a mechanism that better exemplifies how this is discussed and considered on/at ward level.

Area for improvement 4 **Ref:** Standard 8.3 **Stated:** Second time **To be completed by:** 30 April 2024	The Southern Health and Social Care Trust must ensure that whilst communal spaces continue to be shared between patient groups, regular meetings between staff teams are facilitated to enhance relationships, team building and sharing of information. Ref: 5.2.8
	Response by registered person detailing the actions taken: The nurses in charge of each morning shift will complete a written safety brief and handover, for Willows and Gillis and share this with each others teams. To comply with RQIA recommendations: The NIC following handover will meet with their respective counterpart from Willows and Gillis ward. Each team will retain a copy of the handover and safety brief in their office base. The brief meeting between the NIC from Gillis and Willows ward will provide an opportunity to discuss risk pertaining to each ward. Staff from Willows will be responsible for reading the handover for Gillis and vice versa. The nurse in charge for Willows and Gillis will discuss any particular matters of concern, patients with enhanced needs etc. Staff will continue to support each other in relation to ensuring safe staffing levels and in response to alarms. Opportunities for shared team building will be explored when appropriate .
Area for improvement 5 **Ref:** Standard 5.3.1 **Stated:** Second time **To be completed by:** 30 April 2024	The Southern Health and Social Care Trust must ensure that all staff receive appropriate up to date mandatory training. Ref:5.2.8
	Response by registered person detailing the actions taken: It was noted during the inspection that Willows training records were up to date and reflected compliance with staff mandatory training. Gillis training records had not been updated. This has since been rectified and reflects compliance with mandatory training requirements. A copy can be provided for assurance.

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

The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews