The Regulation and Quality Improvement Authority

Inspection Report

02 February – 16 February 2022

Western Health and Social Care Trust

Mental Health and Learning Disability Hospital
Lakeview Hospital
12a Gransha Park
Clooney Road
Londonderry
BT47 6WJ
02871860261

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>Registered 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 registered places:

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</td><td>Six</td></tr><tr><td>Strule</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>
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2.0 Inspection summary

An unannounced inspection to Lakeview Hospital (the hospital) commenced on 02 February 2022 at 09.00am and concluded on 17 February 2022, with feedback to the Senior Management Team (SMT). The inspection was carried out by a team comprised of care, pharmacy, estates and finance inspectors with support from RQIA's Clinical Lead.

During RQIA's previous inspection to the Hospital from 16 August to 08 September 2021 a number of matters of significant concern were identified in relation to; adult safeguarding and incident management; financial governance; staffing; patient's physical health care needs and; governance and leadership. As a result of these findings and 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 and during the meeting on 21 September 2021 the Trust submitted a robust action plan to address the issues identified and provided further assurances that improvement work had commenced. At that time RQIA were satisfied that the Trust were taking action and determined not to issue five Improvement Notices. In affording the Trust time and space to improve RQIA made 13 Areas for Improvement (AFI's) that would be assessed during a follow up inspection.

The purpose of the February 2022 inspection was to assess the Trust's progress with these 13 Areas for improvement.

We identified that progress had been made in relation to patients' physical health care needs, patient flow and discharge planning, fire risk, financial governance and staffing. Six out of the 13 AFI's from the previous inspection were assessed as met and one AFI in relation to staffing was assessed as partially met.

The hospital psychiatrist had undertaken a full review of patients' medication, with improved outcomes for patients. Effective governance processes are now in place to manage patient monies and property. Staff reported improved morale in Lakeview hospital and told us the appointment of two new ward managers was having a positive impact.

Six AFI's were assessed as not met and four new AFI's were identified in relation to discharge planning, pharmacy support, patient care documentation and the management of ligature risks.

Limited progress had been made with regards to adult safeguarding and incident management and new concerns relating to the care and treatment of patients were evident and required to be escalated to the Trust's SMT during the inspection for immediate action.

Whilst we recognise that the Trust have made progress in some areas since the previous inspection further work is required to improve the current processes for adult safeguarding and incident management and the care and treatment of patients.

In accordance with our escalation policy the Trust were invited to attend a meeting on 01 March 2022 with the intention of issuing two Improvement Notices. RQIA was not assured that the action plan presented by the Trust at this meeting robustly addressed the concerns identified. In view of this, a decision was made to serve two Improvement Notices: IN000014 relates to adult safeguarding and incident management and IN000015 relates to the safe and effective delivery of patient care, both Improvement Notices were issued to the Trust on 11 March 2022.

Following the decision to issue two Improvement Notices to the Trust and prior to the publication of the inspection report the Trust sent a letter, on behalf of RQIA to each patient's family informing them of our enforcement action and to outline the concerns identified. Families were invited to contact RQIA if they had any further concerns they wished to discuss.

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 patients, relatives, 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 services 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 patients, relatives and staff to approach us with the feedback they may have.

Easy read questionnaires were left on the ward to afford all patients the opportunity to engage with us. We also spoke directly with two patients, one patient's view of the hospital was "ok" and that staff were supportive and one patient indicated they liked the familiarity of the hospital and the staff.

All eight families of the patients were approached for their views. Five families availed of the opportunity to engage with us via telephone. The majority of the relatives reported that staff provided good care and were approachable with others expressing dissatisfaction in relation to the management of incidents, the environment, a lack of therapeutic activities and delays with their family member's resettlement.

We spoke with a wide range of staff, including senior managers, medical staff, nursing staff (permanent, bank and agency), pharmacy, psychology and estates staff. Staff spoke openly about the challenges they faced working in Lakeview Hospital which included ongoing staffing shortages, however most felt that the changes that had been implemented since RQIA's inspection in August 2021 were positive and staff morale had improved with increased support from managers.

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 commenced on 16 August to 08 September 2021 and resulted in 13 areas for improvement.

<table>
<tr><th colspan="2">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)</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for Improvement 1

Ref: 5.3.1 (f)

Stated: Third time

To be completed by:
16 February 2022</td><td>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.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

A full review of antipsychotic medicines was completed by the hospital psychiatrist in August 2021. There was evidence that medicines were regularly reviewed during clinical ward rounds. Patient kardexes stipulated 1st or 2nd line use of PRN medication and provided indication for use and clear direction for nursing staff.

This AFI was assessed as met.</td></tr>
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Area for improvement 2 **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 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.	**Met**
	Action taken as confirmed during the inspection: Data was available to calculate the average length of stay and to record estimated discharge dates and was discussed at weekly multi-disciplinary team (MDT) meetings. This AFI was assessed as met.	
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.	**Not Met**
	Action taken as confirmed during the inspection: The privacy and dignity of patients was not being maintained at all times. There was a lack of therapeutic engagement and interaction with patients, and we observed patients spending long periods of time in corridor areas. There was a lack of quiet areas and day rooms for patients to avail of. This resulted in patients' privacy and dignity being compromised when they were displaying challenging behaviours in corridor areas. The environment in Strule is not a therapeutic environment and is in a poor state of repair as a result of continual alterations and modifications in response to patient needs and behaviours. This area for improvement has not been met and has been subsumed into Improvement Notice IN000015	

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 conducive 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. **Action taken as confirmed during the inspection**: We could not evidence that the patients' environment was conducive to recovery and took into account their assessed needs. The environment in Strule was dark and austere and had deteriorated further since the last inspection. The ward has been significantly modified on the basis that the modifications supported the patients' needs more effectively. There was no evidence of patients' presentations improving as a result of the modifications. We were unable to evidence the full range of MDT input to the hospital, there was a lack of pharmacy input with only 3 hrs per month allocated and there was no dedicated Positive Behaviour Support (PBS) Therapist or ward based occupational therapist (OT) and limited input from psychology and Speech and Language (SLT) professionals. This area for improvement has not been met and has been subsumed into Improvement Notice IN000015	**Not met**

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.	**Met**
	Action taken as confirmed during the inspection: Further adaptions and modifications had been made to Strule. They had not resulted in any increased fire risk. The risks had not changed significantly since the fire risk assessment was undertaken in August 2021. Fire risks were continuously reviewed and assessed by the Trust's fire safety officer and ward staff and we received assurances that this was being managed safely. Repairs to the ward were ongoing to maintain the safety of the environment This AFI was assessed as met.	
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 Fire Risk Assessment's (FRA) are followed up within the time frames specified.	**Met**
	Action taken as confirmed during the inspection: The fire risk assessment for the ward was reviewed and was found to be current with an appropriate action plan in place. This AFI was assessed as met.	

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: • Implement effective arrangements for adult safeguarding (ASG) 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 ASG 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 ASG are improved.	**Not met**
	Action taken as confirmed during the inspection: ASG arrangements were reviewed. The number of ASG referrals was low and the majority of APP1 forms did not detail the interim protection plans and those that were in place did not provide enough assurance that the plans were robust and suitably protective. The Trust operate an 'advice and resolution' process. This process involves nursing staff consulting with individual patients' community social workers and ASG team to seek direction and advice before submitting an ASG referral. This approach adds an additional	

	layer onto the regional ASG processes and has the potential to delay the implementation of protection plans and did not empower nursing staff to independently make referrals. Some key nursing staff could not access the new ASG database on the Trust's SharePoint site. Staff lacked knowledge about ASG and a significant amount of staff had not attended the Trust's updated mandatory ASG training. There was no evidence of audit or analysis to inform the Trust of themes or trends to identify learning, reduce reoccurrence and drive improvement. This area for improvement has not been met and has been subsumed into Improvement Notice IN000014	

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.	
	Action taken as confirmed during the inspection: On review of a sample of Datix (Datix is the Trust's electronic incident reporting system) incidents we identified that 20% would have met the threshold for an ASG referral, however, there was no evidence that a referral had been made. There continues to be a lack of oversight and analysis in relation to incident management at Lakeview. The gaps we identified in the current processes do not provide us with the necessary assurances that there is appropriate oversight and governance arrangements in place to effectively manage incidents and support learning and improvement. This area for improvement has not been met and has been subsumed into Improvement Notice IN000014	**Not met**

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.	**Not met**
	Action taken as confirmed during the inspection: A new restrictive practices group had been established however the membership of this group did not reflect a MDT approach to review restrictions in line with best practice. There was no representation from psychology, medical, speech and language therapy or occupational therapy teams. This group were tasked to complete a restrictive practice audit and we were informed that this work is in progress. Until such times as it is complete full and complete oversight of restrictive practices in Lakeview Hospital will not be achieved. There was no evidence that restrictive practices were being audited, analysed or themed with a view to reducing restrictive interventions in Lakeview hospital. This AFI was assessed as not met.	

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.	**Met**

	Action taken as confirmed during the inspection: Improvements have been made and evidence was available that the Trust are appropriately discharging its full responsibilities, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986. Record keeping and the processes for managing patients' finances and property had improved in both wards. There were processes in place to ensure that transactions were recorded and receipted, both for monies received and for purchases undertaken on behalf of patients. Training records evidenced that all staff had attended mandatory training delivered by the Trust Finance Department in relation to the safeguarding of patients' monies and property. Senior managers were completing a monthly audit of patients' monies. Since the last inspection Business Services Organisation (BSO) have completed an audit of financial arrangements and made a recommendation for the Trust to obtain written confirmation from the Department for Communities (DfC) to act as the appointee for one patient and to retain a copy of the confirmation in the patient's files. This process was ongoing at the time of the inspection. This will be reviewed at the next inspection of Lakeview. This AFI was assessed as met.	

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.	**Partially met**

	Action taken as confirmed during the inspection: Ward managers were using the Telford Model to inform safe nurse staffing levels in the hospital. The actual staffing levels and the required staffing levels as indicated on the Telford model were not achieved on a frequent basis due to short and long term absences. An escalation policy was in place when staffing levels dropped below required levels. Staff reported low staffing levels via Datix and undertook a daily Sitrep (Situation Response) exercise to assess staffing levels daily. The staffing numbers recorded on the Sitrep records did not always align with the number of actual staff working as indicated on the rota and this had the potential to cause confusion. If staff rotas are not accurate it could be difficult to establish which staff members were actually working which could for example cause difficulty determining which staff were on duty in the event of an accident or incident, particularly when there is a high use of bank and agency staff working in the hospital. Inaccurate rotas also have the potential to impact planning and organising shifts to meet patient needs. There was no evidence of engagement with other key stakeholders or the commissioner for care to define the staffing model and determine safe staffing levels. RQIA recommend that the Trust's SMT liaise with other Trust services to determine how they improved staff's understanding and awareness of the Telford model and source appropriate training for staff on the use of the model. Staff reported improved morale and communication due to increased support from management, SMT being more approachable and the positive benefits following the introduction of post incident debriefs. This AFI was assessed as partially met.	

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.	
	Action taken as confirmed during the inspection: We observed a health care pathway to be in place for each patient admitted to Lakeview Hospital. Physical health care plans were evident in patient records. Patients were able to access routine health screening through referral - including dentistry, podiatry and optician. All patients were registered with a General Practitioner (GP). There was evidence that patients had routine blood tests and also blood tests for specific reasons such as physical illness or to ensure the safe prescribing and monitoring of certain medications. Electrocardiography (ECG) checks were provided to those prescribed anti-psychotic medication. The pharmacist had also developed a high dose antipsychotic care pathway however this is yet to be fully implemented. This AFI was assessed as met	**Met**

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; 3. Define a programme of audit across: all care and treatment interventions, patient finance; incident management; adult safeguarding; environment; and staffing levels. 4. 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 5. 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. 6. Implement an effective assurance framework.	**Not met**
	Action taken as confirmed during the inspection: The Trust had established a Project Management Board (PMB) to oversee the progress in relation to the AFI's identified by RQIA during the previous inspection. We were concerned that the impact of the PMB work was not evident at ward level and had not progressed at pace. Governance arrangements and oversight had strengthened in some areas such as financial governance. Governance and oversight in relation to ASG and incident management and restrictive practices needs to be strengthened. Leadership and culture need to be strengthened within Lakeview Hospital. We could not evidence effective leadership skills at ward level and observed there to be a lack of coordination and delegation of tasks on shifts with staff slow to respond to patient safety risks raised by inspectors. The system in place to facilitate the escalation	

	or cascading of information in relation to governance issues between the SMT and ward staff was not effective. Minutes of key meetings were reviewed and it was evident that outcomes had not been shared between teams. This area for improvement has not been met and has been subsumed into Improvement Notice IN000014 and IN000015	

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 at the right time 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.

We established that there were eight patients in Lakeview Hospital. Five of the patients were receiving active assessment and treatment and three patients were delayed in their discharge. The length of patient stay ranged between one week to over four years. Data was available to calculate the average length of stay and to record estimated discharge dates and was discussed at weekly multi-disciplinary team (MDT) meetings.

Three out of eight patients had plans in place for discharge however timeframes were unrealistic. Some patients had not yet been assessed as fit for discharge and some community facilities were not available to the accommodate patients on the dates indicated. As a result the discharge plans were unachievable. This has the potential to cause distress and disappointment to patients and their families with expectations of discharge raised and then not met.

We assessed the previous area for improvement in relation to patient flow and discharge planning (AFI 2) as met. A new area for improvement has been made in relation to the requirement for robust discharge plans for all patients that are both realistic and achievable.

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 safe, therapeutic and compassionate care and met the needs of the patients.

At the previous inspection concerns about patient privacy and dignity in Strule Ward were highlighted. Since then a door had been fitted to the bathroom and a portable screen was also available to maintain privacy and dignity.

One of the wards is did not present as a therapeutic space for patients or the staff working there. An activity room was situated in the ward, however this room was only used to store equipment and was not a designated space that patients could avail of to engage in therapeutic or recreational activities. There was no evidence that works had commenced in relation to improving the environment. The Trust previously informed RQIA that they were developing a low stimulus room for patients and were purchasing therapeutic equipment. Progress in relation to these projects could not be provided.

With the exception of painting one of the wards which had minimal impact, no further improvements had been made to ward environment. The wards were stark with no signage, patient information, therapeutic displays or evidence of any patient centred activities / projects available.

The wards were not cleaned to an acceptable standard. Floors were dirty and dusty particularly behind sofas and under patients' beds. Used mop buckets and cleaning equipment had not been locked away, beds remained unmade by late afternoon, some furniture was ripped, patients' pillows were observed to be in a poor condition and malodours were detectable throughout. The system for monitoring the cleanliness of both wards was not robust and we could not evidence any regular cleaning audits, action plans for improvement or regular communication between the ward management team and the support services manager. There was no evidence of daily managerial environmental walk arounds.

The patients' main dining room in Melvin ward was small, cramped and cluttered and was also being used for activities and not exclusively as a designated dining room. The dining room was not conducive to a pleasant or safe dining experience for patients. Dining furniture was old and worn and there was a large quantity of activity equipment stored in the room including tubes of paints which were easily accessible and not stored safely in line with COSHH (Control of Substances Hazardous to Health) guidelines. There was no signage or information displayed to inform staff of patients' dietary requirements or speech and language therapy (SLT) recommendations. During the lunchtime meal we observed patient safety risks in relation to choking and escalated our concerns to the ward management team. Appropriate action was taken during the course of the inspection and a larger designated dining room was reinstated for patient use, information was displayed regarding patients' dietary requirements and SLT recommendations.

Ligature risks were identified in Melvin ward, a shower fitting in a patients' shower room and an unused profiling bed with cables attached to it in an occupied patient bedroom. Staff were not aware of the ligature risks despite some patients who are admitted due to low mood and suicide ideation. We shared our concerns about the ligature risks to both the ward management team and SMT who agreed to address. We were unable to evidence MDT discussions in relation to environmental ligature risks and there was no evidence of an up to date ligature risk assessment. We received a ligature risk assessment two days later; however it did not contain an action plan to inform staff on how to manage ligature risk in the ward environment. The management of ligature risk has been identified as an area for improvement.

The previous AFI 4 in relation to the environment was assessed as not met.

Fire Risk

The arrangements for fire safety were reviewed. Our previous inspection highlighted a number of concerns in Strule ward due to the significant amount of adaptations and modifications made to facilitate the complex needs of patients.

The environment in Strule Ward is in a very poor condition with evidence of extensive damage to multiple surfaces and finishes. While further adaptions and modifications had been made to the ward this had not resulted in any increased fire risk to the premises. The risk had not changed significantly since the main fire risk assessment of August 2021. Staff reported that when changes were made to the ward that could impact fire safety, for example, the recent covering up of fire swipe access boxes, the ward manager would liaise directly with the Fire Safety Officer for advice and guidance. Ward managers met with the estates team monthly and as required to discuss any issues. Staff reported they had a positive working relationship with the estates team and that there were effective communication channels which resulted in a timely response to requests for repairs/advice this included requests made outside of normal working hours.

The fire risk assessment for the ward was reviewed and was found to be current with an appropriate action plan in place. The fire risk assessment was accessible to all staff and retained in the fire safety folder held in the ward manager's office.

The previous AFI's 5 and 6 in relation to the fire risk in Strule Ward were assessed as met.

5.2.3 Adult Safeguarding (ASG)

ASG arrangements were reviewed. ASG 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).

We acknowledge that some progress has been made in relation to this area for improvement. The previous practice of different pathways for referral had ceased and all ASG referrals (APP1 forms) were submitted directly to the ASG team. ASG was discussed at the weekly MDT meetings and a new ASG database was available to staff via the Trust's online SharePoint system however we found not all key staff knew how to access this.

Some senior nursing staff had attended the higher level of ASG training which equips staff to become ASG investigating officers (IO's). While it was positive that staff had undertaken this training we would recommend the Trust consider the appropriateness of this level of training based on previous inspection outcomes. We reviewed the training matrix and found that less than 33% of staff had attended the recently updated ASG training for staff. We recommended that the Trust expedite this training for all staff.

We found that the number of ASG referrals in Lakeview Hospital was low, most APP1 forms did not have interim protection plans and those that were in place did not provide enough assurance that the plans robustly met the protective needs of the patients.

On review of Datix we identified that some incidents which would have met the threshold for an ASG referral had not been recognised or reported by staff.

We escalated our concerns to the management team and requested that the Trust adhere to the ASG regional guidance and make a referral under ASG for the unreported incidents, this was actioned during the inspection. As a result of our findings we were not assured that the safeguarding arrangements in place were suitably protective. As we identified ASG incidents were not consistently recognised and reported in a timely manner or robust protection plans were in place.

During the inspection in August 2021 and this inspection we identified concerns in relation to the Trust's 'advice and resolution process' for managing ASG referrals. Prior to submitting an ASG referral the process requires ward staff to contact patients' individual community social workers and the Trust's ASG team for advice and direction to assess the appropriateness of making an ASG referral. This has the potential to delay the implementation of patients protection plans thus placing patients at further risk. The process itself does not empower nursing staff to independently report abuse or screen referrals in line with the regional guidance and is not in keeping with the Regional Adult Safeguarding Protocol. Nursing staff lacked knowledge about interim protection planning and there was confusion about what incidents were reportable and what met the threshold for ASG across all grades of staff and other disciplines. We were not assured that staff fully grasped the importance of adult safeguarding including reporting ASG as part of their role.

The previous AFI 7 in relation to ASG was assessed as not met and as a result of the concerns identified the Trust were invited to attend a meeting on 01 March 2021, signalling our intention to issue an improvement notice in relation to ASG.

Whilst we recognise that the Trust has made some progress in this area since the previous inspection we remain significantly concerned about ASG in Lakeview Hospital. In view of this, a decision was made to serve an Improvement Notice in relation to ASG and incident management: IN000014 was issued to the Trust on 11 March 2022.

5.2.4 Incident Management

A sample of incidents recorded on Datix from 21 September 2021 to 31 January 2022 were reviewed.

In relation to incident management it was positive to note that some progress had been made at ward level. Safety briefs had been introduced to facilitate effective communication between staff and to improve patient safety. Post incident debriefs were in place to support staff's psychological wellbeing and staff spoke positively in relation to their impact.

One ward manager has completed a 'train the trainer' course for MAPA (Management of Actual or Potential Aggression). MAPA is behaviour management training and provides staff with strategies and skills to safely respond to anxious, hostile or violent behaviour. This specialist training equips the ward manager with the skills required to support the team to utilise MAPA safely, effectively and appropriately. There was also evidence that the MAPA Team Lead was attending the fortnightly incident review meetings.

Some governance systems in relation to incident management had been implemented. Two levels of incident review meetings had been introduced, fortnightly for ward staff and monthly for MDT, however the purpose of these meetings was unclear.

We could not determine if the ward based incident review meetings were patient specific or were to review all incidents that had occurred on the wards as the minutes of the meetings lacked detail in relation to the discussions that had taken place.

There was some evidence of incident analysis however it was more quantitative than qualitative. A qualitative analysis of data would have ensured that the incidents were scrutinised and would have enabled the Trust to identify trends and themes which could be used to drive improvement, support learning and prevent recurrence. The weaknesses in the current processes do not provide us with the necessary assurances that incidents are safely and effectively managed in Lakeview Hospital.

The previous AFI 8 in relation to incident management was assessed as not met and as a result of the concerns identified the Trust were invited to attend a meeting on 01 March 2022, signalling our intention to issue an improvement notice in relation to incident management.

We recognise that the Trust has made some progress in this area since the previous inspection however as a result of our findings we remain significantly concerned about the governance and oversight of incidents in Lakeview Hospital. In view of this, a decision was made to serve an Improvement Notice in relation to ASG and incident management: IN000014 was issued to the Trust on 11 March 2022.

5.2.5 Restrictive Practices

Restrictive practices in use included; locked doors; enhanced patient observations, use of rapid tranquilisation medication and physical intervention. The Trust Policy in relation to the use of restrictive interventions was shared with us and was due for review in May 2022.

A new restrictive practices group has been established (first meeting 17 January 2022). The membership of the group did not reflect the full MDT. The group aims to develop and undertake a restrictive practices audit. In line with best practice any restrictive practice should be reviewed by the MDT. The restrictive practice group should seek opportunities to strengthen reporting mechanisms through the governance structures in the Trust.

There was no evidence of audit, analysis, trending or theming in relation to restrictive practices which was concerning given the high levels of physical restraint and PRN medication used in the hospital. The lack of audit does not support discussions around the use of alternative interventions to reduce restrictions and improve quality of life for patients.

Whilst we acknowledge the improvements to date, the governance and oversight of restrictive practices in Lakeview Hospital requires further strengthening to ensure that restrictive practices are managed safely and effectively and should include regular MDT review and audit programme.

The previous AFI 9 in relation to restrictive practices was assessed as not met.

5.2.6 Financial Governance

Financial governance was reviewed at Lakeview Hospital in line with RQIA's statutory functions; this was to ensure that the Trust were appropriately discharging its full responsibilities, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986.

We were assured that the financial governance in both wards had improved significantly since the last inspection in August 2021.

It was evident that record keeping and the processes for managing patients' finances and property had improved in both wards. All staff had attended mandatory training in relation to managing patient finances and mechanisms were in place to ensure that staff were adhering to Trust policy.

We evidenced governance and oversight of patient finances and observed that senior managers were completing a monthly audit of patients' monies.

A recent audit undertaken by the Business Services Organisation (BSO) identified a recommendation in relation to Department of Communities (Dfc). The Trust are progressing with this and this will be reviewed on the next inspection.

The previous AFI 10 in relation to financial governance was assessed as met.

5.2.7 Staffing

The arrangements for staffing in Lakeview Hospital were reviewed. Staffing numbers should be calculated using an evidence based staffing tool such as the Telford Model, this will establish the number of staff required to ensure the safe and effective operation of each shift. The calculations are based on individual patient need and considers levels of support required. This contributes to the delivery of safe and effective patient care.

An escalation policy was in place which provided direction to staff when they experienced staffing shortages on shift and this included contact with SMT. A review of Datix incidents evidenced that staff were reporting short staffing levels.

It was positive to note that Ward managers were using the Telford Model as a tool to inform safe nurse staffing levels in Lakeview Hospital however not all staff had a good understanding on it's use. We identified the required staffing levels as indicated on the Telford model were not achieved on a frequent basis due to short and long term absences.

We acknowledge however that all efforts were made to secure additional staff and that there was regular contact with the Trust nurse bank and nurse agencies. We were informed by staff that The Trust workforce appeal is ongoing and that a recruitment drive continues for band 5 nursing staff and above with interviews pending for six applicants. Ward Managers also reported improved team working between wards when staffing fell below the desired level.

It was positive that staff were undertaking a daily Situation Response (Sit Rep) exercise in relation to assessing staffing levels daily. However the staffing numbers recorded on the Sit Rep records did not always correlate with the staff rota or the number of staff actually working; this had the potential to cause confusion.

If staff rotas do not correspond with sit rep report information it could be difficult to establish what staff members were actually working. This could cause difficulties tracking staff for example if there was an incident. The issue is further compounded due to a high use of bank and agency staff in the hospital. In contrast if staffing levels were recorded as higher on the rota than they actually were this could impact staffing arrangements, planning and escalation and result in unsafe staffing levels.

Staff feedback confirmed that morale and communication had improved since the last inspection and that they could see the benefit of the changes already made. Increased support from the management team on a daily basis was reported and the introduction of post incident debriefs was proving beneficial for staff.

The Trust is currently making attempts to recruit a full-time dedicated psychiatrist for Lakeview Hospital with an ongoing recruitment campaign in place. However we also identified there to be insufficient pharmacy input, no ward based OT, no dedicated positive behaviour support therapist and limited input form psychology and SLT professionals.

The previous AFI 11 was assessed as partially met.

5.2.8 Physical Health Monitoring

The management of patients' physical health care needs, including anti-psychotic medication monitoring had significantly improved since our previous inspection. We found that there was a health care pathway in place for each patient admitted to Lakeview.

Patients were able to access routine health screening through referral - including dentistry, podiatry and optician. Some patients were of an age where particular types of screening are advised and would routinely be organised through a GP. We found that each patient had the name of their GP recorded in their clinical records and there was evidence that all patients had access to seasonal and Covid-19 vaccinations.

There was evidence that patients had routine blood tests completed and also blood tests for specific reasons such as physical illness or to ensure the safe prescribing and monitoring of certain medications. Electrocardiography (ECG) checks were provided to those prescribed anti-psychotic medication however attempts were not always successful due some patients' complex challenging behaviours. It was positive to note that staff had sought additional support from community services to support an ECG for one patient with complex challenging behaviours. This demonstrated a collaborative approach to this patients care as reasonable adjustments had been put in place to achieve physical health screening.

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.

A full review of antipsychotic medicines was completed by the hospital psychiatrist in August 2021. There was evidence that these medicines were regularly reviewed during clinical ward rounds which has led to improved outcomes for patients regarding reduction in medication.

The pharmacist had developed a high dose antipsychotic care pathway. This had not yet been implemented in full as the aim is to implement the pathway across all Trusts, working with the regional Mental Health Pharmacist Group. This will enhance patient care once implemented.

A review of all patient kardexes in both wards showed that medicines that were prescribed on a PRN "when required" basis had a rationale for use, first and second line medicines were specified and the minimum dosage intervals and maximum daily dosage were stated. This ensured that registered nurses had clear directions for use of these medicines.

Audits completed by staff showed an improving picture with regard to record keeping in relation to medicines review. It was evident that action had been taken as improvements were noted however there was no formalised documented action plan completed, this would have supported consistency, oversight and monitoring.

The pharmacist support allocated to the ward was three hours per month. This limited the input of the pharmacist to reviewing audits and supporting education and training for staff. Additional pharmacist support would enhance governance systems in medicines management, support safe prescribing, provide guidance on physical healthcare needs, support antibiotic stewardship and contribute to continuity of care.

Some issues were identified in relation to storage and medicine stock control these were addressed during the inspection with staff.

The Trust should consider pharmacy technician support to the wards which would support nurses in stock management and storage. This was identified as a new area for improvement.

The previous AFI 12 was assessed as met. A new area for improvement has been identified in relation to pharmacy input and action plans following medication review.

5.2.9 Care and Treatment

The care and treatment of patients in Lakeview Hospital was reviewed.

We found that while repairs to the ward were ongoing to maintain the safety of the environment works had not sufficiently progressed to promote and support patients' recovery. We could not access a current ligature risk assessment inclusive of action plan for the wards (please refer to section 5.2.2). We also found there was a lack of therapeutic engagement by staff and observed patients spending a lot of their time in corridor areas, this resulted in a lack of privacy and dignity particulary for patients who were presenting with distressing, challenging behaviours. There was a lack of leadership, coordination and delegation of tasks on shifts, patients beds were unmade and patient mealtimes were observed to be delayed and disorganised with no structured approach in place.

A positive behaviour support assistant was allocated to one ward however patients had limited access to psychology services, speech and language and occupational therapy. Positive behaviour support (PBS) is an analysis of the behaviour of an individual it is based on assessment of the social and physical environment in which the behaviour happens and includes the views of the individual. PBS was not sufficiently embedded in either of the wards to optimise impact. RQIA recommend that a full MDT approach is taken to support patients' recovery and rehabilitation including the allocation of a full-time behaviour support therapist.

There was a no evidence of patient centred therapeutic or recreational activities/projects, quality improvement initiatives and the hospital lacked a therapeutic ambience. There was no dedicated occupational therapist (OT) based on the ward therefore patients did not have access to OT assessments or activities. Positively one patient did have access to daily outings with staff and enjoyed going swimming.

Patients were observed eating meals unsupervised in ward day rooms and side rooms and there were delays with the serving of meals.

We were concerned that the regional learning, as shared by the Health and Social Care Board (HSCB), following serious adverse incidents (SAI's) involving patients who had adverse outcomes as a result of choking, was not being adhered to and this presents significant risks to patient safety.

We reviewed patient care plans. All care plans were in paper files which were bulky and difficult to manage. This made it time consuming to access information and track the patient's journey. There was no progression to electronic care recording in line with best practice. Care plans were extremely lengthy making them difficult to follow. Some care plans had not been reviewed updated and were not reflective of the current needs of the patient. We found duplicated care plans for the same need which has the potential to lead to confusion for staff delivering the care. It was evident from our findings that care plans had not been audited. A new area for improvement has been identified in relation to patient care plans.

We recognise that the Trust is undertaking a journey of improvement however as a result of our recent findings we have significant concerns about the care and treatment of patients. In view of this, a decision was made to serve an Improvement Notice in relation to care and treatment: IN000015 was issued to the Trust on 11 March 2022.

5.2.10 Governance & Leadership

Some progress has been made in relation to improving the governance processes within Lakeview Hospital since the previous inspection. The Trust had established a Project Management Board chaired by the Director of Mental Health and Disability services to oversee the progress directly relating to the 13 AFI's made following RQIA's previous inspection. In relation to incident management it was positive to note that safety briefs had been introduced within the wards and staff spoke positively in relation to their impact. However, we remain concerned about the governance and oversight of ASG and incident management, and the quality of leadership across all grades.

Whilst it was positive that a project team had been established to oversee work in relation to the AFI's from our previous inspection, the impact of the work completed by the Project Board was not evident at ward level and that the work has not progressed at pace. The Project Lead was not a protected role which has possibly contributed to the lack of progression made. The governance and oversight of incidents in Lakeview Hospital needs to be strengthened. It was positive that some quantitative analysis of incidents had taken place but we could not evidence any further scrutiny of incidents to inform trends and themes this would prevent recurrence, support learning and drive improvement.

Since our last inspection some progress had been made in relation to ASG however we could not evidence effective governance and oversight processes in relation to ASG and there was a lack of audit to inform future learning. Nursing staff informed us that the leadership and staff morale in the hospital had improved however we could not evidence any staff meetings being held since October 2021 to support communication and improve care. We had concerns about the quality of leadership amongst all grades of staff during the course of the inspection. We escalated patient safety issues in relation to the dining experience and were concerned that these were not addressed promptly, we observed there to be a lack of coordination and delegation of tasks on shift with no oversight to ensure that therapeutic interventions were being delivered. We could not be assured that information in relation to governance issues was effectively escalated or cascaded between the SMT and ward staff. Minutes of key meetings were reviewed and it was evident that outcomes had not been shared between teams.

The senior management team acknowledged that work had commenced regarding improving the staff culture at Lakeview Hospital, and that the newly appointed ward managers were being supported through a peer support process with other ward managers across MHLD services within the Trust. The SMT informed us that this work remains ongoing and will take time to progress and embed practices. We met with the SMT and they informed us they had commenced leadership walk arounds of Lakeview. To date we could not evidence a schedule of visits being planned or any formal outcomes of the visits.

AFI 13 was assessed as not met. We are concerned that the necessary steps have not progressed to strengthen governance arrangements to ensure patient safety and manage any collating risks within the service. In view of this, a decision was made to serve two Improvement Notices in relation to ASG and incident management and care and treatment: IN000014 and IN00015 were issued to the Trust on 11 March 2022.

5.2.10 Staff Engagement

We spoke with a wide range of staff during inspection.

Staff discussed the ongoing impact of staffing shortages and informed us that some days can be quite challenging although all confirmed that they were getting access to breaks and overall morale had improved.

Staff told us they were “firefighting” a lot of the time and had no time to focus on improvements or innovation due to low staffing levels and reported a lack of team meetings in recent months due to low staffing levels and Covid-19. Staff were complimentary of the two newly appointed ward managers and said they were approachable, proactive and motivated. One newly appointed member of staff reported that they had received a very good induction to the ward.

Some staff felt there could be more activities on the ward for patients and most felt the ward environment had improved as it had been recently painted. Some staff suggested that pods on the ward would enhance patient care and support privacy and dignity.

5.2.11 Family Engagement

The families of patients in Lakeview Hospital were approached for their views.

Three family members stated they were happy with the care their loved one received. They described staff as very good, patient and approachable. All three said they could approach staff or ward management if they had any issues.

Some family members had mixed views on their loved ones being in Lakeview Hospital and felt that not enough had been done to support with discharge and resettlement, however did recognise the complexities of caring for their relative.

Some families had concerns that their loved ones were the subject of adult safeguarding investigations due to incidents that had occurred in Lakeview Hospital and also about the lack of activities for patients.

One family member was concerned about the environment and cited this as a contributing factor to the patient’s decline. This relative advised they were not permitted to visit throughout the pandemic and attributed this to more difficult visits now.

One relative advised they had been asked to provide food for a patient who tends not to like what is on the menu. This issue was escalated by RQIA to the ward manager who has since resolved the issue.

6.0 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	6

The total number of areas for improvement includes two that have been stated for a second time.

Enforcement action resulted from the findings of this inspection for Lakeview Hospital. The enforcement action relates to the ASG and incident management and, care and treatment.

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**: Standards 4.1 & 5.1 **Criteria** 4.3, 5.3.1, 5.3.3 **Stated:** Second time **To be completed by:** 17 June 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. 3. Engage the support of the other key stakeholders, including the commissioner in defining the model to determine safe levels of nurse staffing. 4. 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: 1. Staffing levels are currently based on the Telford model and additionally the Northwick Park Tool has been applied in the context of our patient population to determine the enhanced care levels required for Lakeview Hospital, with Ward Managers involved in this work. The particular staffing levels required for Lakeview Hospital in terms of normative baseline nursing configuration will be represented in a Paper shared at the WHSCT Nurse Stabilisation Working Group, ahead of presentation to the Corporate Management Team (CMT). A daily sit rep report shared with the Head of Service allows for a review of staffing levels daily. The Head of Service meets with Managers on a regular basis to review normative staffing levels in line with admissions and discharges and patient acuity. 2. The Lakeview team use a local escalation policy that ensures staffing deficits are brought to the attention of the Assistant Director and Director as appropriate.

	In line with Trust processes, identifed staffing deficits are managed by securing staff through 1.Overtime/ Additional hours 2.Corporate Bank 3.Agencies. The Hospital have also sought to be included in the Trust's Protocol for the Payment of Critical Clinical Shifts given the staffing pressures. Staffing pressures are also recorded on Datix and escalation has included the use of the Early Alert process at critical periods. 3 Work on determining safe staffing levels is supported by Trust nursing governanace and determiniation of relevant pressures are being brought to the attention of SPPG. 4 The availabilty of a local nursing management structure, with an emphasis on open door policy provides increased responsivity to matters related to morale, culture and emerging concerns. There is a regular presence of SMT members that encourgages active engagement.

Area for improvement 2 **Ref:** Standard 5.1 **Criteria:** 5.3.1,5.3.3 **Stated:** Second **To be completed by:** 17 June 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. The use of restrictive practices is routinely audited and reported through the WHSCT assurance framework. 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: 1. The retrospective and ongoing review of all Datixes encompasses consideration of restrictive practices and aligned with best practice requirements. 2 Work is ongoing on the development of a restrictive practices strategy with relevant MDT input and informed by best practice guidance and local learning from the incident reviews. 3. Audit of restrictive practice will be undertaken on a monthly basis additional to the incident reviews described. Related assurance frameworks will be informed and shaped by the recently established Trust local network focusing on work on the Restraint Reduction Network Standards and which will also lead on updating the WHSCT Restrictive Practices Policy.
Area for improvement 3 **Ref**: Standard 5.1 **Criteria**: 5.3.1 **Stated:** First Time **To be completed by:** 17 June 2022	The Western Health and Social Care Trust must ensure that Lakeview Hospital is allocated a pharmacy technician to support nurses with the stock and storage of patient medications. Consideration should also be given to developing an action plan on completion of audits to support the medication review.
	Response by registered person detailing the actions taken: The recruitment of a temporary Band 8a Pharmacist for a period of 12 months is underway, with the intention that specifc needs related to the Hospital will be more fully understood including e.g. the appropriateness of the role of pharmacy technician at the end of that period. In the meantime medication audits are ongoing, overseen by the Specialist Mental Health Pharmacist in conjunction with Mental Health Liaision Nurse for Learning Disability with identifed areas for improvement taken forward in a relevant action plan. The Specialist Mental Health Pharmacist is supporting Ward staff in ensuring safe storage of all medications.

Area for improvement 4 **Ref**: Standard 5.1 **Criteria**: 5.3.1, 5.3.3 **Stated:** First Time **To be completed by:** 17 June 2022	The Western Health and Social Care Trust must ensure that there are robust discharge plans in place for all patients in Lakeview Hospital that include realistic and achievable discharge dates.
	Response by registered person detailing the actions taken: Monthly MDT discharge planning are ongoing in respect of all patients and has been effective in achieving recent discharges. The pace of discharge is influenced by the availabilty of suitable accomodation and community supports, including in localities of origin. To support the required focus on discharge planning, there is increased emphasis on comprehensive MDT assessment of patient needs to ensure that endeavours to secure discharge plans are based on the most up-to-date and comprehensive undertsanding of need.This increases the potential for anticipated discharge dates to be more meaningful and accurate.
Area for improvement 5 **Ref**: Standard 5.1 **Criteria**: 5.3.1 **Stated:** First Time **To be completed by:** 17 June 2022	The Western Health and Social Care Trust must ensure the ligature risk assessment for both wards includes an action plan and timeline as to when ligature points requiring removal or replacement will be completed.
	Response by registered person detailing the actions taken: Ligature audit tool and risk assessments remain under daily review and are incorporated into the safety brief and the AM/PM staff handovers. They are reviewed regularly by the Head of Service for Nursing in line with oversight and governance arrangements, with ongoing and regular engagement with Estate's and Risk Management colleagues regarding any changes or remedial actions requirments.
Area for Improvement 6: **Ref**: Standard 5.3.1 (f) **Criteria**: 5.3.1 **Stated:** First Time **To be completed by:** 17 June 2022	The Western Health and Social Care Trust should ensure that care plans are written in accordance to NMC standards. Consideration should be given to: 1. Progression to electronic are plans in line with best practice guidance 2. Regular review of patients care and treatment 3. Undertaking a programme of audit of all patients care plans
	Response by registered person detailing the actions taken:: 1. Head of Service has met with System Administrator/Team Manager ICT with a view to having staff access to Paris (which includes patient information, care plans and risk assessments). As the Trust Community Information System Project has ended there is more limited opportunities to consider and prioritise any change requests or new initiatives that need to be implemented on Paris. Preliminary work is ongoing to support staff access but will be

	influenced by the available resource within the ICT support Team- an anticipated date in September 2022 has been shared. 2. Weekly Ward Rounds and MDT meetings provide the forum for review of patient care and treatment as does ongoing adherence to social work care management processes. 3. An audit of current patient care plans is ongoing, overseen by the Head of Service. This baseline data will inform relevant improvement work required across the MDT input to care planning, including any required staff development/training needs.

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