Inspection Report

25 July- 02 August 2022

Southern Health and Social Care Trust

Willow 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)	**Responsible Individual:** Dr. Maria O'Kane Chief Executive Officer, SHSCT (The Trust)
Person in charge at the time of inspection: Joe Walker, Interim Assistant Director, MHLD Inpatients, SHSCT	**Number of registered places:** 10 bedded inpatient facility
Categories of care: Mental Health Acute Admission for persons aged over 65 years	**Number of patients accommodated in the ward on the day of this inspection:** Nine patients
Brief description of the accommodation/how the service operates: Willow ward provides inpatient care to men and women aged 65 years and over who require assessment and treatment in an acute psychiatric care setting. Patients are admitted either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO). The ward is situated within the Bluestone Unit which is located on the grounds of Craigavon Area Hospital. In May 2022 Willow ward reduced its capacity to admit patients over the age of 65 with a functional mental illness from 20 beds to 10. This temporary change was to make provision for 10 dementia care beds following the closure of Gillis Memory Centre which was situated on St Luke's Hospital site.	

2.0 Inspection summary

An unannounced inspection commenced on 25 July 2022 at 09:00 and concluded on 02 August 2022 with feedback to the Trust's senior management team (SMT). The inspection team comprised of two care inspectors.

RQIA has a statutory responsibility under the Mental Health (Northern Ireland) Order 1986 and the Health and Social Care (Reform) Act (Northern Ireland) 2009 to make inquiry into any case of ill-treatment, deficiency in care and treatment, improper detention and/or loss or damage to property.

Intelligence received from a whistle-blower prior to the inspection indicated the conditions within Willow ward had deteriorated following a temporary change in provision.

From 4 May 2022 changes to the existing footprint of the ward resulted in a reduction of acute mental health beds for older persons within Willow ward in order to accommodate the transfer of 10 patients from Gillis Memory Centre. Communal spaces, including the dining and living room areas, became shared areas for use by patients from both wards. At the date of inspection each group of patients had a dedicated nursing staff team including ward managers.

Prior to the inspection Trust communication indicated substantial dementia informed remedial work had been undertaken to Willow ward environment in keeping with the safety requirements for these patients.

Intelligence received to RQIA prior to this inspection informed our inspection themes. The inspection focused on nine key themes; adult safeguarding (ASG), incident management, environment, staffing, care records, physical health, restrictive practices, resettlement/discharge planning and governance. Due to a Covid-19 outbreak at the time of inspection, some themes including the environment and restrictive practices could not be fully assessed as inspectors were unable to gain direct access onto the ward. Furthermore, inspectors were unable to meet and speak with patients, observe the dining experience at meal times or directly observe care delivery. These areas will be assessed more fully during future inspection activity.

Good practice was identified in relation to effective post incident debrief involving ASG team members and ward staff. Records reviewed indicate the teams operate within a culture of reflection and learning which supports information sharing and staff learning thereby improving patient care.

Three areas for improvement (AFI) included in the Quality Improvement Plan (QIP) from the most recent inspection were reviewed. We found progress had been made in relation to the updating of the Trust's policy on the safeguarding of children and young people and assessed this AFI as met. One AFI in relation to patient activities was assessed as not met and will be stated for a second time in the QIP for this inspection. One AFI in relation to complaints has been reworded and stated for a second time.

Five new AFIs were identified in relation to ASG referrals, communication between staff teams, patient experience, staff training and environmental risk assessment.

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 patients, relatives, staff and management and observe practices throughout the inspection.

The information 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 services were performing at the time of our inspection, highlighting both good practice and any AFI. 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.

During this inspection we reviewed staffing arrangements, including the profile of staff. We engaged with the multi-disciplinary team (MDT) and Senior Management Team (SMT), and reviewed a range of relevant patient and governance documentation. The experiences and views of patients, their families and staff were also gathered.

4.0 What people told us about the service

Posters and patient/relative leaflets were placed throughout the ward inviting patients, relatives and staff to speak to inspectors and feedback with their views and experiences. There were no completed patient/relative questionnaires received post inspection.

Opportunities to speak with patients and relatives during our onsite inspection were limited due to an active Covid-19 outbreak on Willow ward at the time. Consequently all families were offered the opportunity to engage with us via telephone. Five patient relatives availed of this opportunity.

The majority of relatives reported that staff provided good care and showed dignity and compassion for their family member. Families shared a view that communication was very good from nursing staff with regular updates provided following MDT meetings, incidents and accidents. There were however mixed views received in relation to the ward's management of the Covid-19 outbreak and relatives expressed concern for the impact reduced visiting had had on their loved one. Not all relatives were aware of their right to complain and some indicated they did not like to complain. Relatives also informed inspectors that they know they can telephone the ward at any time.

Staff interviews with both Trust and agency staff were conducted. Staff were generally positive and reported there to be adequate staffing levels, good team work, and positive staff morale. We spoke to a range of staff during the inspection including members of the MDT.

Some concerns regarding the ward environment were also expressed by staff including challenges experienced in relation to the change in patient profile and the impact the sharing of facilities was having on outcomes for patients. Staff indicated that communication and preparation in respect of the move of Gillis Memory Centre to Willow ward could have been better.

Relatively new staff to the team informed us that they had experienced a good induction; they were made to feel welcome and felt very much part of the team.

5.0 The inspection

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

The last inspection to Willow ward was undertaken on 27 June 2017 and resulted in three areas for improvement.

Areas for improvement from the last inspection on 27 July 2017		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 5.3.1 (f) **Stated:** First Time **To be completed by** 25 July 2017	Activities offered to and completed with patients were not always recorded in patients care records to evidence patients' participation in each activity and their presentation throughout the activity.	**Not Met**
	Action taken as confirmed during the inspection: Patient notes reflected limited recorded evidence of activities offered to and completed with patients. This area for improvement was assessed as not met. The required improvement has been reworded and is stated for a second time.	
Area for Improvement No. 2 **Ref:** Standard 6.3.2 (g) **Stated:** First Time **To be completed by** 25 July 2017	Two patients were not aware of their right to make a complaint.	**Not Met**
	Action taken as confirmed during the inspection: Inspectors were unable to speak directly with patients due to an active Covid-19 outbreak at the time of inspection. Not all relatives were aware of their right to complain. This AFI has been reworded and will be stated a second time.	

Area for Improvement No. 3 **Ref:** Standard 5.3.1(c) **Stated:** Second Time **To be completed by** 25 December 2017	The Trust's Policy, Procedures and Guidance for Registered Nurses, Midwifes and Specialist Community Public Health Nurses on Safeguarding Children and Young People was not updated.	**Met**
	Action taken as confirmed during the inspection: The Policy was up to date and care plans demonstrated staff awareness of the policy to inform practice.	

5.2 Inspection findings

5.2.1 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 likely to occur without intervention.

Staff at ward level demonstrated good understanding and knowledge of what constituted an ASG incident; however it was custom and practice for approval to be sought from the ward manager before referrals were made to the ASG team. This practice has the potential to delay protection plans for patients and is not in line with best practice as per the regional Adult Safeguarding Prevention and Protection in Partnership Policy (July 2015). An area for improvement was identified in relation to this.

Patient comprehensive risk assessments were in place and were appropriately updated to reflect any changes in risk. Individual daily progress notes for patients were also up to date and reflected the Datix number under a description of the incident and follow up actions (Datix is the electronic system for recording incidents within the Trust).

We found the number of ASG referrals from Willow ward was low. On review of Datix we identified that some incidents which would have met the threshold for an ASG referral had not been reported by staff. Incidents were however graded appropriately and consistently in keeping with the Trust's policy. Post incident debrief records were maintained and used to inform team learning with input from the Trust's safeguarding specialist as needed. All incidents were reviewed weekly at MDT meetings and there was evidence of effective audit and review of ASG processes.

5.2.2 Environment

Due to a Covid-19 outbreak at the time of inspection, the environment could not be fully assessed as inspectors were unable to gain direct access onto the ward. This impacted on the inspection team's ability to determine if the environment was safe and conducive to the delivery of safe, therapeutic and compassionate care.

Relevant infection prevention and control (IPC) information was available for staff. Environmental cleaning audits were completed in April 2022 and July 2022; however, evidence of an infection control audit having been completed since the onset of the current Covid-19 outbreak in July 2022 was not evident. In order to establish levels of IPC compliance it is recommended that audits be undertaken at regular intervals to strengthen existing IPC practice including hand washing audits and personal protection compliance audits.

Willow ward reduced its bed capacity to admit patients over the age of 65 with a functional mental illness from 20 to 10 in order to make temporary provision for 10 dementia care beds. Communal spaces including a lounge, the dining room, and a treatment / drug preparation room have since become shared spaces for patients from both wards. Staff told us these arrangements are not satisfactory and not conducive to positive patient outcomes. We recommend the Trust undertake a review of the environment to ensure the arrangements are suitable for all patients. An area for improvement is included in the QIP to reflect this improvement.

Documentation to evidence environmental walk around outcomes carried out by senior management was not available. The absence of associated records was escalated to the SMT and an assurance was given that an effective walk around system used in another ward would be replicated in Willow ward.

The ligature risk assessment was not up to date. We were informed that some previous ligature risks had been addressed however due to the lack of an up to date risk assessment we were not assured that the associated ligature risk action plan was fully mitigating against risk. These risks were discussed with the SMT who provided assurance that ligature risk assessments would be reviewed.

The arrangements for fire safety were reviewed. The most recent review of the Fire Risk Assessment (FRA) was completed in October 2021. Evidence to confirm that all recommendations on the fire risk assessment (FRA) had been actioned was not available. Daily checks of the fire panel were also not completed consistently. A number of staff had not received up to date mandatory fire training although we were informed by SMT that arrangements were in place for this training to take place.

Given the change of patient profile on Willow ward and a number of outstanding environmental risk concerns, an area for improvement has been made.

5.2.3 Staffing

The arrangements for staffing in Willow ward were reviewed and safe staffing levels were evident.

The escalation process in relation to staffing shortages is well understood and there is effective management team safety huddle arrangements each morning to review staffing levels. The management of reduced staffing levels is through block booked agency staff, to promote continuity of care.

Staff training records were not up to date and not all staff had received up to date mandatory training. The ward manager confirmed that plans were in place to address this within two weeks following the inspection. An area for improvement has been made.

Staff told us they had access to regular supervision and an annual appraisal and this was evidenced via the supervision and appraisal matrix.

Concerns expressed by staff in relation to the lack of communication following recent changes to the ward were not effectively addressed. Staff meetings where operational arrangements could be established and agreed were not happening. Some staff expressed concerns about the visibility and support from senior management. These matters should be taken forward by the leadership team. An area for improvement is made in relation to staff meetings.

5.2.4 Record Keeping, care and treatment plans and risk management

The quality of record keeping in relation to patient care and treatment was reviewed.

Patient records were maintained in an electronic format which staff access via a secure password system. Records reviewed were well maintained and there was evidence of regular MDT input including regular medical review. Care plans were individualised, patient centred and reflective of mental and physical healthcare needs of the patients; they were sufficiently detailed and referred to patient consent and dignity throughout. Arrangements were in place to recommence the auditing of care records from 31 July 2022.

A daily safety brief was in operation where the care for each patient is summarised. This was noted positively and is reflective of good practice.

There was evidence of patient's financial needs being considered with input observed from the hospital social work team and appropriate referral to the Office of Care and Protection. The Office of Care and Protection is an office within the High Court in Northern Ireland which supervises individuals who are appointed to manage the financial and property affairs for adults who lack the capacity to do so for themselves.

We observed regard to patient consent and patient's right to confidentiality from a sample of care plans. Patients were consulted before information was shared with their families or next of kin (NOK). Patient consent was referred to throughout any interventions delivered.

We were informed that the current shared space arrangements on the ward were impacting on the delivery of patient activities and there was limited recorded evidence of activities offered and completed with patients. For people admitted to acute mental health wards, a therapeutic environment provides the best opportunity for recovery. This area for improvement was assessed as not met and is stated for a second time in the QIP.

5.2.5 Restrictive Practices

Restrictive practices in use included locked doors, enhanced patient observations, use of rapid tranquilisation and PRN medication, (pro re nata – as required medication). Some items were not permitted onto the ward and voluntary patients were asked to sign a book upon leaving and on their return to the ward.

Restrictive practices in place were proportionate to the level of assessed risk and care plans contained the rationale for their individual use. In line with best practice any restrictive practice measure in place should be reviewed regularly by the patient's MDT. Weekly MDT review arrangements are in place to ensure restrictive practice measures remain the least restrictive option available to manage the level of presenting risk and do not unnecessarily deny patients of their rights. Advocacy contact details were available to share with patients.

Audit arrangements were in place for the use of PRN and rapid tranquilising medications however the associated records were found to lack analysis of the data collected. In order to identify trends and themes in relation to the use of restrictive practices, including the use of PRN medication and in order to inform learning and facilitate improvement, we recommend the Trust review the current audit process.

The use of physical intervention and MAPA (managing actual and potential aggression) was low. The ward manager advised that the use of MAPA in the Willow was low and this was evident from the sample of Datix incidents reviewed.

5.2.6 Patient flow and Discharge Planning

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

We established there were ten patients in Willow Ward. Length of patient stay ranged from three days to 180 days. A lack of suitable and appropriate community placements, including specialist care homes were identified as barriers to patient discharge.

There was limited evidence with regard to actions taken in relation to referrals to other care establishments, discussions with family or patient's wishes, and patient progress notes held limited information in relation to discharge.

The MDT meeting template did not reflect discharge as a standing agenda item. We were however informed that regular MDT discussions in relation to discharge planning happen. These discussions should be documented clearly on patient records and included as a regular agenda item at the weekly MDT meeting.

5.2.7 Physical Health

The management of patients' physical health needs was reviewed.

Patients' physical health care needs were being effectively met with baseline observations taken on admission along with assessments for tissue viability, falls and nutritional needs including choking risk.

Care plans were informative and included evidence that patients had been assessed by other members of the MDT team including Speech and Language Therapist (SLT) and other medical specialists as required.

There was evidence of physical health monitoring of blood sugars for patients with diabetes and food and fluid charts and repositioning charts were being used effectively, where clinically indicated. Patients were reviewed medically post fall and a head injury protocol was available for staff to follow.

5.2.8 Governance

We assessed the governance arrangements for Willow through examination of documentation and from discussion held with members of the senior management team.

A daily, morning huddle arrangement was in place across the site with senior management and all ward managers in attendance. Team learning is supported through post incident debrief arrangements for staff.

We were informed of weekly ward manager meetings however meeting minutes were not available for inspection. As previously noted staff team meetings were not happening at ward level. We recommend this be reviewed to support effective communication and improved outcomes for patients and for staff.

Willow ward staff spoke positively about the management of the ward and felt they were well supported by the ward manager.

The operational policy for Bluestone which details the purpose and function of each ward should be updated to reflect the temporary inclusion of Gillis Memory Centre to the Bluestone Hospital site. It is acknowledged however that the longer term provision for Gillis Memory Centre was not determined at the date of inspection. Plans were in place to progress decision making following public consultation and staff engagement exercises. Whilst future provision is consulted upon an interim document should be developed to explain the current arrangement.

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).

	Standards
Total number of Areas for Improvement	7

The total number of areas for improvement includes two that have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Joe Walker, Interim Assistant Director MHLD Inpatient Service, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).	
Area for improvement 1 **Ref:** Standard 5.3.1 **Stated:** Reworded and stated a second time	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
To be completed by: 30 November 2022	**Response by registered person detailing the actions taken:** The provision of activities across the span of 7 days had been a challenge during the interim contingency measure of Gillis ward and Willows ward collocating. In part this was due to space, acuity and the transition period. Presently we are working to overcome these challenges and activities are taking place & the patients are participating as far as their illnesses and/or symptoms allow We are currently recruiting for a Dementia Champion post where activity planning and provision will bee a key remit of their role. Activities are documented on our electronic records system.
Area for improvement 2 **Ref:** Standard 6.3.2	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

Stated: Reworded and stated a second time **To be completed by:** 30 November 2022	**Response by registered person detailing the actions taken:** Relatives & patients are provided with this information on admission. Information in this regards to this is visible and available on the ward notice board outside the visiting room. Bluestone have now published its patient, carers, family and supporter's information booklet where the complaints process and their rights re the complaints procedure are documented, these are provided at the point of admission.

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
	Response by registered person detailing the actions taken: Staff on the ward are aware of how to make direct referrals to the adult safeguarding team. Bluestone have appointed a Social work lead who provides scheduled team talks to support all staff across the MDT, but this also provides regular focus around ASG processes, expectations, roles and responsibilities. All ASG data are analysed and any learning shared on a weekly basis.
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
	Response by registered person detailing the actions taken: The Safety Brief is available in the office for sharing. Any significant risk/changes to ward environment is communicated on a daily basis. The new Gillis Ward Manager will commence post over the next few weeks and there are plans thereafter to discuss communication, handovers, harmonisation of process and operational meetings.
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 Willow and Gillis wards. Ref: 5.2.2
	Response by registered person detailing the actions taken: We are working to safely optimise the spaces within the shared spaces to minimise any impact on the service user. We continue to engage with service users and their families in this to assure ongoing support and discuss any concerns or issues. The Future Dementia Inpatient Service Consultation ends on the 23rd December 2022 which will dictate our route of travel going forward.

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
	Response by registered person detailing the actions taken: The Fire Risk Assessment was completed at the time on inspection but unfortunately this was not available as the Fire Officer had removed the folder to complete checks, thus it was unavailable on the ward at the time of inspection. The Ligature Risk is due to be reviewed by Management & Ward Managers, and this has now been completed.

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
	Response by registered person detailing the actions taken: At the time of Report some of the mandatory training compliance was affected by ward demands and staffing issues. This now has relaxed and the ward manager is focusing via and agreed strategic plan to ensure that all staff complete relative outstanding Mandatory Training. This is reviewed on a weekly basis by the senior management team

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

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS