The Regulation and Quality Improvement Authority

Inspection Report

20 April - 30 April 2021

South Eastern Health & Social Care Trust

Downe Acute
Downe Hospital
2 Struell Wells Road
Downpatrick
BT30 6RL
Tel No: 028 4461 3311

Ward 12 Lagan Valley
Lagan Valley Hospital
39 Hillsborough Road
Lisburn
BT28 1JP
Tel No: 028 9266 5141

Ward 27 Ulster
Ulster Hospital
Upper Newtownards Road
Dundonald, Belfast
BT16 1RH
Tel No: 028 9048 4511

Ward 27 Downshire
Downshire Hospital
53 Ardglass Road
Downpatrick
BT30 6JQ
Tel No: 028 4461 3311

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: South Eastern Health and Social Care Trust	**Responsible Person:** Mr. Seamus McGoran, Interim Chief Executive Officer, South Eastern Health and Social Care Trust (SEHSCT)
Person in charge at the time of inspection: Margaret O'Kane, Director of Adult Services and Prison Healthcare, South Eastern Health and Social Care Trust	**Number of commissioned beds:** Downe Acute: 25; Ward 12 Lagan Valley: 21; Ward 27 Ulster: 24; Ward 27 Downshire: 6 PICU (Psychiatric Intensive Care Unit), 10 slow stream rehabilitation
Categories of care: Mental Health (MH) Acute Admission Psychiatric Intensive Care	**Number of beds occupied in the wards on the day of this inspection:** Downe Acute: 25; Ward 12 Lagan Valley: 20; Ward 27 Ulster: 21; Ward 27 Downshire: 6 PICU, 8 slow stream rehabilitation

Brief description of the accommodation/how the service operates:

There are three mental health acute admission wards across the South Eastern Health and Social Care Trust (the Trust). These wards provide assessment and treatment for people aged between 18 and 65 with acute mental health needs. Ward 27 Downshire provides both psychiatric intensive care and slow stream rehabilitation, for people aged between 18 and 65. All four wards are mixed gender. Patients are admitted either on a voluntary basis or in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).

Downe Acute has single occupancy ensuite bedrooms and is situated in the ground floor of Downe Hospital.

Ward 12 has a mix of single occupancy rooms and multi-patient dormitories. There are no ensuite facilities on the ward. Ward 12 is situated on the first floor in the care of the elderly unit in Lagan Valley Hospital.

Ward 27 Ulster has a mix of single occupancy rooms and multi-patient dormitories. The single rooms have ensuite bathrooms. Ward 27 is situated in the first floor of the care of the elderly Ulster Hospital.

Ward 27 Downshire has a mix of single occupancy rooms and multi-patient dormitories. There are no ensuite facilities on the ward.

The design of the ward does not enable the separation of patients requiring PICU from those in need of a slow stream rehabilitation environment. Ward 27 is situated in the grounds of Downshire Hospital.

2.0 Inspection summary

An unannounced inspection to the Mental Health (MH) acute admission wards across the Trust commenced on Tuesday 20 April 2021 and concluded on 30 April 2021 with feedback to the senior management team (SMT).

The inspection was carried out by a combination of care and pharmacy inspectors, with input from RQIA's Clinical Lead.

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

This inspection focused on eleven key themes: patient flow; environment; restrictive practices; management of incidents/accidents/adult safeguarding; patient comfort; care and treatment; staffing; medicines management; governance and leadership; patient engagement and staff engagement. Each theme was assessed by inspectors to determine if over occupancy was affecting the delivery of safe care. Additionally, any areas for improvement identified during or since the last inspection that directly impacted over occupancy were reviewed.

This inspection identified that the Trust's acute mental health inpatient wards were frequently over occupied. We determined that the over occupancy had a minimal impact on the ability of staff to deliver safe care to patients.

Communication mechanisms were identified as an important factor in supporting the delivery of safe and effective care at times when the service was over occupied. Staffing levels were safe and staff were routinely observed providing a high standard of care and treatment. Patients told us they were treated with dignity and respect and felt that staff actively listened to them and attended their needs. Patients said that their care and treatment was helping them feel better. A total of 11 areas for improvement (AFIs) were identified, including five AFIs which relate specifically to Ward 27 Downshire.

Areas that require improvement relate to incident management and data analysis, environmental risk assessment, oversight of audits, compliance with regional guidance on learning matters, recognition and management of Adult Safeguarding events, staff mandatory training, patient privacy, dignity and human rights, infection prevention and control, use and governance of low stimulus room, physical health monitoring, and establishment of a staffing model for categories of care. AFIs from previous inspections were reviewed and all have been met with the exception of two for Ward 27 Downshire, which have been subsumed into an Improvement Notice and will be monitored as part of the monitoring of the improvement notice.

The two AFI which had not been met in Ward 27 Downshire relate to the ward environment and mixed model of care. These concerns were first identified in 2015 and an AFI was made. During inspections in July 2017 and November 2018 we determined that the AFI had not been met and were subsequently stated for the second and third time. Following the inspection in November 2018 we invited the Trust's SMT to a serious concerns meeting on 22 January 2019. At this meeting the Trust agreed to consider and present options detailing their plans to address the concerns with the ward environment and mixed model of care. During 2019 we held a series of serious concerns meetings with the Trust's SMT. During these meetings we were assured that the concerns would be addressed with the completion of a new PICU and refurbishment of the existing Ward 27 Downshire. Completion was expected by October 2020. During this inspection the same concerns were identified in relation to the ward environment and the mixed model of care. A dedicated PICU had not been realised and the condition of the existing ward environment had further deteriorated. The ward environment does not provide the therapeutic environment required to meet the needs of the complex and vulnerable group of patients being supported within it. There are inadequate and poorly maintained bathroom facilities for all patients and few appropriate private spaces where patients can avail of quiet time. Patients have limited space for their personal belongings and only single use bed rail curtains are used to support patient's privacy and dignity.

As a result of our significant and sustained concerns we invited the Trust's SMT to an Intention to Serve an Improvement Notice Meeting on 21 May 2021. At this meeting the SMT described well advanced plans for an extension to provide a dedicated PICU, which were at the planning application stage. Unfortunately the Covid-19 pandemic intervened. We recognise this was outside of the Trust's control. We were informed of current robust plans for the delivery of a distinct and separate PICU to be completed on site by September 2022; concurrent refurbishment of the existing ward and a focused plan for discharging/resettlement of patients considered able to transition to community living. Whilst assured that the action plan was appropriately detailed, realistic and indicated a significant investment in the service, we remained concerned about the current compromised environment and the unacceptable period of time over which these concerns had not been addressed. In view of this, a decision was made to serve an Improvement Notice; Improvement Notice IN000009 was issued to the Trust on 25 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 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.

4.0 What people told us about the service

Posters were placed throughout wards inviting patients and staff to complete an electronic questionnaire.

One patient submitted a written response and 14 patient interviews took place where patients gave a verbal account of their experiences. Patient responses indicated that they felt their care was safe and effective, that they were treated with compassion and that the service was well led. Some concerns were raised in relation to availability of showers, the need for psychological therapies, and the use of plastic bags.

There were no staff questionnaires returned; however there were 26 staff interviews conducted. Staff responses indicated that they felt patient care was safe, effective, that patients were treated with compassion and that the service was well led. All staff indicated that they felt supported in their roles and although staff reported the SMT were responsive and supportive there was limited visibility of them on some wards. Some staff expressed concerns about maintaining patient privacy, comfort and dignity when the wards were over occupied.

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 inspections undertaken and the AFIs are identified as follows:

- Downe Acute on 5 December 2017 had five AFIs.
- Ward 12, Lagan Valley Hospital on 22 January 2018 had three AFIs.
- Ward 27, Ulster Hospital on 31 May 2017 had four AFIs.
- Ward 27, Downshire Hospital on 28 November 2018 had two AFIs.

<table>
<tr><th colspan="3">Areas for improvement from the last inspections</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Mental Health Order (Northern Ireland) 1986 and 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
Downe Acute

Ref: 6.3.2 (f)

Stated: Second Time

To be completed by: 6 June 2018</td><td>It is recommended that the Trust puts a mechanism in place to ensure that patient information is shared appropriately and timely with relevant professionals. Ensuring that all aspects of agreed care and treatment plans are comprehensively implemented.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

The Trust has implemented a fit for purpose Version 2 MAXIMS system which provides greater flexibility, accessibility and usefulness than the previous system.
Clinical records are held within the secure system and are accessible to clinical staff both within and out of hours.</td></tr>
<tr><td rowspan="2">Area for improvement 2
Downe Acute

Ref: Standard 5.3.1 (a)

Stated: Second Time

To be completed by: 6 March 2018</td><td>In the five risk assessments reviewed there was no up to date management plan or contingency plan in place.

In the ‘update/change in risk, and alteration to risk management plan, section of the risk assessment updates were completed in relation to incidents on the ward. However, this section should detail changes in the risk management plan so staff are aware of how to manage risks for each patient.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Risk management plans are in place and evidence contemporaneous updates and changes which enable staff to effectively manage risks.</td></tr>
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<tr>
<td rowspan="2">Area for improvement 3
Downe Acute

Ref: Standard 6.3.2 (f)

Stated: Second Time

To be completed by: 6 June 2018</td>
<td>Patients care records were stored in two different locations, the electronic recording systems MAXIMS and a paper file. All members of the multidisciplinary team (MDT) were recording on the MAXIMS system apart from the medical staff; therefore the approach to record keeping was not consistent.

The MAXIMS system did not appear to be fit for purpose as staff were not able to complete all assessments onto this system and had to also use a paper file.</td>
<td rowspan="2">Met</td>
</tr>
<tr>
<td>Action taken as confirmed during the inspection:
The Trust has implemented a fit for purpose Version 2 MAXIMS system which provides greater flexibility, accessibility and usefulness than the previous system. This system is used by all staff disciplines, including medical staff.</td>
</tr>
<tr>
<td rowspan="2">Area for improvement 4
Downe Acute

Ref: Standard 6.3.2 (f)

Stated: Second Time

To be completed by:
6 March 2018</td>
<td>Nursing staff were completing the same records in a number of different sections in the MAXIMS system creating more work for them, extra time spent in the office and less time on the ward with patients:

• When medical staff record their review of a patient in the paper file the nurses then copy this same information into the MAXIMS system.
• Incidents involving patients were recorded in each patient's risk assessment and this same information was also copied into the contact sheets.
• Information was recorded on the MDT template (paper copy) and the nurses also recorded an account of who attended the meeting and the outcome of the meeting on the MAXIMS system.</td>
<td rowspan="2">Met</td>
</tr>
<tr>
<td>Action taken as confirmed during the inspection:
The Trust has implemented a fit for purpose Version 2 MAXIMS system which provides greater flexibility, accessibility and usefulness than the previous system. This system is used by all staff disciplines, including medical staff, thus removing the need for nurses to duplicate work.</td>
</tr>
</table>

Area for improvement 5 Downe Acute **Ref**: Standard 5.3.1 (a) **Stated:** Second Time **To be completed by: 6 February 2018**	MDT records were not completed fully: • Each care record detailed decisions agreed but did not include the responsible person agreed to implement the actions. • It was not clear if the patient had attended the MDT meeting or not as there was no record on the MDT template.	**Met**
	Action taken as confirmed during the inspection: Medical staff are recording the outcomes of the Team Assessment Meeting (TAM)including identifying the responsible person agreed to implement the actions. Patient attendance at TAM/MDT is recorded on the Trust MAXIMS system.	
Area for improvement 1 Ward 12 Lagan Valley **Ref**: Standard 5.3.1 (f) **Stated:** Second Time **To be completed by:** 23 April 2018	The TAM record documentation was not completed in full. There was nothing recorded to indicate if the patient was specifically invited to attend their meeting and nothing to evidence if they choose not to. TAM records did not identify which professional would action areas discussed. TAM records were not signed or filed appropriately.	**Met**
	Action taken as confirmed during the inspection: Medical staff are recording the outcomes of the TAM including identifying the responsible person agreed to implement the actions. Patient attendance at TAM/MDT is recorded on the Trust MAXIMS system.	
Area for improvement 2 Ward 12 Lagan Valley **Ref**: Standard 5.3.1 (a) **Stated:** Second Time **To be completed by:** 23 February 2018	It is recommended that the Trust ensures that medical staff updates patient progress records on the Trust's MAXIMS system.	**Met**
	Action taken as confirmed during the inspection: Medical records are held within the secure electronic MAXIMS system and are accessible to medical staff both in and out of hours. Medical staff are now using the system to update patient progress records.	

Area for improvement 3 Ward 12 Lagan Valley **Ref**: **Stated:** First Time **To be completed by: 23 April 2018**	The emergency alarm system has been reported as ineffective. The alarms in the airlock corridor are not linked to the ward alarm system and the overall alarm system does not always respond when activated.	**Met**
	Action taken as confirmed during the inspection: A new alarm system has been installed and is linked to the ward alarm system.	
Area for improvement 1 Ward 27 Ulster **Ref**: Standard 6.3.1 (c & d) **Stated: First Time** **To be completed by:** 25 August 2017	One of the occupational therapists allocated to Ward 27 is on long term leave for one year. There has been no back-fill for this vacancy which has had a direct impact on the occupational therapy service.	**Met**
	Action taken as confirmed during the inspection: Appropriate staffing levels within the occupational therapy department have been achieved.	
Area for improvement 2 Ward 27 Ulster **Ref**: Standard 6.3.1 (a) **Stated:** First Time **To be completed by:** 29 June 2017	There was a lack of activities for patients. The selection of board games was poor and some were incomplete. Patients reported a lack of activities in the evenings, weekends and bank holidays.	**Met**
	Action taken as confirmed during the inspection: There was a good selection of games available on the ward which were in good working order. OT service delivery was noted to be good. The range of activities available to patients has been extended to include various outings to local attractions.	
Area for Improvement 3 Ward 27 Ulster **Ref:** Standard 5.3.3 (d) **Stated:** First Time **To be completed by:** 30 November 2017	There is no clinical psychology input to the ward.	**Met**
	Action taken as confirmed during the inspection: Clinical psychology is available to all patients through referral.	

<table>
<tr><td rowspan="2">Area for Improvement 4 Ward 27 Ulster

Ref: Standard 5.3.1(a)

Stated: Second Time

To be completed by: April 2018</td><td>Patient care records continue to operate over three systems. (one electronic recording system (MAXIMS and two paper files).</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

The Trust has implemented a fit for purpose Version 2 MAXIMS system which provides greater flexibility, accessibility and usefulness than the previous system.</td></tr>
<tr><td rowspan="2">Area for improvement 1 Ward 27 Downshire

Ref: Standard 5.3.1 (f)

Stated: Second Time

To be completed by: 1 November 2020</td><td>The toilet/bath/shower areas were in very poor condition and should be refurbished in a timely manner. Areas of concern included:

• Damaged/flaking paintwork.
• Stained and damaged flooring (especially at fitted coved skirting).
• Mould and damaged sealant in shower areas.
• Malodours in some of the bathrooms.</td><td rowspan="2">Not Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The ward, including the toilet/bath/shower areas are in need of significant repair and does not meet the National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) Minimum Standards for Psychiatric Intensive Care in General Adult Services 2014 (NAPICU, 2014). National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) Minimum Standards for Psychiatric Intensive Care in General Adult Services 2014 (NAPICU, 2014)

There are inadequate bathroom facilities for all patients.

The general cleanliness of the ward falls significantly below acceptable standards with no evidence of environmental cleaning audits or oversight.

This area for improvement has not been met and has been subsumed into Improvement Notice IN000009.</td></tr>
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<tr>
<td rowspan="2">Area for improvement 2
Ward 27 Downshire

Ref: Standard 5.3.3(h)

Stated: First Time

To be completed by: 1 November 2020</td>
<td>The Trust should continue to progress the capital works plan devised to address the needs of the mixed patient population on Ward 27. This should include:
• Building a separate six bedded PICU beside the existing Ward 27
• Upgrading the existing Ward 27 environment; and
• Appointing a new staff team to manage the PICU.

The Trust must ensure that the ward’s environment and layout meet the needs of patients in accordance to National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) Minimum Standards for Psychiatric Intensive Care in General Adult Services 2014 (NAPICU, 2014)</td>
<td rowspan="2">Not Met</td>
</tr>
<tr>
<td>Action taken as confirmed during the inspection:

Plans to address the mixed patient population and the environment by building a new six bedded PICU adjacent to Ward 27, and a subsequent refurbishment of Ward 27 to address the ongoing environmental risks, have not progressed. It is acknowledged the Covid-19 pandemic impacted the progression of the planned works (see section 5.3.1) There is no specific staff team assigned to manage the PICU (see section 5.3.7).

This area for improvement has not been met and has been subsumed into Improvement Notice IN000009.</td>
</tr>
</table>

5.2 Inspection Finding

This inspection focused on eleven key themes. Each theme was assessed by inspectors to determine if over occupancy was having an impact on the delivery of safe care.

- Patient Flow
- Environment
- Restrictive practices
- Management of Incidents/Accidents/Adult Safeguarding (ASG)
- Patient comfort – human rights, privacy and dignity
- Care and treatment

- Staffing
- Staff engagement
- Patient engagement
- Medicines Management; and
- Governance and Leadership

The outcomes for each theme that pertain to all wards have been reported within section 5.2. However, some specific outcomes for Ward 27 Downshire have been reported separately in section (5.3) of this report as these findings were specific to Ward 27.

5.2.1 Patient Flow

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

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

The Trust is commissioned for 70 beds across its three acute admission wards, Downe Acute, Ward 12 Lagan Valley, and Ward 27 Ulster. It was evident on the days of the inspection that the Trust have been operating over the recommended 85% acute bed occupancy recommended by The Royal College of Psychiatrists. A recommendation of 85% has been set as operating a service with high levels of bed occupancy may affect patient care, as directing patients to the bed most suitable for their care is less likely to be possible.

In an effort to increase bed capacity the Trust were utilising Portland chairs, which are chairs that can be reclined into a bed, placing additional beds in non-designated sleeping areas for patients to sleep in, and at times using beds of patients who were on leave. Staff were not submitting Datix (the Trust system to report incidents) incident forms on every occasion of over occupancy despite direction to do so within local policy. A lack of incident reporting in relation to over occupancy makes monitoring the frequency and duration difficult. An area for improvement has been made.

The Regional Bed Management Protocol for Acute Psychiatric Beds (Aug 2019) is the regional guidance developed by the Social Care Commissioning Lead for acute mental health in collaboration with the five Trusts in Northern Ireland. It was developed to guide the Trusts in managing their acute mental health inpatient beds and support admission of patients to an appropriate facility to meet their individual needs in a timely manner. Staff were familiar with the protocol; however, there was limited evidence that the protocol was being fully embedded in practice.

Policies and procedures relating to bed management and over occupancy were aligned to the Regional Bed Management Protocol for Acute Psychiatric Beds May 2016 and included escalation arrangements, guidance on the use of leave beds, and the use of Portland chairs. The Trust bed management policy was being updated to reflect the 2019 version of the Regional Bed Management Protocol.

There was limited evidence of a two way flow of information. Bed management performance data was not shared with ward staff. The recent recruitment of a Bed Capacity Network Coordinator to acute mental health inpatient service has been positive in establishing a more co-ordinated and collaborative approach to patient flow both within the Trust area and across the region. This individual is responsible for coordinating all bed management plans which includes, the number of beds available, occupied beds, patients allocated on leave, patients supported on level of observations and patients that are identified for potential discharge. An important aspect of this role is the engagement through a regional network with other Trusts which supports the understanding and subsequent co-ordination of bed pressures across the region. The plans to recruit a complex discharge co-ordinator will further enhance the bed flow system. There was good MDT involvement into decisions relating to patient flow and good inter Trust working was evident when out of Trust patients were admitted to Trust beds. Some work is ongoing to determine staffing levels based on patient acuity.

All patients should have an estimated discharge date (EDD) set on admission (as per Trust policy), reviewed daily and updated as required to provide an accurate indication of when each bed in the hospital will become available for use by another patient. Staff including managers told us that when EDDs were not agreed early in the patient’s journey, this could lead to delays in discharge. Patient clinical records evidenced each patient had an estimated discharge date (EDD) recorded. Quality improvement Initiative (QI) work was ongoing to identify early potential blocks to patient discharge.

There was evidence that over occupancy caused disruption to patients in mixed gender wards, where single occupancy accommodation was not available, as wards had to be reconfigured to facilitate additional male or female patients. Patients were asked to relocate, and on occasions to sleep in a non-designated sleeping area, when additional patients were being admitted over and above the number of commissioned beds. An area for improvement has been made.
Ward 27 Downshire is commissioned for 16 beds, six for patients requiring PICU and ten for patients requiring slow stream rehabilitative care. Staff advised this ward does not over occupy, with 16 patients being the maximum number at any time; there was evidence to support this. Therefore no issues in relation to over occupancy in Ward 27 Downshire arose during this inspection.

5.2.2 Environment *(See section 5.3.1 for Environmental issues for Ward 27 Downshire)*

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

A range of documentation was reviewed, including minutes of meetings; risk assessments; staff training records and environmental audits, across all three wards. We also observed staff Infection Prevention and Control (IPC) practices. Covid-19 general risk assessments were completed and information to guide staff, patients and visitors on the Covid-19 measures to be taken was displayed in each area. There was evidence of inconsistency in the managerial oversight of the documentation across the three wards.

The standard of environmental cleaning of clinical and non-clinical areas throughout wards was generally good. All communal areas were relatively free from clutter. Patients had limited space for the storage of their belongings.

Ward 27 Ulster and Downe Acute had not completed mattress audits. A selection of patient mattresses in both wards were checked by the inspection team and a small number were found to be damaged or stained and not fit for purpose. Each of these wards failed to achieve compliance in their most recent environmental audits and there were no action plans available to address the identified issues. There was no evidence of managerial oversight of environmental audits in these two wards. An area for improvement has been made. Staff were knowledgeable on IPC practices and good compliance was observed with staff IPC practices in relation to hand hygiene practices, equipment cleaning, and use of PPE.

The three wards had identified two spaces to accommodate over occupied beds. In each ward one space accommodated a Portland chair, while the second space could facilitate a hospital bed, assembled temporarily when needed. In Downe Acute the area being used to accommodate the second contingency bed obstructed a fire exit. The fire risk assessment had not been updated to reflect this risk. This was raised with the ward manager on inspection, who contacted the Trust estates team immediately. On admission patients are informed of the need to accommodate them in the contingency areas. If they are unhappy with the arrangement, staff negotiated with other patients to facilitate the admission by asking patients to swop beds. We determined that over occupancy was having an impact on the provision of a safe and therapeutic environment. An area for improvement has been made in relation to the obstruction of a fire exit in one ward, when the ward was over occupied.

Patients raised concerns about the availability of showers (see section 5.2.9). Bathroom and showering facilities in Ward 12 Lagan Valley and Ward 27 Ulster were inadequate in number to meet the demands of the patients. Patients without a single occupancy room with ensuite bathroom had to use communal facilities designated for all genders. It is acknowledged that both wards are on the first floor with no options to increase the number of bathroom facilities for patients.

Patients had access to an outside area attached to each of the three wards. These areas were spacious with appropriate seating. Smoking shelters were also available. In the outside areas of Ward 12 Lagan Valley and Downe Acute the ashtrays were full, and all three outside areas had smoking debris on the ground. There was evidence that patients had been smoking in the stairwells of Ward 27 Ulster and Ward 12 Lagan Valley despite staff identifying smoking areas to patients at the point of admission and signage on the wards advising where smoking is and is not permitted. Staff should revisit signage and educating patients on smoking areas / arrangements.

On 17 October 2018 the Health and Social Care Board (HSCB) and Public Health Agency (PHA) issued a safety and quality learning letter to all Trusts advising that plastic bags should not be used in inpatient mental health wards and asked each Trust to ensure that the IPC team advise how to manage this issue in keeping with infection control measures and the need for a safe and effective disposal of clinical waste. A Trust information leaflet was available for patients and carers explaining plastic bags were not to be brought on to the ward. A review of the inpatient governance meeting minutes for February and April 2021 evidenced discussion and assurances were given from ward managers of compliance with the guidance on the use of plastic bags. However each ward had plastic bags in use within bathrooms, bedrooms and communal areas. This was raised with each ward manager and with the SMT. An area for improvement has been made.

5.2.3 Restrictive practices *(See section 5.3.2 for restrictive practices pertaining to ward 27 Downshire)*

The management of restrictive practices across the three wards was reviewed to determine if over occupancy was having an impact on the use of restrictive practices.
Restrictive practices in use included locked doors; level of patient observations and physical intervention. We determined that restrictions which were in place had been risk assessed and were proportionate to the level of risk in keeping with best practice guidance.
Staff demonstrated good awareness of restrictive practices. It was evident that leadership across the wards, with the multi-disciplinary team (MDT) oversight promoted a least restrictive approach to care.

Patient's care records reflected detailed recording and a plan of care for any restrictions. There was evidence that consideration had been given to the patient's human rights including deprivation of liberty safeguards. Care plans were recorded on MAXIMS, the Trusts electronic recording system, and reflected detailed documentation regarding restrictive practices. Where there were any changes in a patients risk status, a review took place with the MDT and the risk was assessed and individually managed.

The Trust's rapid tranquillisation guideline was in place and the staff were aware of its' content. A review of the medication records indicated that rapid tranquilisation was infrequently required and staff applied appropriate de-escalation techniques with patients with good effect. Staff advised that staff and patient debriefing took place as soon as was practical after an incident where rapid tranquillisation was used. A report of the use of rapid tranquillisation was made on a Trust electronic incident form known as Datix. Staff confirmed that there was good oversight and monitoring of the use of rapid tranquilisation at patient's MDT review meetings.
There was no association that over occupancy was having a detrimental effect on the use of restrictive practices.

5.2.4 Management of Incidents/ Accidents and Adult Safeguarding *(See section 5.3.3 for Management of incidents/Accidents and Adult Safeguarding for Ward 27 Downshire)*

Incidents recorded on the Trust's electronic reporting system, Datix, for March and April 2021 were reviewed to determine if there was an increase in number or complexity of incidents as a result of over occupancy. From our review we determined that there was no direct correlation between the two.

There was evidence that staff were using the Trust grading matrix to grade incidents, based on the inherent risk and not the outcome of the incident, with the majority being graded correctly. There were detailed entries in progress notes, with MDT input where appropriate, when an incident had occurred.

Examination of staff training records for incident management identified some deficits; however this was not having a negative effect on the reporting of incidents. Staff training overall evidenced less than half of the staff had attended adult safeguarding training. Members of SMT advised that any deficits in training resulted from staff pressures during the Covid-19 pandemic and provided assurance of steps to address any lapsed training. An area for improvement has been made.

Datix incident reports clearly evidenced when an adult safeguarding (ASG) referral was considered or made. Discussions with staff demonstrated good knowledge of what constituted an ASG concern however the process of completing an ASG referral was not robust. It was evident that referral forms known as APP1 forms had been completed; however, it was not always possible to locate the completed referral form in paper copy as most were completed electronically and emailed onto the Designated Adult Protection Officer (DAPO); these emails were not easily located. The completion of an APP1 form was seen as an isolated process and did not link into the patient's assessment of need or nursing care plan. An area for improvement has been made.

ASG incidents were discussed at handovers and safety brief meetings and evidence of this was available in the patient's care records. All staff were familiar with the DAPO and knew how to contact them; however none of the wards had an ASG champion or lead identified. The DAPO confirmed that data in relation to the number of referrals was collated and that this was shared with members of the SMT but not with ward staff. There was no evidence that learning arising from safeguarding incidents was implemented or shared. Nursing and social work staff at ward level did not have oversight of data in relation to trends to prevent reoccurrence. There was no evidence of auditing or analysis of incidents to support safeguarding prevention.

Discussions took place about ASG protection plans. Staff across all wards have been addressing safeguarding incidents by risk management of the perpetrator and not the protection of the person affected by the incident. There were no protection plans in place in any of the wards. Staff depended on their own knowledge of patients within the ward to safeguard them. An area for improvement has been made.

Minimal ASG information was displayed along with a safeguarding folder in Ward 27 Ulster but nothing was available in either of the other two wards.

There was no evidence from the information reviewed that over occupancy was impacting on the number of or the management of incidents or adult safeguarding; however areas for improvement have been made in relation to staff completion of ASG processes, lack of protection plans for those affected by incidents, and poor compliance with staff training in ASG.

5.2.5 Patient comfort *(See section 5.3.4 for patient comfort relating to Ward 27 Downshire)*

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

Patients were observed to be treated with kindness and respect by staff who delivered care in a committed and compassionate manner. The absence of single occupancy bedrooms for patients within wards and patients having to use communal bathrooms posed some obvious privacy challenges.

Patients were provided with information on admission which included advocacy services, meal times, property, the environment, discharge planning and how to make a complaint and consent. Advocacy arrangements were in place and consideration was given to human rights. When wards were over occupied patients were required to sleep in areas that were not designated for sleeping purposes and did so in Portland chairs or in an undesignated room in a contingency bed. Such areas do not have adequate facilities to accommodate patient belongings or provide satisfactory privacy and dignity.

On one ward, a CCTV camera was noted in an undesignated room which was used when the ward was over occupied. The ward manager gave assurances that this video footage was only viewed by nursing staff and the camera could be turned off when the room was being utilised to accommodate a patient. There was no evidence of any system or process in place to mitigate against CCTV being used whilst the room was used for over occupancy. The Trust should address this immediately to uphold patient privacy, dignity and human rights. An area for improvement has been made in relation to the use of CCTV.

It was evident that over occupancy did impact on a patients experience and the care they received as it is not ideal for patients to sleep in Portland chairs in areas not designated as sleeping areas. However this is outside the Trust's control and has been identified as a theme within the wider regional over occupancy review.

5.2.6 Care and Treatment *(See section 5.3.5 for Care and Treatment of patients in Ward 27 Downshire)*

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

Local policies and procedures were available to guide staff on the admission and discharge of patients. Each patient had an admission assessment completed by a doctor and nurse in line with Trust policy and had comprehensive risk assessments completed and care plans in place to reflect their individual needs. The records contained the patients' signatures indicating their involvement in planning their care. The standard of documentation was good, records were contemporaneous and there was evidence of ongoing mental health assessments completed. Access to care and treatment was appropriate and timely and there was evidence of good MDT working relationships. There was evidence of MDT input, ongoing treatment plans and of contact with the patients' key workers. It was noted patients had been referred for assessment of physical health needs.

Staff and patients confirmed that patients had access to a wide range of professionals to support them during their stay. We observed a high level of therapeutic engagement with patients amongst nursing and OT staff.

There was no evidence that over occupancy had an impact on patients care and treatment.

5.2.7 Staffing *(See section 5.3.7 for staffing relating to Ward 27 Downshire)*

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

We met with a range of staff across all wards to include, nursing; ancillary; medical; social work; psychiatry; and OT. Staff reported that staffing levels were safe and whilst there were occasions when there were staffing deficits, this did not impact on care delivery.
The Trust use the Telford model to establish normative staffing levels for each ward to ensure safe staffing levels. A recent review of staffing levels has resulted in additional Deputy Ward Managers posts being secured, enhancing the leadership across the wards. Staff described this as a positive outcome of the review and noted that it assisted with the retention of nursing staff as it provided opportunities for career progression.

Levels of staff absences were low across all the wards. At times agency staff are used to cover deficits in shifts, although the Trust strive to keep agency staff usage to a minimum. The Trust also makes use of bank staff; these staff are largely retired staff that have joined the nurse bank. Utilising this cohort of staff enhances the safe delivery of care as these staff have experience working in mental health wards. There were good relationships evidenced between the nursing teams across all wards to support each ward when short staffed.

A review of staffing rotas evidenced an increase in staff numbers when a patient required a higher level of observation for a period of time or when there was a new admission to the ward. Across all wards the use of enhanced levels of observations to support patients was low. The Trust gave assurances they were endeavouring to recruit and retain staff for all staff vacancies with focus on one ward that had a greater number of posts to fill. We found staffing levels were appropriate to meet patient need.

The MDT consists of social work, nursing, psychiatry, medical and occupational therapy staff. There was no clinical psychology input in the MDT but a referral can be made for any patient based on assessed need.

We determined that over occupancy did not impact on safe staffing levels and staffing levels were safe to deliver an effective service. Staffing levels were also available to meet any increase in demand on the services. This included times when the wards were over occupied.

5.2.8 Staff engagement

We met with staff to seek their views regarding the impact of over occupancy on the delivery of patient care.

Overall staff feedback was positive. Staff reported that morale was good and that they were well supported by their manager. Staffing levels were reported to be satisfactory but shortfalls can occur; however staff advised managers work to rectify this. There was recognition that the Covid-19 pandemic had impacted on staffing levels and there was evidence of good team work when staff faced challenges with staffing levels.

Staff reported that despite the added pressures of over occupancy, the standard of patient care remained high. Over the last year there were more patients, who required admission, and this impacted the need for escalation beds, and Portland chairs. Some staff expressed difficulties in maintaining patient comfort and dignity when patients were accommodated in non-designated bed spaces.

5.2.9 Patient engagement

We met with patients to determine if over occupancy was affecting the delivery of their care. Patients across the three wards gave their views in the form of a structured discussion which reflected the themes of safe, effective and compassionate care. Questionnaires were also left on the ward for patients who did not wish to give their views in person. One written return was received during the inspection. No questionnaires were received after the inspection.
Patient comments were overall positive in relation to care and treatment provided and in the main, patients told us they were treated with dignity and respect and felt that staff actively listened to them and attended their needs. Patients said that their care and treatment was helping them feel better.

It was observed that patients were well cared for and were supported by compassionate staff who spoke to patients in a dignified respectful manner and who sought consent from patients before engaging in interventions.

Concerns raised by patients were in relation to the availability of showers, and their confusion when they were told patients are not to use plastic bags yet they were present on the ward. These issues were discussed with management during the inspection, (see section 5.2.2).

5.2.10 Medicines management

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

On Ward 12 Lagan Valley and Downe Acute pharmacist support was provided on a part time basis, while on Ward 27 Ulster and Ward 27 Downshire pharmacy support was provided by a pharmacy technician. The part time pharmacist support included medicines reconciliation for newly admitted patients as well as regular review of prescribed medicines, while the pharmacy technician provided support for the medicine ordering process and expiry date checks of medicines. On Ward 27 Downshire the pharmacy technician reviews medication once a week for patients in PICU and once a fortnight for patients who are in slow stream rehabilitation. Staff in all wards were complimentary of the pharmacy support to the wards and the contribution to the safe management of medicines.

Nursing staff were very knowledgeable regarding the medicines management processes and the medication needs of individual patients.

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

Kardexes were well maintained in each of the wards, with medicine entries, dosage regimes and the patient's allergy status appropriately recorded. The good practice of highlighting dates for medicines prescribed, for example, at twice weekly or weekly intervals was acknowledged. The records indicated that patients were administered their medicines as prescribed. On most occasions, staff recorded why a medicine was omitted; however there was evidence of occasional missed doses.

On one ward both nurses were observed signing the kardex after administration as per Trust policy; however on another ward it was established that one nurse would sign both staffs' initials which is in breach of the Nursing and Midwifery Council (NMC) standards. This issue was raised with the ward manager during the inspection and was addressed immediately.
Where a patient refused to take a medicine, there were arrangements in place to inform the medical team and this was reviewed at the MDT meetings. The medical team regularly review patients' medicines.

Staff demonstrated a variable knowledge of critical medicines and the need for their timely administration. Staff were familiar with the arrangements for ensuring the timely supply of prescribed medicines including medicines required during out of hours.

The management of medicines prescribed on a "when required" (PRN) basis was reviewed There were clear parameters specified on the medicine kardexes to direct the administration of medicines prescribed on a "when required" (PRN) basis for distressed reactions. This included the indication for the medicine, the minimum frequency intervals and the maximum daily dose. In instances where more than one PRN medicine was prescribed for managing distressed reactions it was clear which medicine was first, second and third line.

Clozapine was supplied to the wards on a named patient basis and staff were aware of the requirement for regular blood monitoring. Arrangements were in place for regular review and monitoring of Clozapine treatment in all wards. Signed patient Clozapine care plans were observed, demonstrating patient involvement in medicines management.

There was evidence of regular review of those patients on Lithium therapy including blood monitoring and documenting rationale for dose changes.

Medicines were stored in locked cupboards and medicine areas were clean, tidy and organised. Staff advised that the medicine trolleys only contained medicines for current patients. This is good practice.

In relation to the cold storage of medicines the daily minimum and maximum medicine temperatures of the medicine refrigerator should be recorded to ensure that medicines are stored in accordance with the manufacturers' specifications. The recording of the daily current, minimum and maximum medicine refrigerator temperatures was inconsistent. The temperatures were all within the recommended range; however, the need to record minimum and maximum temperatures was discussed with staff.

Controlled drugs which required safe custody were stored appropriately and stock balances were reconciled at shift changes. Controlled drug cupboard keys were carried by the appropriate person and records indicated that two staff were involved in the receipt, administration and disposal of controlled drugs. Evidence of quarterly controlled drug audits by a Trust pharmacist was observed.

The management of medicine related incidents was reviewed. Staff on each ward advised that these rarely occurred and that any incidents were raised through management, including the ward pharmacist.

Satisfactory systems were in place for medicines management on all wards. Overall, medicines were managed safely and patients were administered their medicines as prescribed. Over occupancy has not impacted on the safe management and administration of medicines.

5.2.11 Governance and leadership

Governance and leadership was reviewed to ensure effective mechanisms of communication, senior decision making and escalation arrangements when admitting patients when wards are over occupied.

At ward level there was evidence of cohesive teams with good working relationships between the ward manager and their staff to promote the delivery of safe and effective care. There was good multidisciplinary working across all disciplines.

There were some inconsistencies across sites in relation to how handovers and safety briefs were recorded and shared. Two wards were using a comprehensive handover template which contained all relevant patient and ward risks which was updated as and when situations occurred, ensuring the document was live and reflected changes from one shift to the next. This was discussed during feedback and the Trust were encouraged to share the template across all four sites.

The Adult Mental Health Governance structures have been reviewed and funding approval had been agreed for a number of lead posts to augment the governance team. There were good governance systems and structures in place amongst senior managers. Staff reported a lack of visibility of senior management on the wards.

There was evidence of regular SMT meetings detailing risks, sharing of information, identifying emerging trends and themes across the directorate and evidencing how senior managers were seeking assurances on compliance with good practice and regional guidelines, SAI recommendations and HSCB learning letters. There was weekly performance data collected and reviewed to identify trends and pressures on the system. Data around weekly admission and discharge rates and length of stay over the past year has been produced. However this data is not shared with ward managers. Sharing data at ward manager level and below would inform wards of their performance and improvements and enhance a collective ownership of the directorate's goals.

The decision to admit patients to wards when they are over occupied was considered and only agreed as a last resort when risks to patients were high and no other treatment pathway was available in the community. Arrangements were in place for reporting and escalating over occupancy within the Trust and at regional level.

The SMT were aware of the bed pressures across the Trust and the impact over occupancy had on patient and ward risks.

There was a fortnightly MDT Acute Bed Pressure meeting to focus on bed flow, delayed discharges and identify solutions e.g. supported living opportunities.

There was evidence of plans to develop an audit programme. Findings on environmental and mattress audits indicate the need for this programme to be expedited. Evidence in relation to ASG (section 5.2.4) noted there was no audit assurance mechanism in place to monitor adherence to the Trust / Adult Safeguarding Operational Procedures 2016.

Areas for improvement have been made in relation to ensuring there is a robust governance process to monitor compliance with environmental audits and adherence to ASG processes.

5.3 Ward 27 Downshire

5.3.1 Environment

As mentioned in the inspection summary (section 2) of this report, RQIA has had serious concerns around the environment and mixed model of care on Ward 27 Downshire since 2015. The ward environment had significantly deteriorated since the previous inspection in 2018. The ward was not clean, and the environment was in need of significant repair. The fabric of some walls and woodwork required cleaning, repair and repainting. The low stimulus room required urgent attention as it did not meet an acceptable level of cleanliness.

There was no evidence of any environmental cleaning audits or management oversight of the cleanliness of the ward. We escalated our concerns to senior management who took immediate action to address the cleanliness and condition of Ward 27, Downshire, including assurance the ward would receive a deep clean within 48 hours. An area for improvement has been made in respect of environmental cleanliness and governance oversight of same.

There were inadequate privacy arrangements in place for female patients in bay areas and a lack of quiet areas for patients. The bathroom and shower facilities were inadequate to accommodate the mixed gender population and the number of patients on the ward.

Mixed Model of Care

The ward continues to operate a mixed model of care for patients who require PICU and those that require slow stream rehabilitation. There was one psychiatrist and one MDT providing clinical care to all patients in the ward. There was limited evidence that care and treatment for patients who required PICU and those who required slow stream rehabilitation was different even though the needs of both groups of patients were evidently different. Human rights for patients were compromised with only paper screens available to protect privacy and dignity in a mixed gender environment.

There was no evidence of individualised rehabilitation or resettlement plans to address the rehabilitative needs of patients, with some patients living on the ward for over 20 years. It is acknowledged that due to recent Covid-19 restrictions it has been difficult to carry on with community activities, however, with the exception of one OT session per week, there were very little therapeutic/recreational activities. Staff were however providing safe supervision of patients.

The serious concerns we identified during this inspection in relation to the ward environment and the mixed model of care were identified during an inspection of Ward 27 in 2018. Despite Trust assurances in 2019 a dedicated PICU has not been realised and the condition of the existing ward environment had further deteriorated. RQIA acknowledged that some delay was caused by Covid-19 restrictions but we remain concerned that the same environmental issues which were identified in 2015 had still not been addressed.

As a result of our significant and sustained concerns we invited the Trust's SMT to an Intention to Serve an Improvement Notice Meeting on 21 May 2021. At this meeting the SMT described well advanced plans for an extension to provide a dedicated PICU, which were at the planning application stage. Unfortunately the Covid-19 pandemic intervened. We recognise this was outside of the Trust's control. We were informed of current robust plans for the delivery of a distinct and separate PICU to be completed on site by September 2022; concurrent refurbishment of the existing ward and a focused plan for discharging/resettlement of patients considered able to transition to community living. Whilst assured that the action plan was appropriately detailed, realistic and indicated a significant investment in the service, we remained concerned about the current compromised environment and the unacceptable period of time over which these concerns had not been addressed. Due to the length of time these serious concerns have been discussed with the Trust and the lack of progress thus far an Improvement Notice; IN000009 was issued to the Trust on 25 May 2021.

Failure to provide adequate means of protection of patient privacy and human rights was discussed during feedback and the Trust have provided assurances in an action plan to address these issues within the current ward environment.

Measures have been planned in the short term to address the issues identified and efforts to improve the patient experience in the existing ward environment should remain the focus while the new facility is being built.

The Trust will be invited to quarterly meetings to discuss updates on progress and monitoring visits to Ward 27, Downshire, will be conducted by RQIA to evidence the progress made in relation to the Improvement Notice.

5.3.2 Restrictive practices

Patients care records were detailed in relation to restrictive practices with consideration given to human rights and there was good MDT oversight. Data was being gathered and was displayed in the form of a safety cross. When a restrictive practice was implemented the record was comprehensive. A culture of openness with regard to restrictive practices was evident.
The seclusion room is a newly refurbished room which has been fitted with padding on all surfaces. Concerns were raised about the fabric of the room and how it might impact on patient's mental wellbeing and what thoughts it might conjure for a patient. Staff were unable to evidence the rationale behind the decision making process for installing a seclusion room of this nature. Due to the fabric, ventilation in the room was very poor. In relation to infection prevention and control cleaning practices, the mat padding on the floor was glued down and it was not possible to remove the padding to clean in between or underneath the mats.
The seclusion room was not being used in accordance with the standard operating procedure. Staff would offer the use of the seclusion room to patients to support them at times of agitation. During these occasions whilst the patient made use of the seclusion room, the room door remained open and staff stood at the doorway to support the patient. The Trust referred to this practice as open seclusion. Data around open seclusion was being collated; however we would ask the Trust to review this practice and terminology.

A low stimulus room was also available on the ward. When not occupied, this room was used as a store for PPE equipment. The low stimulus room is in frequent use. A patient had been nursed in the low stimulus room for 48 hours, however there was no documentation available to support any review of this patient by the multi-disciplinary team. The standard operating procedure and policy which supports the use of the low stimulus room was not up to date. The low stimulus room was not always being used in proportion to the level of risk presented. The use of the low stimulus area is not reflected within the Safety Cross. These concerns were discussed with the ward manager and RQIA requested that the practices, policy and procedures be reviewed. An area for improvement has been made.

Areas for improvement have been made in relation to the governance arrangements and use of the low stimulus room.

5.3.3 Incidents/Accidents and Adult Safeguarding Management

Together with the findings in relation to the management of incidents and accidents as noted in section 5.2.4 a review of the 15 most recent Datix incident forms relating to Ward 27 evidenced that the majority of incidents were categorised as inappropriate aggressive behaviour. One third of these incidents recorded the use of the low stimulus environment as part of the incident management. As detailed in section 5.3.2 there is no data collated or analysed to identify themes and trends arising from the use of the low stimulus room.

The processes for the recognition and management of adult safeguarding in Ward 27 Downshire were also reviewed. There was evidence that adult safeguarding referral arrangements, protection plans and embedding safeguarding protocols was not robust. The findings in section 5.2.4 also pertain to Ward 27 Downshire with the following additional findings;

A review of patient notes on MAIXIMs was cross referenced with safeguarding referral forms and it was evident that the threshold for safeguarding in Ward 27 Downshire is high with only two referrals made since January 2021. One patient had been involved in both ASG incidents; however, we could not find evidence, as per regional guidance, to support any discussion under ASG strategy meetings when multiple referrals for any one patient have been made. We are concerned that lack of these discussions indicates a lack of consideration to the patient as a vulnerable adult / adult in need of protection.

We identified a number of incidents which met the threshold for an ASG referral. In one instance a patient alleged that they had been the subject of abuse. Consideration had not been given to making an ASG referral. We are concerned that staff lacked the knowledge to report incidents using the ASG process. Staff training records evidenced that two thirds of the staff had not attended ASG training. The audit of incidents and governance oversight did not identify incidents which met the threshold for onward referral to the ASG team.

Areas for improvement are the same as those found across the other wards (section 5.2.4).

5.3.4 Patient comfort

Patient comfort was significantly compromised due to the environment. Ward 27 Downshire is an old ward that is tired, and not fit for purpose. The environment was not conducive to therapeutic betterment for patients. There were challenges in maintaining adequate privacy and dignity for female patients and insufficient quiet rooms for patients with no option for gender specific areas apart from sleeping bays. There was limited space for patient’s belongings some of whom have lived in the ward for over 20 years.

5.3.5 Physical Health Needs

There was no evidence of systems in place to ensure patients, who have resided on the ward for long periods of time, could avail of routine health screening. These patients do not have access to a GP. Medical staff expressed concern that this cohort of patients was missing out on identification and management of chronic conditions. An area for improvement has been made in relation to routine health screening and GP access.

5.3.7 Staffing

Concerns have been identified regarding the staffing levels in conjunction with patient acuity for the ward. There was no delineation of staff for each category of care. The patient acuity was discussed with ward staff who were unable to determine any difference in levels of acuity between patients requiring PICU and those requiring slow stream rehabilitation. Staff were unable to articulate what level of staffing was required for each category of patient care, making identification and escalation of gaps in staffing impossible. Appropriate supervision of patients was observed in dayrooms, however, there were no therapeutic interventions observed. An area for improvement has been made.

5.3.8 Patient engagement

Patient feedback from Ward 27 was mixed. Some patients reported that they feel safe on the ward while others expressed fear of other patients who they perceived to be threatening towards them. Patients also advised that as a result of staff being busy doing paperwork that there was little to no time for activities such as playing snooker, table tennis as these activities need to be supervised.

Patients also commented on the lack of personal space and having to share rooms with other patients. Some patients reported they felt they were treated with dignity and respect and were involved in decision making about their care while others reported that this was not the case.

6.0 Conclusion

On reviewing our inspection findings it was evident that the effects of over occupancy were not compromising the delivery of safe and effective care.

While on occasions the Trust was operating over and above their commissioned beds, the impact on patients and staff was minimal. It was evident that the Trust had clear lines of communication and escalation and appropriate actions have been taken to ensure safe staffing based on patient acuity. The leadership at ward and senior management level has enabled the Trust to deliver a safe and compassionate service whilst embedding a least restrictive approach to supporting people with mental illness.

Based on our assessment of the 11 key themes, we are satisfied that Downe Acute, Ward 12 Lagan Valley Hospital and Ward 27 Ulster Hospital are providing safe and effective care in a caring and compassionate manner while managing the risks of over occupancy. We have identified 11 areas for improvement (five of which specifically relate to Ward 27 Downshire) that will further support the Trust to deliver improved outcomes for patients and staff.

Enforcement action resulted from the findings of this inspection for Ward 27 Downshire Hospital. The enforcement action relates to the ward environment and the mixed model of care.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were 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).

	Regulations	Standards
Total number of Areas for Improvement		11

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 Mental Health (Northern Ireland) 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).	
Area for improvement 1 **Ref:** Standard 4.1 Criteria: 4.3(b) **Stated:** First time **To be completed by:** Immediately	The South Eastern Health and Social Care Trust should ensure Datix incident forms are consistently completed for over occupancy, as per Trust policy to enable data correlation. Ref: 5.2.1
	Response by registered person detailing the actions taken: nThe Trust policy has been reviewed and shared with all relevant staff. Datix reports are monitored and reviewed by the Trust Bed Capacity Co-ordinator. A regular and ongoing audit has been established to monitor and provide an assurance that a datix report has been generated with the use of each contingency bed.
Area for improvement 2 **Ref:** Standard 4.1 Criteria: 4.3(i) **Stated:** First time **To be completed by:** 29 June 2021	The South Eastern Health and Social Care Trust must review Fire Risk Assessments which should consider increased risks when wards are over occupied regarding the additional number of patients and use of and position of contingency bed placement to ensure fire exits are accessible and unobstructed. Ref: 5.2.2
	Response by registered person detailing the actions taken: The mental health service bed management protocol highlights where additional beds in each area should be placed to accommodate admissions above normal bed capacity. There is a weekly fire safety audit conducted in each ward, which includes confirmation that all fire exits are free from obstruction. A review of each ward's fire safety risk assessment and general risk assessment (GRA2) has been conducted.

<table>
<tr><td rowspan="2">Area for improvement 3

Ref: Standard 5.1
Criteria: 5.3.1(f)

Stated: First time

To be completed by:
29 June 2021</td><td>The South Eastern Health and Social Care Trust must ensure there is an assurance mechanism in place to monitor environmental and mattress audits, and that items arising from the associated action plans have been completed in a timely manner.

Ref: 5.2.2</td></tr>
<tr><td>Response by registered person detailing the actions taken:
All facilities across mental health hospital services undergo regular environmental cleanliness audits to measure compliance with the regional standard of 90%. At the last audit of ward 27 in May 2021 a 92% compliance was noted.
An audit plan has been established for all inpatient environments, which includes a range of monitoring activities including
mattress audits. A shared folder has been established to enable the uploading of audits, including required actions which are centrally monitored.</td></tr>
<tr><td rowspan="2">Area for improvement 4

Ref: Standard 5.1
Criteria: 5.3.1(f)

Stated: First time

To be completed by:
Immediately</td><td>The South Eastern Health and Social Care Trust must ensure compliance with regional guidance on the use of plastic bags in Mental Health (MH) inpatient wards as noted in LL-SAI-2018-033(MH) and Learning Matters Quality 2020 Issue 8, September 2018. The Trust need to have robust assurance mechanisms in place to ensure compliance with the guidance.

Ref: 5.2.2</td></tr>
<tr><td>Response by registered person detailing the actions taken:
An audit of compliance with the Trust policy on the use of plastic bags was completed on 24th May 2021. An action plan was generated and the trust has sourced an alternative solution, which involves the use of lockable bins. These are being ordered.</td></tr>
</table>

<table>
<tr><td rowspan="2">Area for improvement 5

Ref: Standard 5.1
Criteria:
5.3.1 (c) and (d)

Stated: First time

To be completed by:
29 July 2021</td><td>In relation to Adult Safeguarding The South Eastern Health and Social Care Trust shall ensure:

• all staff fully understand how to recognise the potential for safeguarding;
• there is timely completion and submission of adult safeguarding referrals;
• interim protection plans are appropriately developed and implemented
• referrals are screened appropriately and escalated in a timely fashion
• there is identification of trends and shared learning to prevent similar safeguarding incidents reoccurring
• all staff across the multi-disciplinary team know where ASG referrals are stored on the system and the status of each referral at any given point in time.
• each ward has an adult safeguarding champion

Ref: 5.2.4</td></tr>
<tr><td>Response by registered person detailing the actions taken:
An identified representative has been nominated on each ward and provided with additional training. The representative completes asafeguarding audit each month. The safeguarding lead has oversight of the monthly audits.Safeguarding protection plans are noted and discussed at each safety brief and handover</td></tr>
<tr><td rowspan="2">Area for improvement 6

Ref: Standard 5.1
Criteria: 5.3.1(c)

Stated: First time

To be completed by:
29 June 2021</td><td>The South Eastern Health and Social Care Trust should review the CCTV policy to ensure patient’s privacy, dignity and human rights are upheld when contingency beds are placed in undesignated sleeping areas where CCTV cameras are used.

Ref: 5.2.5</td></tr>
<tr><td>Response by registered person detailing the actions taken:
A scoping exercise of all CCTV completed across wards to ensure there is no breach of patient privacy and dignity. A procedure governing the appropriate use of CCTV is in place. Protocols are currently under development to reflect the potenial use of body worn cameras.</td></tr>
</table>

<table>
<tr><td rowspan="2">Area for improvement 7
Ref: Standard 5.1
Criteria: 5.3.1(f)

Stated: First time

To be completed by:
immediately</td><td>The South Eastern Health and Social Care Trust shall address the following matters in relation to infection prevention and control on Ward 27 Downshire:

• improve the standard of ward cleanliness;
• undertake a survey of the interior fabric of the wards and generate an action plan to repair or replace any issues identified. Particular attention should be paid to floors; walls; lightening and ceilings.
• In consultation with their infection prevention control team ensure the low stimulus room is cleaned effectively.
• Ensure environmental and IPC action plans arising from audits are completed in a timely manner.

Ref: 5.3.1</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Patient Experience have increased daily observational audits completed by the Supervisors to address any cleanliness issues with a cleanliness rectification plan in place. The Patient Experience Operational Manager completes a weekly managerial walkabout in conjunction with the Ward Manager. The work schedules for the ward have been reviewed and patient experience hours have been increased.</td></tr>
<tr><td rowspan="2">Area for improvement 8

Ref: Standard 5.1
Criteria: 5.3.1(c)(f)

Stated: First time

To be completed by:
29 May 2021</td><td>The South Eastern Health and Social Care Trust shall strengthen the governance arrangements around the use of the low stimulus room in Ward 27 Downshire to ensure the SMT are assured that;

• the room is used in accordance with the Trust’s policy;
• care records accurately reflect the time each patient use the room;
• there is appropriate timely review of patients using the room by the nurse in charge and MDT
• Data on the usage of the room should be included in the Trust’s safety cross.

Ref: 5.3.2</td></tr>
<tr><td>Response by registered person detailing the actions taken:
The low stimulus policy has been reviewed and shared with relevant staff for comment. The use of low stimulus is discussed and agreed by the MDT. The use is documented on the patiient's electronic care record. There is a planned audit of low stimulus documentation to ensure compliance with the policy. As the safety cross is a regional initiative, it has not been possible to amend the template. As an alternative, datix reports are generated to identify and report on the use of low stimulus</td></tr>
</table>

Area for improvement 9 **Ref:** Standard 5.1 Criteria: 5.3.1(e) **Stated:** First time **To be completed by:** 29 May 2021	The South Eastern Health and Social Care Trust must ensure the low stimulus room is used only for its designated purpose and is not considered as additional space for storage of equipment. Ref: 5.3.3
	Response by registered person detailing the actions taken: The updated low stimulus policy has been shared with relevant staff. Staff have been advised that this room is only to be used for the designated purpose.This will be monitored by assurance walk arounds by Senior Management.
Area for improvement 10 **Ref:** Standard 5.1 Criteria: 5.3.3(d)(e) **Stated:** First time **To be completed by:** 29 June 2021	The South Eastern Trust must ensure all long-stay patients have access to a GP for the identification and management of chronic conditions and ensure patients have equality of access to the routine health screening programmes in the same manner as members of the public have. Ref: 5.3.6
	Response by registered person detailing the actions taken: The Trust's Physical Health Monitoring Service has completed physical health screening on all 8 remaing long -term patients. None of these patients presented with any long-term physical health care conditions. All long term patients have access to routine health screening as their individual needs dictate. As we implement the discharge plans for each patient, we will be arranging registration with a GP and we have also liaised with the Down GP Federation to discuss temporary registration while patients remain resident in ward 27. We can confirm that the two patients currently transitioning to placements are registering with GP practices.
Area for improvement 11 **Ref:** Standard 4.1 Criteria: 4.3(j) **Stated:** First time **To be completed by:** 29 June 2021	The South Eastern Trust must establish a staffing model based on the Telford Model to meet the needs of both categories of patients accommodated in Ward 27 Downshire. Ref: 5.3.7
	Response by registered person detailing the actions taken: The staffing levels in ward 27 DSH have been reviewed. Two distict staffing groups are identified on a daily basis at the safety brief They are also identified on a board in the day room so each patient is aware of their named nurse for the day. These staffing levels meet the requirements under the Telford Model and the level of staffing is increased as acuity demands, through the use of overtime, bank and agency staff. Many of these staff work in Ward 27 on a regular basis.

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

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Assurance, Challenge and Improvement in Health and Social Care