The Regulation and Quality Improvement Authority

Inspection Report

13 – 28 September 2021

Northern Health and Social Care Trust

Holywell Hospital
60 Steeple Road
Antrim
BT41 2RJ
028 9446 5211

Ross Thomson Unit
Causeway Hospital
4 New Bridge Road
Coleraine
BT52 1HS
028 7034 6114

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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: Northern Health and Social Care Trust (NHSCT)	**Responsible Person:** Ms. Jennifer Welsh, Chief Executive, NHSCT
Person in charge at the time of inspection: Diane Spence, Assistant Director, Mental Health	**Number of commissioned beds:** Lissan 1: Nine Inver 1: Five Tobernaveen Centre: 20 Ross Thompson Unit: 20
Categories of care: Mental Health (MH) Acute Admission Psychiatric Intensive Care	**Number of beds occupied in the wards on day one of this inspection:** Lissan 1: Eight Inver 1: Three and one patient on leave Tobernaveen Centre: 19 Ross Thompson Unit: 18 and three patients on leave
Brief description of the accommodation/how the service operates: Ross Thomson Unit (RTU) is located within the grounds of Causeway Hospital, Coleraine and Tobernaveen Centre (TNC), Lissan 1 and Inver 1 are part of Holywell Hospital based in Antrim. Both hospitals form part of the inpatient mental health services of the NHSCT (the Trust). RTU and TNC are mixed gender, acute mental health admission wards. These wards provide assessment and treatment for patients with acute mental health needs aged between 18 and 65 years old. TNC has capacity to accommodate 10 patients over 65 years old out of its total of 20 beds. RTU and TNC wards consist of multi patient dormitories and single occupancy rooms with ensuite facilities. Lissan 1 and Inver 1 wards are single gender wards that provide psychiatric intensive care for patients who require this level of support. Lissan 1 and Inver 1 consist of multi patient dormitories only. Patients admitted for psychiatric intensive care are detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO) and patients admitted to the acute mental health wards can be voluntary or detained.	

2.0 Inspection summary

An unannounced inspection to the mental health acute admission wards across the Trust commenced on Monday 13 September 2021 at 09:00 and concluded on 28 September 2021 with feedback to the senior management team (SMT).

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

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

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

This inspection identified that the PICU wards were never over occupied and the acute mental health inpatient wards were frequently over occupied. We determined that over occupancy presented some challenges but had a minimal impact on the ability of staff to deliver safe and effective care to patients.

Strong governance and assurance, effective leadership, and clear communication mechanisms were important factors in supporting the delivery of safe care at times when the service was over occupied. Staffing levels were safe and staff were routinely observed providing a high standard of care and treatment.

Incidents and accidents were managed well and in line with Trust policy. We were provided with assurances that the areas of concern we identified relating to ASG had been identified by the Trust and a robust action plan had been created to address these concerns.

Patients told us they were treated with dignity and respect and felt that staff actively listened to them and attended their needs. Patients were observed being supported by compassionate staff who took all necessary steps to maintain their dignity, privacy and comfort at all times. Some ward environments were due for imminent improvement work which would include updating ligature and fire risk assessments.

Effective leadership in most wards and at senior management level has enabled the Trust to deliver a safe and compassionate service whilst embedding a least restrictive approach to supporting people with mental illness.

During previous inspections to the four wards, cumulatively there were 27 AFI identified. This inspection identified that 18 of the 27 AFI have been met.

Four AFI were not met, two relate to the management of ligature risk, one relates to ASG and one relates to the number of staff trained to support patients to use the gym. The AFI relating to ASG and staff training will be stated for a second time.

Four AFI's were partially met these relate to; the management of ligature risks; fire risk assessments, the storage of medicines and patient experience.

All three AFI's not met or partially met in relation to the management of ligatures have been subsumed into one new AFI.

One AFI relating to the risk assessment of the use of plastic PPE will be reviewed at the next inspection.

One new AFI relating to bed flow policy was identified.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. To do this, we gather and review the information we hold about the service, examine a variety of relevant records, meet and talk with staff and management and observe practices throughout the inspection.

The information obtained is then considered before a determination is made on whether the service is operating in accordance with the relevant legislation and quality standards.
Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any 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

Questionnaires were placed on the wards inviting patients and relatives to complete these and post them to us; five were received. Posters were placed throughout the wards inviting staff to complete an electronic questionnaire.

We met with 13 patients and discussed their experience of receiving care. Overall, patients stated that they felt they were treated with dignity and respect and staff actively listened to them. Some concerns were raised in relation to the quality and lunchtime menu options of food and access to the gym and Occupational Therapy (OT). These concerns were discussed with representatives from the Trust's SMT. See section 5.2.8 for further details.

Although no staff questionnaires were returned a number of staff, from a variety of disciplines were interviewed during the inspection.

Staff feedback indicated staff generally worked well together however, they reported they were tired due to the impact of the Covid-19 pandemic. Staff were commended for their resilience. (See section 5.2.7).

5.0 The inspection

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

The last inspections undertaken and the AFIs are identified as follows:

- Inver 1 on 11 January 2018 had three AFIs;
- Lissan 1 on 23 January 2018 had four AFIs;
- RTU on 13 February 2018 had seven AFIs; and
- Tobernaveen wards on 23 to 24 July 2019 had 13 AFIs.

Areas for improvement from the last inspections		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)		**Validation of compliance**
Area for Improvement 1 Inver 1 **Ref:** Standard 5.3.1 (f) **Stated:** Second time	The Northern Health and Social Care Trust shall ensure: • that policies relevant to the ward are subject to review and are appropriately updated in accordance to the Trust's identified timelines.	**Met**
	Action taken as confirmed during the inspection: Trust policies were reviewed by the SMT and submitted to the Policy Committee for scrutiny and sign off. The Governance Department shared the updated policy to the Trust library. Staff confirmed during discussions that they understood where and how to access Trust policies.	

Area for Improvement 2 **Inver 1** **Ref:** Standard 5.3.1 (f) **Stated:** Second time	The Northern Health and Social Care Trust shall: • confirm the bed capacity of the ward; and • ensure that patients admitted to the ward require care and treatment in a psychiatric intensive care unit (PICU). **Action taken as confirmed during the inspection**: The ward's operating capacity was confirmed as five beds; four beds in the patient bay area and one side room. The Trust had developed mechanisms to ensure that patients admitted to the ward required care and treatment in a PICU environment. Further detail is provided in section 5.2.1.	**Met**
Area for Improvement 3 **Inver 1** **Ref:** Standard 6.3.2 (a) **Stated:** First time	The Northern Health and Social Care Trust shall ensure: • there are curtains in shower cubicles to offer privacy and dignity to patients. **Action taken as confirmed during the inspection**: We were assured that the privacy and dignity of patients was being protected when showering.	**Met**
Area for improvement 4 **Lissan 1** **Ref:** Standard 5.3.1 (f) **Stated:** Second time	The Northern Health and Social Care Trust shall ensure: • ligature risks identified within the ward have a clear plan as to how they would be managed to help ensure patient safety. **Action taken as confirmed during the inspection**: A robust plan to address ligature risks was in place. Decisions regarding the risks associated with the ligatures on this ward are being carefully managed and are directly linked to the timeliness of a ward decant and loss of critical PICU beds across the region. Staff we spoke with were knowledgeable about how to mitigate the risks. RQIA will monitor progress through the submission of a specific ligature risk action plan.	**Met**

	Further detail is provided in section 5.2.2.	
Area for Improvement 5 **Lissan 1** **Ref:** Standard 5.3.3 (b) **Stated:** Second time	The Northern Health and Social Care Trust shall ensure: • the work required to remove or replace ligature risks is completed.	**Partially Met**
	Action taken as confirmed during the inspection: Some estates works required to address the ligature risks on this ward had been completed. Other ligature risks required a decant and closure of the ward to facilitate work by the Estates Department. Decisions regarding the risks associated with the ligatures on this ward are being carefully managed and are directly linked to the timeliness of a ward decant and loss of critical PICU beds across the region. Staff we spoke with were knowledgeable about how to mitigate the risks whilst awaiting a ward decant for completion of Estates work. An imminent decant of the ward was expected to facilitate work by the Estates Department. This area for improvement has been partially met and has been subsumed into a new AFI which will require the Trust to submit an action plan to RQIA detailing their plans for the completion of the ligature risk work. Please see section 5.2.2 for further discussion.	
Area for Improvement 6 **Lissan 1** **Ref:** Standard 5.3.1 (f) **Stated:** First time	The Northern Health and Social Care Trust shall ensure: • the system to request and follow-up items for repair or replacement is effective; • there is guidance for ward staff about which documentation to complete; and • ward staff have contact details for the various estates/trade managers to follow up on work requested.	**Met**
	Action taken as confirmed during the inspection: Staff were knowledgeable regarding the mechanisms for reporting estates issues.	

	Over the course of the inspection we observed the effectiveness of the current system in repairing broken equipment.	
Area for Improvement 7 **Lissan 1** **Ref:** Standard 5.3.3 (b) **Stated:** First time	The Northern Health and Social Care Trust shall ensure that an audit of the transfer/discharge arrangements for patients is undertaken. This will help demonstrate improvement.	**Met**
	Action taken as confirmed during the inspection: Since our last inspection of Lissan 1 the Trust has employed a Bed Capacity Network Coordinator who leads the patient flow team. A member of the patient flow team chairs the daily safety huddle meeting. Every ward is represented at this meeting and patients who require imminent discharge/transfer to an open ward are discussed and plans are made to ensure patients are transferred or discharged without delay.	
Area for Improvement 8 **Ross Thomson Unit** **Ref:** Standard 5.3.1 (a) **Stated:** Second time	The Northern Health and Social Care Trust shall ensure that access to the ward is controlled.	**Met**
	Action taken as confirmed during the inspection: It was confirmed that appropriate mitigations to control access to the ward were in place. All staff were aware of these arrangements.	
Area for Improvement 9 **Ross Thomson Unit** **Ref:** Standard 5.3.1 (f) **Stated:** Second time	The Northern Health and Social Care Trust shall ensure robust risk documentation and recording.	**Met**
	Action taken as confirmed during the inspection: Appropriate risk assessments were in place and regularly reviewed by the Multidisciplinary Team (MDT). Staff were knowledgeable regarding patients who had a Promoting Quality Care (PQC) risk assessment including their review arrangements. Staff were also aware that additional, specialist risk assessments did not replace the patient's Comprehensive Risk Assessment (CRA).	

Area for Improvement 10 **Ross Thomson Unit** **Ref:** Standard 5.3.1 (e) **Stated:** First time	The Northern Health and Social Care Trust shall ensure the ward's ligature risk assessment includes an action plan and timeline as to when ligature points requiring removal or replacement will be completed. **Action taken as confirmed during the inspection**: The current ligature risk assessment and associated action plan for Ross Thomson Unit was not accurate or robust. It is disappointing that the ligature risks in Ross Thomson Unit have not progressed in line with ligature risk work across the remaining acute mental health inpatient wards. This AFI has been assessed as not met and has been subsumed into a new AFI which will require the Trust to submit an action plan to RQIA detailing their plans for the completion of the ligature risk work. Further detail is provided in Section 5.2.2	**Not met**
Area for Improvement 11 **Ross Thomson Unit** **Ref:** Standard 5.3.1 (f) **Stated:** First time	The Northern Health and Social Care Trust shall ensure that ventilation systems within ward toilets are working. **Action taken as confirmed during the inspection**: The ventilation systems in the ward toilets were addressed by the Estates Department in 2018 with no further concerns identified.	**Met**
Area for improvement 12 **Ross Thomson Unit** **Ref:** Standard 5.3.1 (f) **Stated:** First time	The Northern Health and Social Care Trust shall ensure that alert systems within ward toilets are working and easy for patients to access. **Action taken as confirmed during the inspection**: The call alert systems in the patients' toilets on the ward were repaired in 2018. In one toilet, the call system could not have been reached by the patient but staff advised us that, as this toilet was designed for patients with a disability; there would always be staff present to assist.	**Met**

<table>
<tr><td rowspan="2">Area for Improvement 13
Ross Thomson Unit

Ref: Standard 5.3.3 (d)

Stated: First time</td><td>The Northern Health and Social Care Trust shall ensure that there is a sufficient number of staff trained to provide patients with support to use the ward’s cardiovascular gym equipment.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

Currently only one member of staff is trained to support patients in the safe use of the ward’s gym equipment. As a result of their current availability gym access is further limited.

This AFI has not been met and has been stated for a second time.</td></tr>
<tr><td rowspan="2">Area for Improvement 14

Ross Thomson Unit

Ref: Standard 6.3.2 (a)

Stated: First time</td><td>The Northern Health and Social Care Trust shall ensure that the door connecting the ward to the main hospital building does not compromise patient privacy.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
It was confirmed that action to address the privacy issue was taken following the inspection in 2018. The Estates action at that time was only a temporary solution and over time there was evidence of degradation.

This was brought to the attention of the ward manager during the inspection and a temporary adjustment was made.

A job request was also made to the Estates Department to resolve this issue by a permanent solution.</td></tr>
</table>

Area for Improvement 15 **Tobernaveen wards** **Ref**: Standard 5.1 **Criteria:** 5.3.1 (c) **Stated:** First time	The Northern Health and Social Care Trust shall ensure that all staff know how to facilitate, manage and risk assess children visiting the wards. Each ward should have its own procedure outlining how they can facilitate these visits taking cognisance of room availability, proximity to the exit, protecting visitors from witnessing patients in distress, patient needs and staffing ratios.	**Met**
	Action taken as confirmed during the inspection: Staff were knowledgeable about the Trust's "Children Visiting Inpatient or Residential Mental Health Facility Guidelines" (2012) to manage safe children's visits to the ward. In addition we were informed that the Trust's "Therapeutic Visiting of babies of Post-Partum Mothers who are Admitted to an Acute Mental Health Unit" (2017) guidance was also available. Due to the Covid-19 pandemic there have been no children visiting the wards.	
Area for Improvement 16 **Tobernaveen wards** **Ref**: Standard 5.1 Criteria: 5.3.2 (a) **Stated:** First time	The Northern Health and Social Care Trust shall address the following issues in respect of the recognition and management of adverse incidents and ensure; • appropriate training is provided to staff to recognise and manage adverse incidents and near misses and record them appropriately in Datix; • there is a robust assurance mechanism that will identify data entry errors or omissions in a timely manner; • there is incident debriefs conducted following any significant incident; • that learning arising from the incident is shared across teams, wards and disciplines and services in a timely manner; • a robust assurance mechanism that will test the implementation of relevant learning is embedded in practice; • that potential new risks are taken into account when planning the actions required to address current risks; • strengthen the current processes using data	**Met**

	to analyse patterns and trends from incidents and near misses, to inform future planning; and • that the process for disseminating learning from Serious Adverse Incident Investigations, learning letters and early alerts is working effectively.	
	Action taken as confirmed during the inspection: Robust incident management procedures were in place. There was evidence of auditing incidents for trend analysis over time and accurate grading of incidents with appropriate follow up actions taken. Learning from SAIs was disseminated from SMT to ward staff and there was evidence of incident debriefing following significant incidents. Further detail is provided in Section 5.2.4	
Area for Improvement 17 **Tobernaveen wards** **Ref**: Standard 4.1 Criteria: 4.3 (i) **Stated:** First time	The Northern Health and Social Care Trust shall ensure; • an update and review of the ligature risk assessments for each ward is completed to ensure that relevant risk assessments accurately reflect the ligature points to include weight bearing capacity; • in conjunction with the Estates department, the identification of capital works required, associated costs and timescales for completion of the removal or replacement of ligature points is completed; • improved governance and assurance mechanisms at service manager level to identify, prioritise and manage risks through to completion; • an improved process to identify the status of and progression of minor capital works requested through to completion; and • the plans to strengthen the current assurance framework to ensure that the directorate governance team are updated with respect to ongoing risks.	**Partially met**

	Action taken as confirmed during the inspection: The Trust has reviewed and updated their ligature risk assessment tool. Tobernaveen Centre's ligature risk assessment reflected the ligature points on the ward with the exception of profiling beds. This was discussed with the ward manager who was aware that profiling beds were not on the risk assessment. The ward manager confirmed this risk is mitigated by requesting additional staff to observe patients. A plan was in place and appropriate job requests were submitted to the Estates department to complete works to remove or replace all remaining ligature points. This AFI was partially met and has been subsumed into a new AFI which will require the Trust to submit an action plan to RQIA detailing their plans for the completion of the ligature risk work.	
Area for Improvement 18 **Tobernaveen wards** **Ref:** Standard 5.1 Criteria: 5.3.1 (c) **Stated:** First time	The Northern Health and Social Care Trust shall ensure: • staff's knowledge and training in respect of safeguarding is embedded into practice. • this should include, front line staff implement immediate protection plans for those patients for whom a safeguarding referral has been made; and • the patient's notes details the follow-up action taken following a referral.	
	Action taken as confirmed during the inspection: Staff knowledge about the ASG process was not embedded in practice. There was over reliance on the ward social worker to make referrals to Adult Protection Gateway Team (APGT) and there was poor understanding of the requirement to develop protection plans when ASG concerns were identified. This AFI was not met and has been stated for a second time. Further detail is provided in Section 5.2.4.	**Not met**

<table>
<tr>
<td rowspan="2">Area for Improvement 19
Tobernaveen wards

Ref: Standard 4.1

Criteria: 4.3 (i)

Stated: First time</td>
<td>The Northern Health and Social Care Trust shall ensure:

• each ward has an up-to-date fire risk assessment completed;
• items to be addressed are actioned and recorded when completed, by whom and by what date;
• appropriate governance of the adherence to the fire policy in respect of: fire doors remaining closed and weekly fire alarms are conducted; and
• all staff know where to locate the fire grab box and are familiar with what it should include and that all contents and the information contained within it are in date and correct.</td>
<td rowspan="2">Partially met</td>
</tr>
<tr>
<td>Action taken as confirmed during the inspection:
Fire risk assessments were reviewed for all wards visited during this inspection and were up-to-date. There were a number of management control items listed that have not been implemented. The management control issues include Fire Warden training and the completion of fire drills.

Tobernaveen centre had a grab box and staff were knowledgeable about what should be contained in it.

It was confirmed that this AFI was partially met and has been stated for a second time.

Further detail is provided in Section 5.2.2</td>
</tr>
</table>

Area for Improvement 20 **Tobernaveen wards** **Ref**: Standard 5.1 Criteria: 5.3.1 (f) **Stated:** First time	The Northern Health and Social Care Trust shall address the following issues in respect of medicine management and ensure; • all medical records are legible and easy to read; • ensure that the indication for when PRN medication is used is recorded, identifying first and second line medication, the reason for it and whether or not the administration had the desired outcome; • there is a system in place to check the prescribing during a patients stay on the ward in relation to rewriting kardexes, prescribing new medicines and making changes to dosages in medicines.	**Met**
	Action taken as confirmed during the inspection: All medical records were legible and easy to read. The indications for when PRN medication was to be used was recorded and we would remind medical staff to highlight first/second line. The patient's medical review each week ensured that kardexes could be rewritten, new medicines prescribed and changes to dosages in medicines made.	

Area for Improvement 21 **Tobernaveen wards** **Ref**: Standard 5.1 Criteria: 5.3.1 (f) **Stated:** First time	The Northern Health and Social Care Trust shall address the following issues in respect of medicine management and ensure: • all medicines are stored in original or pharmacy containers; • there is a robust daily monitoring system for the cold storage of medicines; to ensure that the minimum and maximum medicine refrigerator temperatures are recorded, the thermometer is reset every day and medicines are stored in accordance with the manufacturers' instructions; and • access to emergency resuscitation bags are not delayed by locating the key to the treatment room; the contents of the bags are regularly inspected to take account of expired medicines and damaged packaging.	
	Action taken as confirmed during the inspection: Medicines were stored in the original or pharmacy containers. There were no delays reported or seen in relation to accessing the keys to the treatment room. The temperatures of medicines refrigerators were appropriate but the minimum and maximum medicine refrigerator temperatures were not being monitored and recorded appropriately and the refrigerator thermometer was not being reset daily. We found evidence of regular checks recorded for resuscitation bags. However, on one ward, a small number of expired medicines were observed. This was addressed immediately. We determined this AFI was partially met and has been stated for a second time. Further detail is provided in Section 5.2.10	**Partially met**

<table>
<tr><td rowspan="2">Area for Improvement 22
Tobernaveen wards

Ref: Standard 5.1

Criteria: 5.3.1 (f)

Stated: First time</td><td>The Northern Health and Social Care Trust shall address the following issues in respect of medicine management and ensure:

• missed doses are reported as an incident;
• medical and nursing staff have knowledge of all medicine related SAI's and there is recorded evidence of how learning is shared and implemented following discussion at the medicines incident sub group of the Drugs and Therapeutic Committee; and
• medicine related incidents are routinely shared with the ward pharmacist and there is evidence of the outcomes of incident review maintained at ward level.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
There were only a small number of missed signatures and missed doses. Datix incidents had been submitted for the missed doses. There was good staff knowledge of medicines related Serious Adverse Incidents (SAI's) and there was evidence that learning was shared and implemented following discussion of the SAI.</td></tr>
<tr><td rowspan="2">Area for Improvement 23
Tobernaveen wards

Ref: Standard 4.1

Criteria: 4.3 (b)

Stated: First time</td><td>The Northern Health and Social Care Trust shall address the following issues in respect of medicine management and ensure:

• the governance arrangements for medicines management are robust and include regular medicine management audits and outcomes; and
• there is a robust assurance mechanism in place to verify adherence to all of the above areas, and the Trust's policies and procedures in relation to medicine management.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
We were satisfied that there were robust governance arrangements in place for medicines management via the audit process.</td></tr>
</table>

<table>
<tr><td rowspan="2">Area for Improvement 24
Tobernaveen wards

Ref: Standard 5.1

Criteria: 5.3.1 (f)

Stated: First time</td><td>The Northern Health and Social Care Trust shall ensure immediate maintenance work is undertaken to improve the fixtures, fittings, walls, flooring and en-suite facilities in all Tobernaveen wards.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
There was evidence that maintenance work had been undertaken to improve the fixtures, fittings and building fabric in the Tobernaveen wards.</td></tr>
<tr><td rowspan="2">Area for Improvement 25
Tobernaveen wards

Ref: Standard 5.1

Criteria: 5.3.1 (f)

Stated: First time</td><td>The Northern Health and Social Care Trust shall ensure:

• an immediate risk assessment on the use of PPE and plastic material is carried out. This should be completed in conjunction with the IPC team in order to ensure the potential risks to patient safety are managed; and
• an assurance system should be introduced to monitor action and reviewing patient safety, staff practice and risk assessment.</td><td rowspan="2">Carried forward to the next inspection</td></tr>
<tr><td>Action taken as confirmed during the inspection:
This AFI was not reviewed and it will be carried forward to the next inspection.</td></tr>
</table>

Area for Improvement 26 **Tobernaveen wards** **Ref**: Standard 6.1 Criteria: 6.3.2 (g) **Stated:** First time	The Northern Health and Social Care Trust shall ensure: • patients' overall experience is monitored and reviewed on the wards; • patient satisfaction surveys are completed; and patient forum meetings are held on the ward; • the outcomes of audits are displayed for patients' carers or members of the public visiting the ward to view; • there is information displayed in relation to patients' views of their care and treatment or their experience of the ward; and • this information is used to help with service improvement in accordance with Personal and Public Involvement (PPI) Standards (March 2015).	**Partially Met**
	Action taken as confirmed during the inspection: Patients overall experience is monitored and reviewed and there was evidence of relevant audits displayed on the ward. Evidence of the actions taken or planned to address concerns raised was not available and we asked the Trust to enhance the current processes to take account of this. This AFI was partially met and has been stated for a second time. Further detail is provided in Section 5.2.5	

<table>
<tr>
<td rowspan="2">Area for Improvement 27
Tobernaveen wards

Ref: Standard 5.1

Criteria 5.3.2 (a)

Stated: First time</td>
<td>The Northern Health and Social Care Trust shall ensure:
• all SAI’s are tracked to ensure actions identified in the action plan are implemented by the responsible owner and within the timeline identified;
• a robust assurance mechanism is in place to capture, question and analyse incidents that occur at ward level;
• a robust assurance mechanism is in place to test and determine if learning has been implemented and sustained over a period of time; and
• key clinical service measures /reports in relation to incidents are evidenced. Examples should be recorded where these have driven service improvement or highlighted areas of good practice on each ward.</td>
<td rowspan="2">Met</td>
</tr>
<tr>
<td>Action taken as confirmed during the inspection:
A review of the minutes of the Trust’s Mental Health and Learning Disability & Community Wellbeing, Divisional Safety and Quality Forum confirmed that SAIs were a standing item on the agenda.

The minutes evidenced how learning from SAI investigations could be implemented, and the need for further audits following the identification of patterns within SAI report recommendations.</td>
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</table>

5.2 Inspection findings

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

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

5.2.1 Patient Flow

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

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

The Trust is commissioned for 94 beds across its acute mental health inpatient services. It was evident on the days of the inspection that all of the wards were operating over the 85% acute bed occupancy recommended by The Royal College of Psychiatrists. This recommendation had been set as operating a service with high levels of bed occupancy may affect patient care, as directing patients to the bed most suitable for their care is less likely to be possible.

The Trust was successful in appointing a Bed Capacity Network Coordinator in December 2020. This has been positive in establishing a more coordinated and collaborative approach to patient flow within the Trust area and across the region. This individual is responsible for coordinating all bed management plans which includes, the number of beds available, occupied beds, patients allocated on leave, patients supported on observations and patients that are identified for potential discharge. An important aspect of this role is the engagement through a regional network with other Trusts which supports the understanding and subsequent coordination of bed pressures across the region.

There was evidence of the sharing of information relating to over occupancy issues within mental health in patient units regionally; the Trust shares performance data relating to bed pressures at regional senior management level and with the Health and Social Care Board.

There was a daily morning safety huddle across the site which was led by the Bed Capacity Network Coordinator. At this huddle, ward occupancy, patient acuity, patient observation levels, incidents, accidents, staffing levels, use of leave beds, transfers from PICU to acute admissions wards and back to originating Trusts, and potential discharges were discussed to understand which parts of the site needed assistance. Referrals to hospital were robustly triaged to consider appropriate alternatives to hospital admission such as community or home treatment teams. We determined there was good governance and senior management oversight of patient flow.

Ward managers were knowledgeable about the reasons for delayed discharges, which were largely due to wait times for specialist accommodation or packages of care, and the SMT were actively engaged with a variety of stakeholders to facilitate discharge when possible.

We saw evidence of an exceptional piece of work which provided assurance about MDT decision making relating to admissions to PICU. This PICU triage admission procedure detailed patient risk, medications, working diagnosis, aims and rationale for admission to PICU, and what measures had been taken to prevent admission.

The MDT was involved in discharge planning early in patients' admissions and while the patient often was not informed of an estimated date of discharge (EDD), they were provided with an over view of their stay in hospital and potential arrangements/plans leading to discharge. We were informed by staff that when there was no planned discharge date in place patients and ward staff could be informed at short notice of a discharge, leading to delays in patients vacating beds and thus impacting negatively on bed availability. This was discussed with members of the SMT during feedback who advised that in as far as possible short notice of patient's discharge is at times unavoidable if there is an urgent need for admission. The decision for discharging a patient is reached following review of their risks and assessed needs.

Staff demonstrated good knowledge about the escalation process when beds were unavailable and they told us the Regional Bed Management Protocol for Acute Psychiatric Beds (August 2019) is used as a guide. However we found a variety of local policies which support patient flow/bed management were not available as recommended in this policy. For example, there was no local escalation policy which clearly defined the level of bed usage and bed management strategies to manage the Trust's bed capacity. In addition, there was no "On Leave from Inpatient Care" policy which would outline explicitly how such leave is planned and what to do if an unexpected re-admission occurs. We were informed by the SMT that the policy for the Admission and Discharge to Mental Health Beds in Holywell Hospital and Ross Thomson Unit, Causeway Hospital (August 2021) was in draft and required sign off at Trust Executive level.

Ratifying the Admission and Discharge to Mental Health Beds in Holywell Hospital and Ross Thomson Unit, Causeway Hospital (August 2021) policy and developing supporting policies such as the Trust's escalation and use of; "on leave" beds was identified as an area for improvement.

In general we found good bed flow management during periods when wards were over occupied.

5.2.2 Environment

Environmental cleanliness and infection prevention control

Lissan and Inver 1 wards are old and dated. Both wards required significant refurbishment to ensure they are maintained to a good standard. This was raised with representatives from SMT who advised that a programme of works was planned to refurbish these wards and a series of meetings were planned with Estates department to negotiate priorities of work within allocated budgets.

The flooring throughout TNC was not cleaned to an acceptable standard, a fire exit was found to be blocked and there were no soap or paper towels in the staff toilets. These issues were brought to the attention of the ward manager and were rectified on the day. Mould was noted within bathroom areas and mattress audits were not available. These concerns were raised with the ward manager who agreed to review these areas and take remedial action where necessary.

Overall the RTU was clean and tidy. The domestic store was cleaned to an extremely high standard. Areas of clutter were observed in patient recreation spaces and the nurse's station. Some patients' personal items had been left in shower areas. This was brought to the attention of the ward manager and was promptly addressed. The ward manager confirmed they would remind staff to complete regular checks of bathrooms to ensure personal items were removed and commence a regular programme of de-cluttering. Staff completed a variety of Infection Prevention and Control (IPC) audits for example hand hygiene, environmental cleanliness and mattress audits and there was evidence good compliance scores had been achieved.

Adherence to Infection Prevention Control (IPC) standards and transmission based precautions on all wards was of a high standard. Hand hygiene practices, and access to and the use of Personal Protective Equipment (PPE) were appropriate. There was appropriate IPC signage including guidance on Covid-19, social distancing and hand hygiene in wards and staff confirmed there was good support from IPC team.

Ligature risks

During the inspection of Tobernaveen wards in July 2019, RQIA identified significant concerns about the number of ligatures on the wards and a lack of progress to address these ligatures some dating back to 2015. Following the 2019 inspection RQIA invited representatives of the Trust's SMT to a number of serious concerns meetings in line with our escalation policy. The outcome of the serious concerns meetings was that the Trust would submit a detailed action plan evidencing how these ligature points would be addressed i.e. removed or replaced, the timeframes for completing the works, the responsible person and evidence that finances were secured to complete the work. RQIA requested the Trust submit updated action plans initially on a fortnightly basis and thereafter on a monthly basis until such time as the work was completed. In November 2020 the Trust invited senior representatives from RQIA to visit the Tobernaveen wards to review the progress on work completed thus far. Due to a number of issues, not least the Covid-19 pandemic, representatives from RQIA did not have capacity to visit the wards until this inspection.

Despite the challenges posed by the pandemic and the necessity to close some acute inpatient beds significant work to address the ligature works had been completed across the Tobernaveen wards with a detailed plan in place and funds secured to complete the outstanding work.

In respect of Lissan 1 we received assurances from a senior representative of the SMT that there was a comprehensive environmental risk assessment completed that informed a detailed anti-ligature work plan which was held by the estates department. All staff were well informed of the ligature risks and the mitigations in place to safeguard patients. Some estates works required to address the ligature risks on this ward had been completed. Other ligature risks required decant and closure of the ward to facilitate work by the Estates Department. Representatives from the SMT informed us that the decision to decant the ward needed to be balanced against the need to meet the demand for inpatient PICU beds and staffing resources in the midst of the Covid-19 pandemic. The SMT and staff on the ward were aware of the ongoing ligature risk management plan and mitigations required and agreed to update RQIA when this work commences. The benefits of ensuring ligature risk assessments are reviewed in line with the Trust's ligature risk assessment policy and retained at ward level were discussed.

We determined that ligature risks were not being managed effectively in RTU. The General Risk Assessment did not contain accurate information about current ligatures. Staff's knowledge of the ligature risks was poor and we were not assured that current ligature risks would easily be highlighted to staff unfamiliar with the ward. We observed a number of mobile ligature risks around the nurses' station which could be easily accessed by patients. These risks were addressed immediately having been brought to the ward manager's attention. It is disappointing to note that improvements, in the management of ligature risks, identified in the Tobernaveen and Lissan 1 wards has not been replicated across all mental health inpatient wards.

Four AFI in relation to ligature risk management had been made previously relating to three wards. It is our determination that further work is required to manage ligature risks across the mental health inpatient units. A new AFI has been made which takes account of the previous AFI which had not been met or only partially met.

Fire risk assessments

There were 'Fire Grab Boxes' on each ward which were well maintained and included a floor bed plan which would be easily accessible to staff in the event of an emergency. Although none of the wards had contingency beds in use during the inspection we were satisfied that staff had sufficient knowledge of how the floor bed plans could be adapted if contingency beds were used.

Fire Risk Assessments (FRAs) were not an accurate reflection of current fire risks on each ward. In one ward the oxygen tank in the resuscitation bag was not on the FRA as a combustible risk. We established that there were insufficient numbers of staff trained as fire wardens and were not assured that each shift had a fire warden scheduled to work. On one ward there had been no fire drills or walk/talk drills done in the last year despite the high number of agency staff.

This AFI was partially met and will be stated for a second time and is applicable to all mental health wards in the Trust.
We determined that the deficits observed were not caused by wards being over occupied.

5.2.3 Restrictive practices

The management of restrictive practices was reviewed to determine if over occupancy was having an impact on the use of restrictive practices.

Restrictive practices in use included locked doors, enhanced observations and physical intervention. We determined that the restrictions in place had been risk assessed and were proportionate to the level of risk in keeping with best practice guidance. There was no evidence that patients were on enhanced observations for any reasons pertaining to over occupancy.

Staff demonstrated a good awareness of what constituted restrictive practices. There were good examples of the manual handling arrangements for patients with specific needs which were detailed in their care plans should physical intervention be required. Patient care records reflected detailed recording when restrictions were required. There was evidence that consideration had been given to the patient's human rights including deprivation of liberty safeguards.

There was evidence of quality improvement (QI) work in relation to the use of restrictive practices; the Trust had developed a "Minimising Restrictive Practice QI Project Group". The aim of the project was to reduce the use of restrictive practices by 30% by December 2021. As part of the project, the Trust was piloting the Safety Cross in three wards. The Safety Cross is a regional tool for collecting data about the use of restrictive practices (this project is linked to the regional Towards Zero Suicide Patient Safety Collaborative) and specifically aims to reduce seclusion, rapid tranquilisation and the use of PRN medication.

There were daily MDT review of patients' restrictions; this provided assurance that restrictions were regularly assessed and proportionate to the risk presented. We confirmed that staff had attended or were booked to attend 'Safety Intervention Training'; this training had replaced Management of Actual or Potential Aggression (MAPA) training. The Safety Intervention Training incorporates more de-escalation skills which is hoped will lead to less use of physical intervention. Staff told us that physical intervention was used as a last resort and de-escalation techniques were prioritised to support patients. We observed staff display good de-escalating skills to potentially volatile situations.

Seclusion episodes were recorded in detail within patient care records and seclusion records which noted the date of seclusion, the time seclusion commenced and ended. There was evidence of good aftercare following episodes of seclusion; this included medical examination and a debrief with the patient. Appropriate use of 'My Safety and Support Plan' with patients was observed following seclusion episodes.

There were effective communication systems in place to facilitate the handover of patient restrictions to staff including the PIPA board, daily safety brief, and handover sheets. The site wide Joint Daily Report contained information relating to Datix incidents including those which involved physical intervention.

The seclusion room in the female PICU ward was not in use as the observation window in the door needed to be replaced. The Estates Department had been in contact with the specialist manufacturer to replace this. Female patients from the ward who required seclusion would have been facilitated within the male PICU. This situation had not arisen to date but would potentially compromise the female patients' privacy and dignity. The Trust agreed to provide an update as soon as the work had been completed.

We determined that there was no increase in the use of restrictive practices during periods of over occupancy.

5.2.4 Management of Incidents /Accidents and Adult Safeguarding (ASG)

Incidents recorded on the Trust's electronic reporting system, Datix, for the last three months were reviewed to determine if there was an increase in number or complexity of incidents as a result of over occupancy. We determined that there was no evidence that incidents increased at times when wards were over occupied.

Overall incidents were graded appropriately. Incident reports provided good detail and contained information such as the use of seclusion and physical intervention. This information accurately correlated with information contained in patients care records.

There was evidence of senior management oversight of incidents from our review of the Acute Care Forum Meeting Minutes and evidence of analysis of incident trends in the Safety and Quality Booklet which informed the Acute Care Forum. Incidents were presented by type and location and indicated an increase or decrease in specific types. Incidents analysed included the use of seclusion, physical intervention, self-harm, absence without leave (AWOL), medication incidents and falls. All incident types were analysed per ward and over a period of a year. We were unable to evidence that the incident analysis outlined in the Safety and Quality Booklet was being shared with staff at ward level and would suggest this information be shared.

On one ward 32 Datix reports had not been reviewed. We were informed by the ward manager that this was due to exceptional leave required by staff as a result of Covid-19. It was suggested that senior managers should provide increased support if a similar situation occurred again.

There were five incidents in one ward (RTU) which indicated the need for an ASG referral to be made, however, only one incident had been referred to ASG. The ward manager made arrangements to refer the others that day. During discussions with the ward manager we determined there was an over reliance on the wards' social worker for guidance as to when an ASG referral should be made.

Two open ASG cases on one ward were reviewed. The Designated Adult Protection Officer (DAPO) provided a timeline which indicated that there had been good communication between the DAPO and the ward manager. The discussions had not been shared at ward level and ward staff did not have access to protection plans. Protection plans were only available in one ward.

Whilst ward managers were aware what stage any ASG case/referral had reached, information about decision making or why a referral had been screened out was not shared with other staff. We found inconsistencies in the recording of ASG incidents in care records.

We discussed these issues with the SMT and were satisfied that the Trust was aware of the deficits in their application of the regional Northern Ireland Adult Safeguarding Partnership: Adult Safeguarding Operating Procedures (2016) and had already developed an action plan to address the deficits. They shared the action plan with us and we determined it addressed all of the areas of concern we identified.

As part of the action plan, the Trust planned to review all ASG policies in use and to review the staffing workforce available to provide an ASG service. The workforce review plans took into account lines of professional and operational accountability. It was positive to note from the action plan that particular focus will be given to developing Alternative Care Plans/Alternative ASG Responses. This will outline how a patient will be supported if an ASG referral is screened out. It was also good to see that a template will be developed to provide staff with a consistent way to record their decision-making. We noted from the action plan that inconsistencies regarding the application of criteria to meet ASG thresholds will be addressed.

We determined that the previous AFI relating to ASG had not been met and will be stated for a second time.

We determined that the deficits evidenced relating to ASG were not caused by over occupancy.

5.2.5 Patient Comfort

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

Patients detained under the Mental Health (Northern Ireland) Order (1986) (MHO) were provided with a leaflet explaining their rights and information about how to access the Mental Health Review Tribunal.

We were informed about the compassionate decision to allow patients in a PICU ward, to be supported during the Covid-19 pandemic, to use smart phones so they could engage with their families using zoom/skype. Patients normally would only be permitted a basic mobile phone with no internet or camera. As Covid-19 restrictions eased and increased visiting was permitted, this practice had been stood down. Patients also had access to the ward phones.

Most of the patient beds were located in multi patient dormitories however we saw privacy being maintained as best as possible. For those patients accommodated in single occupancy rooms, we observed staff knocking doors before entering.

There was evidence of MDT attention to patients' human rights. An advocacy service was available to patients on each ward and staff informed us about how patients were supported to access this. Occupational therapy (OT), physiotherapy, psychology, speech and language therapy (SALT) were accessible for patients who required these services.

We observed that the PIPA board which contained confidential information about patients was visible from an outside area in one ward and could have been accessed by other patients. The PIPA model is a new approach to managing a patient's journey from admission through to discharge. It focuses the multidisciplinary team on treating the patient, based on a formulation of their needs. The approach requires the attendance of all members of the MDT in a specific room every day to review and plan what tasks each discipline is required to do next in respect of each patient. The tasks are noted and logged on a board and an update is provided the following day. This model is designed to reduce the time patients remain in hospital and helps support them to leave as soon as they are well enough. We brought this to the attention of the ward manager who addressed the issue during the inspection.

On review of Datix incidents, we identified that when some patients were acutely unwell, there was an increased risk they may display inappropriate behaviour which, on a mixed gender ward, could potentially compromise their dignity. We saw evidence that staff reconfigured the ward area to protect patient's dignity by ensuring the allocation and location of male/female beds better meets the ratio of male: female patients. We suggested that the Trust give consideration to undertaking a scoping exercise to understand the risks associated with mixed gender patient population.

Despite the challenging ward environments staff made great efforts to maintain patient's privacy and dignity. There were no patients sleeping on sofas/Portland chairs. We observed positive meal time experiences for patients in the RTU; dietary requirements were well catered for in most wards.

A noted improvement was evident during this inspection from that of the 2019 Holywell inspection on how the Trust captured and monitored the patient experience. In most wards patient forum meetings occurred monthly. Upon review of the minutes of patients meetings in Holywell Hospital there was evidence that patients there were less happy about food quality and choice of options available to them (in particular the lunch time menu). This was discussed with the service user consultant who advised that they are actively engaged in a process with the head of the hospital canteen to discuss lunch time menu options. The Covid-19 pandemic had resulted in new restrictions placed upon kitchen staff who could no longer make fresh sandwiches on site. On the Holywell site we found that there was a lack of follow-up actions recorded to evidence how staff addressed the patients' concerns.

We determined that the AFI relating to patient experience was partially met and will be stated for a second time.

Overall, we did not find evidence that periods of over occupancy affected patient comfort.

5.2.6 Care and Treatment

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

We found that patients nursing and medical assessment on admission were carried out in line with identified time frames and access to care and treatment was appropriate and timely. There was good MDT working and care plans were up to date and accurately reflected patients assessed needs and risks. Care records showed good detail about the therapeutic input by the MDT. We saw particularly good liaison with physical health care services for one patient with ongoing self-harming behaviours. Some wards recently introduced PIPA and we saw an example of the benefit that model provided; a patient's medication was changed very quickly after the decision was made at the PIPA meeting.

Staff were observed to treat patients with kindness and respect and were compassionate in manner and we observed staff maintaining a respectful distance during 1:1 special observations. We were informed of a Therapy Healthcare Assistant (HCA) initiative being piloted in TNC which aimed to assure satisfactory levels of activity for patients. We will be interested to hear about the findings of this pilot.

Some wards had recently started using the PARIS IT system and we found that some information was being stored on two different systems (PARIS and paper records).

Care plans were not on PARIS but recorded on paper and held in the patients file, and risk assessments were printed off on admission and held in paper form for review when required. On discharge a summary review of risk was then recorded on the risk assessment. We discussed this with the SMT and determined these problems may be attributed to teething issues. We would recommend that the Trust embeds and harmonises the use of PARIS across all wards.

When patients declined to sign their care plans or care plan reviews, there was no evidence that this had been revisited during the patient's admission. In one ward there were two patients with swallowing difficulties who did not have dysphagia nursing care plans in place. This was discussed with the ward manager who took immediate action to ensure dysphagia care plans were in place for these patients. We also discussed the importance of robust communication systems to ensure all staff are aware of patients with swallowing difficulties, their individualised care needs and SALT recommendations. The ward manager agreed to address this and implement a system highlighting those patients with identified swallowing difficulties using the daily nursing hand over and patient white board. In the same ward it was noted that patients were weighed weekly but their Malnutrition Universal Screening Tool (MUST) score was not always updated weekly. The Trust should consider introducing an audit of supplementary records to monitor and improve completion of the MUST screening tool.

Overall, we did not find any evidence that periods of over occupancy affected patients care and treatment.

5.2.7 Staffing

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

We acknowledged the ongoing impact of Covid-19 on staff and we were informed by staff that they were tired. We commended them on their resilience. We determined that staff were experienced and on the whole worked well together. There was evidence that the wards were well staffed but we acknowledged that there was a higher than normal use of agency staff which had potential to increase substantive staffs workload. Staff we spoke with generally felt supported by the SMT. The site was able to quickly adapt to deficits in staffing following the site wide call every morning. We saw evidence that Datix incident reports were submitted if staffing levels impacted on patient care. An ongoing recruitment initiative recently generated a positive result in securing three band 6 nurses. The Trust also created Band 4 positions to help recruit student nurses awaiting their registration number with the Nursing, Midwifery Council (NMC) the professional regulatory body for nurses.

A representative from the SMT provided an update on the ongoing investigation into allegations received under whistleblowing arrangements relating to staffing concerns within the site. The Trust agreed to update us on the outcome of the investigation.

We determined that over occupancy was not the main contributor to staffing pressures and safe staffing levels were maintained during periods when wards were over occupied.

5.2.8 Patient engagement

We spoke with patients to determine if over occupancy was affecting the delivery of their care. Patients told us they were treated with dignity and respect and that staff actively listened to them and attended their needs.

They informed us that staff involved them in all aspects of their care and they had the opportunity to attend meetings about their care. Patients were aware of the advocacy services available to them. They did not raise any issues related to wards being over occupied.

We left questionnaires on each ward inviting patients to comment on their care. Five questionnaires were returned by patients and all were positive. Two of those five patients indicated that they would like more OT/activity and gym time. We were assured that the Therapy HCA pilot initiative would assist in providing more activity for patients, and we informed the SMT about patient's requesting more gym time.

The AFI to support patients to use the gym in RTU has been stated for a second time.

We also determined that over occupancy was not affecting the patient experience.

5.2.9 Staff engagement

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

Staff reported there was a high standard of patient centred care delivered on the wards. On the whole, staff felt they were well supported by their managers who were knowledgeable and approachable. Ward managers were visible throughout the unit and staff described the delivery of care as compassionate.

Staff reported there were clear mechanisms for feedback and learning from incidents and audits via staff meetings, local de-briefs emails, minutes, clinical supervision and verbal communications. Supervision and appraisals were up to date and staff reported good communication/support between peer networks.

The admission of patients with a learning disability caused concern among some staff as they felt they lacked expertise and additional training in caring for this category of patient and managing behaviours that challenge. In some wards specialist in-reach staff from community learning disability services was supporting patients. The Trust is also in the process of opening a three bedded inpatient unit for patients with a learning disability who require assessment and treatment for their mental health. The Trust are recruiting staff for the unit with experience of working with people with a learning disability who will be able to share their knowledge, skills and experience with staff.

There was mixed opinion about staff morale however it was evident that staff felt tired following the exceptional circumstances created by the Covid-19 pandemic. It was further noted by staff that the increased reliance on agency staff, to maintain adequate staffing levels, created more work for the substantive staff. They welcomed the block booking of agency staff which they felt provided a level of continuity.

We determined that periods of over occupancy added to staff pressures however all staff were confident that patients still received a high standard of care despite the challenges.

5.2.10. Medicines management

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

There was evidence overall that satisfactory systems were in place for medicines management. Medicines were managed safely and patients were administered their medicines as prescribed.

Clinical pharmacy support was provided by one full time pharmacist and several pharmacy technicians on the wards of the Holywell site. The site was supported by the Trust Lead Mental Health Pharmacist. Staff were complimentary about the pharmacy support provided to the wards and the contribution to the safe management of medicines. The clinical pharmacist's support to the wards included medicines reconciliation for newly admitted patients, attendance at MDT patient case reviews as required, kardex reviews, and in patient discharge planning. There was no clinical pharmacy support in RTU but the on-site clinical pharmacist was available by phone for queries. The pharmacy dispensary technician co-ordinated the medicine ordering and stock control processes, including reviewing the expiry dates of medicines. Another technician was responsible for the management of clozapine. The clinical technician on the Holywell site was on a period of extended leave.

The nursing staff were knowledgeable regarding the medicines management processes, critical medicines and the medication needs of individual patients. Appropriate arrangements were in place for the safe management of medicines during the patient admission and discharge processes.

Kardexes and medicine administration records were maintained in a satisfactory manner on each of the wards; with medicine entries, dosage regimes and the patient's allergy status appropriately recorded. On the Holywell site, the medicines kardexes were signed by the pharmacist to confirm that medicines reconciliation had been carried out. We observed one incident where a medicine had been administered on a daily, rather than the prescribed weekly basis; there was no negative impact to the patient but it highlighted the need for regular training /updates about medicines not regularly used on the ward.

Staff recorded when and why any prescribed dose of a medicine was omitted and reported to the prescriber instances where patients had refused medicines. Medicine changes were appropriately recorded on kardexes and details of the rationale was documented on PARIS. Care records demonstrated clear decision making and there was good involvement of the clinical pharmacist on how to manage medicines for patients with special conditions.

On all wards there were parameters specified on medicine kardexes to direct the administration of medicines prescribed on a "when required" (PRN) basis. This included the indication, the minimum frequency intervals and the maximum daily dose. In most instances where more than one PRN medicine was prescribed, it was recorded which medicine was first, second and third line. We would remind medical staff to ensure this is consistently recorded on every occasion. The reason for and outcome of administration was evidenced in the patient notes recorded on the PARIS system.

The Trust Rapid Tranquillisation Policy was in place and staff were familiar with the contents. Posters of the policy were displayed in treatment rooms. Staff advised that staff and patient debriefing took place as soon as was practical after an incident where rapid tranquillisation was needed. A report of the use of rapid tranquillisation was made on a Datix incident form. Staff confirmed that the frequency of use of these medicines was monitored and reviewed at MDT patient case reviews.

Regional care pathways were in place for both clozapine and lithium. Clozapine was supplied weekly to the wards on a named patient basis. Arrangements were in place for regular review and monitoring of clozapine and lithium treatments, including blood monitoring.

A satisfactory standard of storage and stock control of medicines including controlled drugs was observed across all wards. Medicines were stored in locked cupboards and medicine areas were clean, tidy and organised. Controlled drugs were safely and securely stored and the controlled drugs registers were appropriately maintained. Reconciliation stock checks were completed at shift handovers. A Trust pharmacist carried out a quarterly audit on the management of controlled drugs on each ward.

In relation to the cold storage of medicines, while the temperatures of medicines refrigerators were within the recommended range, the minimum and maximum medicine refrigerator temperatures were not being monitored and recorded consistently and the refrigerator thermometer was not being reset daily. To ensure that medicines are stored in accordance with the manufacturers' instructions, staff must ensure that refrigerators are maintained between 2°C and 8°C. This had been identified as a previous AFI and will be stated for a second time.

Regular checks were recorded for resuscitation trolleys. However, on RTU, a small number of medicines were observed to be expired. This was addressed immediately.

We determined that medicines management was not compromised during periods of over occupancy.

5.2.11 Governance and leadership

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

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

There was a comprehensive Mental Health & Learning Disability & Community Wellbeing (MHLDCW) Safety and Quality Assurance Booklet produced each month which detailed the month's incidents by type and location. The data collected was discussed and interrogated at the monthly Acute Care Forum Meeting to determine trends and acuity of patients. Further detail about this is provided in Section 5.2.4.

The weekly SMT meeting provided assurance that senior managers had oversight of staffing levels, skill mix, staff vacancies, Covid-19 issues, incident reviews, use of MAPA, consultant cover, social work concerns and bed occupancy rates.

We were updated about the Trust's plans to open a formerly disused ward to accommodate learning disability inpatients. This will address some of the problems in accessing acute inpatient care for patients that have a learning disability given that the regional hospital specialising in this category of care remains closed to admissions. Work had commenced to refurbish the ward and was progressing well.

We spoke with the head of social work and the hospital lead for ASG and were given information about the governance and operational structures for the hospital social work and the ASG team. We were informed that social workers were assigned to individual wards and were operationally line managed by the ward manager. The ASG lead provided professional supervision for these social workers. The hospital based social work structure in place in the Trust was unique within the region. The Trust's ASG action plan referenced in Section 5.2.4 provided assurances that the Trust recognised the deficits this type of system caused and this will be addressed by the work planned to review ASG processes within the Trust. The Trust agreed to keep us updated about this work.

Our findings in relation to environmental audits, ligature risks and fire risk assessments indicate a need for the Trust to strengthen its governance oversight of these areas. Representatives of the SMT need to assure themselves that outcomes of environmental audits and risk assessments that require action should be regularly monitored reviewed and updated as and when action is taken to mitigate the risks identified.

Overall, we determined that the Trust's governance systems responded appropriately to periods of over occupancy.

6.0 Conclusion

On reviewing our inspection findings it is evident that, while on occasion the Trust was operating over and above their commissioned beds, the effects of over occupancy are not compromising the delivery of safe and effective care within this service.

Based on the inspection findings and discussions held with the Trust, we are satisfied that care is provided in a compassionate manner across all wards. Eight areas for improvement were identified that will support the Trust to deliver improved outcomes for patients and staff.

7.0 Quality Improvement Plan/Areas for Improvement

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

	Standards
Total number of Areas for Improvement	8*

* The total number of AFIs includes six that have been stated for a second time, one which was not reviewed during this inspection and one new AFI.

Areas for improvement and details of the Quality Improvement Plan were discussed with representatives from the SMT as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).	
Area for improvement 1 **Ref:** Standard 5.1 Criteria: 5.3 (5.3.1) (f) **Stated:** First time **To be completed by:** 23 August 2019	Carried forward from previous inspection The Northern Health and Social Care Trust shall ensure; • an immediate risk assessment on the use of PPE and plastic material is carried out. This should be completed in conjunction with the IPC team in order to ensure the potential risks to patient safety are managed; and • an assurance system is introduced to monitor action and reviewing patient safety, staff practice and risk assessment. Ref: 5.1
	Response by registered person detailing the actions taken: The Trust advises that this area for improvement was initially evidenced in July 2019 (IN035232) and was addressed within the Action Plan at that time. The Trust acknowledges that this was not reviewed by RQIA as part of the 2021 inspection.

Area for improvement 2 **Ref:** Standard 5.1 Criteria: 5.3 (5.3.1) (f) **Stated:** First time **To be completed by:** 28 December 2021	The Northern Health and Social Care Trust shall ensure that the Admission and Discharge to Mental Health Beds Policy is ratified and includes; • a local escalation policy which clearly defines the level of bed usage and bed management strategies to manage the Trust's bed capacity; and • information on the use of leave beds within inpatient care, that is explicit on how such leave is planned and what to do if unexpected re-admission occurs. Ref: 5.2.1
	Response by registered person detailing the actions taken: The Trust have undertaken a review of the Admission and Discharge Policy which is in the final stages of approval. This policy takes cognisance of learning from recent developments within the Regional Bed management protocols and Acute Bed demand. The Trust have also devised a local bed escalation policy, in line with and in consultation with the Regional Bed Management policy. This policy, which is in the final stages of approval, clearly defines the level of bed usage and bed management strategies to manage the Trust's bed capacity. Consideration on the use of leave beds within inpatient care, is included within the local bed escalation policy.
Area for improvement 3 **Ref**: Standard 4.1 Criteria: 4.3 (i) **Stated:** First time **To be completed by:** 28 March 2022	In respect of managing ligature risks the Northern Health and Social Care Trust shall ensure; • each ward, accommodating patients with a mental health and/or learning disability need, has an up-to-date ligature risk assessment which accurately reflects the ligature points and control measures which is available to all staff at ward level; • relevant staff at ward level are aware of the ligature risks on their ward and the relevant mitigations; • that RQIA are furnished with an action plan detailing the anti-ligature works which require to be completed. The action plan should include timescales for the planned completion of the works. Ref:5.2.2
	Response by registered person detailing the actions taken: A process to identify the status and progression of minor capital works associated with ligature risk assessment has been established with Estates services. Estates services attend the senior nurse meeting with service and ward managers on a monthly basis, and go through each

	individual ward's minor works and ascertain it's status whilst giving feedback to the service manager and respective ward manager. Awareness sessions are planned for the Senior Inpatient Management Forum , to ensure all are utilising the ligature risk assessment tool appropriately. This will ensure that all key stakeholders, as stipulated in the policy, are included in the completion of the assessment. The Trust will also seek to ensure consistency of approach to the completion of these audits across all ward environments and that all are held consistently to enable easy access for staff at ward level. The Ward Staff Meeting agenda will contain a standing agenda item in respect of ligature risks, thus ensuring a focus for all staff within the ward area on risk assessment and associated action plans. Ward representatives will share information from the Senior Inpatient Management Forum via Ward Safety Briefings and Ward Staff Meetings, to ensure all staff are aware of all ligature risks on their ward and the relevant mitigations. All ward ligature risk assessments are up to date and action plans in place. PICU: The Trust recognises the ligature risks in PICU and has submitted a general capital bid for funding to segregate the PICU wards into single bed areas. This will also include the replacement of doors and handles. The Division await the outcome of the bid process. In the interim, risks identified are managed and effective communication mechanisms are in place with Estates colleagues to ensure timely progression of minor capital works where required. Ross Thomson Unit: The Ligature risk assessment tool for Ross Thomson Unit has been updated and forwarded to RQIA to highlight the risk that was not incorporated at the time of inspection. Some remedial action has been taken to reduce the number of locally managed ligature risks within the unit while work continues to identify long term solutions to mitigate these risks.

<table>
<tr>
<td rowspan="2">Area for improvement 4

Ref: Standard 4.1

Criteria: 4.3 (i)

Stated: Second time

To be completed by:
28 December 2021</td>
<td>In relation to mitigating fire risks the Northern Health and Social Care Trust shall ensure;

• each ward has an up-to-date accurate fire risk assessment;
• oxygen tanks in resus bags are noted as a combustible gas in fire risk assessments;
• there are sufficient numbers of staff trained as fire wardens to ensure a fire warden is scheduled for each shift; and
• appropriate governance of the adherence to the fire policy in respect of completing annual fire drills or walk/talk fire drills are completed.

Ref: 5.2.2</td>
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<td>Response by registered person detailing the actions taken:
Each ward has an up-to-date accurate fire risk assessment.

The Fire Officer and the AD for Acute MH Services have reviewed all fire risk assessments to ensure that oxygen tanks in resus bags are noted as combustible gas hazards.

All qualified staff are attending fire warden training in order to ensure that a fire warden is scheduled for each shift.

Appropriate governance of the adherence to the fire policy is supported via the Holywell Fire Safety Subgroup, chaired by Inpatient Nursing Services Manager. This group meets on a quarterly basis to ensure that there are adequate structures of accountability for fire safety arrangements and evacuation planning across the hospital wards. This includes ensuring that all Departments have an appropriate number of staff trained as Lead Fire Wardens / Fire Wardens for Fire in respect of Evacuation Plans. A compliance report, detailing dates of Fire Warden training, fire drills, risk assessments and evacuation plans is maintained. This report assists the Service Manager, in collaboration with the Fire Safety Team, in identifying training needs to assist in the development and implementation of training programmes for all staff commensurate with their roles in fire safety and evacuation. A series of Walk & Talk drills were scheduled and undertaken across the Holywell site in October 2021.

Fire Safety is also a standing agenda item at the weekly senior inpatient manager’s forum.</td>
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Area for improvement 5

Ref: Standard 5.1

Criteria: 5.3.1 (c)

Stated: Second time

To be completed by:
28 December 2021

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<td>

The Northern Health and Social Care Trust shall ensure;

- staff's knowledge and training in respect of safeguarding is embedded into practice;
- up-to-date safeguarding policies and procedures are easily accessible for staff;
- immediate protection plans are implemented for those patients for whom a safeguarding referral has been made;
- there is consistency in the recording of the incident including details of the action taken following a referral;
- the rationale for decision making to screen out a referral is recorded and shared with ward staff; and
- ward staff are aware of what stage in the ASG process each referral is at.

Ref: 5.2.4

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Response by registered person detailing the actions taken:
NHSCT Safeguarding Action Plan (2022) is attached.

The NHSCT SMT has recently approved a reform programme which echoes the work streams under the Interim Adult Protection Board. Work streams will review staffing of ASG, training needs of all staff, data collection and alternative safeguarding responses. Workstreams will be led by senior members of staff and will feed back via the AD for Safeguarding to the SMT.

The ASG service has already begun some of this work in Holywell Hospital (following a whistleblowing allegation) with a review of accessibility of policy and procedures having been carried out; updated flowcharts made available to the ward; "mustard" box containing all protection plans in clear view on wards and checked by ward SW on a weekly basis; further workshops and training provided in February 2022 and meetings with ward managers and B6 nursing staff to be held in March 2022.

Unannounced visits to wards to monitor understanding of ward staff about ASG will take place during March and April 2022 by members of the ASG central team.

All staff attend Mandatory training in relation to Adult Safeguarding and Safeguarding Children. There is a monthly table collated and forwarded to Nursing Service Managers for action to address any outstanding training deficits and raise with respective Ward Managers.

Safeguarding has also been incorporated into the weekly Senior Inpatient Management Forum as a standing agenda item whereby any recent Safeguarding incidents are discussed,

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	protection plans reviewed and actions taken to address any deficits. Safeguarding has also been added as a topic for the academic afternoons to share learning from recent safeguarding incidents. Safeguarding incidents and actions are reviewed and discussed every morning at the daily Safety Briefing (a unit-wide safety huddle) with senior managers being able to guide staff to appropriate policy or actions in management of same. Service Managers conduct periodic audits of case notes to review record keeping and actions plans from recent safeguarding incidents.
Area for improvement 6 **Ref:** Standard 5.1 Criteria: 5.3.3 (d) **Stated:** Second time **To be completed by:** 28 December 2021	The Northern Health and Social Care Trust shall ensure there are a sufficient number of staff trained to provide patients with support to use the ward's cardiovascular gym equipment. Ref: 5.2.5
	Response by registered person detailing the actions taken: The Trust are in the process of sourcing an accredited training supplier in order to provide training. The previous training plan was impacted by the COVID 19 restrictions with the identified company not resuming its services after the lifting of restrictions. Work is ongoing with our physiotherapist teams to identify time tabling of activities in the gym as an interim measure, while awaiting the training of staff.

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<tr><td rowspan="2">Area for improvement 7

Ref: Standard 6.1

Criteria: 6.3.2 (g)

Stated: Second time

To be completed by:
28 December 2021</td><td>The Northern Health and Social Care Trust shall ensure;

• the outcomes and follow up actions taken by staff to address the issues raised at patient forum meetings are documented and recorded and reported back to patients, service user consultants/patient advocates and SMT.

Ref: 5.2.5</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Weekly Patient/Staff meetings are held. The Service User Consultant regularly attends. Minutes of meetings and planned follow up actions are displayed on the patient information boards within the wards. Responsible persons are identified to take forward each action with feedback provided at the next meeting.

The Division is in the process of developing a “You Said, We Did” visual display that will offer opportunities for new patients and visitors to see and speak to staff about those identified issues and associated actions.

Patient/staff concerns and sources of dissatisfaction are also discussed on a daily basis in the Safety Briefing involving senior managers, other multi-disciplinary senior team members and medical consultants. Following these meetings, actions are agreed to mitigate the impact of identified issues.

A record of this feedback is put on the daily 24 hour report which is sent every morning to all senior managers, medical consultants, MDT members and offers an opportunity for SMT to also review this daily.</td></tr>
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Area for improvement 8 **Ref**: Standard 5.1 Criteria: 5.3.1 (f) **Stated:** Second time **To be completed by:** 28 December 2021	The Northern Health and Social Care Trust shall ensure; • there is a robust daily monitoring system for the cold storage of medicines; the minimum and maximum medicine refrigerator temperatures are recorded, the thermometer is reset every day and medicines are stored in accordance with the manufacturers' instructions; and • the contents of the bags are regularly inspected to take account of expired medicines and damaged packaging. Ref: 5.2.10
	Response by registered person detailing the actions taken: An audit of medicine cold storage was conducted across all wards which identified that there were different fridges in use. Standardised fridges have been ordered in order to establish a consistent approach across the Division. An instruction manual for use of each fridge, to include the need for regular inspection to take account of expired medicines and damaged packaging, has been devised. The checking process of fridge temperatures and expired medicines checking has also been updated on the induction pack for each ward. Checks of fridge temperature occur daily.

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

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Assurance, Challenge and Improvement in Health and Social Care