Inspection Report

16 August - 08 September 2021

Western Health and Social Care Trust

Mental Health and Learning Disability Hospital
Lakeview Hospital
12a Gransha Park
Clooney Road
Londonderry
BT47 6TF
028 7186 4371

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

1.0 Service information

<table>
<tr><td>Organisation/Registered Provider:
Western Health and Social Care Trust (WHSCT)</td><td>Responsible Person:
Mr Neil Guckian
Chief Executive, WHSCT</td></tr>
<tr><td>Person in charge at the time of inspection:
Janet Doherty
Acting Head of Service & Professional Nurse Lead, Adult Learning Disability Services</td><td>Number of beds:

There are two wards operating within Lakeview Hospital:

<table><tr><td>Name of Ward:</td><td>No of Patient's accommodated:</td></tr><tr><td>Melvin Ward</td><td>Six</td></tr><tr><td>Strule Ward</td><td>Two</td></tr></table></td></tr>
<tr><td>Categories of care:
Learning Disability (LD) Acute Admission</td><td>Number of beds occupied in the wards on the day of this inspection:
Eight</td></tr>
<tr><td colspan="2">Brief description of the accommodation/how the service operates:

Lakeview Hospital is a Mental Health and Learning Disability (MHLD) Hospital managed by the Western Health and Social Care Trust (the Trust). The hospital consists of two wards, Melvin and Strule and provides inpatient care to adults 18 years and over who have a learning disability and require care and treatment in an acute psychiatric care setting. Patients are admitted either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).</td></tr>
</table>

2.0 Inspection summary

An unannounced inspection to Lakeview Hospital commenced 16 August 2021 at 09.00am and concluded on 08 September 2021, with feedback to the Senior Management Team (SMT). The inspection was carried out by by a team comprised of care and finance inspectors with support from pharmacy and estates inspectors and RQIA's Clinical Lead.

RQIA received an anonymous letter on 2 August 2021. The letter outlined concerns about the standard of care, staff morale, training, recruitment practices and the governance arrangements of the Adult Learning Disability Services within WHSCT. In response to this information RQIA decided to undertake an unannounced inspection.

Taking account of the intelligence received the inspection focused on eleven key themes; patient flow and discharge planning, environment, adult safeguarding (ASG) , incident management, restrictive practices, financial governance, staffing, physical health monitoring, governance and leadership and staff and family engagement. The inspection also sought to assess progress with areas for improvement (AFI's) identified during the previous inspection.

Areas of good practice were identified. We observed staff deliver compassionate care. Care plans were detailed and patient centred and there was evidence of multi-disciplinary team (MDT) input into discharge planning with consideration given to safety, location and patient/carer preference. It was positive to see that some planned discharges were to bespoke environments, and return to home.

A number of significant concerns relating to adult safeguarding and incident management; financial governance, staffing, physical health care and hospital governance were identified. Some of these concerns were escalated to the Trust's Senior Management Team (SMT) during the inspection for immediate action. In line with our escalation policy the Trust were invited to attend a meeting on 21 September 2021with the intention of issuing five Improvement Notices.

Prior to the meeting on the 21 September 2021 it is important to acknowledge that the Trust had already completed or commenced a significant amount of work in relation to medication management, financial governance and ASG and had provided an update of the actions they had taken. Consideration was given to the information provided following the inspection, during the meeting with the Trust on the 21 September 2021 and following a review of the Trust's action plan. As a result we determined not to proceed to issue the five Improvement Notices. The significant concerns are detailed in this inspection report and Areas for Improvement (AFI) have been made. RQIA will undertake a further unannounced inspection in the future to assess the Trust's progress on the implementation of their action plan.

A total of 13 AFI were identified one of which has been stated for a third time. Areas that require improvement relate to the environment, adult safeguarding, incident management, restrictive practices, financial governance, staffing, physical health monitoring and leadership and governance.

3.0 How we inspect

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

The information obtained is then considered before a determination is made on whether the service is operating in accordance with the relevant legislation and quality standards.

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

4.0 What people told us about the service

Posters and patient/relative leaflets were placed throughout the wards inviting staff, patients and relatives to approach us with the feedback they may have.

We spoke with four relatives during the inspection by phone. Relatives expressed concerns in relation to staffing, incidents, restrictive practices and the environment. All of the relatives acknowledged that staff were compassionate and resilient and felt that despite the challenges their loved one was well cared for and safe.

We spoke with a wide range of staff, senior managers, medical staff, nursing staff (permanent, bank and agency), occupational therapy staff and finance staff. A number of staff contacted us by phone after the inspection. Staff spoke openly about the challenges they faced working in Lakeview which included staffing shortages, increases in the amount of incident related staff injuries, the environment and they also expressed concerns about the lack of leadership and support to 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 Lakeview Hospital was undertaken on 06-07 February 2018. Three areas for improvement were made.

<table>
<tr><th colspan="2">Action required to ensure compliance with The Mental Health (Northern Ireland) 1986 Order and 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: 5.3.1 (f)

Stated: First Time</td><td>The responsible person shall ensure that the ward’s MDT should ensure that patient care records do not contain any records that are not secured within the patient’s file.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

Patient care records within patient files were secure, available, and up to date at the time of inspection.</td></tr>
</table>

Area for Improvement 2 **Ref:** 5.3.1 (f) **Stated:** Second time	The responsible person shall ensure robust management of Pro Re Nata (PRN) medications. There were a lot of PRN medications which had • no indications for use written; • no minimum intervals indicated and; • there was no indication of which drugs should be used 1st line in the event that the indication for some different drug was the same. If PRN medications were used as prescribed, patients would have received over the maximum 24-hour recommended dose as recommended in the British National Formulary (BNF). The BNF is a pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about many medications available on the UK National Health Service (NHS). There was limited review of patients daily and PRN medication.	**Not Met**
	Action taken as confirmed during the inspection: Patient Kardexes did not always stipulate 1st line or 2nd line use of PRN medication or provide indications for use. Kardexes did not always indicate the dosage intervals. Staff were administering more than one PRN medication at a time for one patient. Several patients were prescribed multiple anti-psychotic medications some of which were prescribed over the BNF recommended maximum daily dosage. Patient kardexes had not recently been reviewed by the ward medical team. This area for improvement has not been met and has been stated for the third time. Due to the seriousness of these findings this matter was escalated to the SMT on 17 August 2021. Please refer to section 5.2.8 of this report for further detail.	

Area for Improvement 3 **Ref:** 5.3.3 (d) **Stated:** Third time	The responsible person shall ensure that patients can access ward based occupational therapy support.	**Met**
	Action taken as confirmed during the inspection: Patients had access to occupational therapy support at the time of inspection. While there was access to an occupational therapist they were not ward based and only accessible via referral. This issue has been highlighted in Section 5.2.9 of this report.	

5.2 Inspection findings

5.2.1 Patient Flow & Discharge Planning

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

On the days of inspection there were eight patients in Lakeview Hospital two in Strule and six in Melvin. Four of the patients were in active assessment and treatment and four were delayed in their discharge. Some patients had been in hospital for up to four years although it was noted that six patients had plans in place for discharge. In respect of the other two patients one had two unsuccessful discharges and the other had only recently been admitted.

An admission pathway was implemented at Lakeview in February 2021, this was to be completed for each admission then shared with the MDT to facilitate further discussion. The admission pathway consists of important questions including what current community supports are already in place for the patient and the reason for the patient's admission. This promotes effective sharing of information and will support the MDT to plan for discharge at the point of admission.

There was evidence of MDT input on discharge plans and careful consideration had been given to patient safety, support mechanisms and the location of family and friends. It was positive to see that the planned discharges were to bespoke environments, and return to home and not all were placements to alternative care facilities.

There was no data available to accurately calculate the average length of patient stay or record estimated discharge dates. Access to up to date and accurate information relating to length of stay is crucial to patient flow and should be readily available and shared across all relevant systems and structures throughout the Trust to ensure a proactive and joined up approach is

taken with respect to patient discharge planning. The data was received following the inspection.

An area for improvement was identified in relation to patient flow and discharge planning.

5.2.2 Environment

We visited each of the wards to review and assess if the environment was safe and conducive to the delivery of care.

The main entrance into the hospital was bright and clean with appropriate Infection Prevention Control (IPC) signage and guidance on Covid-19, social distancing, and hand hygiene displayed throughout. The reception area was warm and welcoming and decorated with art supplied from a local school. The corridors leading to the wards were clean and clutter free and there was suitable seating areas situated throughout.

Melvin Ward was a bright spacious area for patients with seating and furniture observed to be in a good state of repair. The utility and equipment stores were not clean and were being used inappropriately for storage. A number of items of equipment were in a poor state of repair requiring replacement. A recent mattress audit indicated the need to condemn and replace two mattresses. There was no evidence to confirm or indicate that this action had been completed.

A large amount of bottled water was noted to be stored in various areas throughout the ward, it was suggested that these be relocated to one suitable area. We were concerned the storage of this water in public areas could increase risk of harm to others for example, during an incident or increase the likelihood of trips/falls. The nurse in charge agreed to address this issue.

Strule Ward had been divided into two areas with one patient accommodated in each of these areas. The ward had undergone a significant amount of modifications and adaptations to the environment in order to accommodate patients with complex needs. As a result of the modifications the ward was stark and did not provide a therapeutic space for patients. We observed damage to vinyl flooring, décor, and fixtures and fittings throughout.

Patients' bedroom areas had been adapted to meet the patient's preferences however they did not present as comfortable or provide a therapeutic space. There was no door or covering of the doorway in the bathroom area. The privacy and dignity of patients had not been upheld and we escalated our concerns urgently to the SMT. The situation regarding the bathroom door was immediately rectified by the positioning of a screen over the entrance of the bathroom doorway.

Recognising the challenges faced in meeting individual patient needs we determined that a full MDT approach would be required in this case to explore options to enhance the environment and provide a more therapeutic space which ensures patients' privacy and dignity is met at all times. The SMT gave verbal assurances that alternatives would be explored to modify patients' bedroom spaces to provide a more dignified environment.

Areas for improvement relating to patients' privacy and dignity and the environment have been identified.

Fire Risk

The arrangements for fire safety were reviewed. A number of significant concerns were identified in Strule Ward as a result of the adaptations which had been made. The adaptations had been made to facilitate the complex needs of patients and included wood panelling being used throughout the ward to repair damaged floors and doors and the removal of fire retardant windows, emergency lighting, and evacuation signage. Increased wood panelling and removal of fire safety equipment significantly increases the risk to patients and staff in the event of a fire on the ward. Wood panelling could potentially increase the risk of ignition and the lack of emergency lighting and signage hinder evacuation.

We were informed by the Trust's Fire and Environment Manager that risks were mitigated by the ongoing assessment of the environment and liaison between Fire Safety Officer and Ward Staff. These concerns were immediately discussed with the SMT and assurances were sought regarding Fire Risk Assessment (FRA) in relation to patient and staff safety.

An area used to store personal protective equipment (PPE) had two fire retardant windows removed and was in a poor state of repair. A recent FRA had recommended either the windows were replaced with suitable fire rated glazing or panels, or the PPE was stored elsewhere, this had not been actioned.

The most recent FRA was completed in August 2021 and was signed by the Trust's estates department; the FRA was due for review in November 2021. The removal of emergency lighting, and fire evacuation signage, and the additional wood panelling that had been fitted were referenced in the FRA, however, there were no remedial actions in place. We were assured that the SMT were aware of the findings and that the Director had signed the general risk assessment for Lakeview Hospital with these risks identified. A copy of this was received post inspection to confirm that this was the case.

RQIA Estates Inspector liaised with the Trust's Fire and Environment Manager regarding the FRA for Lakeview. Whilst satisfied that assessments were in place, the areas of deviation from the Department of Health (DOH) Fire Code Guidance 1995 remained a concern. The Trust's Fire and Environment Manager advised of ongoing liaison with ward staff regarding the areas of deviation.

Assurance is required that all environmental changes made in response to patient need must be subject to assessment by the Fire and Environment Manager. We also require confirmation that the areas listed on the action plan of the FRA have been addressed to the satisfaction of, and within the timeframes outlined, by the assessor.

The fire risk in Strule Ward has been identified as an area for improvement.

5.2.3 Adult Safeguarding (ASG)

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

Staff did not have access to records pertaining to ASG; including previously completed APP1 (adult at risk of harm/concern) referral forms. This information was accessible to the ward manager only.

This made tracking APP1 referral status, actions taken, and protection plans difficult and did not promote effective sharing of information or communication between staff. Potentially patients could be placed at risk due to a deficit in staff knowledge for example, lack of awareness about a patient's current protection plan. Considering the high use of bank and agency staff on the ward it was concerning that this information was not readily available to staff.

The Trust operated two different processes in relation to ASG referrals; patients aligned to the southern sector of the Trust followed the regional safeguarding policy but those aligned to the northern sector followed a process of advice and resolution with referrals screened by each patient's individual social worker. The southern sector process was not in keeping with the Regional Adult Safeguarding Policy: 'Adult Safeguarding Prevention and Protection in Partnership' July 2015 and did not lend itself to continuity and consistency of approach for staff working in Lakeview. This initially started as a pilot project but had been running for three years with no evidence of oversight or analysis from the Trust's ASG Team. The lack of external scrutiny of ASG incidents from the ASG Team could reduce the level of protection for patients.

Staff were knowledgeable about the two different referral routes but not about the regional ASG process despite a significant number having completed ASG mandatory training. Staff of various grades did not understand the term Designated Adult Protection Officer (DAPO). There was no DAPO, ASG champion, or ASG lead identified for the wards. The lack of ASG expertise and staff knowledge could result in ASG incidents not being reported and vulnerable patients not receiving the protection they require.

There were no assurances that ASG referrals were being managed appropriately. A review of 464 Datix incidents (Datix is the Trust's electronic incident reporting system) from May to August 2021 highlighted that only eight incidents had been followed up with an ASG referral, however an additional six incidents met the threshold for an ASG referral.

Intelligence was received during inspection about another ASG incident and upon request, we reviewed the associated documentation. The protection plan lacked sufficient detail and we were not assured from the information provided that the patient was being adequately protected. There was no evidence to confirm the decision making process in relation to the protection plan and there was a delay of one month reporting the incident to the management team.

Our concerns about ASG processes were immediately escalated to the Trust's SMT. Discussion took place regarding the need for the Trust to undertake an urgent review of ASG practices and develop a robust process to assure themselves that staff adhere to the regional policy. The review should also consider the use of closed-circuit television (CCTV) as a tool to support adult safeguarding, staff training and development. The SMT should seek information and advice from colleagues in other Trusts where CCTV is in operation.

As a result of the concerns we identified in relation to ASG and incident management the Trust were invited to attend a meeting on 21 September 2021, signalling our intention to issue an improvement notice in relation to ASG and incident management. At this meeting the Trust outlined the actions they had taken to improve ASG processes. We were assured that progress had been made to strengthen the governance and oversight of ASG and, that further work is planned for the coming months.

We have determined not to serve an Improvement Notice in relation to ASG and Incident Management, however we will continue to monitor ASG closely and will seek evidence of improvements through action plans and further inspections.

An area for improvement has been identified in relation to ASG.

5.2.4 Incident Management

Incidents recorded on, Datix, from May to August 2021 were reviewed. The majority of incidents recorded on the Datix system related to self-harm and violence and aggression with a significant number being attributable to patients who presented with challenging behaviours.

A significant number of incidents indicated the use of MAPA (Management of Actual or Potential Aggression). MAPA is a physical intervention utilised by staff to safely manage incidents such as aggression and self-harm. Despite frequent use of MAPA there was no evidence of analysis, or consultation with the Trust's MAPA team. This was concerning given the number of incidents involving the use of MAPA and the regular use of it for individual patients. Staff confirmed during discussion that a review and analysis of all incidents was in progress with a view to identifying any patterns or trends within the incident data.

There was no evidence supporting the use of a safety brief to facilitate the daily handover of important safety information. A safety brief is a simple but effective tool that ward staff use to share information about potential safety problems and concerns on a daily basis (for example, incidents and issues in relation to the environment). The absence of a safety brief has the potential to impact negatively on patient safety.

Incidents relating to individual patients were reviewed at weekly and monthly incident review meetings, copies of minutes evidenced appropriate MDT discussion in relation to the patients including review of recent incidents, current behaviours and the use of therapeutic interventions such as the TEACCH model. The TEACCH model supports people with autism and promotes meaningful engagement in activities, flexibility, independence and self-efficacy and helps them have a better understanding of their environment.

A review meeting is being held fortnightly to discuss the needs of one patient. This meeting was attended by a behaviour specialist, social worker, the patient's relative and the agency that will be supporting the patient when they are discharged from hospital into the community. This demonstrated good practice and family engagement and supported ongoing and detailed analysis of the patient's needs.

Additionally a review meeting to discuss all patients was held monthly. Patients with complex needs were often the main focus of the monthly meeting and as a result the less complex patients may not be receiving an adequate or regular review.

The minutes of the incident review meetings evidenced some analysis and theming of incidents for specific patients, however did not provide a full oversight of all incidents. We were not assured that systems to manage incidents were robust.

Concerns were identified with respect to the management of staff injuries, both physical and psychological, sustained during incidents. There was no evidence of a debrief mechanism following an incident and no evidence of support to staff from SMT.

Staff reported they had experienced long-term psychological effects following incidents where they had been assaulted by patients. Governance and oversight arrangements such as a daily safety brief were not included in the operational management of the wards despite the high level of incidents. Effective communication was not evident to inform staff of ward events or incidents and we were unable to evidence the twice daily handover sheet which staff advised was the mechanism used to keep them updated.

As a result of the concerns we identified in relation to incident management the Trust were invited to attend a meeting on 21 September 2021, signalling our intention to issue an improvement notice in relation to ASG and incident management. At this meeting the Trust outlined the actions they had taken and planned to take to robustly manage incidents which includes analysis; trending; the introduction of safety debriefs; strengthening of governance oversight; and staff training.

We have determined not to serve an improvement notice, however we will continue to monitor incident management and will seek evidence of improvements through reviewing updated action plans and by undertaking further inspections.

An area for improvement has been identified in relation to incident management.

5.2.5 Restrictive Practices

The management of restrictive practices across the two wards was reviewed to determine staff's knowledge and application of restrictive practices and if they were proportionate to patient risks and in keeping with best practice guidance.

Restrictive practices in use included; locked doors; level of patient observations, use of rapid tranquilisation medication and physical intervention. Incidents involving physical restraint were recorded appropriately on Datix. Comprehensive patient centred care plans for restrictive practices were in place, it was positive to note that care plans directed staff firstly to de-escalation before considering the use of restrictive practices.

The governance and oversight of restrictive practices was not robust there was no data available, no evidence of debrief, analysis of patterns, trends or frequency following the use of physical intervention. Staff were using high levels of MAPA to manage challenging behaviours. Documentation following the use of MAPA had not been completed and there was no evidence of input from or consultation with the MAPA team for advice, guidance or direction on best practice and technique.

On review of patient kardexes a high level of Pro re nata (PRN) medication was regularly administered. PRN is additional prescribed medication and administered on an as required basis. There was evidence PRN medication had been used for patients who had displayed challenging behaviours (see section 5.2.8).

Considering our concerns regarding restrictive practices and the lack of SMT oversight we requested an urgent review of all restrictive practices with a view to facilitating a culture of learning from incidents and support the delivery of safe and effective care.

An area for improvement has been identified in relation to restrictive practices.

5.2.6 Financial Governance

The management of patient finances and property were reviewed to ensure that the vulnerable adults being cared for in this facility are safeguarded from financial abuse. Financial abuse is the unauthorised and improper use of funds, property or any resources belonging to an individual.

Poor record keeping and inadequate processes for patients' finances were found in both wards. There were no running balances of cash held on wards for patients and money was unaccounted for in the cash box with receipts unavailable for some transactions. Money deposited for patients was not appropriately recorded or receipted. The evidence indicated that patients' monies were exposed to potential financial abuse as there were insufficient safeguards to protect them. The Trust finance office was not aware that staff had direct access to substantial amounts of patients' money. There was no evidence that staff had received training on the management of patients' finances. These concerns were immediately escalated to the SMT and we sought assurance that action would be taken promptly with issues identified managed through ASG processes.

In response to our significant concerns the Trust finance department undertook a visit to Lakeview and completed an audit to assess the systems in place and to identify areas where Trust cash handling procedures were not operating effectively. The findings of the Trust's finance department audit correlated with our concerns and they compiled an action plan. The Trust have provided assurance that all staff will be provided with training on the management of patient finances and that all patients would have a financial care plan in place.

We acknowledge the action taken by the Trust finance department and have requested assurance from them that a system-wide process to safeguard monies for patients in hospital and those residing in the community is in place. This assurance will require the Trust to clarify what governance arrangements are in place and evidence senior management oversight. We have suggested the Trust seek a full internal audit with regards to patient finances.

As a result of the concerns we identified in relation to financial governance the Trust were invited to attend a meeting on 21 September 2021, signalling our intention to issue an improvement notice. At this meeting the Trust outlined the actions they had taken to improve financial governance. We were assured that progress had been made to strengthen the financial governance arrangements and that further work is planned for the coming months.

We have determined not to serve an Improvement Notice in relation to financial governance at this time, however, we will continue to monitor this aspect of care closely and will seek evidence of improvements through action plans and further inspection.

An area for improvement has been identified in relation to financial governance.

5.2.7 Staffing

The arrangements for staff supervision and appraisal were reviewed. Staff received supervision every three months. Staff were appraised annually with the majority completed for 2021. The ward manager had plans to address the outstanding appraisals.

The service was not operating against a suitable staffing model.

There was no evidence provided to indicate the described minimum staffing levels were based on assessed need with the exception of patients prescribed observations. Acuity of patients was not accounted for. Staffing levels reflected that the prescribed minimum staffing levels were not always being achieved.

Staff sickness levels were high with multiple factors given as the cause; these included injuries from incidents, sickness, and covid related absence. Approximately two thirds of staff were off sick in one ward. There was a high reliance on agency and bank staff which was challenging due to short notice cancellation of shifts.

The duty rotas did not reflect actual staffing on shift which created confusion regarding who was scheduled to work and which bank and agency were booked. Accurate records of staff on shift should be retained to enable clear information to be available should an incident or allegation of a safeguarding nature be made.

Staff reported an inability to have meaningful breaks throughout their shift and discussed how they were frequently asked to swap shifts at short notice. They reported being contacted endlessly when off duty to cover the rota, which led to increased stress levels and low morale.

Staff discussions focused heavily on staff shortages, the extensive use of bank and agency staff, unsafe staffing levels and no opportunity to have breaks, food or drinks. In the absence of an agreed staffing model it was not clear whether the compliment of staff enabled the delivery of safe and effective care to the patient group.

The ward manager covered staffing deficits on a regular basis resulting in limited time for them to fulfil their management responsibilities including support for staff.

All relatives we spoke to highlighted poor staffing levels and a high use of agency staff. One family member made reference to a patient's care plan which indicated the need for staff consistency and staff familiar to the patient. This patient was prone to be distressed with the potential of an escalation of challenging behaviours when cared for by staff they were not familiar with.

There was evidence of a recent recruitment drive for Band 3 and Band 5 nursing staff however there was a limited success at interviews. The Trust have offered incentives internally to support staffing and have provided assurances that they are committed to explore all options with regards to increasing their nursing workforce.

Minutes of the monthly nurse governance meetings evidenced discussions regarding unsafe staffing levels and actions being taken to address the risks included contact with the bank office to request block bookings and use of agency staff. Staff submitted Datix incident forms when staffing dropped below what was perceived to be the safe level. There were 57 incidents reported from May to August 2021 in relation to short staffing all of which were graded appropriately. There was no evidence, at senior management level, of analysis of Datix incidents in relation to staffing or information about actions taken.

Staff Skill Mix & Competency

It was positive to note that the compliment of Band 6 Deputy Ward Managers had increased from four to six since December 2020.

We were unable to evidence that all of the Band 6 Deputy Ward Managers were operating at the appropriate level of delegated responsibility and accountability. An appropriate level of support for the ward manager to manage these staff was not available; we suggested a visible presence of an experienced manager and members of the SMT would be beneficial in supporting all staff.

On some occasions newly qualified nurses had been allocated the role of Nurse in Charge. We could not find evidence to determine if the Trust had a programme in place to ensure newly qualified nurses had the experience and competency to take charge of a ward particularly given the complexity of the patient group and the high levels of challenging behaviour.

Some staff raised concerns about the skills and expertise of some agency staff. It was unclear how agency staff were assessed to have the necessary competence and skill to work in Lakeview. There was evidence that the induction process for agency and substantive staff was completed and signed off in one day. Induction documentation was in the form of a tick box list and was not indicative of a robust induction processes that took account of the staff members understanding of their roles and the Trust expectations of them.

As a result of the concerns we identified in relation to staffing the Trust were invited to attend a meeting on 21 September 2021, signalling our intention to issue an improvement notice in relation to staffing. At this meeting the Trust outlined the actions they had taken to improve staffing such as the introduction of the Telford Staffing Model, the upskilling of managers to produce robust off-duty rotas based on patient need and acuity and the recruitment of an additional ward manager. There is an ongoing recruitment drive in place to secure additional nursing staff and the Trust indicated they will continue to explore other initiatives to improve staffing levels. Staff culture remains a concern with an evident lack of professional regard and respect between certain groups in relation to following evidence based plans of care such as positive behavioural support plans. We were however assured that progress had been made to strengthen staffing and, that further work is planned for the coming months.

We have determined not to serve an Improvement Notice in relation to staffing, however we will continue to monitor staffing closely and will seek evidence of improvements through action plans and further inspections.

An area for improvement has been identified in relation to staffing.

5.2.8 Physical Health Monitoring

The management of patients' physical health care needs, including anti-psychotic medication monitoring was reviewed. There was no evidence of physical health care pathways in patient records. It was not clear when each patient last had their physical health care needs checked or when they were due to be reviewed. This was concerning as some patients have resided in Lakeview for up to four years.

We were not assured that patients were able to avail of routine health screening including dentistry, podiatry and optician. Some patients were of an age where particular types of screening would be advised and would routinely be organised through a GP, however, we found no evidence of discussion or arrangement to indicate that health screening had been considered or organised.

Patients' physical health was not being monitored in conjunction with their learning disability needs. Patient's medical records did reflect where attempts had been made to gain blood samples and when patients had not been compliant with this. There was evidence of patient weight being monitored but no evidence of actions taken to address for weight loss or gain.

Patients accommodated in Lakeview for extended periods of time should have access to GP services to ensure they receive the appropriate health screening as per the Public Health Agency screening programme.

Anti-psychotic monitoring

The monitoring of anti-psychotic medication was reviewed. Monitoring is important so that medication can be adjusted accordingly to minimise side effects and ensures that physical health interventions can be offered if needed.

Lakeview had no system in place to monitor patients' physical health in relation to anti-psychotic medication.

On review of patient kardexes we found that some patients were regularly prescribed multiple anti-psychotics with dosages exceeding BNF recommendations and there was no evidence of instruction to nursing staff with regards to the safe and effective administration of PRN medication.

We were informed by the SMT that the full-time locum consultant had recently left post and as a result there was reduced consultant cover in Lakeview. This was concerning as medications were not subject to regular medical review and this could compromise patient safety.

We escalated our concerns to the Trust's SMT during inspection and they responded promptly with a full review of all patients medications. As a result of the concerns we identified in relation to physical health monitoring the Trust were invited to attend a meeting on 21 September 2021, signalling our intention to issue an improvement notice in relation to physical health monitoring . At this meeting the Trust outlined the actions they had taken to improve physical health monitoring. The outcome of the medication review was shared as part of the Trust's action plan and evidenced the reduction, discontinuation or planned discontinuation of anti-psychotic and PRN medication for some patients. Additional instructions to support nurses with the appropriate and safe administration of PRN were also included on patient kardexes.

Further to this the Trust have secured further support from an Acute Learning Disability Liaison Nurse, a Mental Health Liaison Nurse and nursing governance team to progress with patient's physical health screening, annual health checks, onward referrals to Primary Health Care and the development of anti-psychotic and physical health monitoring pathways. Training will be provided to nursing staff regarding anti-psychotic medication monitoring.

We were assured that progress had been made to strengthen the monitoring of patients' physical health and, that further work is planned for the coming months.

We have determined not to serve an Improvement Notice in relation to physical health monitoring, however we will continue to monitor this aspect of care closely and will seek evidence of improvements through action plans and further inspections.

An area for improvement has been identified in relation to physical health monitoring.

5.2.9 Governance & Leadership

As a result of our findings we established that there were issues related to the leadership and governance of Lakeview Hospital. Staff described a lack of leadership and support from the SMT and we had significant concerns in relation to ASG, incident management, financial governance, staffing and physical health monitoring.

We identified that the ASG systems and processes in Lakeview were not sufficient to effectively safeguard vulnerable adults. The ASG referral pathway was inconsistent with no external oversight from the ASG team. There was no Adult Safeguarding Champion or DAPO allocated to Lakeview.

With regards to incident management we could not evidence any trend analysis or senior management oversight. There was no scrutiny of recurring incidents or expert input from the MAPA team to reduce the risk of injury to patients and staff.

There were issues with financial governance and the management of patient finances. We found that systems and processes were not adequate to safeguard patients' monies. There was a lack of senior management oversight and audit. Staff had not been provided with the required training to manage patient finances. The finance department had not been made aware that staff had access to one patient's bank card with a significant amount of funds.

Staffing levels were also an area of concern with high levels of staff sickness and there was an increasing reliance on bank and agency staff to cover rotas. Agency staff and newly qualified nurses were regularly in charge of shifts and we could not be assured that they had the required skills or knowledge to manage the environment. We found that some staff were not assuming the responsibilities of their banded role and staff discussed low morale within the team.

Some staff expressed negative comments about the input of allied health care professionals in patient care. This behaviour created conflict within the team and was tainted with bias allowing staff dominance and attitude to over-ride patient need and assessment. Conflict within the staff team which had not been appropriately managed had the potential to impact negatively on the safe delivery of patient care. There was evidence to indicate a closed culture within the staff team that was unsupportive, disrespectful and disjointed.

There was an Occupational Therapist (OT) aligned to Lakeview however, they were not ward based and only accessible via referral. There was no evidence of regular OT input to the wards or the MDT meetings. The majority of relatives commented on the lack of activity, and access to a day centre for the patients.

There were no physical health care pathways to evidence the monitoring of patients physical health. There was a lack of routine health screening or monitoring of patients physical health in conjunction with their learning disability needs. There was no system in place to monitor the health of those in receipt of antipsychotic medications and medication kardexes were not regularly reviewed due to the reduced level of consultant cover in the hospital.

As a result of the concerns identified in relation to leadership and governance the Trust were invited to attend a meeting on 21 September 2021, signalling our intention to issue an improvement notice in relation to leadership and governance. In response to our findings the Trust submitted an action plan which is committed to strengthening the current leadership and governance arrangements.

We were assured that work had already commenced to improve the leadership and governance at Lakeview. Staff engagement initiatives are planned for the coming months in collaboration with the Trust's human resources colleagues; the aim of this is to provide additional support to staff and improve the culture. The Trust also confirmed there will be increased SMT oversight in relation to governance processes and systems.

We have determined not to serve an Improvement Notice in relation to leadership and governance at this time; however, we will continue to monitor this aspect of care closely and will seek evidence of improvements through action plans and inspections.

An area for improvement has been identified in relation to governance and leadership.

5.2.10 Staff Engagement

We spoke with a wide range of staff during inspection and some staff contacted us by phone and email after.

Staff discussed the impact of staffing shortages and the high level use of agency and bank staff. Staffing levels were described as unsafe and staff reported that it was a regular occurrence that they did not get any breaks during 12 hour shifts. Nurses reported they were often the only qualified staff member on shift in the ward and relied on support from nurses in the other ward, who were not always in a position to be able to assist. Newly qualified nurses were often allocated the role as nurse in charge, including those who had completed their preceptorship within the last few weeks. All staff reported the high level of assaults on staff but did not apportion blame to the patients, who they described as complex and in need of care beyond that which they were receiving.

Staff raised fire safety concerns which they had onward reported but were not informed of the outcomes.

Staff advised they experienced a feeling of dread going to work and some were in receipt of counselling and support to enable them to process the incidents they had witnessed. All staff reported a love for the job, learning disability nursing and the patients they were caring for but had concerns about the health and wellbeing of the team based on the current staffing levels and resources to meet patient needs.

5.2.11 Family Engagement

The majority of relatives were happy with patient care and felt staff were compassionate and resilient; three out of four relatives felt the ward was well led. All relatives were aware of how to make a complaint.

All relatives commented on the staffing shortages and felt that the patients needed consistency, with experienced staff working alongside agency staff. One relative expressed that staff were doing the best they could however they were not confident staff had the appropriate training or experience.

Relatives reported they were usually informed immediately about incidents and physical intervention, however, one relative reported a one month delay in being informed of an ASG incident (see section 5.2.3). One relative commented on the inappropriate use of physical intervention and felt the use of MAPA had increased.

Another family member discussed how she attended fortnightly MDT incident review meetings about her son with the Behaviour Support Team in attendance.

Despite not being an ideal environment one relative felt their loved one was safe. Another expressed concern that medication was being overused and combined with lack of physical activity had resulted in weight gain.
Most relatives commented about the lack of stimulation for patients and the poor access to day services. A relative described the loss of social skills after patients were admitted to the hospital.

This information has been shared with the SMT at the Trust.

6.0 Conclusion

Based on the inspection findings we had serious concerns about the delivery of safe and effective care. These concerns related to;

- Adult Safeguarding;
- Incident management;
- Financial Governance;
- Staffing;
- Physical health monitoring;
- Governance and leadership

There were also areas for improvement identified in relation to patient flow and discharge planning, the environment and restrictive practices.

Enforcement action resulted from the findings of this inspection.

We met with the Trust's Chief Executive and the Senior Management Team at an intention to serve meeting. Five improvement notices were considered, however, an action plan submitted by the Trust outlined immediate actions that had been taken by them to address the concerns. This provided us with assurances that a significant amount of progress had been made in each of the areas of concern. It was agreed that it would be reasonable to afford the time required to implement all actions committed to, and as a result we decided not to escalate the matter any further at that stage.

We will continue to monitor and review the quality of service provided in Lakeview Hospital and progress made through revised action plans and will carry out further inspections to assess compliance with the standards.

It should be noted that continued noncompliance may lead to further enforcement action.

RQIA would like to take this opportunity to thank the hospital staff, patients and families for taking time to speak with us. This has enabled us to deliver our findings with the overall aim of providing betterment for the patients and a more supportive working culture for the staff.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

	Regulations	Standards
Total number of Areas for Improvement	N/A	13

The total number of areas for improvement includes one area for improvement in relation to the management of PRN medication stated for a third time. 12 new areas for improvement were identified in relation to patient flow, the privacy and dignity of patients, fire risk, adult safeguarding, incident management, restrictive practices, financial governance, staffing, physical health monitoring and hospital governance.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Neil Guckian, Chief Executive, WHSCT 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 Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006)

Area for Improvement 1 **Ref:** 5.3.1 (f) **Stated:** Third time **To be completed by:** 16 February 2022	The responsible person shall ensure robust management of Pro Re Nata (PRN) medications. There were a lot of PRN medications which had • no indications for use written; • no minimum intervals indicated and; • there was no indication of which drugs should be used 1st line in the event that the indication for some different drug was the same. If PRN medications were used as prescribed, patients would have received over the maximum 24-hour recommended dose as recommended in the British National Formulary (BNF). The BNF is a pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about many medications available on the UK National Health Service (NHS). There was limited review of patients daily and PRN medication.

	Response by registered person detailing the actions taken: Following the RQIA Inspection, the Western Health and Social Care Trust (WHSCT) developed a robust Action Plan that incorporates this Improvement area. Work remains ongoing and is overseen by a Project Management Board chaired by the Director of Mental Health and Disability Services. Particular actions related to this area have included: The Consultant Psychiatrist and Acute Mental Health Liaison Nurse undertook a review of all patients' medications including Pro Re Nata (PRN) medications and related Kardexes on 25th August 2021- patient specific medication adjustments have been made/are ongoing and clarity provided on Kardexes in terms of instructions to support nursing staff in respect of prescribing practices/ including PRN usage. Regular reviews of all medication including anti-psychotic medication and PRN has been established and is managed through a range of approaches including weekly Ward rounds -the structure and format of Ward rounds has been amended to ensured increased emphasis on patient clinical and medical needs. This work is led by an experienced Consultant Psychiatrist permanently employed by the Trust, who currently provides the psychiatry input to the Wards. This work is supported by resource from the Learning Disability Mental Health Liaison Nurse who is providing a direct educative and support role to Lakeview staff on a weekly basis as well as undertaking Audits, overseen and supported by Pharmacy. The Acute Nurse Lead for Governance has audited case notes and undertook an omitted dosage medication audit. She will revisit on 19th of January 2022 to review progress across both areas. Her support will be ongoing.

Area for improvement 2 **Ref:** Standard 5.1 **Criteria** 5.3.1 **Stated:** First time	The Western Health and Social Care Trust must ensure all relevant staff have access to detailed and current information regarding patients who have completed their active assessment and treatment and are awaiting discharge from Lakeview Hospital. This information should include each patient's average length of stay to facilitate effective patient flow and discharge planning.
To be completed by: 16 February 2022	**Response by registered person detailing the actions taken:** Following the RQIA Inspection, the WHSCT developed a robust Action Plan that incorporates this Improvement area. Work remains ongoing and is overseen by a Project Management Board, chaired by the Director of Mental Health and Disability Services. Particular actions related to this area have included: Administrative officer for Medical Records updates patient specific information on current Hospital admissions that allows for a calculation of the average length of stay and estimated discharge dates. The information is shared with Multi-disciplinary team members on a weekly basis and is accessible on the Wards. The table includes the admission date, expected discharge date and relevant detention/DOLS information. A monthly MDT is held to discuss the inpatients in Lakeview Hospital with a specific focus on discharge planning to support and maintain flow. Delayed Discharges in Lakeview Hospital have been added to the Terms of Reference for the Regional Community Integration Programme

Area for improvement 3 **Ref:** Standard 5.1, 7.1 **Criteria** 5.3.1, 7.3 **Stated:** First time **To be completed by:** 16 February 2022	The Western Health and Social Care Trust must ensure that the privacy and dignity of patients is maintained at all times, with consideration shown to the Human Rights Act 1998.
	Response by registered person detailing the actions taken: Following the RQIA Inspection, the WHSCT developed a robust Action Plan that incorporates this Improvement area. Work remains ongoing and is overseen by a Project Management Board chaired by the Director of Mental Health and Disability Services. Particular actions related to this area have included: Patient specific remedial actions related to concerns raised by RQIA Inspection Team regarding privacy and dignity were implemented with immediate effect. A MDT approach is being used to explore options for enhancement of the environment in Strule Ward, sensitive to patient need and choice. This includes planned repairs to the basic fabric of the Ward as well as development of a dark room. The progress of work is being managed to avoid patient distress. Estates Services work very closely with Ward staff including during Out of Hours to maintain safety within the Ward environment. Ward Managers and SMT members ensure and reinforce the importance of promoting privacy and dignity in all aspects of patient care.
Area for improvement 4 **Ref:** Standard 5.3 **Criteria** 5.3.1 **Stated:** First time **To be completed by:** 16 February 2022	The Western Health and Social Care Trust must ensure that patients' environment is conductive to recovery and takes into account the assessed needs of the patient, their risk assessment and ensures that privacy and dignity is maintained. This should be subject to regular MDT review.
	Response by registered person detailing the actions taken: Following the RQIA Inspection, the WHSCT developed a robust Action Plan that incorporates this Improvement area. Work remains ongoing and is overseen by a Project Management Board chaired by the Director of Mental Health and Disability Services. Particular actions related to this area have included: Monthly environmental meetings between Head of Service and Estate Services, provide for regular review

	of environmental issues and ensure all environmental needs in Lakeview both internal and external are met within a timely manner and in line with patient therapeutic needs. There is very regular and responsive support from Estates colleagues addressing remedial actions on a day to day basis. Painting has commenced in both Wards; however progress in Strule ward is impacted by patient preferences. Estates services are supporting the development of a dark room which will have an open door and sensory items for one particular patient. A trike and trampoline have been purchased for another patient in Strule ward. Funding has been identified for new furniture, sensory and decorative items for both Wards to support more therapeutic environments- a Deputy Manager with admin support is leading on engaging the purchasing processes including obtaining quotes for required items. A monthly meeting is held with the Assistant Support Services Manager to ensure required attention to the general and any specific cleaning needs. Recently appointed Ward Managers will oversee a daily managerial walk around of the Ward environment to note and ensure a timely response to health and safety matters including trips/hazards, faults, and any cleanliness requirements. The Head of Service attends a Mental Health and Disability Services Directorate bi-monthly Environmental Safety group, which reports as a sub-committee of the Trusts Corporate Governance arrangements. Attended by colleagues from mental health services, estates and support services, this Forum discusses environmental issues that may have patient safety or experience implications, and to ensure necessary actions or escalations. Attendance will be extended to include recently appointed Ward Managers Plans are being developed with MDT input for longer-term reconfiguration of the Hospital wards in line with the need to reinstate Strule as an environment with increased patient capacity as well as ensuring a range of suitably therapeutic environments for changing patient profiles- a business case is being developed and Commissioner support will be sought.

Area for improvement 5 **Ref:** Standard 5.3 **Criteria** 5.3.1 **Stated:** First time **To be completed by:** 16 February 2022	The Western Health and Social Care Trust must ensure that any increase in fire risk due to the modification of patients' environment, is continuously reviewed and assessed by the Trust's fire safety advisor(s) with assurances provided that risk is being managed safely. **Response by registered person detailing the actions taken** Following the RQIA Inspection, the WHSCT developed a robust Action Plan that incorporates this Improvement area. Work remains ongoing and is overseen by a Project Management Board chaired by the Director of Mental Health and Disability Services. Particular actions related to this area have included: Fire risk assessments are kept up to date and any deviations from the fire safety code are signed off by management including the Director of Mental Health and Disability Services. A schedule of regular meetings is in place with WHSCT Fire officer who physically attends the Wards to review changes in the Hospital environment and in Strule Ward in particular to ensure all risk assessments are accurate and up to date. The Fire risk assessment in Strule Ward has been placed on the Mental Health and Disability Directorate Risk Register with an associated action plan identified and updates made as required.
Area for improvement 6 **Ref:** Standard 5.3 **Criteria** 5.3.1 **Stated:** First time **To be completed by:** 16 February 2022	The Western Health and Social Care Trust must ensure that remedial actions stated on FRA's are followed up within the time frames specified. **Response by registered person detailing the actions taken** Following the RQIA Inspection, the WHSCT developed a robust Action Plan that incorporates this Improvement area. Work remains ongoing and is overseen by a Project Management Board chaired by the Director of Mental Health and Disability Services. Particular actions related to this area have included: Fire Risk Assessments relating to Strule Ward are regularly reviewed with Trust Fire Officer, with any identified remedial actions taken forward within the specified timeframes. There is close and frequent liaison between Ward staff, Estates Services and the Fire Officer given the frequent changes to the Ward environment.

Area for improvement 7 **Ref:** Standard 5.3 **Criteria:** 5.3.1 **Stated:** First time **To be completed by:** 16 February 2022	The Western Health and Social Care Trust must: 1. Implement effective arrangements for adult safeguarding at Lakeview Hospital as per Adult Safeguarding Operational Procedures 2016 and ensure: a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations; b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively; c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care; d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding are improved. 2. Implement an effective process for oversight and escalation of matters relating to adult safeguarding across the hospital site; this should include ward managers, hospital managers, WHSCT senior managers and / or the Executive team as appropriate. 3. Implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding in the hospital.
	Response by registered person detailing the actions taken: Following the RQIA Inspection, the WHSCT developed a robust Action Plan that incorporates this Improvement area. Work remains ongoing and is overseen by a Project Management Board chaired by the Director of Mental Health and Disability Services. Particular actions related to this area have included: Interim Adult Safeguarding process were immediately introduced following RQIA Inspection, with all Adult Safeguarding concerns relating to Lakeview Hospital being referred directly to Adult Safeguarding Team by Head of Service- this is applied consistently for all patients, irrespective of place of origin. The Adult Safeguarding Team screen all referrals and agree appropriate action/outcome with

	the Head of Service. The Adult Safeguarding Team have assumed the role of DAPO for All Adult Safeguarding Investigations relating to in-patients. The Head of Service has been appointed as Adult Safeguarding Champion for the Hospital. These measures all support increased governance and oversight of adult safeguarding related activity. All Adult Safeguarding documentation from APP1 Referral and subsequent ASP documentation have made available for all staff to access. A SharePoint site has been set up which contains: ASG Database capturing all ASG activity within the Hospital, all ASG Documentation, policies, procedures and relevant training materials. Deputy Managers and above have access to the Sharepoint site, with hard copies of all materials provided in both Wards for all staff to access. By reverting to the use of APP1 referral forms for all patients ensures the timely consideration of the need for involvement from other relevant stakeholders and organisations. Adult Safeguarding Workshops have been delivered, with all staff invited to attend. This began with "Safeguarding conversations" to allow a determination of staffs' Adult Safeguarding practice knowledge, perceived challenges to timely safeguarding interventions and to inform the development of Adult Safeguarding Training to meet staff's needs. All Band 5,6,7 and 8 Nursing staff currently in post within Lakeview Hospital have received the 2 day Investigating Officer Adult Safeguarding Training- this is in line with regional Adult Safeguarding requirements. Additional dates will be provided for staff who were off at the time of training/ new starts. All other Hospital staff will receive 1 day Adult Safeguarding training, with dates to be arranged. Lakeview Managers will avail of peer support from Ward Managers in Grangewood Hospital in respect of Adult Safeguarding practice and safety planning. This will facilitate learning from the more established effective processes currently embedded within Grangewood Hospital. The Adult Safeguarding Team Manager assumes the role of direct link for all Adult Safeguarding matters at Lakeview Wards, which includes providing support around the completion of APP1 referrals and protection planning where required. The introduction of fortnightly Incident Review Meetings and

	analysis of data relating to incidents enables escalation of safeguarding concerns where trends and patterns are emerging Initial discussions and a related site visit have been had regarding installation of CCTV. There is approval in principle for CCTV introduction although timeframes have not been agreed. Costings are currently being determined.
Area for improvement 8 **Ref**: Standard 5.1 **Criteria:** 5.3.1, 5.3.2 **Stated:** First time **To be completed by:** 16 February 2022	The Western Health and Social Care Trust must strengthen the oversight of incident management to ensure: 1. Data relating to incidents in Lakeview Hospital is collated, analysed and interrogated. 2. Trends are identified and learning is implemented. 3. A safety brief and incident debriefs are embedded at ward level. 4. Implementation of a programme of audit to provide assurance that the established processes are operating effectively.
	Response by registered person detailing the actions taken: Following the RQIA Inspection, the WHSCT developed a robust Action Plan that incorporates this Improvement area. Work remains ongoing and is overseen by a Project Management Board chaired by the Director of Mental Health and Disability Services. Particular actions related to this area have included: Fortnightly incident review meetings have been introduced. In addition a monthly MDT Incident Review Meeting has also been established. During these meetings data in relation to incidents is analysed and discussed in order to identify trends and learning. Managers and deputy managers are also working with their teams at Ward level to improve knowledge and confidence in this area. Daily safety briefs have been introduced to both Wards and remain work in progress. MAPA debrief tools are being utilised within both Wards and work is also being progressed in respect of the use of a debrief tool for non-MAPA related incidents. Audit activity is ongoing to oversee and ensure the embedding of these approaches. Recently appointed Ward Managers will focus on further consolidation of these processes with all staff across all shifts. Datix and Incident Management Training is being provided to relevant staff within both wards- staff attended training on Monday 13th December; Friday 14th January with further attendance planned at training arranged for Thursday 17th

	February. Ward based improvement meetings have been introduced attended by MDT members to support staff development and related accountability with the aim of achieving competence in specific and key areas. e.g. behaviour support. The Project Lead for Lakeview Hospital has also carried out several audits within both wards to review management of incidents, patient and staff support needs and identify continued learning and areas for improvement. The Head of Service has an ongoing schedule of audit related activity. The Mental Health Liaison Nurse is also undertaking audits on PRN mental health medication.
Area for improvement 9 **Ref:** Standard 5.1 **Criteria:** 5.3.1,5.3.3 **Stated:** First time **To be completed by:** 16 February 2022	The Western Health and Social Care Trust must: 1. Undertake an urgent review of the current and ongoing use of restrictive practices at Lakeview Hospital whilst taking account of required standards and best practice guidance. 2. Develop and implement a restrictive practices strategy across Lakeview that meets the required best practice guidance. 3. Ensure that the use of restrictive practices is routinely audited and reported through the WHSCT assurance framework. 4. Review and update WHSCT restrictive practices policy and ensure the policy is in line with best practice guidelines.
	Response by registered person detailing the actions taken: Following the RQIA Inspection, the WHSCT developed a robust Action Plan that incorporates this Improvement area. Work remains ongoing and is overseen by a Project Management Board chaired by the Director of Mental Health and Disability Services. Particular actions related to this area have included: The WHSCT Mental Capacity Act Lead and Head of Service has developed an action plan in respect of Mental Capacity Act/Deprivation of Liberties (DOLS) requirements within Lakeview Hospital. The Trust MCA lead will provide support to Lakeview Hospital in the form of training and mentoring. In addition the specific DOL's related requirements for current patients who are not formally detailed but remain subject to restrictions will be considered for relevant Authorisations,with MDT members and Key workers supported in making Panel applications.

	A Restrictive Practice Working group with the aim of providing strategic overview of the current and future use of restrictive practices is being established with an initial scoping on Terms of Reference and membership scheduled for 17th January 2022. This work will include the review and development of a relevant restrictive practices strategy for use across Lakeview Wards, in line with best practice. CPI Training on Safety Interventions has been arranged for March 2022 for 2 Band 7 Managers with an aim to developing and improving knowledge on restraint reduction. As qualified Train the Trainers these Managers will have a pivotal role in influencing restraint related practice with an emphasis on reduction, where possible. The MAPA team have been providing a level of assistance to the Head of service and staff within Lakeview in order to collaboratively reduce the level of physical restrictive interventions within Lakeview. Review of incident reports has allowed for identification of key themes. MAPA team leader has been on the ward to provide a level of observation alongside Head of Service- September 2021 MAPA Team leader has also attended, Lakeview's fortnightly incident review meetings to provide input from a MAPA perspective regarding the incidents. A Ward-based Behaviour Support Therapist supports ongoing attention to the relevant Behaviour Support Plans in place for patients, an important element in influencing culture.

Area for improvement 10 **Ref:** Standard 4.1, 5.1 **Criteria:** 4.3, 5.3.1 **Stated:** First time **To be completed by:** 16 February 2022	The Western Health and Social Care Trust must ensure that with regards to patient finances: 1. The WHSCT is appropriately discharging its full responsibilities, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986. 2. In respect of those patients in receipt of benefits for whom WHSCT is acting as appointee, that appropriate documentation is in place and that individual patients are in receipt of their correct benefits. 3. Implementation of a robust system to evidence and assure that all arrangements relating to patients' monies and valuables are operating in accordance with The Mental Health (Northern Ireland) Order 1986 and WHSCT policy and procedures; this includes: a) that appropriate records of patients' property are maintained; b) that staff with responsibility for patients' income and expenditure have been appropriately trained for this role; c) that audits by senior managers of records retained at ward level are completed in accordance with WHSCT policy; d) that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in Lakeview Hospital.
	Response by registered person detailing the actions taken: Following the RQIA Inspection, the WHSCT developed a robust Action Plan that incorporates this Improvement area. Work remains ongoing and is overseen by a Project Management Board chaired by the Director of Mental Health and Disability Services. Particular actions related to this area have included: An Audit was completed by the Trust Finance Department on 16th September 2021 and an action plan for improvements was identified for both Wards. Finance revisited on 8th December 2021 for re-audit purposes with progress identified against the Action Plan-minor improvements were recommended and are being actioned. A request has been made to Internal Audit to undertake an Audit of the finance controls in respect of the management of patients' monies and valuables- a copy of the Draft RQIA Inspection Report has been provided as background. A commitment has been provided by Internal Audit to undertake

	the work but dates have not yet been agreed. Band 5/6 Nursing staff within both Wards have read and signed financial regulation documents and been provided with training in respect of financial management. Further to the training, the Finance Department have provided Q&A sessions for staff. Governance folders are available in Nurses Stations of both Wards which include financial governance documentation. Arrangements will be made for staff who return from periods of absence/ new starts to avail of same. Head of Service for Lakeview met with Community Social Work Team Managers on 7th December 2021 and agreed that updated assessments in respect of current patients would be provided to include information on financial benefits, power of attorney; capacity, legal requirements/orders. A follow up meeting attended by Social Work Managers and the relevant key workers took place on 7th January 2022 with additional input from the Mental Capacity Act Implementation Lead and Trust Financial Assessments Officer Trust MCA Lead has developed a schedule of support sessions with Social Workers to ensure adherence to specific MCA related financial issues.

Area for improvement 11 **Ref**: Standards 4.1 & 5.1 **Criteria** 4.3, 5.3.1, 5.3.3 **Stated:** First time **To be completed by:** 16 February 2022	The Western Health and Social Care Trust must: 1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at Lakeview, which; a) is based on the assessed needs of the current patient population; and b) incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements. 2. Implement an effective process for oversight and escalation to senior management and the executive team when challenges in nurse staffing arise. 3. Implement an effective assurance mechanism to provide oversight of the implementation of the model and escalation measures. 4. Engage the support of the other key stakeholders, including the commissioner in defining the model to determine safe levels of nurse staffing. 5. Continually review and monitor staff morale, culture and concerns and take responsive steps to address them in a timely manner.
	Response by registered person detailing the actions taken: Following the RQIA Inspection, the WHSCT developed a robust Action Plan that incorporates this Improvement area. Work remains ongoing and is overseen by a Project Management Board chaired by the Director of Mental Health and Disability Services. Particular actions related to this area have included: Work is progressing to triangulate staffing models including the Telford and Shelford models to support a developed understanding of safe staffing levels for both registrants and non-registrants responsive to acuity and dependency. This information will be shared with the Commissioner regarding associated funding deficits. Ward staffing levels are reviewed on a daily basis. Remedial actions including recruitment initiatives, block booking of Agency staff and use of the Work Force Appeal are routinely engaged, with support from WHSCT Human Resources Services. Staffing challenges are communicated through Head of Service to the Assistant Director and Director with relevant escalation to the DoH as required. Psychological Staff support from internal and external providers is being provided and offers a range of measures that affords staff individual choice in determining the most

	appropriate approach to support their needs. The recent appointment of 2 Ward Managers will support and extend the consolidation of staff support measures and provided in a timely and responsive fashion. There is additionally a visual presence of other Senior Management Team members. Specific support for the Managers and Deputies in line with the NHS Leadership Framework is being facilitated by the Practice Educator. As part of this process the staff are being assigned a nursing colleague mentor, Band 7 and above to support the learning and development journey. Work is underway to establish a peer led forum across the WHSCT mental health and learning disability in-patient Hospitals to share experiences and learning for development and improvement, and mutual understanding.
Area for improvement 12 **Ref**: Standard 5.1 **Criteria**:5.3.1 **Stated:** First time **To be completed by:** 16 February 2022	The Western Health and Social Care Trust must develop and implement a systematic approach to the identification and delivery of physical health care needs to ensure: 1. That the entire range of patients physical health care needs are met to include gender and age specific physical health screening programmes. 2. Ensure that patients in receipt of antipsychotic medication receive the required monitoring in accordance with the hospital's antipsychotic monitoring policy.
	Response by registered person detailing the actions taken: Following the RQIA Inspection, the WHSCT developed a robust Action Plan that incorporates this Improvement area. Work remains ongoing and is overseen by a Project Management Board chaired by the Director of Mental Health and Disability Services. Particular actions related to this area have included: The Acute Liaison Nurse has led on the development of a new Patient Health Pathway which is being implemented across both Wards Patient Physical Health checks are continuing to be completed within the Ward for current patients- this includes referring to population specific physical health screening programmes. The complex presentation of some of the patients has resulted in this work progressing slowly and in line with required associated desensitisation work. . Lakeview Improvement Project Lead and Acute Liaison Nurse have carried out audits on Patient Health checks to ensure

	identified and required actions have been followed up. Ward Rounds have been reviewed and restructured to support an increased focus on clinical and health needs of all patients. Education – training requests have been submitted to the CEC for the purpose of ECG, ILS and venepuncture. Available dates have been disseminated appropriately to ward staff with attendances scheduled over the incoming months Antipsychotic monitoring /mentoring staff The CEC are currently unable to deliver antipsychotic monitoring training to staff due to ongoing Covid-19 pressures and reduced programmes within the Trust. In the interim, the Mental Health Liaison Nurse provides weekly mentoring and support to staff with a focus on ensuring that antipsychotic monitoring is ongoing for each patient-related documentation has been introduced A folder is available on the both wards including clinical guidelines. Relevant desensitization and visual programmes are implemented as required and take account of particular patient complexity and needs that can impact on the progression of this work. Clinical observation levels are taken on a daily basis to ensure that if there are any issues in regards to the patients' health that staff alert the appropriate professional. Pharmacy are supporting the development of a relevant clinical pathway that requires the prioritisation of staff receiving the required training Work is being completed on patient care files, with files now having a new structure for ease of accessing relevant information.

Area for improvement 13 **Ref**: Standards 4.1 and 5.1 **Criteria** 4.3, 5.3.1 **Stated:** First time **To be completed by:** 16 February 2022	The Western Health and Social Care Trust must review the governing arrangements in Lakeview Hospital and consider the following matters in order to strengthen the governance arrangements; 1. Define a programme of audit across: all care and treatment interventions, patient finance; incident management; adult safeguarding; environment; and staffing levels. 2. Establish and communicate with all staff the various forums, committees, meetings, and professional leads to report to and seek support from in terms of embedding and strengthening a robust governance framework 3. Ensure all staff know the robust reporting system and escalation pathways of governance oversight from ward level right through to SMT, Directorate and the Trust's Executive Team. 4. Implement an effective assurance framework.
	Response by registered person detailing the actions taken: Following the RQIA Inspection, the WHSCT developed a robust Action Plan that incorporates this Improvement area. Work remains ongoing and is overseen by a Project Management Board chaired by the Director of Mental Health and Disability Services. Particular actions related to this area have included: Currently a system of Audit connected to the improvement areas is being developed and overseen by the Lakeview Inspection Project Board, chaired by the Director. In the longer term this work will be aligned with key Directorate Audit priorities led by the Assistant Directors for Quality, Safety and User Experience (Nursing and Social Care At a local level, a suite of Audit activity is and will continue to be undertaken/ overseen by Head of Service across all areas of patient related care- this is both proactive and reactive . A range of meetings in support of Hospital governance has been established under the leadership of the Head of Service with relevant reporting mechanisms to sub-directorate, Directorate and Trust Board as required. Additionally the Assistant Directors for Quality, Safety and User Experience will provide support in respect of the Hospital and wider Directorate Governance and Assurance Framework, with direct input to staff.

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

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

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

Assurance, Challenge and Improvement in Health and Social Care