The Regulation and Quality Improvement Authority

Inspection Report

21 November – 13 December 2022

Downe Dementia Ward

Downe Hospital
2, Struell Wells,
Downpatrick
BT30 6RL

Tel No: 02844 838254

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 (SEHSCT)	**Responsible Individual:** Ms Roisin Coulter Chief Executive, SEHSCT
Person in charge at the time of inspection: Gary Doherty, Ward Manager Downe Dementia Ward	**Number of registered places:** 20
Categories of care: Dementia assessment and treatment.	**Number of patients accommodated in the ward on the day of this inspection:** 18
Brief description of the accommodation/how the service operates: Downe Dementia ward is a 20 bedded mixed gender ward providing assessment, care and treatment to patients with dementia. Patients are admitted either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO). The ward is located in the Downe Hospital in Downpatrick.	

2.0 Inspection summary

An unannounced inspection of Downe Dementia Ward commenced on 21 November 2022 at 09:00 and concluded on 13 December 2022, with feedback to the Trust's senior management team (SMT). The inspection team comprised of three care inspectors who were supported by administrative staff.

The inspection focused on eight key themes including adult safeguarding (ASG) and incident management, environment, staffing, care records, physical health, restrictive practices, resettlement/discharge planning and governance/leadership. Inspectors directly observed mealtime experience and care delivery.

Intelligence received by RQIA prior to the inspection raised concerns in relation to adult safeguarding. These concerns were reviewed as part of the theme relating to adult safeguarding.

Eight areas for improvement (AFI) in the Quality Improvement Plan (QIP) from the most recent inspection of Downe Dementia on the 15-16 June 2017 were reviewed. Two AFIs were assessed as met, one was assessed as partially met, four were not met and one AFI was removed from the QIP.

Fifteen AFI's are reflected in the QIP following this inspection. These are in relation to dementia screening tool, risk management; behaviour/psychological support; medication; staff training; adult safeguarding; theming and trending of incidents; fire safety; ligature risks; management of plastics; dining experience; care planning; deprivation of liberty safeguards; quality assurance systems and staff support mechanisms.

During the inspection we observed staff to be kind, caring and compassionate in their interactions with patients.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

As part of the inspection 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 care practices throughout. The information obtained is considered and triangulated before a determination is made on whether the service is operating in accordance with the relevant legislation and quality standards.

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.

4.0 What people told us about the service

Posters and easy read leaflets were placed throughout the ward inviting staff and patients to speak to inspectors and feedback their views and experiences. Feedback received was complimentary of staff and the care provided.

Patients and relatives indicated they were satisfied with the care provided. We were unable to directly ascertain the views of families who were not present during the inspection as patient next of kin details were not provided.

Staff spoke positively about the support they received from managers and reported adequate staffing levels were maintained with good team work and positive staff morale.

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 Downe Dementia ward was undertaken on 15-16 June 2017. Progress towards achieving compliance with the eight areas for improvement identified was assessed as part of this inspection. The findings are as follows:

<table>
<tr><th colspan="3">Areas for improvement from the last inspection to Downe Dementia on 15-16 June 2017</th></tr>
<tr><th colspan="2">The responsible person must ensure the following findings are addressed:</th><th>Validation of compliance</th></tr>
<tr><td>Area for Improvement 1

Ref: Standard 5.1
Criteria 5.3.1(a)

Stated: Second time

To be completed by:
13 August 2017</td><td><u>Risk assessments/risk management</u>

Only two out of four patients reviewed had a dementia risk screening tool completed. It was acknowledged that this is a pilot and was commenced four weeks prior to the inspection.

Each patient’s risk assessment in relation to the use of profiling beds had not been reviewed since admission.</td><td rowspan="2">Not met</td></tr>
<tr><td></td><td>Action taken as confirmed during the inspection:
The use of a dementia risk screening tool was not evident within the sample of patient records reviewed.

This area for improvement is not met and will be stated for a third time in the QIP with revised wording.</td></tr>
</table>

Area for Improvement 2 **Ref:** Standard 5.1 Criteria 5.3.1(f) **Stated:** Second time **To be completed by**: 13 August 2017	<u>Medication</u> The following was noted on review of the medication kardexes: • The front page and medicine management section was not always completed in full with the name of the consultant, date of admission, height, and weight. • The maximum dosage in 24 hours was not always recorded.	**Met**
	Action taken as confirmed during the inspection: Medication records included complete medicine management information with the responsible consultant's full name, the patient's date of admission, their height and their weight. The maximum dosage permitted within a 24 hour period was clearly recorded.	
Area for Improvement 3 **Ref: Standard 5.1 Criteria** 5.3.1(a) **Stated:** Second time **To be completed by:** 13 January 2018	<u>Behavioural/psychological support</u> Patient care records reviewed by the inspector evidenced that one of the three sets of patient records contained a behaviour that challenges screening tool. This tool explored the patient's behavioural and functional presentation and had been used to inform the patient's care plan. The inspector was informed that patients, relatives or staff did not receive support from clinical psychology services to support those patients who presented with behaviours that challenge	**Not met**
	Action taken as confirmed during the inspection: There was no comprehensive review of behaviour related incidents to determine root cause or how staff responded. Patients presenting with behaviours that challenge were not referred for psychology support. This area for improvement is not met and will be stated for a third time in the QIP with revised wording.	

Area for Improvement 4 **Ref: Standard 5.1 Criteria** 5.3.1(a) **Stated:** Second time **To be completed by:** 13 August 2017	Braden scale and MUST assessments completed with patients were not completed in accordance to the required timelines. **Action taken as confirmed during the inspection**: Braden scale and MUST assessments were completed weekly in accordance with the requisite timescales.	**Met**
Area for Improvement 5 **Ref:** Standard 5.1 Criteria 5.3.3 **Stated:** Second time **To be completed by:** 13 January 2018	<u>Compassionate Environment</u> A small number of patients (six) had to eat their meals in a corridor. **Action taken as confirmed during the inspection**: Patients were observed to have their meal served in the corridor and lounge areas. This is referenced further in 5.2.2. This area for improvement is not met and will be stated for a third time in the QIP with revised wording.	**Not met**
Area for Improvement 6 **Ref: Standard 5.1 Criteria** 5.3.1(f) **Stated:** Second time **To be completed by:** 13 October 2017	<u>Medication Governance</u> There was no evidence that an audit of the kardexes had been completed. There was no pharmacy support for overview of the prescription and administration of medication. **Action taken as confirmed during the inspection**: There was no evidence of the completion of comprehensive medication kardex audits. This is further referenced in 5.2.7. Pharmacy support is available to the ward on a part-time basis providing informal audit and MDT support. This area for improvement is partially met and will be stated for a third time in the QIP with revised wording.	**Partially met**

<table>
<tr>
<td rowspan="2">Area for Improvement 7

Ref: Standard 5.1 Criteria 5.3.1 (c)

Stated: Second time

To be completed by:
13 January 2018</td>
<td><u>Policies and Procedures</u>

Eight policies and procedures were out of date:

• Good practice guidance on assessment and management of risk (July 2016)
• Fire safety policy (June 2015)
• Code of practice on protecting the confidentiality of service user information (Feb 2016)
• Policy on the prevention of inpatient and residential facilities falls and essential care after falls (May 2014)
• Policy of guardianship (Nov 2015)
• Preparation for enhanced care planning meeting (Dec 2014)
• Discharge of patients from South Eastern Trust hospitals (July 2016)
• Policy of the management of violence and aggression and the use of restraint (September 2015)</td>
<td rowspan="2">Removed from QIP</td>
</tr>
<tr>
<td>Action taken as confirmed during the inspection:
The review and updating of Trust policies and procedures is the responsibility of the SEHSCT and not specific to the Directorate.

This area for improvement will be reviewed during the next MDT/ Trust inspection and will be removed from the QIP.</td>
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Area for Improvement 8 **Ref:** Standard 4.1 Criteria 4.3 (j) (m) **Stated:** Second time **To be completed by:** 13 January 2018	<u>Staff Training</u> Out of 27 nursing staff the following staff had not received up to date training: • Manual handling – 6 • Fire Safety – 2 • Patient handling – 4 • Infection prevention – 3 • Care and Responsibility – 2	**Not met**
	Action taken as confirmed during the inspection: Training records were incomplete and did not provide a team overview position. This area for improvement is not met and will be stated for a third time in the QIP with revised wording.	

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 is likely to occur without intervention.

A review of DATIX (DATIX is the Trust's electronic system for recording incidents) identified incidents had been reported, however a sample of incidents over a six month period (April – November 2022) revealed an inconsistent approach to grading. A number of incidents were not graded in accordance with the HSC Regional Risk Matrix and repeated incidents were not graded to reflect cumulative impact.

There was no evidence of a robust mechanism for quality assurance of incident management and patient risk assessments did not adequately reflect measures to mitigate against the risk of recurrence. The Trust should review the current arrangements to ensure a robust response to incident management is developed, appropriate audit processes are implemented and regular audit practice undertaken.

Staff could identify indicators of harm and the process of reporting ASG concerns. Some incidents that met the threshold for referral to ASG however were not reported in line with ASG procedures, and there was no evidence of protection plans in place to adequately protect patients within the ward. There was no observable guidance available for staff on the ward to follow and support with decision making.

ASG referral forms identified a lack of quality assurance and it was not established that discussions had taken place with other members of the multi-disciplinary team. Some concerns were not escalated and not all staff including senior staff were appropriately trained in adult safeguarding procedures.

Concerns in relation to ASG and incident management were escalated to the SMT during the inspection. SMT representatives provided assurance that ASG arrangements would be prioritised and current ASG practices improved immediately.

Post inspection an action plan to ensure improved governance oversight, training for staff, audit of DATIX incidents and an audit of APP1 records was completed by the Trust and submitted to RQIA. Review of the action plan content was found to be satisfactory. The Trust must ensure appropriate action is taken to robustly address any incident that may compromise the safety and well-being of patients.

Two areas for improvement in relation to adult safeguarding and incident management are included in the QIP.

5.2.2 Environment

The inspection sought to determine if Downe Dementia ward environment was safe and conducive to the delivery of safe, effective and compassionate care and met the assessed needs of the patients.

The environment presented as bright with good signage throughout to help with orientation.

Both internal and external areas of the ward could benefit from maintenance attention for example, the patient's en-suite showers had vinyl flooring which was stained and lifting in places thereby presenting an infection control risk and potential trip hazard.

The ward operates two separate areas, a larger area provides 14 beds and a smaller six bedded area provides a low stimulus space which is separated by a locked door. The 14 bedded part of the ward has an open plan sitting area which was a busy, noisy space that may lead to increased levels of distress and agitation for patients. A small lounge area, used as a visitor's room was locked and not accessible to patients. Consideration should be given to offering patients this area to provide an additional quiet space.

Patient bedroom doors had dry wipe board name plates. Patient names were either partially missing or not written clearly on these. Information boards within individual patient bedrooms were not being used effectively. A whiteboard mounted in the main corridor area of the ward contained confidential, sensitive information regarding patients. This was raised at feedback to Trust senior management team and recommended that the Trust should review the use and location of this board.

There was a lack of storage within the ward which resulted in staff using the only available bathroom to store equipment. This area was notably cluttered and presented a hazard whilst also denying patients the opportunity to have a bath if desired. This was raised during feedback to the Trust and should be urgently reviewed with alternative storage arrangements sought.

Serious concerns were identified in relation to fire safety. The fire risk assessment provided for inspection was out of date. An up to date fire risk assessment was provided on the second day of inspection. Personal Emergency Evacuation Plans (PEEPs) for patients were not in place and weekly fire safety checks had not been completed since August 2022. PEEPs were completed for all patients during the inspection however these fell below an acceptable standard. Fire awareness training for staff was found to be less than the minimum annual requirement. The absence of a coordinated approach to fire safety was escalated to senior management during the inspection and assurance given that the deficits identified would be immediately addressed. An area for improvement in relation to fire safety is included in the QIP.

Ligature risks were identified during the inspection. Inspectors found that staff awareness of ligature risk was limited and there was no ligature risk assessment in place. RQIA highlighted this risk to senior management at Trust feedback and requested the Trust to urgently review and address the issues surrounding ligature risk on the ward. An area for improvement in relation to ligature risk is included in the QIP.

The use of plastic and nitrile gloves on the ward was identified as a risk issue for patients. Recommendation was provided to liaise with the Trust's Infection Prevention Control team to agree suitable alternatives that would mitigate against the risk that such items may present for patients. An area for improvement was identified in relation to patient access to plastic and nitrile gloves.

The dining room had insufficient space for the number of patients accommodated on the ward which meant that a number of patients were required to have their meals in a corridor or lounge area. An area for improvement is stated for a third time in the QIP in relation to this.

Infection prevention and control measures were satisfactory. IPC audits which should include staff compliance with IPC measures however were not available for inspection. Recommendation is made to the Trust to complete regular IPC staff compliance audits to improve practice in this area.

IPC issues identified during the course of this inspection were previously identified by the Trust as part of a cleaning audit completed in June 2022.

Concerns relating to the safe management, storage and security of medicines were identified and raised with the ward pharmacist and nursing staff who addressed the concerns immediately. The Trust must ensure safe storage arrangements for medicines are adhered to at all times.

5.2.3 Staffing

The staffing arrangements were reviewed through the analysis of staffing rotas, discussion with staff, review of Datix records and observation of the number of staff on shift during the days of inspection.

A specific staffing model was not in use to determine staffing levels for the ward. Staffing levels were reviewed and evidenced through staff discussion, and review of senior staff meetings. The ward was found to be reliant on agency and bank staff to achieve safe staffing levels, with agency staff block booked to provide continuity. There was evidence of escalation when the ward has been short staffed.

The Trust requires that a registered mental health nurse takes charge of each shift, however the low number of mental health nurse registrants available has made this arrangement a challenge to achieve. The Trust should identify the specific 'nurse in charge' competencies and seek to address these through appropriate training. This will enable a wider pool of nurses to undertake training and increase availability for the nurse in charge role.

Staff training information was not available for the majority of mandatory training requirements including adult safeguarding and fire awareness training. Information available did not provide a team overview position. The Trust must ensure all staff deployed on the ward are sufficiently skilled and competent to meet the individual needs of the patients. Identified mandatory training must be available to staff and appropriate records maintained. An area for improvement in relation to staff training is included in the QIP.

Multi-Disciplinary Team (MDT) working was good with a variety of professionals involved; this included consultant psychiatry, occupational therapy (OT), social work, nursing staff and a pharmacist. Psychology input is available only by referral. Records were reflective of good MDT attendance and contribution to patient care and treatment at weekly team assessment meetings (TAM).

The coordination and availability of meaningful activity for patients on the ward could be much improved. The importance of purposeful activity for patients was acknowledged and we were informed that an activities coordinator would be beneficial. We would encourage the Trust to review the coordination arrangements in place for patients to access appropriate activities and determine if additional resource is needed.

5.2.4 Care Records and Physical Health

Electronic patient records containing daily progress notes along with paper copy files which contained care plans and assessment tools were reviewed.

Physical health needs were well managed and effectively addressed. Appropriate physical health risk assessments such as Braden, Malnutrition Universal Screen Tool (MUST) and falls risk assessments were in place and reviewed in accordance with identified risk.

Charts for monitoring distressed behaviours were also completed but lacked detail and did not indicate any antecedent behaviours to the incident or how staff responded. Greater emphasis on purposeful activity that has meaning for individual patients should be developed and will support with the reduction of agitation and distress. The Trust should review how these incidents are recorded and monitored for shared learning. An area for improvement in relation to behavioural and psychological support is stated for a third time in the QIP.

There was a good choice of menu and patients could have second helpings if desired and a good variety of snacks were available for patients out with mealtimes. Foods considered high risk in relation to choking for example, sausages, was raised with staff serving the meal. The Trust should consult with Speech and Language Therapist (SLT) colleagues where risk to patients is identified.

Patients on modified, textured diets were provided with appropriate meals and there was information provided in the dining room to inform staff about individual patient needs. This was consistent with the care plans. SLT recommendation sheets were not freely available and accessible for staff on the ward as recommended in the RQIA Review of the implementation of recommendations to prevent choking incidents across Northern Ireland (May 2022). On the whole staff were observed to be caring and compassionate in their interactions during mealtimes, however a small number of staff were noted to stand over patients whilst supporting them with their meal. This behaviour compromises patient safety and dignity and should be promptly addressed with staff when it occurs. Implementation of meal time experience audits would help inform improvement in this area. As stated in section 5.2.2 an area for improvement has been included in the QIP for a third time in relation to the dining experience.

Care plans were not individualised, they lacked detail and much of the information recorded had been pre-populated. A number of patients had a 'Reach out to Me' document completed which detailed personal information and likes/dislikes for patients. This information should be used to improve the behaviour support responses / behaviour management arrangements for individual patients. An area for improvement in relation to care planning is included in the QIP.

5.2.5 Restrictive Practices

There were 18 patients on the ward at the time of the inspection. Fifteen patients were detained under the Mental Health (Northern Ireland) Order 1986 (MHO). Relevant forms were available for viewing and there was clear documentation within the records.

Restrictions in use included the use of locked doors to manage egress from the ward, levels of patient observations, the use of Pro re Nata PRN medication and physical intervention.

Deprivation of Liberty Safeguards (DoLS) were not in place for voluntary patients accommodated within the locked ward environment. The inspection team was informed that the ward's social work staff were progressing this following the inspection. RQIA requests that the Trust confirm in writing when these safeguards are in place. An area for improvement in relation to DoLS provisions is included in the QIP.

Enhanced observation records highlighted that medical staff did not review all patients daily as directed by the SEHSCT policy. Governance arrangements in relation to the oversight of enhanced observations which includes the frequency of medical review should be strengthened to ensure this restriction continues to be necessary and to support with arranging required staffing levels.

Profiling beds and bedrails were in use. The Trust should ensure there is an identified need for the use of profiling beds and that a risk assessment is in place. Where restrictive interventions are necessary to mitigate risk, appropriate risk assessments must be completed. An area for improvement has been in relation to appropriate risk assessment.

5.2.6 Discharge Planning

The ward has capacity for 20 patients. At the date of inspection there were 18 patients on the ward. It was evidenced that the longest stay was 655 days due to difficulty finding a suitable community placement. Challenges regarding discharge were noted to centre around a lack of specialist care provision available within the community for people with dementia who have particular support needs.

Discharge arrangements were reviewed at the weekly MDT review meeting. The ward has two dedicated social workers (one recently appointed) who focus specifically on discharge planning. Social work staff were actively involved in discharge planning and working closely with patient families and MDT colleagues to determine the progress made by patients and to coordinate and support effective discharge planning.

5.2.7 Governance, Leadership and Culture

Following a period of consultation, services for older persons including Down Dementia Ward, moved to the Mental Health Directorate within the Trust. This change happened from 01 November 2022. RQIA acknowledges the recent transfer of functions to the Trust's Mental Health Directorate.

Concerns relating to the governance arrangements in place at ward and senior manager levels for ASG and incident management, fire safety and ligature risk were escalated to the Trust's SMT during this inspection. Deficits identified indicate a lack of oversight and effective management and a lack of awareness of the impact on care quality and patient safety. The Trust should review the training needs of the current staff team and ensure appropriate training, development and supervision is provided.

Twice weekly MDT team assessment meetings (TAM) were in evidence. The minutes of these meetings were well documented within the electronic records sampled.

A quality improvement project was underway within the ward to reduce the number of patient falls by 25% by April 2023. Future inspection activity will consider the impact of this work.

Audit results for medication missed doses, documentation, nutritional screening and tissue viability provided data on compliance levels, however there was limited commentary and no action plan evident to drive improvement. Key Performance Indicator information displayed was not current and there was no indication of a plan to have this information updated.

A robust audit system to monitor operational effectiveness, patient safety and ward performance must be developed to address the concerns escalated during this inspection and the various deficits highlighted by this inspection. An area for improvement in relation to the development of robust quality assurance systems is included in the QIP.

Staff reported there were no formal debriefs following behavioural incidents. The Trust should ensure that staff debriefs take place to capture any themes or concerns from staff as part of the staff well-being strategy and that appropriate measures are put in place to support staff.

One staff meeting had taken place within the past seven month period. A commitment was made by the Trust to ensure team meetings happen more frequently. The Trust should review the support processes for staff which should include regular staff meetings, staff debriefs following incidents, and regular supervisions in line with Trust policy. An AFI has been added to the QIP to reflect this improvement.

5.2.8 Patient/Relative Engagement

Relative feedback is a valued part of our inspection process. Relative contact information was requested but not provided. RQIA require this information to be provided on request during future inspection activity. This matter was raised with SMT during inspection feedback.

One relative spoke highly of the staff and the care provided and had no concerns. They reported that staff maintain good contact, they provide information following incidents however they would like more visits.

5.2.9 Staff Engagement

During the inspection staff were observed to be kind, caring and they displayed compassion in their interactions with patients. Staff reported that they were well supported by managers. Members of the MDT complemented ward staff for the high standard of care delivery they observed.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

	Standards
Total number of Areas for Improvement	15

* the total number of areas for improvement includes five that have been stated for a third time and one has been removed from the QIP

Areas for improvement and details of the Quality Improvement Plan were discussed with 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) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006)

Area for Improvement 1 **Ref:** Standard 5.1 Criteria: 5.3.1(a) **Stated:** Third time **To be completed by**: 28 February 2023	The South Eastern Health and Social Care Trust must ensure that all patients with dementia have an individualised evidenced based risk screening tool completed. Ref: 5.1
	Response by registered person detailing the actions taken: All patients with dementia have an individualised evidence based risk screening tool completed.
Area for Improvement 2 **Ref:** Standard 5.1 Criteria: 5.3.1(a) **Stated:** Third time **To be completed by**: 28 February 2023	The South Eastern Health and Social Care Trust should ensure that appropriate risk assessments are completed for profiling beds and the use of bed rails. Ref 5.2.5
	Response by registered person detailing the actions taken: Risk assessments are completed for profiling beds and use of bed rails
Area for Improvement 3 **Ref:** Standard 5.1 Criteria 5.3.1(a) **Stated:** Third time **To be completed by** 28 February 2023	The South Eastern Health and Social Care Trust must review the approach to recording and analysis of distressed behaviours. Staff should be supported to develop the skills, knowledge and expertise to analyse behaviours, determine why the behaviour has occurred and develop person specific support plans that aim to reduce the person's distress. Ref: 5.2.4
	Response by registered person detailing the actions taken: A number of Task and Finish Groups have been established following the RQIA inspection, as follows: 1- Adult Protection 2- Care and Treatment 3- Governance 4- Staffing 5- Environment - and work is ongoing across all of these areas, as reviewed on a monthly basis by an Oversight Board.

	Occupational Therapy experiential training in Engagement in Meaningful Activity and the Impact of Environment took place on 20.1.23, with staff on the ward. The behavioural and psychological symptoms of distress can be a response to the person's sensory impairment, the impact of the environment and any barriers as well as lack of appropriate stimulation 'occupation'. This training explored how dementia impacts the persons ability to perceive their environment, engage in everday activity and communicate effectively, with practical strategies for all staff to support people. There has been very positive feedback from staff who felt they had learned significant new information. This training will be built on and the need for it to be repeated and/or used alongside specific QI projects such as 'dining experience' and/or 'personal care experience' will be kept under review by the appropriate Task and Finish groups. Pool Activity Level Assessments are now summarised and laminated in every room indicating people's routines previous to hospital admission, interests, abilities and current difficulties with examples of activities and levels of appropriate intervention provided. Laminated copies of 'Supporting people in care homes to engage in meaningful activity' have been issued to the staff team, These include pictures and descriptions of relevant activites suitable for people with dementia. CLEAR training provision, which includes the recording, analysis and treatment planning in relation to distressed behaviours, has been reviewed in the ward for the wider multi-disciplinary team, including medical staff. A patient baseline is established at the point of admission, and this will be reviewed at subsequent Team Assessment Meetings (TAM). CLEAR training Level 4 has been arranged for March 2023. This will equip a number of people on the ward to deliver CLEAR training to the staff team and to monitor and evaluate its use, including antecedents to identified behaviours and the development of person-specific support plans. CLEAR Workbooks have been provided for all staffl trained in CLEAR Level 3 and their use will be reviewed in supervision and in team meetings. 'ABC' guidance in relation to the recording and analysis of behaviours has been provided to the staff team and the senior

	nursing staff on the ward will audit notes on a regular and ongoing basis to ensure an 'ABC' overview is meaningfully reflected and documented. Electronic diary dates for Audit have been set up and will be shared with all staff. Information regarding patient preferences//what keeps them safe/their usual routine etc. ie. 'Reach Out to Me' - will be kept up-to-date in all patient rooms, and a copy will be available in a file in the Nursing Station. All bank and agency staff will be given access to this. Psychological support is available on the ward and a Consultant Psychiatrist has been approached to deliver reflective practice sessions to support staff. The Ward Manager completed 'Hot Debrief' training on 27.1.23. This pilot training will be rolled out to other Band 6 nurses on the ward. Dementia Capable Care training, again as a pilot, has been delivered to the staff team, with a view to this being added to Directory of Training on an ongoing basis. Staff Wellbeing - dates will be offered to the ward by the Trust Wellbeing Project Officer to meet with staff, ascertain their views/encourage their ideas and involvement, with a view to maintaining morale and providing holistic support, recognising that , in the current climate in particular, a ward can be a high-pressured environment.

Area for Improvement 4 **Ref:** Standard 5.1 Criteria 5.3.1(a) **Stated:** Third time **To be completed by** 28 February 2023	The South Eastern Health and Social Care Trust must ensure that a medication audit of the kardex is completed as part of the quality assurance process Ref: 5.1 and 5.2.7
	Response by registered person detailing the actions taken: In conjunction with the ward pharmacist, an Audit of Nursing Documentation On Kardexs proforma has been devised, and a medication audit of the kardex will be completed on a monthly basis by an identifed nurse on the ward. These will be reviewed at the TAM, as a live, evolving document/process. This pilot commenced on 27.2.23. The ward Pharmacist will offer 'bite-sized' teaching sessions to ward staff to maintain a quality assurance focus on all aspects of medication management. .On a weekly basis, as part of her defined role, the pharmacist will also review all kardexes to ensure safe & legal prescribing and to identify potential errors, blanks, trends in, for example, prn use. The Governance Pharmacist for the Trust will complete a Governance review on the ward and will continue to work in partnership with the team in relation to identified areas for improvement. A review of datixes involving medication over the last 6 months has been completed. All nurses on the ward will have completed CEC Medicines Management Training via Zoom by December 2023.
Area for improvement 5 **Ref:** Standard 4.1 Criteria: 4.3 (j) (m) **Stated:** Third time **To be completed by:** 28 February 2023	The South Eastern Health and Social Care Trust must ensure that all staff currently working on the Downe Dementia ward have received up to date mandatory training and it is recorded in a format that easily identifies staff training requirements. Ref: 5.1 and 5.2.3
	Response by registered person detailing the actions taken: All staff currently at work on the Downe Dementia Ward are either up to date with their mandatory training or have been booked/will be booked in for this at the next available date.Bespoke training will be also be made available in the ward, eg. Fire Safety Training has been booked for 21.3.23. While information is available on HealthRoster for individual training, an overall training matrix has also been devised and

	this will be updated on an ongoing basis so that staff training is easily identified. Mandatory training will be reviewed by the ward manager and will be a standing item agenda at supervision sessions. .
Area for improvement 6 **Ref:** Standard 5.1 Criteria 5.3.1 (c) **Stated:** First time **To be completed by:** Immediate and ongoing	The South Eastern Health and Social Care Trust must implement effective governance arrangements for adult safeguarding to ensure compliance with regional Adult Safeguarding guidance. The Trust must ensure: a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations; b) there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively; c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care; d) ensure regular audit of adult safeguarding referrals and incidents; e) ensure that all staff including SMT have completed the appropriate level of ASG training for their roles and responsibilities. Ref: 5.2.1
	Response by registered person detailing the actions taken: An initial action plan detailing governance arrangements for adult safeguarding was shared with RQIA following the RQIA verbal feedback session. Following the establishment of an identified Task and Finish group responsible for Adult Protection improvement, and ongoing partnership working with the Trust Adult Protection Team, the Trust can confirm: All staff have been issued with the policy, and with guidance and flowcharts regarding the procedures to follow in relation to adult safeguarding, and the completion of appropriate documentation/referring on/notifying other stakeholders and

	organisations. All incidents are considered through an Adult Safeguarding 'lens', and Adult Safeguarding is a standing agenda item at Team Assessment Meetings and on the daily safety brief. The Adult Protection Team have offered bespoke training dates for the staff team All staff, including SMT, have completed, or have been booked into complete, training appropriate to their grade: Level 1 and Level 2 training - all staff at Band 5 and under, via CEC Level 3 training - Band 6 staff and ward manager The ward social worker is an Approved Social Worker and has also completed DAPO training. An Adult Protection monthly audit tool is in place in relation to all aspects of the Adult Protection process, including potential Adult Protection incidents. This is accessed via a shared folder and is reviewed by the DAPO/Interim Social Work Lead. Rolling sessions have been planned to support the Ward Manager and staff team in, for example, the identfication of cases/ completion of APP1 and Protection Plans.
Area for improvement 7 **Ref:** Standard 5.1 Criteria 5.3.2 (a) (c) **Stated:** First time **To be completed by:** 28 February 2023	The South Eastern Health and Social Care Trust must ensure there are robust quality assurance systems in place to review and analyse incidents to determine any patterns or emerging themes and take appropriate action to ensure patient safety. Ref: 5.2.1
	Response by registered person detailing the actions taken: As previously stated, a specifc Governance Task and Finish group has been established, and quality assurance systems will be on this agenda. The ward has now adopted the Governance matrix developed and used by Adult services, which details themes and allows for clarity regarding appropriate action and the review of same. The Ward Manager and Interim Nurse Lead for the ward will attend a 6 weekly Governance Forum to support the ongoing development and establishment of robust quality assurance systems.

	Datixes have been reviewed and will be monitored on a daily basis by the ward manager, who will also be supported in this by the Interim Nurse Lead, and by the current Quality Improvement and Governance Lead for Nursing in Primary Care. A new Datix/Incident reviewer is in place to support the ward manager/staff team. A Page Tiger for Datix Training has been established and stff will be required to sign when they have completed this. Top Tips/Check List for staff re reporting and analysis of incidents has been laminated and is available at the Nursing Station for all staff. Datix training for all staff has been arranged for 1ST/2ND March 2023 The daily Ward Safety Brief Handover includes a Datix review.
Area for improvement 8 **Ref:** Standard 5.1 Criteria 5.3.1 (a) (c) **Stated:** First time **To be completed by:** 28 February 2023	The South Eastern Health and Social Care Trust must ensure that the fire risk assessment is up to date and available for inspection. • Personal Emergency Evacuation Plans must be completed and kept under regular review to ensure the safe evacuation of patients in an emergency. • All fire safety checks must be completed as detailed in Trust policy and records maintained for inspection. • Fire training must be completed in line with Trust policy for fire safety training. Ref: 5.2.2
	Response by registered person detailing the actions taken: Personal Emergency Evacuation Plans are completed as part of the admission pathway. Copies are also stored in the Fire Manual and these are reviewed on at least a monthly basis, as detailed on the Monthly Audit Sheet. Fire Safety Checks have been completed. These are kept in the Fire Manual and are reviewed on a weekly basis. Fire Safety Training - bespoke training has been arranged for 21st March.

Area for improvement 9 **Ref:** Standard 5.1 Criteria 5.3.1 (a) (c) **Stated:** First time **To be completed by:** 28 February 2023	The South Eastern Health and Social Care Trust must ensure that a ligature risk assessment for Downe Dementia ward is completed and disseminated to all staff. The risk assessment should include clear actions to mitigate identified risks. All staff must have a working knowledge of the ligature risks and how these are managed Ref: 5.2.2
	Response by registered person detailing the actions taken: TheTrust is commited to addressing and managing Ligature risks. However, in relation to Downe Dementia ward, and in line with Occupational Therapy advice, we would also state that a balanced approach needs to be taken regarding the outcome of any risk assessment as many environmental barriers can be created, particularly for people with dementia who need 'familiar' environments/equipment. A Ligature risk assessment/audit visit has been planned for the ward ,and this will be disseminated to all staff. The Ward Manager and another staff member completed ligature training on 10.2.23. Further dates to be identifed for all staff..
Area for improvement 10 **Ref:** Standard 5.1 Criteria: 5.3.1 (c) **Stated:** First time **To be completed by:** Immediately upon receipt of report.	The South Eastern Health and Social Care Trust must ensure compliance with regional guidance for the use of plastic bags in Mental Health (MH) inpatient wards and Learning Matters Quality 2020 Issue 8, September 2018. A robust assurance mechanism must be implemented in conjunction with the Trust's IPC team to ensure compliance with the guidance. Ref: 5.2.2
	Response by registered person detailing the actions taken: DATU will make arrangements to comply with the regional mental health guidance. A roll-out of policy will be extended from MHSOP MH Beds to DATU. All uncessary plastic bags have been removed.from the ward. Current use is restricted to bins only whilst awating new Hybrid MH Bins rcently ordered. Staff now formally request that patients and relatives, and MDT members do not bring plastic bags into the ward.

	The IPC Team were contacted on 21.2.23 to review compliance with the guidance. The Governance Quality Improvement Officer from the Safe and Effective Care Team is not currently at work and has been contacted again on 27.2.23 to also inform compliance with the guidance. The Environment Task and Finish Group have established a 30 minute plastic bag check, with a checklist to be completed by ward staff. This is also on the Safety Brief. Posters will be put up on ward to raise initial awareness.
Area for improvement 11 **Ref:** Standard 6.1 Criteria 6.3.2 (a) **Stated:** Third time **To be completed by:** 28 February 2023	The South Eastern Health and Social Care Trust must undertake a review of the dining experience to ensure that patients have their meals in an appropriate environment that supports their dignity. Ref:5.2.2
	Response by registered person detailing the actions taken: Recognising the challenges of the geography of the ward, the Trust secured funding to reconfigure the physical layout of the ward, however, regrettably there is no current capacity in the Estates Department to move on this within this financial year. This will be kept under ongoing review. A multi-disciplinary group has made changes within the ward overall to create a warm environment that supports patient safety and wellbeing. This will be built on with a planned environmental audit and will continue with the work of the Environment Task and Finish Group. A dining room audit has been completed, and the ward plans to move to piloting 2 sittings within the dining room. Staff are aware of how to support patients in a manner that upholds and supports their dignity. In line with Occupational Therapy guidance, appropriate dementia-enabling tables and chairs have been ordered, along with appropriate crockery etc. Items chosen to ensure colour contrast, acoustic management & biophylics are in the process of being purchased. The ward Housekeeper has liaised with Patient Experience and relevant pictoral and laminated menus are displayed each day, as appropriate to choice and asessed patient need.

Area for improvement 12 **Ref:** Standard 5.1 Criteria 5.3.1 (a) **Stated:** First time	The South Eastern Health and Social Care Trust must ensure that care plans and risk assessments, are person centred and contain sufficient detail for staff to deliver safe, effective and compassionate care. Ref: 5.2.4 and 5.2.5
To be completed by: 28 February 2023	**Response by registered person detailing the actions taken:** In line with the compassionate and person-centred care noted by RQIA, Care plans and risk assessments have been reviewed to reflect this, and will be monitored by the Ward Manager and Senior Management. The NIPEC recommendation PACE will be revisited. Pool Activity Level Assessments are summarised and laminated in every room indicating people's routines previous to hospital admission, interests, abilities and current difficulties with examples of activities and levels of intervention provided. The Care and Treatment Task and Finish Group will continue to monitor and support developments in this area. Of note, a posting on Care Opinion on 28.2.23, highlighted the following: 'Just want to say how amazing the staff in Downe Dementia Unit are! The love, care and attention they give my mum while she was a patient (for what turned out to be a long stay) was amazing! Also the support and communication given to myself - I always felt content that she was in the best care with the most kind loving staff'.

Area for improvement 13 **Ref:** Standard 5.1 Criteria 5.3.1 (a) (c) **Stated:** First time **To be completed by:** 28 February 2023	The South Eastern Health and Social Care Trust must ensure that ward staff have an understanding of Deprivation of Liberty Safeguards (DoLS) and where voluntary patients are subject to continual supervision and are not free to leave that DoLS are put in place. Ref:5.2.5
	Response by registered person detailing the actions taken: Recognising the interface complexities of the Mental Health Order/Mental Capacity Act (MCA), MCA Leads in the Trust met to discuss this matter on 4.10.22, with medical staff having consulted DLS prior to this date. A formal consultation meeting with MCA Leads/ward medical staff and DLS took place on 15.12.22. Where there is an assessed lack of capacity, and where there is continual supervision and people are not free to leave, all voluntary patients not subject to the Mental Health Order will have an application made to MCA Panel to determine the validity of DoLs . All staff will be trained in MCA DoLS to the appropriate level.
Area for improvement 14 **Ref:** Standard 5.1 Criteria: 5.3.3 (b)(e)(f)(g) **Stated:** First time **To be completed by:** 28 February 2023	The South Eastern Health and Social Care Trust must ensure that a comprehensive quality assurance system with robust audits to monitor operational effectiveness, patient safety and ward performance is developed and the outcomes of these shared with staff to promote improvement in practice. These should include auditing of incidents, care planning documentation and medication. Ref:5.2.7
	Response by registered person detailing the actions taken: Quality Assurance/Operational effectiveness/Patient Safety and Ward Performance will fall under the ongoing remit of the afore-mentioned Task and Finish Groups, which in turn will be held to account by an Interm Project Lead and by a multi-professional DATU Oversight Board. It should be stated that ward staff, the senior management team and the Trust have welcomed the RQIA inspection as this has promoted focused, person-centred Performance planning across a wide range of areas, beyond the extent of this report.

	Governance reporting has changed, as stated, and ward staff will attend an ongoing Governance forum, cascading any learning to the wider staff team to improve practice. KPI reporting mechanisms have changed and new KPI quarterly reports will be overseen and discussed with ward staff by the Trust Governance Lead. To support current and ongoing audit activity, in conjunction with identified senior management members and the Audit and Quality Assurance Manager from the Trust Safe and Effective Care Team, an audit plan has been devised. This will be kept under ongoing review by the Governance Task and Finish Group, who are next due to meet on 28.2.23. This Audit plan, due to commence on 1st April 2023, as the start of the new audit year, covers the following areas: News 2 Fall safe SSKIN Bundle MUST Omitted medication Nursing Documentation 30 minute checks Carer involvement Person centered care Meal time Matters Mattresses Pharmacy: Medication Controlled Drugs Hygiene/Cleanliness Infection Control: Hand hygiene Catheter Periperal cannula Patient Experience: Cleaning Resus Team Audit: Cardiac trolley The Audit Plan will work in partnership with a wall planner in the ward, identifying ward staff responsibility for completing each audit area, with a second person identified in the event of staff being on leave.

	This centralised system will provide averages and a running compliance rate, meaning that the ward manager and staff team will be able to review identified actions/learning.
Area for improvement 15 **Ref:** Standard 5.1 Criteria: 5.3.3 (c) **Stated:** First time	The South Eastern Health and Social Care Trust must ensure that staff have access to support processes which focus on a culture of learning and include regular staff meetings, staff debriefs following incidents, and regular supervision. Ref 5.2.7
To be completed by: 28 February 2023	**Response by registered person detailing the actions taken:** The senior management team and the Trust are committed to developing and maintaining a culture of learning and support for staff. Creative options being considered include the use of staff/patient/MDT Artscare-faciliated workshops and training to encourage a holistic response to patient care that is embedded in principles of co-production. Debrief training, as stated, has been arranged, and debriefs will take place after incidents, as appropriate. Staff meetings will take place on at least a quarterly basis, and the ward manager will in turn attend senior management staff meetings, as well as availing of his own individual supervision. Supervision has been arranged/planned for all staff. Team Assessment Meetingswill continue, The Trust Health and Wellbeing Project Lead will visit the ward and will meet with staff to afford them ongoing support and to ascertain their views as to what is important to them/what will support them in their roles and in their careers. The MHSOP Interim Assistant Director and all MHSOP senior managers are also actively involved in meeting/supporting staff. Psychological Services staff are offering support to the staff team. A number of Champions have been identifed on the ward, eg. - Tissue Viability/Falls/Encompass Superusers

	Stirling Best Practice in Dementia Care Certificate - the Dementia Service Improvement Lead will attend this on 6th March, and the ward manager will complete this in June 2023. This will equip them as facilitators to extend this training across the staff team.

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

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