Unannounced Inspection Report
21-22 September 2020

Belfast Health & Social Care Trust

Type of Service: Neuro-behavioural Rehabilitation Unit
Knockbracken Healthcare Park
Saintfield Road
Belfast
BT8 8BH

Tel No: 028 9504 2047

Inspectors: Jill Campbell, Cairn Magill and Gavin Doherty

www.rqia.org.uk
Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

The Neuro-behavioural Rehabilitation Unit (NRU) is a six bedded inpatient service situated on the Knockbracken Healthcare Park site. The purpose of the ward is to provide rehabilitation to male patients who require continuing care due to an acquired brain injury.

There have been no admissions to NRU for the past four years as NRU has been scheduled for closure. The Trust has not finalised the closure plans for NRU and we have not been advised of a definitive date for closure.

It remains open for three patients. A new community based service has been identified as potential accommodation for two patients however it is a new facility which is not yet open. The third patient is currently out on leave to a community facility that was identified as being able to

meet his needs. The Trust indicated the end of November 2020 to be the timeframe for the last two patients to be discharged.

3.0 Service details

Responsible person: Dr Cathy Jack, Chief Executive Officer	**Ward Manager:** Joanne McNally
Category of care: Neuro-behavioural Rehabilitation Unit	**Number of beds:** 6
Person in charge at the time of inspection: 21 September 2020 - Ms Joanne McNally, Ward Manager, NRU, BHSCT 22 September 2020 – Ms Mary Scott, Deputy Ward Manager, NRU, BHSCT	

4.0 Inspection summary

We undertook an unannounced onsite inspection of NRU on 21 September 2020 from 09:00 – 17:00 and 22 September 2020 from 14:00 – 22:00. This inspection was undertaken by two care inspectors supported by an estates inspector.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

During recent inspections of other wards across the Trust we had identified a number of wards, including outlying wards, in which staff had poor knowledge of adult safeguarding procedures and restricted practices. The inspection was undertaken to assess staff's knowledge of and adherence to adult safeguarding procedures and restrictive practices.

The previous Quality Improvement Plan (QIP) relating to this ward was also reviewed, to assess if the Trust had addressed areas of improvement (AFI) identified during the most recent inspection of NRU on 16 August 2018. There were ten AFI's identified on the QIP from the previous inspection of August 2018. AFI No. 5 was removed following discussions with Trust, and the remaining nine were followed up during this inspection (see section 6).

We visited the ward and reviewed the care and treatment processes. We evidenced the following outcomes:

We were assured that staff had good knowledge of safeguarding procedures and processes and implemented restrictive practices as a last resort which was supported by risk assessments, appropriate care plans and best interest meetings.

Eight of nine previous AFI have been met; one AFI relating to the fire risk assessment was stated for a second time.

Four new areas for improvement were identified in relation to; water safety; communication between teams; senior management involvement in discharge planning; and the need for contingency plans to be in place.

4.1 Inspection outcome

Total number of areas for improvement	5

There are five areas for improvement arising from this inspection, comprising of four new areas for improvement and one area for improvement which has been stated for a second time. These are detailed in the QIP.

Details of the inspections findings/quality improvement plan (QIP) were discussed with the Trust's chief executive and members of the senior management team as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

This inspection did not result in enforcement action.

5.0 How we inspect

Prior to inspection a range of information relevant to the service was reviewed, including the following records:

- Previous inspection reports
- Serious Adverse Incident notifications
- Information on Concerns
- Information on Complaints
- Other relevant intelligence received by RQIA

The ward was assessed using an inspection framework. The methodology underpinning our inspections include; discussion with patients, relatives and staff, observation of practice; and review of documentation. Records examined during the inspection include: nursing records; medical records; minutes of meetings, duty rotas; Datix (the Trust's electronic incident recording system) records; staff training records; fire risk assessment; audit and performance evaluation reports; and promoting quality care reviews.

Areas for improvement identified at the previous inspection were reviewed and assessment of achievement was recorded as met, partially met or not met.

Posters informing patients, staff and visitors of our inspection were displayed while our inspection was in progress.

We invited staff to complete an electronic questionnaire during the inspection. We did not receive any returned completed staff questionnaires following this inspection.

We met with one patient representative during the first day of the inspection.

Findings of this inspection were shared with the chief executive and members of the Trust's senior management team at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection August 2018

Areas for improvement from the previous Inspection Aug 2018 **Quality Improvement Plan**		Validation of compliance
The responsible person must ensure the following findings are addressed:		
Area for Improvement 1 **Ref:** Standard 5.3.1 (f) **Stated:** Second Time	The contents of the emergency resuscitation equipment were out of date.	**Met**
	Action taken as confirmed during the inspection: We checked the emergency resuscitation bag and noted all items to be in date, with all packaging intact. Replacement items were available and in stock for items approaching their expiry date. There was evidence of a system in place for checking and restocking. This area for improvement has been met.	
Area for Improvement 2 **Ref:** Standard 5.3.3 (e) **Stated:** Second Time	There were five different records for each patient. A hardcopy nursing care plan record, a hardcopy medical file, a hardcopy psychology file along with records held on T-drive which linked in with records on the electronic patient recording system (PARIS).	**Met**
	Action taken as confirmed during the inspection: We examined care records and found most disciplines complete care delivery records on the patient electronic recording system known as PARIS with the exception of Psychology, which is standard practice for the Psychology department. In line with other services nursing care plans were available in hard copy. This area for improvement has been met.	

Area for Improvement 3 **Ref:** Standard 5.3.1(f) **Stated:** Second Time	Patient records and files were not managed and stored in accordance with Trust and Data protection policies and procedures and Nursing Midwifery Council Guidance on record keeping. (Some entries in hard copy medical records were illegible.)	**Met**
	Action taken as confirmed during the inspection: We examined PARIS notes and care plan documentation which evidenced good record keeping standards, noting the date and professional discipline that made the record. All care documents were stored securely. This area for improvement has been met.	
Area for Improvement 4 **Ref:** Standard 5.3.3 (g) **Stated:** Second Time	There was no evidence that audits of the various discipline files were undertaken.	**Met**
	Action taken as confirmed during the inspection: We examined a range of documentation which provided evidence that audits had been completed and satisfactory outcomes achieved. This area for improvement has been met.	
Area for Improvement 5 **Ref:** Standard 5.3.1 (f) **Stated:** Second time	There were a number of BHSCT policies which required a review.	**Met**
	Action taken as confirmed during the inspection: We reviewed the following policies during the inspection; adult safeguarding; restrictive practice; rapid tranquilisation; record keeping; induction; the procedure for grading an incident and the procedure for reporting and managing adverse incidents all of which were in date. This area for improvement has been met.	
Area for improvement 6 **Ref**: Standard 6.3.1 (c) **Stated:** Second Time	There was no information displayed in relation to the wards performance.	**Met**
	Action taken as confirmed during the inspection: Information on the wards performance was displayed on the ward although we suggested that it would require to be displayed in a larger font size for the reader. This area for improvement has been met.	

Area for improvement 7 **Ref**: Standard 5.3.1 (f) **Stated:** First Time	The action points identified in the fire risk assessment were not actioned or updated. Some action points were on the action plan since 2016. There is no reference in the fire risk assessment of the ward storing oxygen cylinders.	**Not met**
	Action taken as confirmed during the inspection: We reviewed the wards fire risk assessment (FRA) and found it was last completed in October 2019, and due for review October 2020. There were items identified for action in the action plan accompanying the FRA. We reviewed the items and noted none of the items were actioned. We also noted that the current FRA still does not reference the ward storing oxygen cylinders which were stored in the clinical room for emergency use. We made contact with the Trust Fire Officer who confirmed that actions on the 2019 FRA had not been completed. This was discussed with SMT during feedback. Further information is contained in section 6.3.3 of this report This area for improvement has not been met and will be stated for a second time.	
Area for Improvement 8 **Ref:** Standard 5.3.1.(a) **Stated:** First Time	One patient's nursing care plan refers the reader to follow the recommendations made by the Speech and Language Therapist's Dysphagia Assessment however this assessment is not on file.	**Met**
	Action taken as confirmed during the inspection: A Speech and Language Dysphagia Assessment was present in a patient's nursing file and referenced in the care plan for the patient. This assessment was also recorded on PARIS records. This area for improvement has been met.	

Area for Improvement 9 **Ref:** Standard 5.3.1(a) **Stated:** First Time	There were inconsistent recording systems from medical staff. Medical entries made on PARIS system did not generate a new case note and multiple entries were made under the same date. Other entries were made in the hardcopy medical file. This practice has the potential to confuse others and create risk in the management of patients if entries are not made in a contemporaneous date order in the one system.	**Met**
	Action taken as confirmed during the inspection: We reviewed PARIS notes and found evidence of new case note entries made by medical staff. We also viewed laboratory reports and National Early Warning Score (NEWS) charts. This is a system for scoring the physiological measurements that can detect and respond to clinical deterioration and is a key element of patient safety. Fluid and dietary intake charts were also held in hardcopy in line with normal practice. This area for improvement has been met.	

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

6.3.1 Safeguarding

We reviewed adult safeguarding referrals and assessed staff's knowledge of the procedures.

There were no recent referrals to the adult safeguarding team. During our discussion with staff two nurses have made safeguarding referrals, one in October 2019 and one in June 2020. These referrals were submitted for patient on patient verbal abuse both were screened out by the ward manager (in line with the procedure) and referred on to the safeguarding team for approval. All staff were familiar with what a protection plan was and confirmed that there were none in place at the time of the inspection.

We reviewed the minutes of staff meetings and noted that safeguarding was a standing agenda item. We were advised by the ward manager and deputy ward manager that adult safeguarding is discussed during weekly ward rounds and at the weekly operational meeting which is attended by senior management. They explained that the senior manager meets monthly with the designated adult protection officer (DAPO) to discuss incident reports and to review referral forms. We observed good governance systems for updating staff, liaison between the ward

team and Adult Protection Gateway Team (APGT), and information sharing with senior management.

All ward staff displayed good knowledge in recognising signs of harm, and knew how to reduce the opportunities of harm occurring, and how and when to report safeguarding incidents.

We reviewed mandatory training records and noted all staff were up to date on their safeguarding training. One staff member was due for renewal in October 2020 and we saw evidence to show this was being addressed.

The ward manager advised that she has not been able to attend safeguarding champion training as it had been put on hold due to Covid-19.

In the foyer of the ward, signage for adult safeguarding was on display and various leaflets were available, however we did not see relevant safeguarding information displayed throughout the ward for staff, visitors and patients. We were informed other relevant safeguarding information had been removed due to ward redecoration. We recommended to the Ward Manager that this information should be put up again with the contact details of the APGT.

6.3.2 Restrictive Practice

We reviewed the use of restrictive practices and assessed staff's knowledge of the safeguards that are required when implementing restrictive practices. We reviewed each patient's care plans and noted that a care plan was in place for each restriction. Care plans were regularly reviewed and updated by the multidisciplinary team.

We interviewed staff who demonstrated a comprehensive knowledge of the various types of restrictive practices used on the ward and were able to advise on the documentation to support this.

Staff also demonstrated their knowledge of managing aggression and potential aggression (MAPA) and where aware that implementing MAPA holds were also considered restrictive practices. We reviewed mandatory training records and were satisfied that all staff had up-to-date MAPA training and were knowledgeable. We found staff had implemented MAPA in accordance with policy and procedure. All incidents requiring MAPA were reported on the trust Datix system.

Throughout the inspection we observed staff implementing restrictive practices for the safety and wellbeing of the patients. We observed compassionate use of de-escalation techniques to good effect and using a person centred approach. We were also assured that staff deploy restrictive practices in the best interests of the patients' safety, supported by a risk assessment and care plan and restrictive practices are used as a last resort.

6.3.3 Environment

We undertook a tour of the ward and noted that the ward environment was well maintained. Since the previous inspection there was evidence of re-decoration and overall there was evidence of a good standard of cleanliness with only some minor issues. These related to the storage of the high dusting mop and the need to sweep the floor area of the room where dirty laundry is stored. These were addressed with the manager during the inspection and were actioned immediately.

The outdoor spaces of the ward have become overgrown in areas and require some maintenance to clear pathways and cut back shrubbery. We also noted that an outside light would be beneficial at the door of the ward for safety and security. These were also raised with the ward manager who agreed to action them.

During our tour we checked the water pressure in a number of sinks and outlets throughout the ward and found hot water pressure to be low in several areas. We contacted our estates inspector and advised about our findings which he agreed to investigate. The issue with water pressure was raised with the Trust's estates department and was attributed to an air lock in the system. Trust maintenance staff began to address this matter during the inspection. We also raised our concerns regarding the flushing of water outlets given there are a number of outlets throughout the ward that are not regularly used. We are satisfied that suitable control measures were in place. We were informed that ward staff are responsible for the weekly flushing regime of hot and cold water outlets, and they are aware of contractors being on-site regularly for the temperature monitoring and disinfection of shower heads. We advised that water sampling should be carried out as a precautionary measure. An area for improvement has been made.

We reviewed the fire risk assessment (FRA) which was last completed in October 2019, and was due for review in October 2020. Although the FRA assessed the risks as "tolerable" there were a number of items identified for action in the action plan accompanying the FRA. We reviewed the items and noted none of the items had been actioned. The outstanding requirements in the action plan relate to the fixed electrical installation and emergency lighting. The Trust informed us a new contractor has been appointed who is addressing these issues and we were assured that the entire Knockbracken site is connected to three emergency backup generators which also reduces the risk with regards to the emergency lighting.

We also noted that the current FRA still does not reference the ward storing oxygen cylinders which were stored in the clinical room for emergency use. We raised this matter during feedback and asked the Trust to review this assessment.

This area for improvement has not been met and will be stated for a second time.

Areas of good practice – Is care safe?

There were examples of good practice found in relation to safeguarding, restrictive practices, and medicines management.

Areas for improvement – Is care safe?

Areas for improvement were identified in relation to water safety and the fire risk assessment.

Number of areas for improvement	2

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome

6.4.1. Informed decision making

We reviewed care documentation and noted that, where necessary, staff respected the preferences of patients and delivered person centred care. We found patients did not have capacity to consent to various aspects of their care plans. In these instances, were possible, patient representatives were consulted and best interest meetings were held with members from the MDT. We found comprehensive evidence that staff gave due consideration to human rights and patient preferences.

6.4.2 Physical Health Care

Patients in NRU have unstable complex physical health care needs. We reviewed care documentation and noted there was specialist involvement from other consultants and specialist nurses who offer additional support and advice in managing their respective health care needs.

Throughout our discussions with staff it was clear that staff knew the patient's conditions and presentations of these extremely well. Staff were skilled in identifying and responding rapidly to the patients respective bespoke management plans.

During our review of the care documentation we noted that an item of equipment that could be used to reduce risk of injury to a patient was not included in the care documentation or risk management plan. However it was clear from discussions with staff that this had been considered and discussed and discounted with good rationale. Staff were able to provide us with written correspondence that reflected the multidisciplinary team (MDT) discussion however this was located in an email and not saved to the patient's record. We suggested to staff that this email provided strong evidence of the MDT having had discussions of this risk management option and should be saved to the patient's electronic care record, care plan and risk assessment. This was actioned during the inspection.

6.4.3 Records management

We observed good standards of record keeping from all disciplines. Patient records and files were managed and stored in accordance with Trust and Data protection policies and procedures and Nursing Midwifery Council Guidance on record keeping.

There were examples of good practice found in relation to records management.

6.4.4 Discharge planning

We found discharge plans were in place for both patients and a community placement identified. In reach work was ongoing and evident during the inspection. In reach staff reported they felt very much supported by the ward staff. They advised that nursing staff had a wealth of knowledge about the patients and were sharing this detailed knowledge with them.

On review of the discharge plans and speaking to staff and patient representative we identified a number of significant concerns about the planning, transitioning and contingency.

Currently patients have access to and receive significant medical support from a GP who provides an onsite service to patients in Knockbracken. The GP arrangements to support the patients in the community have not yet been confirmed and staff fear that given the pressures on community GP practices the patients may not have the same level of access to or enjoy the timely response they currently do from the onsite GP.

Recently the patient's long-term consultant psychiatrist retired and their care is now under another consultant psychiatrist. During our feedback session, there was discussion with members of the senior management team that the patient's care may transfer to another team when they transition to their community placement. The management of patients complex needs requires constant, daily and sometimes hourly vigilance to identify signs and triggers that an acute episode of their condition is about to unfold. Both patients require bespoke and unique care plans. Staff and the patient's representative are not assured that sufficient robust arrangements are in place to safely manage these needs in the community.

Staff and a patient representative are concerned that elements of the patients care plans might be difficult to achieve due to the move to a more communal facility.

Ward staff could not confirm at what level OT input has been to the planning stages of patients discharge and we were told that an OT referral was only made recently.

We advised the Trust to seek assurances that the new community facility can maintain a lifelong placement and that the environment is sympathetic should patients' needs change.

We asked staff if they were aware of any contingency plan for the patients should their new community placements fail. Staff advised that they were not aware of any contingency plan for either patient. This issue is discussed further in the Well-led section of this report. (Section 6.5)

We suggested the Trust consider providing outreach support from the ward staff to the new facility as a means of support to continuity of care.

We acknowledged that significant work was ongoing at ward level to prepare the patients for discharge however there was a lack of communication with members from the rehabilitation team regarding the finer details required to ensure successful arrangements are in place to support the patients in their community facility.

An area for improvement has been made in relation to improving communication with patients, relatives and staff regarding the detail of community arrangements.

Areas of good practice – Is care effective?

There were examples of good practice found in relation to informed decision making, managing the physical health care needs and the delivery of patient centred care.

Areas for improvement – Is care effective?

An area for improvement was identified in relation to communication between teams in relation to discharge planning.

Number of areas for improvement	1

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

6.5.1 Person centred care

Throughout our inspection we observed staff's delivery of care with patients. We observed several examples of care being delivered in a person centred, compassionate manner. During our discussion with staff it was evident that they had used the information and knowledge from many years of caring for patients to deliver care that was often complex, and considered patients' needs and their preferences. This was also reflected in the recording of care documentation. In particular staff were very sensitive to the needs of each patient and considered their wishes and preferences when discussing risk management options.

6.5.2 Patient engagement

We commended staff's efforts when the behaviour of patients had the potential to cease all efforts for them to have a social outing. However staff had used their knowledge of patients to continue engagement preparing patients for an outing as they knew once this particular challenge was overcome the patient would enjoy the outing.

Areas of good practice – Is care compassionate?

There were several examples of good practice found in relation to delivering person centred care in a compassionate manner and excellent patient engagement.

No areas for improvement were identified during the inspection.

Number of areas for improvement	0

6.6 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

6.6.1 Leadership at ward level

We assessed leadership at ward level and spoke with staff on the ward. We identified that the staffing compliment has been consistent for many years. There was evidence of excellent team work and strong leadership. The ward manager was described by staff as "very supportive" and "approachable", and all staff spoke about the "great team" they work within and the support they received from each other, especially when they had been dealing with challenging behaviours.

6.6.2 Leadership at senior management level

During our inspection we met with the divisional lead nurse and the interim assistant service manager. We shared with them the concerns we identified in relation to patients discharge

plans and they told us that due to the recent changes in the leadership team that this level of detail still had to be discussed, planned for and managed. We suggested the senior management team consider all our findings in respect to patients discharge plans. During our meeting the divisional lead nurse agreed to establish contact with other divisional leads to coordinate the involvement of key personnel in the various community teams that would be supporting the management of the patients in the community. The newly appointed interim assistant service manager also agreed to attend multi-disciplinary meetings to plan the discharges of the patients.

The lack of certainty around contingency planning was discussed at the feedback session at the end of this inspection with various members of the Trust's senior management team. We highlighted the concerns we identified about the patient's discharge arrangements. We recommended that involvement from senior management level is required to ensure all potential challenges that could affect the success of the patient's transition to community are explored, risk assessed and mitigated and our inspection findings are considered. We further advised that if necessary further liaison with the commissioners at Health and Social Care Board may be required to secure appropriate funding and contingency arrangements.

Areas of good practice – Is the service well led?

There were examples of good practice found in relation to ward management and leadership, medical governance, and complaints management.

Areas for improvement – Is the service well led?

Areas for improvement were identified in relation to senior management involvement in the discharge planning process and arrangements around contingency planning.

Number of areas for improvement	2

7.0 Patient and staff views

7.1 Staff and Patient Engagement

Throughout this inspection we met with a number of people ranging from front line staff across a number of disciplines, to members of senior management and patient representatives. We also met with staff who worked night duties. Staff advised that they were happy to work on the ward and were confident that the care delivered to patients was safe, effective, compassionate and well led.

Although we engaged with patients during this inspection their communication needs did not enable us to ascertain their explicit thoughts on the care they received. However we did observe their responses to staff engagement and are satisfied that they feel secure and safe on the ward and with staff.

We met with one patient representative who gave positive feedback about the staff on the ward and the care they delivered. They reported that staff were great, had intimate knowledge of the patient's needs and were compassionate in the care that they delivered.

They spoke to us about their significant concerns about the pending move of the patients and the lack of detail around the community infrastructure needed to ensure the transition was successful. The patient representative also expressed her concern that there was no

contingency plan in place should the placement fail. This was discussed during the feedback session.

8.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with SMT on 28 September 2020 as part of the inspection process. The timescales for implementation of these improvements commence from that date.

The Trust should note that if the action outlined in the QIP is not taken to comply with the quality standards this may lead to enforcement action.

It is the responsibility of the Trust to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

8.1 Areas of Improvement

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

8.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to meet the areas for improvement identified. The Trust should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the DHSSPSNI Quality Standards for Health and Social Care (March 2006)

Area for Improvement 1 **Ref**: Standard 5.3.1 (f) **Stated:** Second time **To be completed by:** 22 November 2020	**The Belfast Health and Social Care Trust must:** • Ensure the action points identified in the Fire Risk Assessment are actioned or updated. • Ensure there is reference in the fire risk assessment of the ward storing oxygen cylinders. Ref: 6.1
	Response by the Trust detailing the actions taken: Fixed wire testing & emergency lighting is programmed to be carried out in the coming weeks (the entire Knockbracken site is currently being done) The FRA has recently been updated to include the storage of Oxygen cylinders. Estates manager has requested a list of remedial works to be sent to him. He willl ensure these works are carried out ASAP
Area for Improvement 2 **Ref**: Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 22 October 2020	**The Belfast Health and Social Care Trust must:** • Ensure low water pressure is addressed and rectified. • Ensure testing and water flushing are completed as per legislative requirements and records are held by relevant persons. • Ensure water sampling is completed where necessary. Ref: 6.3.3
	Response by the Trust detailing the actions taken: The water pressure issue has been resolved (Estates Inspector from RQIA attended and witnessed water pressure throughout). Flushing of water outlets is ongoing by staff, with water testing being carried out in in line with Trust policy on water safety. Again Estates Inspector from RQIA was satisfied when he spoke to staff regarding this.
Area for improvement 3 **Ref**: Standard 5.3.3 **Stated:** First Time	**The Belfast Health and Social Care Trust must:** • Provide evidence to RQIA of improved communication, improved co-ordination and improved collaboration of discharge planning, to facilitate a safe transition for both patients to the nominated community facility.

To be completed by: 22 October 2020	• Ensure staff and patient representatives are involved in and apprised of the contingency plans at the earliest opportunity. Ref: 6.4.4
	Response by the Trust detailing the actions taken: 1 Plans in place to manage and meet the patients physical needs in particular -Staff in NRU have made the necessary referrals to the community mental health teams that have been identified as essential for the safe management of the two patients on discharge. -Occupational Therapy assessments have commenced and are continuing to help inform plans to address the environmental needs for the two patients. -Community Rehabilitation Team are leading in fine-tuning the care planning process for one of the patients with Community Brain Injury team leading of the other patient. 2 GP arrangements and input from specialist teams that are currently in place in NRU -The two patients in NRU are open to a GP practice and the GP practice have agreed to accept both men when they move to the community. -Each patient will have specialist input with either Community Brain Injury Team or Community Mental Health Team or both and they will follow up these gentlemen on discharge and will remain involved until their input is no longer required. -Staff in NRU have referred the patients to the respective community specialist teams to include, teams from Diabetes services, Epilepsy services, neuro team at RVH. -There is an identified issue in respect of GP cover when the patients are on trial leave but this is being addressed through detailed care planning. 3 Transition plan eg one at a time with time in between each patient's move -The move out will depend on their needs and dictated by a joint decision from the inpatient team, community team and the team at the community placement. -The Trust is funding the placement whilst the transition is in place and until both patients have been discharged from inpatient services. 4 Contingency Plans – what is senior management input. -Contingency plans are being addressed by the inpatient team responsible for their care in hospital and higher medical and management teams. -The Consultant Psychiatrist is writing formally to the Dr to request information on contingency should: 1. Either men relapse and require hospital treatment during trial leave 2. Should either patient relapse after discharge 3. Plan for phased discharge and at what stage the patients bed is closed. 5 How are relatives being kept informed Regular meeting via inpatient review. Care Manager meets or has telephone contact with the relative of one of the patients on a regular basis. -Relatives have been invited to view the home and encouraged to engage in choosing furniture and décor of the rooms.

	6 How much space is available to each patient -Each patient will have a bespoke purpose adapated room to cater for their individual needs- comprising off a small kitchen area and living area insitu -There is also an individual large private outside garden which will be enclosed and have a roof covering. -Ensuites are bespoke and designed above standard size and for one of the patients the ensuite will have two doors to aide staff to retreat from the area if required for safety. -There is also an additional small living room available for both patients that will be supervised by staff. 7 Outreach from NRU to community placement -This is necessary it helps and supports the two gentlemen settle into their new home and allows the staff in the community to manage any potential difficult behaviours. It embeds the establishment of a new therapeutic relationship. -It is a decision that will be required from Snr management at BHSCT, of note is that inreach from the community has been underway for some months already. 8 Skill Mix -This is a specialist mental health/brain injury unit that can cater the complex needs of BHSCT two patients. - The staff ratio is a minimum of one trained staff and three senior healthcare assistants during the day and three staff at night (at least one qualified nurse)for the two gentlemen. There is also the availability of staff from adjacent unit to respond to any emergencies. -It is proposed to have the input of a Behavioural Support Worker if indicated. The community mental health team will include a consultant psychiatrist, trained mental health nurses, social workers, support workers, psychologists and input from the community brain injury team, with follow through input from Care Management. -The team at the community placement includes nurses and healthcare workers from a variety of experiences including brain injury and mental health whom have already been recruited. -The unit is attached to a larger 9 bedded unit that staff can be drawn from should this be required. 9 Inter-programme working arrangements to date and going forward. -Currently there is in-reach from the staff at the community placement to NRU, the staff within the Community Rehabilitation Team, from care management within mental health and physical health and disability and the Community Brain Injury Team have accepted one of the gentlemen on to their team. -Specialist community teams will also be involved and work has started with these teams including Diabetes, Neurology Dept at RVH 10 Care planning to date and going forward. -Staff from the community placement have been linking in with NRU staff to complete care plans. This work is continuing and is being lead by the Community Rehabilitation Team and the Community Brain Injury Team with input from staff at NRU and the community placement. This will be reviewed at each focus meeting on a two weekly basis.

Area for improvement 4 **Ref**: Standard 5.3.3 **Stated:** First Time **To be completed by:** 22 October 2020	**The Belfast Health and Social Care Trust must:** • Provide assurances that the senior management team have oversight of a robust discharge plan, to ensure each patient has a safe transition to community living. Ref: 6.6.2
	Response by the Trust detailing the actions taken: Senior management are kept up to date with all progress. Meeting re contingency planning has already taken place with Service Managers and Chair of Division
Area for improvement 5 **Ref:** Standard 5.3.3 **Stated:** First Time **To be completed by:** 22 October 2020	**The Belfast Health and Social Care Trust must:** • Provide assurances that the Trust and Board have a robust contingency plan in place, for an appropriate period of time, to ensure each patient has a safe and suitable option should their transition to community living not be successful. Ref: 6.6.2
	Response by the Trust detailing the actions taken: The Chair of Division for Mental Health Services and Service Managers for Community Mental Health and Acute Mental Health Services are meeting on 18/11/20 The meeting addressed the concerns expressed by the Consultant Psychiatrist re contingency planning and a response is being sent to him. There was agreement that in the event of a placement breaking down the patients would access appropriate services, namely acute mental health services or physical disability depending on the nature of their assessed need at the time.

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews