The Regulation and Quality Improvement Authority

Inspection Report

1 November 2022 – 21 November 2022

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 Individual:** Dr Cathy Jack, Chief Executive Officer; BHSCT
Person in charge at the time of inspection: Staff Nurse Tonderai Msonza	**Number of registered places:** 10
Categories of care: Dementia Care	**Number of patients accommodated on the ward on the day of this inspection:** Nine patients
Brief description of the accommodation/how the service operates: Valencia is a 10 bed, mixed gender ward providing care and treatment to patients with dementia within the Belfast Health and Social Care Trust (the Trust). The ward is situated within the grounds of Knockbracken Healthcare Park and is a single storey unit which consists of four dormitory style sleeping areas and four side rooms. There are no ensuite facilities. Patients are admitted either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).	

2.0 Inspection summary

An unannounced inspection of Valencia ward commenced on 1 November 2022 at 09:00 hours and concluded on 21 November 2022 with feedback to the Trust's Senior Management Team (SMT).

The inspection focused on eight key themes including adult safeguarding (ASG) and incident management, staffing, environment, restrictive practice, care records, physical health, resettlement/discharge planning and governance/leadership.

Areas of good practice were identified. Effective governance arrangements were in place with respect to the management of ASG referrals, the staffing model in place, Speech and Language Therapist (SLT) care records, Mental Health Order (MHO) forms, complaints, safety huddle meetings and the use of PRN medications.

The inspection team were assured that progress has continued since previous inspections, and it is our view that this is a result of sustained support and focused leadership. The service moved to the Trust's Mental Health Directorate in 2020. Previous concerns in relating to the isolation of the ward and the group of staff working there have been addressed, which has led to improved outcomes for patients and staff.

This inspection also sought to assess progress made against 10 areas for improvement (AFI) which were identified following the most recent inspection of Valencia ward on 21 July 2021. AFI were assessed as met, partially met or not met.

Five new AFIs have been stated for the first time and are included in the Quality Improvement Plan (QIP). These new improvement areas relate to health and safety, Infection Prevention and Control (IPC), ligature risk management, patient privacy, governance and staff training.

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

Posters were placed on the ward to inform staff, patients and relatives that an inspection had commenced and to invite them to approach the inspection team with any feedback they may have.

We gathered the views of patients, relatives and staff through speaking to them during and following the inspection.

Feedback was generally positive and all responses indicated that people were happy with the care and treatment, communication from staff, environment and service provided.

5.0 The inspection

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

The most recent inspection to Valencia ward was undertaken on 21 July 2021. Ten areas for improvement were identified and these were reflected in the QIP issued to the Trust.

This inspection assessed progress towards achieving compliance with the 10 AFI. Our findings are as follows:

<table>
<tr><th colspan="3">Areas for improvement from the last inspection of Valencia on 21 July 2021</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>Area for improvement 1

Ref: Standard 5.1
Criteria: 5.3.1(f)

Stated: Second time

To be completed by:
08 November 2021</td><td>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.</td><td rowspan="2">Met</td></tr>
<tr><td></td><td>Action taken as confirmed during the inspection:
Data relating to incidents evidenced breakdown to specific categories. Incidents were collated, analysed monthly for trends and were patient specific. The monthly analysis of incidents was discussed at governance meetings and shared with staff. Regular audits are completed on the ward.

This AFI has been met.</td></tr>
<tr><td>Area for improvement 2

Ref: Standard 5.1
Criteria: 5.3.1 (f)

Stated: Second time

To be completed by:
06 August 2021</td><td>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.</td><td>Met</td></tr>
</table>

	Action taken as confirmed during the inspection: Review of ASG records confirmed that protection and interim protection plans were in place and accessible for all staff. Staff spoken to were able to describe how to implement a plan. There was good overview of ASG referrals and processes and flowcharts were available for staff. We evidenced records in relation to escalation. We spoke to a Community Mental Health professional who advised us how ASG referrals were audited / analysed on a monthly basis in conjunction with the Designated Adult Protection Officer (DAPO) to ensure compliance with regional guidance. This AFI has been met.	
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 SLT 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	**Met**
	Action taken as confirmed during the inspection: Patient dining room experience was observed and we evidenced registered nurses plating meals for all patients including those patients with SLT requirements. We noted that SLT recommendations as recorded in the each patients' care plan matched the information readily available in the dining room. This AFI has been met.	

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.	**Met**
	Action taken as confirmed during the inspection: ASG protection plans were available within individual patient's notes. The protection plans were dated and signed and available for all staff to access, to view risks and any necessary changes/updates. We evidenced discussion by the Multi-Disciplinary Team (MDT) on a weekly basis. This AFI has been met.	
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 SLT recommendations are correct and up to date.	**Met**
	Action taken as confirmed during the inspection: SLT care plans were available within patient's notes and were up to date. Review of modified diet requirements matched the information available in the dining room. This AFI has been met.	

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.	**Met**
	Action taken as confirmed during the inspection: Patient care plans were completed on the new Clear Dementia Model of Care (CLEAR) electronic system and a copy printed out and placed in all patients notes. The CLEAR Model of Care is further referenced in 5.2.5 of this report. This AFI has been met.	
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.	**Met**
	Action taken as confirmed during the inspection: Patient risk assessments were completed on the new CLEAR electronic system and a copy printed out and placed in all patients notes. The CLEAR Model of Care is further referenced in 5.2.5 of this report. This AFI has been met.	

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.	**Met**
	Action taken as confirmed during the inspection: Patient documentation was completed on the CLEAR electronic system and a copy printed out and placed in all patients notes for staff access. We evidenced the completion of two audits which evidenced that care records were completed accurately and consistently. This AFI has been met.	
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.	**Met**
	Action taken as confirmed during the inspection: All staff had access to the duty rota which reflected staff on shift which included substantive, bank and agency staff. The rota was colour coded to differentiate between substantive and bank/agency staff and was easy to follow. The Trust uses an e-roster system. The rota is compiled four weeks at a time and is available in a folder which all staff can view. This AFI has been met.	

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.	**Met**
	Action taken as confirmed during the inspection: The Trust Senior Management Team forwarded to RQIA evidence of a number of IPC team audits/outcomes/actions and dates of their visit to Valencia. We have requested that the Trust ensure these are accessible to all staff and that these records are available on the ward for future inspection activity. This AFI has been met.	

5.2 Inspection findings

5.2.1 Adult Safeguarding and Incident Management

The ASG arrangements and incident management for Valencia ward were reviewed in line with the Areas for Improvement made on the last inspection. This is further detailed in section 5.1 of the report.

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

Staff had good understanding/knowledge and were clear about what constituted an ASG incident. A small number of referrals made to the ASG team were completed in accordance with Adult Safeguarding Protection in Partnership (July 2015) policy and procedure.

A review of Datix (Datix is the Trust's electronic system for recording incidents) records identified that incidents had been graded correctly, consistently and escalated to SMT when appropriate.

Staff records in relation to ASG highlighted that not all staff had received up to date training. We found that dates had been planned for those staff and recommend that the Trust ensure this training for those staff takes place.

5.2.2 Staffing

The staffing arrangements for Valencia ward were reviewed in line with the Area for Improvement made on the last inspection. This is further detailed in section 5.1 of the report.

We evidenced that the Telford staffing model was embedded on the ward. This established the number of staff required to ensure the safe and effective care delivery of each shift. The calculations are based on individual patient need and consider levels of support required. This contributes to the delivery of safe and effective patient care.

We noted staffing levels were good on the ward during the inspection and met the needs of the patients. Feedback from staff indicated that the wards are staffed for the level of patient acuity.

5.2.3 Environment

The inspection assessed the environment to determine if it was conducive to the delivery of safe, therapeutic; and compassionate care and to determine if it was suitable in meeting the assessed needs of the patients accommodated.

The standard of environmental cleanliness was good on Valencia ward.

The ward was bright and spacious and patients were observed to move freely around the ward space. A reasonable standard of dementia friendly décor was noted throughout with signage for each area displayed in written and pictorial form. Equipment was stored inappropriately in patients sleeping areas, dining room and toilet areas. This was highlighted and addressed during the inspection.

A bath in the main bathroom was broken and had been out of use for a number of years resulting in only one shower being available for 10 patients. An area for improvement has been made in relation to this.

There was limited evidence of effective governance arrangements in relation to environmental walk arounds of the ward and staff confirmed that whilst managers visit, a record of the managers' observations and any action arising was not maintained.

The Fire Risk Assessment (FRA) and the associated action plan were available for all staff. Personal Emergency Evacuation Plans (PEEPs) had been completed for all patients on the ward. Not all staff had received up to date fire training, this was an action that had been identified on the FRA. An area for improvement in relation to fire safety training is included in the QIP.

The most recent Ligature Risk Assessment (LRA) raised concerns. During a walk round of the environment several ligature risks were highlighted, some of which were not noted on the ligature risk assessment. The Trust must complete a further review of the LRA with view to including the additional ligature risks identified during the course of this inspection. These concerns were raised with SMT at the time of the inspection and assurances were given that action would be taken to address the concerns raised. An area for improvement in relation to ligature risk assessments is included in the QIP.

5.2.4 Restrictive Practice

We noted that the majority of patients on Valencia ward were detained in hospital under the provisions of the MHO. Restrictive practices identified included locked doors. Bed rails were risk assessed to ensure they were used safely and appropriately. All restrictions had been assessed and were found to be proportionate to the risk and regularly reviewed at MDT meetings.

Enhanced observation records highlighted that medical staff did not review all patients daily as directed by the Trust policy. All patients had an enhanced observation care plan in place. The Trust should strengthen its governance arrangements in relation to the oversight of enhanced observations to include the frequency of medical review and to ensure individual restrictions through observations continue to be necessary.

Voluntary patients had Deprivation of Liberty Safeguards (DoLS) in place and human rights considerations were documented within care plans in relation to the locked doors. Regular review arrangements were in place.

A sample of medication kardexes highlighted the administration of 'as and when required' medication was used as a last resort and after all other distraction techniques had been attempted and deemed unsuccessful. Review of medication kardexes evidenced first line and second line medications were used appropriately.

5.2.5 Care and Treatment

Care and treatment was reviewed in line with the Areas for Improvement made on the last inspection. This is further detailed in section 5.1 of the report.

We reviewed the quality of patients' care and treatment. Each patient had an electronic and printed care record which is known as CLEAR. The CLEAR Dementia Care model is a person-centred, holistic model, designed to enable staff to assess and understand behaviour in dementia and to respond more effectively. The model is built upon a principle that behaviour staff may experience as challenging, is the result of an unmet need for the person with dementia.

The records sampled included individualised risk assessments, care plans and progress notes. Care records were organised and completed contemporaneously. Risk assessments were up to date for the patients on the ward.

Individual patient records included evidence of cognitive examination and patient care plans were found to be personalised and relevant with evidence of review at weekly MDT meetings.

We noted good practice in relation to oversight of the MHO for each patient detained. A summary sheet was in place for each patient and clearly identified when review was due.

Staff displayed effective understanding and knowledge of patients' needs.

5.2.6 Physical Health

The management of patients' physical health care needs was reviewed and confirmed that patients' physical health needs were being appropriately addressed. Physical health care was monitored, reviewed and referred to Primary Health Care appropriately.

Access to medical staff was good and there were clear arrangements for patients to access the Consultant Psychiatrist. One junior doctor was also available five days per week. Weekly MDT meetings were held for each patient and CLEAR records completed to reflect a summary and actions agreed.

Patients had been appropriately referred and assessed by Speech and Language Therapy for eating and drinking and where indicated, individualised dysphagia guidelines were in place. Patients were supported by staff to eat and drink in accordance with individualised SLT assessments and recommendations. We were assured that patients were receiving the appropriate level within the International Dysphagia Diet Standardisation Initiative (IDDSI).

The patient dining experience was well coordinated and there was a peaceful and relaxed ambience. Dining room tables had a variety of condiments available for patients. However, we noted domestic services staff conveying food on a tray to a patient located away from the dining room. Whilst we acknowledge the good intentions of this member of staff we reminded the Trust that all staff involved in the delivery of food should adhere to food hygiene standards.

We observed staff delivering care and support without fully closing bed screens to ensure dignity, respect and privacy. An area for improvement has been identified in relation to care and treatment delivery.

The inspection team noted good practice in relation to pathways regarding the use of The Malnutrition Universal Screening Tool (MUST), a screening tool used to identify adults who are malnourished, or at risk of malnutrition (undernutrition).

It was positive to note that patients' fluid and nutritional needs were well addressed with the option within their SLT recommendations for levels of diet depending on their psychological and physical state.

Braden scales (in relation to care of pressure areas), Suspected Deep Tissue Injury (SDTI) in relation to pressure areas, wound charts and National Early Warning Score (NEWS) a tool used for identifying acutely ill patients, were in place and used appropriately to monitor physical health.

5.2.7 Resettlement/Discharge Planning

Patient flow data provided for inspection was accurate and consistent with the profile of patients on the wards. Patients delayed in their discharge were reflected in the data recorded by the Trust. Good discharge planning arrangements were in place.

We were advised by SMT that discharge planning can be difficult due to complexity of patient need.

5.2.8 Governance and Leadership

We observed a daily safety huddle meeting which operates each morning and is attended by all ward managers, nurse leads, medical staff and Head of Service. We found this to be an effective communication platform.

As previously noted in this inspection report, the inspection team were unable to evidence effective governance arrangements in relation to environmental walk arounds of the ward. Whilst staff informed the inspection team that members of the SMT were regularly visible on the wards and were very supportive to staff, we could not find formal evidence of this or assurances that the visits were focused on quality improvement audits. An area for improvement is included in the QIP to address this.

We reviewed the mandatory training records and noted they were not up to date. This included, fire, Managing Actual and Potential Aggression (MAPA) and other relevant training. An area for improvement has been identified in relation to mandatory training.

It was positive to note that there was good oversight at the management of agency staff at ward level.

A process for recording complaints was evidenced in accordance with the Trust's policy and procedures and complaints received since the last inspection were managed in line with policy.

Staff provided the inspection team with the most recent staff meeting minutes and the agenda discussed. Staff gave assurances that the agenda items listed were discussed in length and staff were given the opportunity to contribute to the discussion.

An area for improvement has been identified to strengthen existing governance and leadership arrangements.

6.0 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	5

Areas for improvement and details of the Quality Improvement Plan were discussed with SMT, Ward Manager, 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 5.3 **Criteria:** 5.3.1 (f) **Stated:** First time **To be completed by:** 31 March 2023	The Belfast Health and Social Care Trust must remove and replace the bath in the main bathroom so that a new bath or shower can be installed. Ref: 5.2.3
	Response by registered person detailing the actions taken: Trust response The Trust acknowledges that Valencia Ward is not a purpose built Dementia Unit. A buisness case will be submitted to upgrade the Bathroom facilites in Valencia. This will include the removal of the bath in the main bathroom.
Area for improvement 2 **Ref:** Standard 5.1 **Criteria:** 5.3.1 **Stated:** First time **To be completed by:** 31 January 2023	The Belfast Health and Social Care Trust must ensure ligature risk assessments reflect all identified ligature risks for the ward are up to date. An action plan should include clear timescales to determine when ligature points requiring removal or replacement will be completed. Ref: 5.2.3
	Response by registered person detailing the actions taken: Trust response The Trust acknowledges the incomplete ligature surveys. The survey is due to be repeated February 2023 and a risk assessment will reflect the identifed ligature points. Identifiefd ligature points will have clear documentation of how the risk will be removed or controlled. The buisness case for the bathroom upgrade will include the removal of fixed ligature points.

Area for improvement 3 **Ref:** Standard 6.1 **Criteria:** 6.3.2 **Stated:** First time **To be completed by:** Immediate	The Belfast Health and Social Care Trust must ensure the privacy is maintained for all patients receiving care and treatment in the dormitory style sleeping areas. Ref: 5.2.6
	Response by registered person detailing the actions taken: Trust Response All staff in Valencia have been reminded to ensure dignity is maintained while providing care and observation to patients. Team meeting held on 31/12/2022 has highlighted the use of screens in the bay areas to provide privacy and dignity. Should more space be required to observe a patient or provide care, a portable screen is available for staff to use.
Area for improvement 4 **Ref:** Standard 4.1 and 5.1 **Criteria:** 4.3, 5.3.1 **Stated:** First time **To be completed by:** 31 January 2023	The Belfast Health and Social Care Trust must review governance oversight arrangements for Valencia ward in relation to the environment. SMT should make a formal record evidencing all quality assurance visits and any actions arising from the visit. This record should be available on the ward and shared with relevant staff. Ref: 5.2.8
	Response by registered person detailing the actions taken: Trust Response The Mental Health Senior Management team will pilot assurance visits and provide a written report. This will be carried out quarterly and feedback will be provided to Valencia staff. All future visits from service managers/CLT/assurance visits/co director and director will be recorded on the ward visiting pyramid template.
Area for improvement 5 **Ref:** Standard 4.1 **Criteria:** 4.3 (m) **Stated:** First time **To be completed by:** 31 January 2023	The Belfast Health and Social Care Trust must ensure that all staff have completed all mandatory training appropriate to their roles and responsibilities. Ref 5.2.8
	Response by registered person detailing the actions taken: Trust Response Valencia Staff have been provided with two supported learning sessions taking place on 25/01/2023 and 26/01/2023. These sessions are open for staff to attend to book any outstanding training and have protected time to complete e-learning. Both the Nurse Development Lead and Ward Manager will be present to support staff at the supported sessions. The

	supported learning sessions have been arranged each month up until June 2023. Team meeting held on 31/12/2022 discussed the supported learning sessions to raise staff awareness. All staff have received emails on training needs and the supported learning sessions. Posters have also been provided. Highlighted training needs and trends have been discussed and staff have been instructed on how to book these. BHSCT have provided two laptops and two desktop devices to assist staff with completing e-learning and keeping mandatory training up to date. The staff training matrix has been reintroduced as the preferred method of tracking training allowing staff and management to have a clearer view and indicator of when training needs renewed/updated. Staff training has also now been placed as a standing item on the monthly ward governance meeting.

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