The Regulation and Quality Improvement Authority

Inspection Report

26 April 2022

Northern Health & Social Care Trust

Dementia Intensive Care Unit
Inver 4
Holywell Hospital
60 Steeple Road
Antrim
BT41 2RJ

Telephone number: 02894413359

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

1.0 Service information

Organisation: Northern Health and Social Care Trust (NHSCT)	**Responsible Person:** Ms Jennifer Welsh, Chief Executive, NHSCT
Person in charge at the time of inspection: Ms Karen Gibson	**Number of registered places:** 20
Categories of care: Mental Health (MH) Dementia Intensive Care	**Number of beds occupied in the ward on day one of this inspection:** 16
Brief description of the accommodation/how the service operates: Inver 4 provides care and treatment to men and women who have a diagnosis of dementia and require an admission for assessment and treatment in a Dementia Intensive Care Unit (DICU). The ward is situated in Holywell Hospital. It has a mix of single occupancy rooms and dormitory style sleeping areas. Male and female sleeping areas are separate. Inver 4 is temporary relocated to another vacant ward (Inver 3) in the hospital to facilitate essential repairs and refurbishment works to the original ward. Occupancy levels have reduced from 20 beds to 16 beds due to this relocation.	

2.0 Inspection summary

An unannounced inspection took place on Tuesday 26 April 2022 at 09:00 and concluded on 12 May 2022 with feedback to the Trust's senior management team (SMT). The inspection team comprised of care and pharmacy inspectors.

The inspection focused on eleven key themes: environment, adult safeguarding (ASG), incident management, record keeping, care and treatment plans, restrictive practices, resettlement/discharge planning, physical health and management of medications.

On the days of the inspection there were 16 patients on the ward and all patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986.

Areas of good practice were identified. We observed staff deliver compassionate care to patients. Discharge meetings were facilitated by a multi-disciplinary team and were observed to be patient and family centred. Patient mealtimes were well coordinated with a peaceful ambience and we observed that patients were fully supported by staff to eat and drink.

Two previous AFI's from our inspection on 05 March 2018 in relation to ligature risks and patient observations were assessed as met.

Seven new areas for improvement were identified in relation to; ward cleanliness and infection prevention and control (IPC) , the ward's ligature risk assessment, adult safeguarding (ASG), the recording of speech and language (SLT) assessments, levels of pharmacy cover, a ligature risk identified on the newly refurbished ward's windows and governance and leadership.

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

4.0 What people told us about the service

Posters and easy read leaflets were placed throughout the ward inviting staff and patients to speak to inspectors and feedback with their views and experiences. Due to patients complex presentations we only received feedback from one patient during the inspection. The feedback was complimentary of staff and the care received.

Opportunities to speak with relatives during our onsite inspection were limited as a result of the Covid-19 visiting restrictions; consequently, we offered all families the opportunity to engage with us via a telephone call. Seven families availed of this opportunity. All seven relatives said they with were happy with the standard of care delivered and told us that staff were compassionate, committed and caring.

Staff interviews with both Trust and agency staff were conducted. Staff spoke positively and reported there to be adequate staffing levels, 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 Inver 4 was undertaken 5 March 2018. Two areas for improvement were identified.

Areas for improvement from the last inspection on 05 March 2018		
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)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 5.3.1(a) **Stated:** Second time	The Trust should ensure that the ward's ligature risk assessment and associated action plan accurately reflects the role of the ward staff in monitoring the large number of ligature points present within the ward's environment.	**Met**
	Action taken as confirmed during the inspection: Following RQIA's 2019 inspection of Holywell mental health wards the Trust undertook a programme of works across the Holywell Hospital site to reduce the number of ligature risks in all the wards including Inver 4. These works have addressed the large number of ligature points previously identified in Inver 4. This AFI has been assessed as met. We did however identify that the handles on the windows on the newly refurbished Inver 4 ward have not been replaced and remain a ligature risk. This has been identified as new area for improvement. Refer to AFI 3 in the quality improvement plan (QIP).	
Area for Improvement 2 **Ref:** Standard 5.3.1(c) **Stated:** Second time	The Trust should ensure that observation levels used with patients are clearly stated and supported by a policy and procedure.	**Met**
	Action taken as confirmed during the inspection: A policy and procedure was in place to support the safe management of observation levels. Observation levels for patients were clearly documented on patients' clinical records and ward safety briefs. An enhanced observation prescription form was completed and signed by the MDT for those that required enhanced observations and this was	

	accompanied by an individualised care plan. Observation levels were reviewed at the patient's weekly MDT formulation meeting and the rationale for implementation, continuation or discontinuation documented. This AFI has been assessed as met.	

5.2 Inspection findings

5.2.1 Environment

We visited Inver 4 ward to review and assess if the environment was safe and conducive to the delivery of safe, therapeutic and compassionate care and met the assessed needs of the patients.

Inver 4 had been temporarily relocated to Inver 3 ward which was a smaller environment and as result the capacity of the ward had reduced from 20 to16 beds, this relocation was to facilitate essential repairs and refurbishment works to the original ward.

We observed the ward to be small, cramped and cluttered. There was a lack of dayrooms, quiet rooms for patients and space for them to move about freely. The main patient area was the dining room which was also used for activities, we observed several sofa's located in ward corridors with patients sitting on them. The ward was dirty and dusty in some areas and the floors unclean. The staff bathroom was unclean and untidy and sanitary ward was damaged.

Patient toilets were unclean with damaged flooring. Wash hand basins could not be easily accessed by patients. These concerns were escalated at the time to the ward management team who agreed to address immediately.

A sample of patient mattresses were examined and observed to be clean and in new condition and mattress audits were up to date. We were unable to access up-to-date cleaning, infection prevention and control (IPC) and hand hygiene audits for the ward. Staff confirmed that domestic services had not undertaken any cleaning audits since the relocation of the ward. We could not evidence that any senior management walk arounds of the ward had occurred. We raised the issues in relation to ward cleanliness and IPC during inspection with the ward management team and this has been also identified as an area for improvement.

The ward clinical room was a small area and presented as cluttered however it was clean. The patient meal time experience was observed to be well coordinated and there was a peaceful ambience. We observed patients being fully supported by staff to eat their meal and the food also looked appetising and plentiful. The dining room was observed to be overcrowded during mealtimes with a high ratio of staff present this was further impacted when domestic staff also entered the room. We recognise that nursing supervision is essential to ensure patient safety while eating and drinking however we would suggest that mealtimes are staggered to prevent overcrowding of the area and recommend that domestic staff do not enter the dining room during mealtimes unless it is essential for them to be there. This has been identified as an area for improvement.

The Fire Risk Assessment for the ward was available and was due to be reviewed March 2022, personal emergency evacuation plans (PEEPS) were in place for all patients. Fire Alarm checks were observed to be up to date and the relevant staff had attended fire warden training. All of the nursing staff on the ward had also recently attended their mandatory fire training.

There was no ligature risk assessment available for the ward. On request we were provided with a ligature risk audit for the current ward (Inver 3) which listed the ligature risks however there was no accompanying action plan to inform how the risks were being managed. The ligature risk assessment was also provided for the original Inver 4 however it was dated 2017 will require review and updating prior to return to the newly refurbished ward. The ligature risk assessment has been identified as an area for improvement and was also escalated to the SMT during the inspection.

Inspectors undertook a walk-around of the newly refurbished Inver 4 ward, this was pending some further works and a deep clean before it could be re-opened to patients. The newly refurbished ward presented as large and spacious and had been fitted out with new floors and repainted. It was positive that an updated SALTO door access system had been installed throughout the ward and that a secure airlock entrance area to the ward constructed, this will improve patient safety and ward security. There was access to three garden areas which were pleasant and spacious. While it was positive that previous ligature risks in the ward had been addressed we did identify that window handles were not ligature proof. We remain concerned about this risk as we had already identified that some patients on the ward had a history of self-harming behaviours accompanied by suicidal thoughts. The window handles were escalated as a ligature risk during inspection to the Trust SMT and have also been identified as an area for improvement. Completion of building works and return to the original ward was scheduled for the end of April 2022.

5.2.2 Adult Safeguarding

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

On review of DATIX (DATIX is the Trust's electronic system for recording incidents) we found that staff submitted a DATIX when there were incidents of aggression between patients however we could not evidence that staff had considered these as meeting the threshold for an ASG referral. There was no evidence of protection plans in place within the ward or on care documentation.

We found that staff at ward level lacked understanding and knowledge on what constituted an ASG incident. It was difficult to determine a threshold for making a referral to ASG team, as the ward had only completed one referral in a four month period.

We met with ward staff who described the challenges patients experienced due to their complex needs and the additional impact that a smaller ward environment had resulting in an increase of patient on patient incidents. Staff told us that all measures were taken to maintain patient safety however we found a number of patient on patient incidents that would have met the threshold for an adult safeguarding referral but had not been referred.

Due to the lack of ASG processes we could not be assured that information in relation to ASG such as protection plans was communicated effectively to patients' family members or other involved professionals.

We met with the ASG team and lead for the hospital who acknowledged they were on a journey of improvement regarding raising awareness at ward level. We observed a grab box with an ASG flow chart and processes to support staff with ASG decision making however we found limited evidence that the guidance provided was implemented by ward staff.

RQIA's inspection of Holywell mental health wards in September 2021 identified that the Trust had a robust action plan in place to address deficits in relation to ASG and it was positive to note that in terms of ASG the processes had improved in these wards. This work took into account lines of professional and operational accountability and there was also a new process in place to construct alternative care plans and ASG responses where referrals were screened out providing an additional layer of protection for patients. This improvement work however had not transferred to Inver 4 ward and RQIA would recommend that the Trust adopt the same approach to improving ASG in Inver 4 ward.

We could not evidence any governance arrangements to enable trends and themes to be identified and learning shared to drive improvement on the ward. There were no processes implemented at ward or senior management level to ensure oversight and escalation of ASG.

We escalated our concerns to the ASG team and the SMT and sought assurances that they would prioritise Inver 4 in relation to education of staff to enhance the adult safeguarding arrangements. The Trust told us they will undertake a lookback exercise to ascertain if additional opportunities have been missed in relation to making appropriate referrals.

We could not evidence effective mechanisms to assure compliance with the regional Adult Safeguarding policy in Inver 4 ward. An AFI has been identified in relation to ASG. RQIA have also requested that the Trust share the results of their ASG look back exercise so that progress can be assessed.

5.2.3 Staffing

The arrangements for staffing in Inver 4 ward were reviewed.

The ward manager advised that the Telford model was used by the SMT to calculate appropriate staffing levels. Due to ongoing regional nursing shortages the ward was reliant on agency and bank staff to achieve safe staffing levels. It was however positive that agency and bank staff had been block booked to maintain continuity of care for patients and to encourage good team work. It was positive that some of the agency staff we spoke with indicated that they would consider applying for a substantive post on the ward.

Safe staffing levels were evident and a system was in place to escalate when staffing shortages arise. We observed there to be an induction process in place for new and agency staff, both substantive and agency staff reported they had received a good induction to the ward. The agency employing the staff member was responsible for overseeing the agency staff member's training.

We found staff training to be satisfactory. Staff confirmed that access to training was good and protected time provided to complete training.

Multi-Disciplinary Team (MDT) working was good with a variety of professionals observed to be present on the ward, daily this included the consultant psychiatrist, occupational therapy (OT) staff, social work staff and the ward's OT technical instructor. There was good MDT attendance and contribution to patient care and treatment at weekly patient meetings with the exception of pharmacy which will be discussed under the medicines management theme.

RQIA was assured that the staffing arrangements in place ensured the delivery of safe and effective care to patients and there are no areas for improvement.

5.2.4 Incident Management

The management of incidents was reviewed in relation to Inver 4.

Incidents were recorded on the DATIX system with appropriate grading and follow up of incidents. We were however unable to evidence any consideration of onward referral to ASG for incidents which would have indicated a referral. We identified a number of incidents that met the threshold for an ASG referral however these were not made. Please refer to section 5.2.2.

We found evidence of good practice with staff contacting patients' next of kin (NOK) to inform them of any incidents that had occurred involving their family member and this included the administration of additional medication.

Staff confirmed that post incident debriefs were held regularly however these were not formally recorded. We would recommend that the Trust devise a debrief template to ensure that these discussions are captured and information retained to facilitate improvement and learning from incidents.

Oversight and analysis of incidents with monthly data sets was available to demonstrate analysis of incidents hospital-wide. A dataset was provided specifically for Inver 4 which again demonstrated further analysis of incidents. There was no evidence of any weekly analysis of incidents at ward level. Refer to section 5.2.10

RQIA was assured that incidents were managed safely and effectively and there are no areas for improvement.

5.2.5 Record Keeping, care and treatment plans and risk management

We reviewed the quality of record keeping in relation to patients' care and treatment plans.

During the inspection there were two systems in place for patient record keeping; paper and electronic (PARIS). The ward is in the process of transferring all patient care records to PARIS.

SLT assessments and dysphagia guidance were available in the following areas, care, records, the dining room and staff handover. We found that these were not all updated when any changes were made to patients' SLT assessment. This was escalated to the ward manager who addressed on the day. An area for improvement has been identified in relation to this and RQIA have recommended that the Trust undertake a quality improvement (QI) project to support effective management and communication of SLT assessments.

Patients documentation was well organised and care plans were personalised and addressed the assessed needs of the patient and with evidence of review. Improvements however are required with respect to recording dates of reviews.

Patient documentation was reviewed in relation to incident management and we found that all patients had an up-to-date comprehensive risk assessment and risk screening tool in place. MDT formulation meetings were also well documented in each patient's clinical records. It was positive to note that there was some evidence of discussion and consideration of ASG at the MDT formulation meetings however this was not followed up with an ASG referral.

We found the use of patient names to be inconsistent in quite a few clinical records. Patients' birth names were used in places however their preferred names used in others, this could cause confusion for new staff. The ward manager provided assurances this would be addressed and an audit of patient records was recommended.

Good practice was observed in relation to detailed discharge assessments and summaries for each patient. OT summaries were also available for patients being discharged and there were at a glance snap shots of patient needs.

An area for improvement has been made in relation to the effective recording, management and communication of patients' SLT assessments.

5.2.6 Restrictive Practices

Restriction practices were in place in Inver 4. The unit's model of care was defined as a dementia intensive care unit (DICU). Restrictions included; locked doors, enhanced patient observations, use of rapid tranquilisation and physical intervention. All restrictions had been assessed and found to be proportionate to the risk, used as last resort and regularly reviewed at the weekly MDT formulation meeting.

Patient centred care plans were in place for all restrictive practices. These were detailed, and clearly identified the indicators for the use of a restrictive practice.

MHO forms were present for viewing and were clearly documented in records. All Care plans were strengths based with deprivation of liberty (DOLs) and human rights considered and referred to as a theme throughout.

On review of clinical notes we observed there to be a checklists in place to support the appropriate use of specialist mobility chair for 2 patients who required it. The checklist provided staff with directions regarding the use of the chair with instructions that lap straps should be used for transportation purposes only. We observed staff adhering to the checklist and when spoken with staff demonstrated awareness of the use of lap strap for transportation.

There was low use of rapid tranquilisation on the ward with two incidents of use from Jan 2022 to date of inspection. The use of PRN medication was also well documented and audited weekly with 1st, 2nd line PRN's clearly indicated.

Substantive staff training was up to date in relation to MAPA (managing actual and potential aggression) training. Not all agency staff had completed MAPA training. The ward management team however provided us with assurances that there was always enough MAPA trained staff on shift.

Agency staff that had not completed their MAPA training were allocated to lower risk patients. The SMT informed us that new arrangements were in place for agency staff to access MAPA training via the Trust if required.

RQIA were assured that restrictive practices were safely and effectively managed with consideration for patients human rights demonstrated and there are no areas for improvement.

5.2.7 Resettlement/Discharge Planning

Length of patient stay ranged from 21 days to 4 years 8 days. The main obstacle to discharging patients was the lack of suitable community placements that would meet the complex needs of the patients.

During the inspection we attended an MDT discharge meeting for one patient. MDT attendance at this meeting was good and included the patient's family, community key worker and advocate. The meeting was observed to be well led, patient and family centred with consideration given to patient and family preferences such as the location of the discharge facility and the patient's care and social needs. The meeting was delivered compassionately while providing the necessary information for the family member attending and was a good example of collaborative working.

RQIA were assured that discharge planning processes were effective while remaining patient and family centred and there are no areas for improvement.

5.2.8 Physical Health

The management of patients' physical health care needs was reviewed. RQIA found that patient's physical health care needs were being well addressed. Physical health care was monitored, reviewed and referred through to Primary health care appropriately. Physical health checks were completed twice a year by medical staff with evidence of medication monitoring recorded in patients' clinical records.

Access to medical staff was good as there was a hospital Dr on call 24 hours a day/7 days a week via the on call rota system and we observed that patients requiring emergency care were attended to by the Dr on site and or emergency services.

On review of clinical records we identified areas of good practice. We found that each patient had a record of their physical health observations recorded on admission, patients with weight loss were managed well and patients were medically assessed post fall.

Each patient also had an individual life story book in place which was very positive as this can help people with dementia share their stories, encourage better communication and understanding of the person's needs and wishes.

RQIA were assured that patient's physical health care needs are being met, and there are no areas for improvement.

5.2.9 Medicines Management

Pharmacy support was provided to the ward by one pharmacist on duty across the Holywell site.

The pharmacist attends the ward to undertake medicines reconciliation as soon as possible for new admissions and for planned discharges. When time allows they attend MDT meetings (usually fortnightly) and review patients prescribed medications. The pharmacist is available by telephone and email at other times if necessary.

The management of medication related incidents was discussed with the lead pharmacist and nursing staff. Nurses advised that incidents were reported immediately and investigated to ensure that any learning was shared and changes to practice implemented. Medication incident review was undertaken at quarterly medicines safety committee meetings and the lead pharmacist attends. The level of support provided by pharmacy technicians involved a weekly top up of stock and removal of expired medicines etc.

Arrangements were in place for the safe management of medicines during patient admission and discharge. Details of pre-admission medicines prescribed were routinely obtained as part of the admission process by the admitting doctor and checked by the pharmacist when next on the ward ideally the pharmacist's check would take place within 24 hours of the admission but this was not always possible due to the pharmacist's other commitments. Arrangements were in place to manage medications on discharge this was to ensure a continuous supply of medication and to provide any necessary advice to the patient and their family. An area for improvement has been identified in relation to the ward's pharmacy cover.

There was evidence that medication kardexes (a kardex is the patient's medication and prescription record) and medicine administration records were maintained in a satisfactory manner and most included a photograph of the patient. We recommend this is included for all patients. Positively covid-19 vaccination status and speech and language dietary recommendations were also recorded on kardexes.

There were clear instructions on patient medication kardexes to direct the administration of PRN which included the indication for the medicine, the minimum frequency intervals and the maximum daily dose. The reason for and outcome of administration of these medicines was routinely recorded in the patient case notes on PARIS. There was evidence that their use was reviewed at least weekly.

Although no examples of rapid tranquilisation were observed, any intramuscular (IM) use of PRN medication was well documented in case notes and could be cross referenced with DATIX. The Regional Rapid Tranquillisation Policy was in place and nurses were aware of its' content.

All medicines including controlled drugs were well managed. Medicines were safely and securely stored and satisfactory records maintained and there was evidence of quarterly audit.

An area for improvement has been identified in relation to ward's pharmacy cover. We recommend pharmacy cover is increased to facilitate timely medicines reconciliation at admission and attendance at daily safety huddles and MDT reviews.

5.2.10 Governance & leadership

We assessed the governance arrangements for Inver 4 ward through a range of meetings with the Senior Management Team (SMT) and we also examined documentation relating to governance within the Trust, this included datasets, minutes from MH resettlement project board meetings, complaints and compliments and the daily hospital report.

We reviewed monthly data sets from the Safety & Quality Assurance Group Booklet this contained a hospital-wide data with analysis of incidents and restrictive practices the reports were informative with evidence of trending and theming to support learning from incidents. There was also a dataset provided specifically for Inver 4 which again demonstrated further analysis of incidents whilst this was positive the dataset provided was not recent (dated April 2020 to Dec 2021) and would require updating, there was no evidence of any weekly datasets for the ward.

We were not assured about the governance of ASG in relation to Inver 4 ward. We could not evidence that there was an effective assurance framework in place due to the lack of processes implemented at ward or senior management level to ensure the oversight or escalation of ASG.

Ward staff spoke positively about the ward management team and felt that they were well supported. Staffs' views in relation to the levels of support from SMT differed as some felt the support was good while others felt that SMT could be more responsive. Staff at ward level felt that the wards' assistant service manager was visible on the ward and visited regularly however other members of the SMT less so.

A daily hospital report occurred daily on both morning and night shifts and there was evidence of a detailed staff safety brief. Staff informed us that they received post incident debriefs however there was no documentation to evidence debriefs had occurred.

Although we were informed of leadership walk arounds we could not evidence documentation supporting this. We recommend the ward maintain a record to include any outcome reports following a SMT visit to the ward. An area for improvement has been identified to strengthen Governance and leadership arrangements with regard to Adult Safeguarding.

5.2.11 Staff engagement

We spoke to a wide range of staff during the inspection including members of the MDT.

Staff reported good morale and MDT teamwork stating that all staff worked well together to deliver a high standard of patient care. Nursing staff complimented the ward's medical team and informed us that they provided good leadership and support. There was evidence that other disciplines such as OT and SLT were consulted for advice where needed and their expertise valued and deferred to in all MDT discussions.

The current ward environment was highlighted as the main challenge for staff who reported it to be cramped however all understood this was a temporary arrangement and felt that the move back to the newly refurbished Inver 4 would be positive for staff and patients.

All staff worked long days and indicated that there had been a process of consultation with staff to agree this, staff felt this was a good arrangement to promote continuity of care for patients and supported work-life balance. Staffing levels on the ward were reported as good. Block booked agency staff discussed how they were made to feel like a permanent member of the team and informed us that they were included in all ward and team meetings, some indicated they would consider applying for a substantive role on the ward. Staff reported that post incident debriefs occurred however acknowledged that these were not usually documented.

All of the staff we spoke with stated that they would be happy for a member of their family to be cared for in Inver 4. The reasons stated for were the compassionate staff and the high standard of care delivered.

5.2.12 Family Engagement

We engaged with a number of family members during our inspection some we spoke to on the ward and some were contacted by telephone, we also received three completed questionnaires.

Feedback from families was positive. Families felt that communication from nursing staff was very good with regular updates received in relation to patients' MDT meetings, incidents and administration of PRN medication. Some families expressed frustration about the current restricted visiting arrangements (due to Covid-19) but were understanding of the reasons for this.

Some family members felt that the current visiting area was not ideal as it was a small kitchen area which lacked space for the patient to move around.

All the family members reported staff to be caring and compassionate and dedicated to providing safe and effective care. One family member commented that the MDT support on the ward was excellent and was complimentary about the support they had received from the ward's social work team.

Some expressed that they were pleased with the progress their family member had made since coming into hospital and attributed this to the expertise of the MDT. Some family members indicated that they would prefer it if their family member could remain in the ward long-term, this was due to the high standard of care and the peace of mind that this provided, however they recognised that this was not possible.

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).

	Regulations	Standards
Total number of Areas for Improvement	N/A	8

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 5.3 **Criteria:** 5.3.1 **Stated:** First time **To be completed by:** 31 October 2022	The Northern Health & Social Care Trust must ensure that IPC and ward cleanliness is maintained to an acceptable standard. Regular environmental cleaning and IPC audits should be completed with SMT oversight.
	Response by registered person detailing the actions taken: DICU has recently moved back into Inver 4 during May 22 following its refurbishment. The Trust recognise that the temporary ward environment at the time of the inspection was of a dated standard. However decant was essential and following exploration of options the move to Inver 3 was seen as least disruptive and unsettling for patients as avoided a move to an alternate location. IPC complete an infection Prevention and Control ward visit monthly and a report is completed following this. (last completed Aug 22). An environmental cleanliness audit (Micad) is conducted twice yearly by domestic services (last completed May 22) and a regional environmental cleanliness audit is also completed annually by estates services, IPC, Domestic services & lead nurse. The next regional environmental cleanliness audit is due to be completed during Oct 22. A patient environment leadership walk around is also conducted annually. A weekly audit is also completed by the Domestic supervisor. All issues are reported at ward level by domestic services and escalated to SMT as required.

Area for improvement 2 **Ref:** Standard 5.3 **Criteria:** 5.3.1 **Stated:** First Time **To be completed by:** 31 October 2022	The Northern Health and Social Care Trust must ensure the ligature risk assessment for Inver 4 is up-to-date and includes an action plan. **Response by registered person detailing the actions taken**: The Trust is assured that the Inver 4 ligature risk assessment is up to date having been completed on 12 May 2022. An action plan is in place and in the interim risks identified are effectively managed. A process to identify the status of and progression of minor capital works requested through to completion has been established with estates. Monthly meetings with Estates/AD/HOS are in place to review action plan and timescales.
Area for improvement 3 **Ref:** 5.3 **Criteria:** 5.3.1 **Stated:** First Time **To be completed by:** 31 October 2022 (	The Northern Health and Social Care Trust must ensure that the handles on the windows of the newly refurbished Inver 4 are replaced with ligature free handles. **Response by registered person detailing the actions taken**: A Minor Capital Works has been submitted to replace the handles on the windows with ligature free handles and is currently with the Estates Dept for processing. In the interim staff are aware of all anti ligature risks within the ward environment and the risks are effectively managed..
Area for improvement 4 **Ref:** Standard 5.3 **Criteria:** 5.3.1 **Stated:** First Time **To be completed by:** 31 October 2022	The Northern Health and Social Care Trust must: 1. Implement effective arrangements for adult safeguarding in Inver 4 ward as per Adult Safeguarding Operational Procedures 2016 and 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) that 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) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding are improved.

	2. Implement an effective process for oversight and escalation of matters relating to adult safeguarding in Inver 4; this should include ward managers, hospital managers, NHSCT senior managers and /or the Executive team as appropriate. 3. Implement effective mechanisms to evidence and assure compliance with good practice in respect of adult safeguarding in the hospital.
	Response by registered person detailing the actions taken: All staff are to attend annual Mandatory training in relation to Adult Safeguarding and Safeguarding Children. There is a monthly table collated and forwarded to Nursing Service Managers for information and to address any outstanding training deficits and raise with respective Ward Managers. Bespoke training from Adult Safeguarding team has also been delivered to wards including Inver 4. Following the inspection the ASG team attended the ward to discuss the thresholds for persons at risk of harm and persons in need of protection. All incidents meeting either threshold are now recorded as ASG concerns, APP1 completed and recorded on Datix. Screening can be done by the Ward Manager and/or the DAPO. The DAPO is available for consultation about any areas of concern. ASG staff have attended the B7 seniors meeting and the B6 development day across the hospital to further embed the safeguarding message. Sessions additional to the mandatory training to embed theory into practice has also been offered to AHP staff. Safeguarding incidents and actions are reviewed and discussed every morning at the daily unit-wide safety huddle with senior managers being able to advise and direct staff to the appropriate support or policy to support next steps in management of same. A member of the Safeguarding team also attends the daily safety huddle for advice/guidance and assurance that all incidents are being managed appropriately. DAPO advises ward staff re decision making and updates on a weekly basis where in ASG process referral is. Mustard boxes are now in place across all wards containing flowcharts, policies & Procedures and individual protection plans. The ward SW /ward manager reviews and updates current open SG cases on a weekly basis. The safeguarding team conduct periodic audits of safeguarding mustard boxes. There have been 2 audits since the inspection and neither found any issues of concern on Inver 4.

	The Trust has now employed a stand alone DAPO for the hospital and her role is to focus on ASG issues across the site. She responds in person to any allegations made and is there to ensure that the alternative safeguarding responses/protection plans are appropriate and are being implemented. She will raise any concerns with the Head of Service for ASG The ASG workforce review group meets on a monthly basis and learning from RQIA reports is shared with a view to improving ASG practices across the site. In conjunction with this, the AD for ASG reviews all Datix reports where ASG is recorded on a weekly basis and can provide feedback on any concerns to the hospital management team. The Head of Safeguarding reviews all datixes relating to the ward on a monthly basis to ensure that no incidents are overlooked. ASG referrals from Inver 4 in previous 4 months are as follows: April - 1 referral , May - 14 referrals, June - 6 referrals and July - 9 referrals. This indicates that staff are aware of the reporting requirements.

Area for improvement 5 **Ref:** 5.3 **Criteria:** 5.3.1 **Stated:** First time **To be completed by:** 31 October 2021	The Northern Health & Social Care Trust should implement a robust process that ensures patients SLT requirements are consistently and accurately recorded on all documents and areas applicable.
	Response by registered person detailing the actions taken: Dysphagia Induction checklist is part of all new staff's induction. All nursing staff will be trained in the Food & Drink Safety Pause. Patient's individual eating, drinking and swallowing recommendations are shared with the whole team at important times e.g. during the safety pause before any food, drinks and snacks are served, during handovers, when patients move between wards/hospital settings, at discharge or when family and friends visit. SLT care plans are reviewed weekly or more often if required by Speech & Language Therapist, any changes are discussed with nurse in charge and records updated accordingly. Individual patients SLT requirements are recorded simultaneously in Integrated Care Pathway, Paris and displayed in dining area of Inver 4. The ward is moving to full implementation of Paris and phasing out of paper records. The Dysphagia Management and Choking Risk Reduction Policy for Adult Patients/Service Users who have Eating, Drinking and Swallowing Difficulties (Dysphagia) is available to all staff to ensure staff understand their role/responsibility in delivering safe dysphagia care. There is representation from MHIP at the Trust Dysphagia Group ensuring that there are opportunities to share learning across divisions regarding the management of patients/service users who have dysphagia and that risks and opportunities which have been identified are managed by the relevant service manager and professional lead. In addition there is a Divisonal Dysphagia Group chaired by the Divisonal Nurse for MHLD&CW.

Area for improvement 6 **Ref:** Standard 5.1 Criteria: 5.3.1 **Stated:** First Time **To be completed by:** 30 April 2023	The Northern Health and Social Care Trust must review the provision of pharmacy cover in Inver 4 to facilitate timely medicines reconciliation at admission and appropriate attendance at daily safety huddles and MDT reviews.
	Response by registered person detailing the actions taken: The NHSCT pharmacist is currently undertaking a workforce review across the inpatient units including Inver 4. Due to limited resources routine attendance at the daily safety huddle and MDT reviews is not possible but pharmacy endeavour to attend MDT reviews on request. It is recognised that pharmacy is under resourced and is a vital part of the MDT. This has been highlighted as a need through the regional MH workforce review.
Area for improvement 7 **Ref:** Standard 4.1 and 5.1 Criteria: 4.3, 5.3.1 **Stated:** First Time **To be completed by:** 31 October 2022	The Northern Health and Social Care Trust must review and strengthen the governing arrangements in Inver 4 ward with regard to Adult Safeguarding as follows; 1. Undertake a look back audit exercise over a six month period to ensure all relevant incidents have been referred to the ASG team in line with regional protocol. 2. Implement a mechanism for the governance oversight and review of adult safeguarding, to establish themes, trends and patterns. This information should be used to drive improvement and shared with all relevant staff including all ward staff.
	Response by registered person detailing the actions taken: Following verbal feedback from RQIA Inspectors the following actions were implemented immediately. Datix records were reviewed from Jan – April 2022. A total of 30 Datix incidents were recorded. Only one incident was recorded on an APP-1 ASG referral form. A review of PARIS notes was completed where the response to each incident was recorded. The notes evidence that alternative safeguarding responses were applied, however as these were not identified as safeguarding matters they were not recorded on appropriate APP documentation. The remaining 29 cases were subsequently referred to the Adult Safeguarding team in NHSCT The records were not clear in relation to family being contacted in all cases. Subsequently the staff also contacted families in all but one case to advise of the safeguarding concerns. Families were content with the information provided and actions by the ward.The cases screened did not meet the threshold for protection. The Adult Safeguarding Service responded on the 28th of April by hosting two zoom information awareness safeguarding sessions for Inver 4 staff. Another three sessions were held over the following two weeks to capture all staff including night duty. The operational safeguarding guidance and flow-charts were up-

	dated and presented at the information sessions. All Datix and safeguarding referrals are audited each month allowing for an analysis of trends and patterns. Information in relation to APP referrals, protection plans are reviewed on a weekly basis by the DAPO now appointed to Holywell. From July this information is shared with the senior management team in Holywell and The Assistant Director for Adult Safeguarding reports at the monthly Safety & Quality Divisional meeting chaired by Dr Petra Corr. The ASG team are in the process of establishing e- records on each ward so that all safeguarding referrals will be retained electronically. This will ensure there are clear records and details of all safeguarding concerns and provide a better level of governance and assurance to the SMT.
Area for improvement 8 **Ref:** Standard 5.3 Criteria: 5.3.1 **Stated:** First Time **To be completed by:** 31 October 2022	The Northern Health & Social Care Trust must ensure that patient mealtimes in Inver 4 are effectively and safely managed to prevent overcrowding of the dining room area while patients are eating and drinking. **Response by registered person detailing the actions taken:** The new ward environment has enabled two separate spaces for dining areas preventing overcrowding while patients are eating and drinking.

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