The Regulation and Quality Improvement Authority

Inspection Report

21 July - 06 August 2021

Belfast Health and Social Care Trust

Type of service: Dementia Inpatient Service
Valencia Ward
Address: Knockbracken Healthcare Park, Saintfield Road,
Belfast
BT8 8BH
Tel No: 028 9504 2044

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: Belfast Health and Social Care Trust (BHSCT)	**Responsible Person:** Dr. Cathy Jack, Chief Executive Officer (BHSCT)
Person in charge at the time of inspection: Ms. Billie Hughes, Service Manager, BHSCT	**Number of commissioned beds:** 8
Categories of care: Dementia Care	**Number of beds occupied in the ward during this inspection:** Day 1: 10 patients Day 2: 9 patients
Brief description of the accommodation/how the service operates: Valencia is an eight bedded mixed gender ward providing care and treatment to patients with dementia. The ward is situated within the grounds of Knockbracken Healthcare Park and is a single storey unit which consists of four multi patient dormitories and four side rooms. There are no ensuite facilities.	

2.0 Inspection summary

An unannounced inspection to Valencia ward commenced at 09:00 on Wednesday 21 July 2021 and concluded on Friday 6 August 2021 with feedback to the senior management team (SMT). The inspection was carried out by care, pharmacy and estates inspectors.

The previous inspection of the ward from 10-11 February 2020 resulted in six areas for improvement (AFI) being identified. Within the AFI, serious concerns were identified relating to adult safeguarding (ASG), incident management and leadership/management/culture issues. The Trust subsequently submitted action plans providing assurances that significant improvement had been made against the serious concerns.

Intelligence received since the last inspection related to deficits in; safe delivery of care, safe administration of medication, management of ASG incidents, staff attitudes, leadership/management of the ward, and the environment.

This inspection sought to assess progress with AFI and serious concerns identified at the last inspection and concerns raised in the intelligence received since the last inspection.

There were seven key themes;

- Incident management,
- Adult safeguarding,
- Environment,
- Speech and Language Therapy (SALT) recommendations,
- Record keeping,
- Staffing,
- Governance and
- Medicines management

Since the last inspection we received concerns in relation to wound care and the use of bed rails. We found the ASG process had been followed for these incidents and appropriate actions had been taken.

Relative's that spoke to us during the inspection indicated their experience of the ward was positive. We found family engagement was good.

Staff feedback was generally positive. There was evidence that the Trust were responding to issues raised by staff and had committed to further work to improve staff morale and develop the staff team. Staff reflected on this positively and have welcomed the new management structures and change from Older Peoples Services Directorate to the Mental Health Directorate.

Pharmacy inspectors visited the ward on 29 July 2021 and found medicines management was to a good standard.

On review of the six AFIs from the previous inspection three had been met, two had not been met, and one had been partially met. Three will be stated for a second time. These related to incident management, ASG, and SALT recommendations. New AFIs have been stated as a result of this inspection which relate to ASG, SALT recommendations, record keeping, staffing, and governance.

3.0 How we inspect

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

4.0 What people told us about the service

Relatives were complimentary about the care their relative received and about the staff.

The majority of staff stated they would be happy for a family member to be cared for in Valencia.

Staff were observed to deliver compassionate care when patients were distressed.
On the whole patients appeared relaxed and happy to engage with staff.

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 Valencia was undertaken from 10-11 February 2020 by care inspectors. Six areas for improvement were made.

<table>
<tr><th colspan="3">Areas for improvement from the last inspection 10-11 February 2020</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for Improvement 1

Ref: Standard 5.3.1 (f)

Stated: Third Time

To be completed by:
08 June 2020</td><td>Nursing staff should ensure that patient care plans are completed in accordance to the required standards. This includes evidence of relative /carer involvement in the care planning process.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

Person centred Assessment plan of Care Evaluation (PACE) documentation was being used in Valencia. Care plans had been completed in accordance with the PACE Framework. There was evidence of relative/carer involvement in the care plans, the daily progress notes and following multidisciplinary team (MDT) meetings.</td></tr>
<tr><td rowspan="2">Area for Improvement 2

Ref: Standard 4.3 (a)

Stated: Second Time

To be completed by:
08 June 2020</td><td>The Trust must ensure that there are clear lines of accountability for each member of ward staff and the wards MDT. The Trust should ensure that all staff work in accordance to the Trusts working well together policy.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

Valencia ward had been transferred from the Older Persons Programme of care to the Mental Health Directorate and staff described the new management structure and the lines of accountability within it.</td></tr>
</table>

	The Trust had appointed two ward managers in post, one of which is on an interim basis to help stabilise the team and support the substantive ward manager. Staff stated this had helped improve morale. The working well together policy had been replaced by the Conflict, Bullying and Harassment in the Workplace Policy, which was available to all staff and better suited the needs of the staff. This policy focuses on all staff taking collective responsibility to create and maintain a safe, harmonious working environment, with clear guidance on how to handle conflict, bullying and harassment in accordance with best practice and relevant employment legislation.	
Area for Improvement 3 **Ref:** Standard 5.3.1(f) **Stated:** First **To be completed by:** 08 June 2020	The Belfast Health and Social Care Trust must implement measures to improve the safety of the meal provision. These should include SALT guidance, clear planning in relation to patient staff ratios, and access to trained nursing staff within the dining room during meals.	**Partially Met**
	Action taken as confirmed during the inspection: The mealtime experiences observed were positive. Staff demonstrated compassionate care during meal times. A staff member was present at each table during the meal and there was at least one registered nurse checking adherence to individual SALT care plans before meals were served to patients. The registered nurse remained in the dining area throughout the meal. SALT guidance was adhered to, with information about each patient's dietary requirements available in the dining room and the kitchen, however there were discrepancies in some of the information. **Further detail is provided in section 5.2.4** **This AFI will be stated for a second time**	

Area for Improvement 4 **Ref**: Standard 5.3.1(f) **Stated:** First **To be completed by:** 08 June 2020	The Belfast Health and Social Care Trust must strengthen the oversight of incident management to ensure: a) Data relating to incidents on Valencia Ward should be collated, analysed and interrogated; b) All trends are identified and all learning is implemented; c) Implementation of a programme of audit to provide assurance that the established processes are operating effectively.	**Not met**
	Action taken as confirmed during the inspection: Datix incidents from April – July 2021 were reviewed. On the whole, the grading of incidents was appropriate. On review of the MDT governance minutes there was evidence that monthly incident totals were provided however there was no detail of the discussion or what follow up actions were required from those meetings. We could not evidence a robust system that enabled identification of trends and ensured learning was disseminated to drive improvement. **Further detail is provided in section 5.2.1** **This AFI will be stated for a second time**	
Area for Improvement 5 **Ref :**Standard 5.3.1 (f) **Stated:** First **To be completed by:** 08 June 2020	Adult Safeguarding procedures within Valencia ward should be strengthen to ensure: a) That protection plans are appropriately developed; b) All staff fully understand how to implement the protection plans; c) Identification of trends and safeguarding prevention; d) Effective escalation of adult safeguarding issues; and e) Effective audit and assurance of adherence to trust procedures and Adult Safeguarding Operational Procedures 2016.	**Not met**

	Action taken as confirmed during the inspection: A file was in place which held the regional guidance; Adult Safeguarding: Prevention and Protection in Partnership Policy (2015) for staff to consult and staff were required to sign that they had read it. There was a satisfactory level of up to date ASG training. Bespoke training was delivered to ward staff in May 2020. Protection Plans generated from ASG referrals were available however; there was nothing to indicate which plans were current and which had been discontinued. The date the protection plan commenced was not recorded. The plans were not signed and there was no evidence of MDT involvement in their development. Staff we spoke with were unclear about the difference between an alternative safeguarding response (ASR) and a Protection Plan. On review of the monthly MDT governance meeting agendas it was evident that ASG referral totals were provided however, there was no detail about the interpretation of the data gathered or what actions were identified. We could not evidence a robust system that enabled identification of trends and ensured learning was disseminated to drive improvement. **Further detail is provided in section 5.2.2** **This AFI will be stated for a second time**	
Area for Improvement 6 **Ref:** Standard 4.3 (a) **Stated:** First **To be completed by:** 08 June 2020	The Belfast Health and Social Care Trust must ensure; a clear strategy, led by the SMT, to support and develop the leadership and culture within the ward to include; a) Full implementation of the Belfast's Trust Working Well Together policy to improve culture and morale within the nursing team; b) Updating the action plans and Terms of Reference pertaining to Service	**Met**

	Improvement Group to ensure a clear and robust plan to improve leadership. c) Improvement plans which involve and are communicated to the MDT: and d) Clear systems of accountability through to the Trusts Board for delivery of the required improvements.	
	Action taken as confirmed during the inspection: The Working Well Together policy had been replaced by the Conflict, Bullying and Harassment in the Workplace Policy which was evidenced to be available to all staff. The Service Improvement Group had been unable to meet regularly during the pandemic however, remote meetings had taken place. There was evidence of service improvement working across different disciplines including Adult Protection Gateway Team, Human Resources and the Training Department. The Trust had appointed two ward managers in post, one of which is on an interim basis to help stabilise the team and support the substantive ward manager. Staff stated this had helped improve morale.	

5.2 Inspection findings

5.2.1 Incident Management

The recording of incidents on the Trust's electronic incident management system, known as Datix, between April 2021 and July 2021 was of a good standard.

On the whole, the grading of incidents was appropriate. Staff were using the Trust's grading matrix to grade incidents based on the inherent risk and not the outcome of the incident. There was detailed recording of incidents seen within patient progress notes and evidence of MDT involvement where appropriate. Datix incident reports evidenced when an ASG referral was considered or made.

Staff's mandatory training for incident management was found to be satisfactory. The appropriate staff had attended training for both Adverse Incident Reporting (for Datix handlers) and Quality and Governance Training.

Monthly MDT governance meeting agendas from June 2020 until June 2021 were reviewed, and there was evidence that monthly Datix incident totals were provided at these meetings,

however, there was no evidence of discussion of the incidents, identification of themes and trends and how this data was being used to drive improvement in the service.
This area for improvement will be stated for a second time.

5.2.2 Adult Safeguarding

There was evidence of a satisfactory level of ASG training. Bespoke training was delivered to ward staff in May 2020. The training focused on improving staff's understanding of their roles and responsibilities in identifying an ASG incident, completing an ASG referral and implementing a protection plan in a timely manner. A comprehensive file was in place, which contained the regional guidance; Adult Safeguarding: Prevention and Protection in Partnership Policy (2015) which staff had signed once they had updated themselves on the procedures and policies.

We met with four staff, all of whom had a good understanding of what constituted a safeguarding incident and the process for reporting. There was evidence that appropriate referrals were made, most of which were screened out at ward level with an alternative safeguarding response (ASR) indicated in the referral as the most suitable way to manage the incident(s). We found this alternate response to be appropriate and patient centred. All referrals were filed in the ASG folder which was not easily accessible to all staff. This resulted in some staff not having access to the protection plans or ASR. Access to, and knowledge of, protection plans and ASR by all relevant staff, is a crucial component of the ASG process.

The ASRs were discussed at the safety brief however; they were discussed in less detail than protection plans. Staff were not informed when an ASR had been indicated rather than a protection plan. Staff were not confident when describing the difference between an ASR and a protection plan, despite both identified as the options for outcome of an ASG referral within the APP1 Adult At Risk Of Harm Concern form (APP1).

We reviewed the protection plans contained within the ASG folder. The ward manager advised none were current however; there was nothing to indicate any of the protection plans had been discontinued. None of the protection plans had a date of commencement and only some had the date the incident occurred this meant it was not possible to assess the timeliness of the protection plan. The protection plans were not signed and there was no recorded evidence of MDT involvement. Information on decision making in relation to protection plans was recorded in different locations.

We reviewed two ASG incidents that we were informed of since this last inspection. Both incidents were managed appropriately through ASG processes and an investigation remained ongoing for one of the incidents at the time of the inspection. We found learning had been identified and shared with relevant staff and patient outcomes improved.

Monthly MDT Governance Meeting minutes for the previous year were reviewed and they evidenced that ASG referral totals for the month were provided at these meetings but there was no recorded detail of the discussion this generated or what actions were required. One of the ward managers and the Designated Adult Protection Officer (DAPO) complete a weekly review of protection plans and a monthly analysis of referrals. The reviews and analysis were not available during the inspection and auditing of adherence to the regional ASG procedures was also not available. Four ASG referrals had been made in relation to SALT issues however; there was no evidence how this trend was being managed.
We were unable to evidence any learning being shared and had no assurance that analysis of the data provided was driving improvement.

This area for improvement will be stated for a second time. A new area for improvement was identified to assure that protection plans; are dated and signed, include MDT involvement, are reviewed in a timely manner, and are accessible to relevant staff.

5.2.3 Environment

Valencia ward is an old building and plans are in place to refurbish it. Staff were observed making the best out of the limited space available to them. The ward was brightly decorated throughout with personalised décor to aid orientation. Paintings of local attractions were suitably placed around the ward.

We were informed that the refurbishment plans included the creation of a new nurses' station to replace the existing area which was too small and not fit for purpose. A large white board was located in the central area of the ward which displayed an easy to read list of staff names on duty each day, however, some discrepancies were noted with the names on the board compared with the staff on duty. Another notice board of information for patients, visitors and staff was also available in the same area which contained information pertaining to audit results and incidents. The information was displayed in very small font making it difficult to read. We suggested that the font could be enlarged to make it more accessible which the ward manager agreed to do.

Sleeping arrangements are provided in four side rooms and four dormitory style accommodation. All side rooms were in use and three of the dormitories were being used by patients. The fourth dormitory was being used to store additional seating, new mattresses and Occupational Therapy (OT) equipment with only a portable screen across it to prevent patients entering the area. Staff told us that this area allowed a Covid-19 secure area to be quickly established if required. However the area was not ready for use and we suggested it be cleared in case it was required at short notice for the intended purpose. The ward manager agreed to make arrangements for the area to be cleared.

Minutes of governance meetings, environmental risk assessments, and environmental audits were reviewed and we were satisfied with the subject matters and discussions within. Staff training records for Infection Prevention and Control (IPC) were found to be satisfactory. We observed good staff IPC practices. We noted there was good Covid-19 information and signage displayed around the ward to guide staff, patients and visitors on the measures to be taken to reduce the transmission of the virus.

The standard of environmental cleaning of clinical and non-clinical areas throughout the ward was generally good. Some minor maintenance and housekeeping issues were identified and rectified by relevant staff immediately.

Water pressure throughout the ward was inconsistent with two taps having no water at all. Regular flushing of infrequently used outlets is required and was brought to the attention of the ward manager. SMT and estates personnel examined the issues raised and gave verbal assurances they would be addressed. Estates personnel supplied water testing records which were deemed satisfactory by an RQIA estates inspector. The water pressure inconsistencies and taps with no water were fixed within 24 hours.

The ward benefits from an outside garden area for the patients to enjoy. This area was found to be unkempt and presented slip and trip hazards.

Smoking debris was observed scattered over the ground prompting the need for a safe receptacle for extinguishing and depositing cigarette ends. Shrubbery was overgrown and the space was not inviting for the patients. SMT and estates personnel examined the area and immediate contact was made with an external contractor requesting work to be started on the garden.

5.2.4 Speech and Language Therapy (SALT) recommendations

Staff informed us there was no identified speech and language therapist assigned to the ward however, referrals could be made directly to SALT for immediate assessment if required. Staff identified SALT as a responsive and supportive service.

Patient's SALT recommendations were reviewed. There were at least four recording systems for patient's SALT assessment information and updates. There was a large white board in the dining area with each patient's dietary requirements detailed on it. There was a laminated sheet of pink paper in the kitchen which staff used when plating food for patients. Patient nursing files contained SALT assessments as did the patient medical files.

Inconsistencies were found amongst these sources of information. Locating the most recent SALT recommendations was difficult. SALT assessments and recommendations in the nursing files were not always up to date with the most recent changes only being recorded in the medical file. There were no comments on assessments to indicate if they were discontinued or the most recent assessment. The information on the white board in the dining room did not correlate with the information on the pink sheet in the kitchen. These inconsistencies were brought to the attention of the ward manager who immediately amended the board in the dining room to reflect the information on the pink sheet. A suggestion was made to date and sign the board and the pink sheet as a means of ensuring staff were assured the information available was up to date and correct; the ward manager actioned the suggestion.

One staff member was present at each table throughout mealtimes and at least one registered nurse was available in the dining room. A registered nurse plated patient's meals and presented the food to the staff member assisting that patient. The dining experience was calm and organised. Patients were afforded space and time throughout their meal and staff responded positively when a patient left the table without having finished their food. It was positive to see a folder was available in the dining room containing the International Dysphagia Diet Standardisation Initiative (IDDSI) information on food and fluid consistencies, and general information on choking. We observed that all patients received the correct consistency of food and fluids during meal times.

This area for improvement will be stated for a second time.
A new area for improvement was identified to assure the recording, updating and storing of SALT recommendations.

5.2.5 Record Keeping

Patient care records were reviewed. The Northern Ireland Practice and Education Council (NIPEC) Person centred Assessment plan of Care Evaluation (PACE) framework was in use. Patient assessment of needs was recorded on admission however; the assessments were not copied or updated with each additional PACE continuation booklet used, resulting in care plans not being readily available to staff to inform the writing of daily progress notes.

The care plans recorded in patient admission booklets were found to be generic in nature and not person centred.

During discussions with the SMT, they advised that they were in agreement with our findings and had planned to commence use of the Clear Dementia Model of Care (CLEAR), in September 2021 to replace the PACE framework.

Patients' daily progress notes were up to date and completed contemporaneously. The progress notes were mostly focused on patients' physical health care needs and there was lesser detail relating to patients' mental wellbeing and therapeutic interventions provided. The introduction of CLEAR should address this.

There was evidence that family members/carers were invited to attend a weekly MDT meeting but no evidence recorded that family members/carers had attended. There was limited information recorded to evidence that family members/carers had been involved in ongoing decisions made in relation to patients care and treatment. However, families told us there was that engagement was good between ward staff and relatives.

Each patient's nursing file contained a Dementia Comprehensive Risk Assessment. These assessments were not signed and had not been reviewed within an appropriate timeframe. Risk assessments were not accessible to all grades of staff and could not be accessed by non-substantive staff. Patient risk assessments should be accessible to all relevant grades of staff, including non-substantive staff, involved in the patients care.

Do Not Attempt Resuscitation, (DNAR) status was recorded in patient medical files. There was no evidence of a system to enable nursing staff to determine a patients DNAR status immediately in the event of a life threatening emergency. This concern was also raised by a staff member during a staff interview. A suggestion to have an up to date, easy to access list of patients DNAR status was made. The ward manager agreed to action this.

Personal Emergency Evacuation Plans (PEEPS) were reviewed. PEEPs had been completed for all patients and a ward bed plan and fire list (list of patients) was available. The fire safety file was disorganised and would benefit from a refresh to enable quick access to information in the event of a fire.

Patients' records were disorganised and not in keeping with Nursing & Midwifery Council (NMC) standards. Documents related to patient care were difficult to find. Some documents were found to be unsigned, not up to date and not accurate. An improved system would support the safe and effective delivery of patient care and provide detail on the patients' journey from admission.

Three areas for improvement have been identified in relation to person centred care plans, review and accessibility of patients risk assessments, and the standard of patient records in keeping with NMC guidelines.

5.2.6 Staffing

The Trust funded staffing compliment for the ward was reviewed and we noted that there were three whole time equivalent nurse vacancies. We acknowledge the impact that the national shortage of nursing staff is having on all services across the region and this is not isolated to Valencia.

The ward had block booked agency staff to provide continuity of care to patients.

The staffing levels for a number of randomly selected days/nights were reviewed. All randomly selected dates examined were found to have appropriate staffing levels to meet patient need.

There was evidence that staff were reporting incidents of short staffing and had completed an electronic incident report (Datix) on each occasion.

Ward occupancy for the past year was over 100% based on the number of commissioned beds (eight beds). The use of enhanced levels of observation to support patients was high. On the days of the inspection there were sufficient staff on duty and we noted the flexible staffing system which responded quickly to changing patient need.

The skill mix of staff was reviewed. There was evidence that the desired skill mix had not been met on occasions. The ward manager explained difficulties in securing the desired skill mix when using agency employed staff. There was only one occasion where an agency nurse was in charge of the ward which was a night duty. The ward manager was commended for ensuring substantive staff were in charge of the ward the majority of time.

The staff duty rota did not accurately reflect the actual staffing compliment on shift. It reflected the substantive staff on duty but not the additional agency or bank staff covering the shift. The staff duty rota should reflect the staff on duty, both substantive and agency, to enable traceability of all staff.

An area for improvement was identified in relation to the staff duty rota accurately reflecting all staff on duty.

5.2.7 Governance

The ward previously transferred from the Older Peoples Services Directorate to the Mental Health Directorate within the Trust at the beginning of 2021. Staff reflected this move was positive for patients and staff as it enabled closer links with other mental health services and colleagues.

There was evidence of good working relationships between the SMT, the ward managers and the staff to promote the delivery of safe and effective care. Members of the SMT were available throughout the inspection to support the ward staff. The appointment of two ward managers demonstrates a commitment from the SMT to assist in rectifying previous concerns raised during staff feedback sessions.

The minutes of governance meetings from April 2021 to July 2021 were reviewed and evidenced good discussions on Covid-19 arrangements, patient satisfaction, patient flow/bed management, incidents, risks, staffing and audits, however, we could not find any actions arising from these meetings or a robust system in place for outcomes to be shared with relevant

staff to drive improvement in the service. This was a similar finding on review of the minutes of team meetings from March to May 2021.

There were good governance arrangements at ward level to manage risks and the information detailed on the daily safety brief was comprehensive and supported staff with risk management.

There was evidence of auditing of medicine kardexes, SKIN care bundles, the environment, infection prevention and control (IPC), NEWS, mealtimes, and ligature risk assessment. There was evidence of action plans for the majority of audits, and associated discussions on audit outcomes at various different meeting forums. Care plan audits were completed by personnel independent of the ward using the NIPEC Online Audit Tool (NOAT).

A support visit from an Infection Prevention and Control Nurse was completed during the inspection. Non Covid-19 related visits had not been conducted since August 2020 due to departmental pressures during the Covid-19 pandemic. The IPC nurse advised that written findings of support visits were completed and held by them.

The ward does not receive a copy of the written findings and only receives verbal feedback at the conclusion of the visits. We were concerned that findings from IPC visits may not be shared widely. We discussed this with the ward manager and members of the SMT on the day who agreed to share our findings with the Infection Prevention and Control Departmental Lead.

An area for improvement was identified in relation to written communication of findings from independent IPC audits.

5.2.8 Medicines Management

There was evidence of a good standard of storage and stock control of medicines. Kardexes were well maintained and included reasons for omitted medicines. The patient's medicine allergy status was recorded on all of the kardexes examined. Staff were familiar with the arrangements for ensuring timely supply of prescribed medicines including medicines required during out of hours periods. Staff demonstrated knowledge of escalating to the prescriber in instances where patients refused medicines. Staff were reminded of the need to ensure that the venothromboembolism (VTE - blood clots in the veins) risk assessment is completed on each kardex.

There were clear parameters specified on the medicine kardexes to direct the administration of medicines prescribed on a "when required" (PRN) basis as part of a behavioural management strategy. This included the indication for the medicine, the minimum frequency intervals and the maximum daily dose. In instances where more than one PRN medicine was prescribed as part of a behavioural management strategy, it was clear which medicine was first and second line. The indication for each PRN medicine was documented on the patients' kardexes.

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

In relation to the cold storage of medicines, daily minimum and maximum medicine refrigerator temperatures should be recorded. The records of the refrigerator temperatures could not be located at the time of the inspection.

During the inspection, the temperature was noted to be outside of the recommended range of 2^{o}C and 8^{o}C; this was discussed with staff. The Trust should ensure there are consistent systems in place to monitor the cold storage of medicines.

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

Appropriate arrangements were in place to ensure correct and safe disposal of medicines. Records of disposal were maintained and waste disposal bins observed were stored in a secure area in the treatment rooms.

5.2.9 Staff engagement

Overall staff feedback was positive. Most staff reported morale and team working had improved since the last inspection and they felt supported by the ward managers and the SMT; staff seen the recent transfer to the Mental Health Directorate as a positive move and attributed some of the improved team working relationships to this.

A small number of staff indicated ongoing tension within the staff team and we were informed by SMT that the Trust had commenced work in an effort to address these tensions. The Trust had commissioned an external person to commence a further piece of work with staff, using a trauma informed approach.

Agency staff reported difficulty in securing the necessary MAPA training required to work with the patient group. Agency staff receive training from their employer however those with long term block bookings expressed a wish to receive training from the Trust in line with the training available to substantive staff. Agency staff stated they did not receive clinical supervision from their agency or the Trust. This information was shared with RQIA Agencies Team. All substantive Trust staff advised they had access to both supervision and appraisal. It would be a positive and supportive measure for block booked agency staff to receive regular supervision by the Trust.

The majority of staff stated they would be happy for a family member to be cared for in Valencia.

5.2.10 Relative engagement

Visiting was not permitted in the ward at the time of the inspection due to Covid-19 pandemic restrictions, however one family had been permitted to visit their relative who was receiving end of life care (appropriate IPC measures by staff and the family members were observed), and another family visited at a window during the inspection.

One family member advised they had raised concerns with the ward manager and were satisfied with the response they received.

Both families spoke highly of the care their relative had received and of the staff. They commended the compassion shown to the patients by the staff and felt they could approach the ward managers if they were unhappy.

6.0 Conclusion

As a result of this inspection three areas for improvement in relation to incident management, ASG and SALT recommendations will be stated for a second time. Seven new areas for improvement were identified in relation to ASG, SALT recommendations, record keeping, staffing and governance. Details can be found in the Quality Improvement Plan.

A number of suggestions were raised locally with the ward management and it was positive that steps were taken to address these immediately. These included; minor housekeeping tasks, and the update of all SALT information. Assurances were given that other suggestions would also be actioned. These included; larger font on the staff on duty board, clearance of the fourth dormitory, gardening and maintenance of the patients garden area, creating a list of patients DNAR status for ease of use in an emergency, and consistent recording of medicine fridge temperatures. Estates personnel rectified water pressure issues within one day of them being detected.

Based on the inspection findings and discussions held we are satisfied that this service is providing safe and effective care in a caring and compassionate manner, and that the service is well led by the management team.

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	10

Areas for improvement and details of the Quality Improvement Plan were discussed with representatives of the SMT and both ward managers 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:** 5.3.1(f) **Stated:** Second time **To be completed by:** 08 November 2021	The Belfast Health and Social Care Trust must strengthen the oversight of incident management to ensure: a) Data relating to incidents on Valencia Ward should be collated, and analysed; b) All trends are identified and all learning is shared and implemented; c) Implementation of a programme of audit to provide assurance that the established processes are operating effectively. Ref: 5.2.1
	Response by registered person detailing the actions taken The Trust acknowledges the lack of evidence in relation to discussion of incidents including identification of themes and trends. Incidents including identification of learning, themes and trends are discussed during the ward's monthly governance meeting. Since the inspection the ward has updated the minutes of their meeting to reflect this. Where learning is identified from an incident this is discussed during staff meetings and disseminated via email. Incident report approval status is reviewed by the governance team on a weekly basis. The resulting report is disseminated to Assistant Service Managers to address with their ward sisters/ charge nurses/team leaders.
Area for improvement 2 **Ref:** Standard 5.1 **Criteria:** 5.3.1 (f) **Stated:** Second time **To be completed by:** 06 August 2021	The Belfast Health and Social Care Trust must strengthen Adult Safeguarding procedures within Valencia ward to ensure: a) That protection plans are appropriately developed; b) All staff fully understand how to implement the protection plans; c) Identification of trends to reduce the likelihood of ASG incidents; d) Effective escalation of adult safeguarding issues; and e) Effective audit and assurance of adherence to trust procedures and Adult Safeguarding Operational Procedures 2016. Ref: 5.2.2

	Response by registered person detailing the actions taken: The storage of safeguarding documentation has been reviewed. An adult safeguarding section has now been inserted into patient files where ASG referrals, protection plans etc are now stored. This ensures ease of access for staff. The Ward Sister meets weekly with the DAPO to review ASG documentation including protection plans and to analyse referrals. The Ward Sister is currently meeting with the Assistant Services Manager due to absence of DAPO. Safeguarding including any learning or themes identified is discussed at the ward's monthly governance meeting. Any significant concern will be escalated to relevant personnel and addressed. Safeguarding is also discussed regularly and with staff individually where required. Minutes of these meetings are available on request. Protection plans have always been discussed at multidisciplinary team meetings however it is acknowledged that this was not clearly evidenced at the time of inspection. Action to be taken: - • Assistant Service Manager to speak to the Mental Health Safeguarding Lead regarding audit in relation to adherence to regional ASG procedures. • Meeting to take place with Consultant Psychiatrist and DAPO to amend MDT meeting documentation to reflect discussions regarding

Area for Improvement 3 **Ref:** Standard 5.1 **Criteria**: 5.3.1(f) **Stated:** Second time **To be completed by:** 08 June 2020	The Belfast Health and Social Care Trust must implement measures to improve the safety of the meal provision. These should include SALT guidance, clear planning in relation to patient staff ratios, and access to trained nursing staff within the dining room during meals. Ref: 5.2.4
	Response by registered person detailing the actions taken: As acknowledged during the inspection there are a number of areas where SALT recommendations are recorded and there were discrepancies between them. Following the inspection, a process was put in place. The whiteboard in the dining room is checked against the pink sheet containing SALT recommendations and signed on a daily basis.
Area for improvement 4 **Ref:** Standard 5.1 **Criteria:** 5.3.1 (f) **Stated:** First time **To be completed by:** 06 August 2021	The Belfast Health and Social Care Trust must ensure that ASG protection plans: a) Are dated and signed; b) Are reviewed as required. The review should clearly show the updated risk and when the risk is discontinued; c) Evidence MDT involvement; d) Are accessible to all relevant staff. Ref: 5.2.2.
	Response by registered person detailing the actions taken: Protection plans have always been discussed at multidisciplinary team meetings however it is acknowledged that this was not well evidenced at the time of the inspection. The Ward Sister now meets weekly with the DAPO to review ASG documentation and ensure that they are up-to-date and current. The Ward Sister is currently meeting with the Assistant Services Manager due to absence of DAPO. An adult safeguarding section has now been inserted into patient files where ASG referrals, protection plans etc are now stored. This ensures ease of access for staff. Action to be taken: - • Assistant Service Manager to speak to the Mental Health Safeguarding Lead regarding audit in relation to adherence to regional ASG procedures.

Area for improvement 5 **Ref:** Standard 5.1 **Criteria:** 5.3.1 (f) **Stated:** First time **To be completed by:** 06 August 2021	The Belfast Health and Social Care Trust must ensure that all sources of information relating to patient SALT recommendations are correct and up to date. Ref: 5.2.4
	Response by registered person detailing the actions taken: Following a review of documentation in the ward, only current care plans arising from SALT recommendations are kept in each patient file. Any review or update of same will be completed by SALT in conjunction with the Ward Sister. The Ward Sister has also met with SALT and made them aware of the process. The nurse in charge will check current SALT recommendations on the white board in the dining room daily and sign off.
Area for improvement 6 **Ref:** Standard 5.1 **Criteria:** 5.3.1 (a) **Stated:** First time **To be completed by:** 08 November 2021	The Belfast Health and Social Care Trust must ensure that patient care plans are personalised to reflect individualised assessed needs. Ref: 5.2.5
	Response by registered person detailing the actions taken: As highlighted in the report Trust senior management are in agreement that PACE documentation in place at the time of the inspection was not fit for purpose. A project plan is in place for the implementation of the Clear Dementia Model of Care (CLEAR) which is available on request. Staff on the ward received training on CLEAR on 15/09/2021 and 24/09/2021. The ward is awaiting dates on training for trainers which will allow for the provision of supervision and training of new staff. CLEAR documentation is currently being piloted. This will include documentation in relation to mental state assessment, physical health and resulting care plans and risk assessments. It is envisaged that CLEAR will be fully implemented by end of January 2022.
Area for improvement 7 **Ref:** Standard 5.1 **Criteria:** 5.3.1 (a) **Stated:** First time **To be completed by:** 08 November 2021	The Belfast Health and Social Care Trust must ensure that patient risk assessments are reviewed within an appropriate timeframe and are accessible to all relevant staff. Ref: 5.2.5
	Response by registered person detailing the actions taken: As stated above a project plan is in place for the implementation of the Clear Dementia Model of Care (CLEAR) which is available on request. CLEAR documentation currently being piloted includes patient risk assessments and the PQC dementia risk assessment will be replaced by this once implemented. It is envisaged that CLEAR will be fully implemented by the end of January 2022.

Area for improvement 8 **Ref:** Standard 5.1 **Criteria:** 5.3.1 (f) **Stated:** First time **To be completed by:** 08 November 2021	The Belfast Health and Social Care Trust must ensure that patient records are completed accurately and consistently. Records should be accessible to all relevant staff and stored appropriately. Ref: 5.2.5 **Response by registered person detailing the actions taken:** A review of patient documentation in Valencia Ward has been undertaken and an action plan developed. The implementation of CLEAR model will streamline documentation. Uni-disciplinary files will be closed and multidisciplinary team files put in place. ASG referrals and documentation will be stored in patient files as will SALT care plans and assessments. Files are and will continue to be audited each month by ward sisters. This will include checking to see if documentation is adhering to NMC standards and that information storage is in line with Trust policy. Any issues will be flagged to the relevant staff member to rectify. Any general themes arising from record keeping will be discussed during staff meetings.
Area for improvement 9 **Ref:** Standard 4.1 **Criteria:** 4.3 (j) **Stated:** First time **To be completed by:** 06 August 2021	The Belfast Health and Social Care Trust must ensure the staff duty rota accurately reflects the staff on shift and includes substantive, agency and bank staff. Ref: 5.2.6 **Response by registered person detailing the actions taken:** Whilst all staff can view the e-roster, it can now only be edited by the ward sister's in Valencia. This will help to ensure that the staff rota is accurate.
Area for improvement 10 **Ref:** Standard 5.1 **Criteria:** 5.3.1 (f) **Stated:** First time **To be completed by:** 08 November 2021	The Belfast Health and Social Care Trust must ensure written communication of IPC audit visits/outcomes is provided to the ward manager and shared with all relevant staff. Ref: 5.2.7 **Response by registered person detailing the actions taken:** The Trust's IPC Team are liaising directly with RQIA with regards their concerns and amendments as agreed by the Inspector.

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

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