Inspection Report

23 - 13 May 2024

Southern Health and Social Care Trust
Inpatient Learning Disability Ward

Dorsy Assessment and Treatment Unit
Bluestone Unit,
68 Lurgan Road,
Portadown
BT63 5QQ

Telephone Number: 028 2836 0665

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

1.0 Service information

Organisation/Registered Provider: Southern Health and Social Care Trust (SHSCT)	**Responsible Individual:** Dr Maria O'Kane Chief Executive Officer; SHSCT
Person in charge at the time of inspection: Catherine Meenan Ward Manager	**Number of registered places:** Nine
Categories of care: Learning Disability (LD) Assessment and Treatment	**Number of patients accommodated in the ward on the day of this inspection:** Four
Brief description of the accommodation/how the service operates: Dorsy Assessment and Treatment Unit (Dorsy) provides inpatient care to men and women aged 18 years and over who have a learning disability and require assessment and treatment in an acute psychiatric care setting. A Low Stimulus Environment (LSE) with access to a seclusion room is also available within Dorsy Ward. The ward is situated in Bluestone Hospital which is located on the grounds of Craigavon Area Hospital. Patients are admitted to Dorsy on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).	

2.0 Inspection summary

An unannounced inspection commenced on 23 April 2024 and concluded on the 13 May 2024 with feedback to the SHSCT Senior Management Team (SMT). The inspection team consisted of two care inspectors.

Intelligence received by RQIA before the inspection indicated concerns regarding the layout of the ward and patients' living arrangements within Dorsy. In addition, to manage risk and ensure patient safety, a number of beds were out of commission and the seclusion suite was being used as a bedroom.

The purpose of this inspection was to assess the Trust's progress against the areas for improvement (AFI) identified in the Quality Improvement Plan (QIP) following the last inspection of Dorsy Ward on 1 and 2 June 2023. Findings from this inspection identified that five AFI's had

been met and one partially met in relation to staff training. This will be restated for a second time.

This inspection focused on the following key themes; environment, restrictive practices, patient flow, adult safeguarding and incident management, staffing, physical health, mental health, patient experience, medication management, and governance. Each theme was assessed to determine safe and effective care delivery and treatment.

Good practice was identified in incident management and analysis, adult safeguarding practices and there was comprehensive positive behaviour support (PBS) plans in place for patients. Areas that require improvement are in relation to use of the low stimulus environment and seclusion room and clarity on the use of seclusion in the patient's own living area to ensure it is in line with the Regional Policy on the use of Restrictive Practices.

During the inspection staff were observed to be caring and compassionate in their interactions with patients.

3.0 How we inspect

RQIA has a statutory responsibility under the Mental Health (Northern Ireland) Order 1986 to make inquiry into any case of ill-treatment, deficiency in care and treatment, improper detention, and/or loss or damage to property. Care and Treatment is measured using the Quality Standards (2006) for Health and Social Care to ensure that services are safe, of high quality, and up to standard.

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

The inspection team directly observed patient experiences; staff engagement with patients; how patients spent their day; staffing levels; senior leadership oversight; and ward environments. The inspection team also reviewed patient care records; patient discharge arrangements and governance documentation.

Experiences and views were gathered from staff, one patient, and families.

4.0 What people told us about the service

Posters and easy read leaflets were provided inviting staff and patients to speak with inspectors and give feedback on their views and experiences.

We spoke with a number of patients, relatives and staff. Overall comments from relatives were positive; they spoke with admiration for the staff and the care provided, although it was felt that the outdoor spaces in Dorsy and access to facilities in the local community could be improved.

Staff reflected that the ward was currently challenging to work in, but felt that their role was rewarding. Overall staff reported that they were supported by colleagues and management.

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 Dorsy was undertaken on 1 June 2023 by two care inspectors. Six AFI's were identified and were included in the review of the QIP below.

Areas for improvement from the last inspection on 01 June 2023		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 4.1 **Criteria:** 4.3 **Stated:** Second time	The Southern Health and Social Care Trust should implement 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 SHSCT policy and procedures; this includes: • systematic reviews of the procedures and controls in place at ward level are undertaken by the Trust; and • receipts are provided to families when cash is deposited at ward level for patients.	**Met**
	Action taken as confirmed during the inspection: A review of the systems and process in operation for the management of patients finances was reviewed. This evidenced the Trust had procedures and controls in place at ward level and receipts were provided when monies were deposited for patient's funds. Regular checks and audits of cash balances held were being completed at ward level. This was also a standing agenda item on the Dorsy Operational Meeting ensuring all staff were aware of this.	

Area for improvement 2 **Ref:** Standard 4.1 **Criteria:** 4.3 **Stated:** Second time	The Southern Health and Social Care Trust should strengthen the governance arrangements by: • Analysing the extensive data they have collated in relation to incidents and Adult Safeguarding (ASG); • Themes, trends, and learning identified from the dataset and adult safeguarding incidents are shared with all the relevant staff, including ward staff. • The Trust should develop a method of recording regular leadership walk rounds, schedules of visits or any outcome reports following a visit to the ward.	
	Action taken as confirmed during the inspection: Datix incidents were detailed and well recorded. Incidents and ASG concerns are discussed at the daily safety huddle, Dorsy operational meeting and mental health governance meeting to identify themes and trends. Positive Behaviour Support (PBS) staff review all incidents involving patients and provide a detailed analysis of actual/potential trigger events/situations. The Trust have developed a method of recording leadership walk rounds and outcomes although this has still to be fully embedded.	**Met**
Area for improvement 3 **Ref:** Standard 5.3.1 **Stated:** First time	The Southern Health and Social Care Trust must ensure storage arrangements are reviewed and risk assessed to provide safe therapeutic spaces for patients.	
	Action taken as confirmed during the inspection: This AFI related to a bedroom and bathroom being used to store supplies. This had been addressed.	**Met**

Area for improvement 4 **Ref:** Standard 4.3 **Stated:** First time	The Southern Health and Social Care Trust must ensure staff have access to a personal alarm to summon assistance in the event of an emergency.	**Met**
	Action taken as confirmed during the inspection: It was confirmed that staff have access to an appropriate number of personal alarms to summon assistance. The Trust has also purchased a number of walkie talkies for staff as an additional safety measure.	
Area for improvement 5 **Ref:** Standard 5.3.1 **Stated:** First time	The Southern Health and Social Care Trust must ensure staff complete training as required for their job role. This must include: • Adult safeguarding training • Dysphagia awareness • Deprivation of Liberty Safeguards training All staff should have an annual appraisal as part of their professional development.	**Partially met**
	Action taken as confirmed during the inspection: A review of the training matrix confirmed that training was available for staff and compliance with corporate mandatory training, which includes Adult safeguarding training, dysphagia awareness and Deprivation of Liberty Safeguards training was good; there were gaps in other areas of staff training and no evidence in relation to staff appraisals was available at time of inspection. This AFI has been stated for a second time.	
Area for improvement 6 **Ref:** Standard 5.3.1 **Stated:** First time	The Southern Health and Social Care Trust must ensure that ward staff have an understanding of Deprivation of Liberty Safeguards (DoLS) and where voluntary patients are subject to continual supervision and are not free to leave that DoLS are put in place.	**Met**

	Action taken as confirmed during the inspection: At the time of inspection there were no voluntary patients subject to continual supervision and not free to leave, therefore there were no DoLS required. There was evidence that staff are receiving training in DoLS and on speaking to staff it was evidenced that they had an understanding and knowledge of DoLS.	

5.2 Inspection findings

5.2.1 Environment

The inspection assessed the environment to determine if it was conducive to the delivery of safe, therapeutic and compassionate care. At the time of inspection concerns were identified and raised with the Trust regarding the current model of care in operation; that had resulted in a number of beds being closed to admission with limited access to some areas of the ward for current patients. The Trust acknowledged the challenges and impact this was having upon patients and assurances were provided that all steps were being taken to mitigate the risks.

Dorsy has a bright spacious environment with a number of therapeutic areas. It was positive to note the completion of the sensory room, although this was not always available to patients, due to patients' relationship compatibility and safety. The cleanliness was of an acceptable standard; however, the ward would benefit from some redecoration.

The seclusion room was being utilised as a bedroom, with no available storage for personal items; this is not consistent with best practice and should be reviewed as a matter of urgency. As a result, the seclusion room is not available should it be required for the safety of vulnerable patients. This was raised with the Trust at the time of inspection and during feedback.

Post inspection RQIA contacted the Trust seeking assurances that all alternative living/sleeping arrangements were being explored and reviewed on an ongoing basis. Where no alternative arrangements are identified the Trust must ensure that patients are provided with appropriate furniture to ensure dignity and for storage of personal belongings; this should be risk assessed to ensure patient safety.

An AFI has been identified in relation to the use of the seclusion room and low stimulus environment.

There was limited information regarding therapeutic activities available or staff on duty displayed in the communal area. Information regarding the ward, advocacy services and general information was available in the entrance hall to Dorsy.

Dorsy has an internal courtyard and an enclosed garden for patients. Both of these areas require remedial works to ensure they provide a safe environment for patients. Relatives

commented that these were under used and would like to see the works progressed to make these areas more accessible. It is recommended the Trust liaise with patients and families to seek their views regarding the use of the outdoor spaces.

The Fire Risk Assessment (FRA) was due for review in December 2023. The ward manager stated that this had been reviewed however no evidence was provided at the time of inspection to support this. The Trust must implement a system to ensure that the FRA is reviewed in a timely manner and evidence of this is readily available.

Personal Emergency Evacuation Plans (PEEPS), which inform staff of the level of assistance a patient needs to safely evacuate in an emergency, were reviewed and were found to be up to date.

The Ligature Risk Assessment (LRA) has been reviewed and updated; not all actions included an update on progress to date. The overall risk rating states that actions must be completed within six months, however the LRA does not include a target date for completion.
The Trust should review the LRA and include a target date for the completion of actions agreed and that a progress update is provided.

5.2.2 Restrictive Practice

Restrictive Practice is the term used to describe any intervention that restricts a person's freedom of movement. This may include a locked door; enhanced/prescribed patient observations; physical interventions; the use of 'when required' (PRN) medication; rapid tranquillisation; CCTV and seclusion.

Dorsy operates as a locked ward with access/exit controlled by staff. Review of care plans evidenced that restrictive practices contained a rationale for their use with considerations of human rights taken into account. Restrictive practices were reviewed on a daily basis as part of the safety huddle and at the weekly MDT meeting. The level of observation for one patient may not be the least restrictive option and the Trust should undertake a review of this patient's level of observation.

It was positive to note that patient records and care plans contained a disengagement strategy which was drawn up as part of MDT/PBS plans. This provided guidance for staff on how and when to disengage from the patient's personal spaces to ensure the safety of the patient and staff. This is part of the patients care plan and has been risk assessed as the least restrictive option.

On review of documentation the use of seclusion was recorded when the disengagement strategy within the patient's immediate area was implemented. This is not in line with the Regional Policy on the use of Restrictive Practices in Health and Social Care Settings (November 2023) which states that seclusion in hospital must only be used '*in a room or suite specifically designed for this purpose'.*

The Trust must review the use of the terminology of seclusion when used in the context of patient disengagement, occurring within the patient's own living area.

The Trust should further review PBS plans and care plans to ensure that management of dysregulated/distressed behaviours are congruent with current best practice and that this is shared with staff to ensure a consistent approach is applied in managing patient distress.

An area for improvement has been identified in relation to the disengagement /seclusion.

It was noted that CCTV was being used in an area of the ward where the patients' needs did not warrant this. This matter was brought to the attention of the Trust who confirmed during feedback that this practice had ceased.

The use of PRN medication was reviewed. Records were maintained and these were available for review and audit purposes. It was positive to note that there was evidence of a reduction in the use of PRN medication over the previous three months.

5.2.3 Patient Flow

At the time of the inspection Dorsy was operating at 44% occupancy with a number of beds closed to admissions. Three patients were delayed in their discharge/resettlement.

Inspectors were informed that the main barriers to discharge included the lack of suitable community placements and appropriately skilled staff that could meet the complex needs of the patients in a homely environment.

There was good evidence to demonstrate the Trust working with community teams and specialist providers to promote resettlement into the community. Discharge planning meetings were taking place fortnightly involving MDT, Advocacy services and community MDT. Directorate Assurance meetings had commenced, led by the Director of Mental Health services at Bluestone. Regional oversight is provided via the Learning Disability Resettlement Oversight Board with RQIA representation who meet monthly with the Trusts.

The Trust should continue to progress discharge arrangements to ensure that patients are cared for in the most appropriate environment which meets their needs.

5.2.4 Adult safeguarding and incident management

Adult Safeguarding (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 is likely to occur without intervention.

There is a Designated Adult Protection Officer (DAPO) aligned to each ward within the Trust who provides support and guidance to staff if required. A system was in place that included good management oversight to ensure compliance with ASG policies and procedures. ASG processes and contact details for the DAPO were clearly displayed within the nurses' station. This included how to contact the Adult Protection Gateway Team (APGT) out of hours.

All ASG referrals are recorded on the Trust's electronic system for recording incidents (Datix). A number of these were reviewed and noted to be appropriately graded. ASG referrals that do not meet the threshold for escalation to the APGT were appropriately screened out by the ward manager.

Staff demonstrated a good awareness and knowledge of the ASG process, with reporting forms and protection plans completed to a good standard. Staff compliance/completion of ASG training was 86%.

A review of incidents for the previous six months was sampled. DATIX recording contained a good level of detail about the incidents and actions taken. The majority of incidents reviewed were graded consistently in line with HSC Risk Matrix.

The use of physical interventions, and patient on staff incidents were predominantly graded as insignificant or minor. These did not take account of the level of intervention or outcome, which may result in significant incidents not being escalated to senior management. A number of repeated incidents were not graded correctly to reflect the cumulative impact. This has the potential to expose patients and staff to repeated risk. An area for improvement has been identified in relation to incident management,

Incidents were reviewed daily at the morning MDT huddle which is good practice to determine if further actions are required to manage risks and promote safety.

5.2.5 Staffing

In addition to nursing and care staff, Dorsy has a full MDT complement including Psychiatrists, Psychology, Speech and Language Therapy, Physiotherapy, Behaviour Support Nurses, Occupational Therapy and Activities staff.

Nursing staffing levels were determined by the use of the Telford Model which is a tool to assist staff in ensuring appropriate staffing levels based on patient acuity.

During the period of inspection, the arrangements for staffing were reviewed and safe staffing levels were evidenced through staff discussion, daily safety huddle, analysis of staff duty rotas, staff allocation sheets and observation of staff on shift.

There were sufficient staff on duty with agency staff being utilised to cover shortfalls. Staff reported that staffing levels had been challenging although had improved due to staff recruitment. An escalation policy provides staff with guidance regarding the management of staff absence /shortages. Staffing shortfalls and challenges were recorded on DATIX. A number of these were graded as insignificant which may not reflect the potential impact or risks for patients and staff.

The Trust should review the grading of these incidents to include the potential impact and cumulative effect. An AFI has been identified in relation to grading of incidents (see also Section 5.2.4).

Agency staff were utilised to cover shortfalls and although not block booked, the ward made every attempt to ensure continuity by using the same agency staff where possible. Agency staff stated they enjoyed working in Dorsy with the work both rewarding and challenging.

Staff expressed satisfaction with the ward management and reported good teamwork and support from colleagues. Staff acknowledged they were offered support and an opportunity to debrief following an adverse incident.

Some staff expressed frustration regarding their professional development, in that opportunities were limited at present which had been discussed with the ward manager at supervision.

A review of the training matrix confirmed that training was available for staff and compliance with corporate mandatory training, which includes Adult safeguarding was good. Safety intervention training, dysphagia awareness and Deprivation of Liberty Safeguards training also demonstrated a good level of compliance. There were gaps in other areas of training including e-learning and bespoke training such as Working with Adults with Autism and Understanding Behavioural Distress. There was no evidence available at time of inspection to evidence staff appraisals were being completed.

Staff had requested training in Makaton to support patients with speech difficulties.

An area for improvement has been stated for a second time in relation to staff appraisals and a new AFI regarding bespoke training to support patients in Dorsy.

5.2.6 Physical Health

There was evidence that patient's physical health needs were being monitored with appropriate referral to specialist services where indicated. A physical health pathway is in place for all patients which allows medical staff to record investigations and blood results completed.

Physical health is monitored using a range of risk assessment tools including Malnutrition Universal Screening Tool (MUST), Braden for skin integrity and Abbey pain scale. It was noted that for some patients the MUST was not totalled correctly to give an accurate assessment. The Trust must ensure all staff are clear about the importance of the accurate completion of these records.

Mealtime co-ordinators oversee mealtimes in line with the regionally agreed framework 'Mealtimes Matter'. Information relating to individual patient's dietary needs was consistent with care plan information and available for all staff involved in serving patient meals, including support service staff.

Patients were appropriately referred and assessed by Speech and Language Therapy (SLT) and individualised dysphagia guidelines were in place where required. These were consistent with the International Dysphagia Diet Standardisation Initiative (IDDSI) and available to all staff.

A physiotherapist is employed as part of the MDT.

5.2.7 Mental Health

Four patients on the ward were detained under the provisions of the Mental Health (Northern Ireland) Order 1986 (MHO). On review of patient records not all MHO forms were held together. The Trust should review storage arrangements to ensure that all MHO forms are held together for ease of access.

Mental health assessments commence on admission and patient's mental health is discussed at the daily safety huddle.

A weekly MDT meeting involves patient advocates to discuss care and treatment with actions and goals reviewed for each patient.

Behaviour support nurses provide guidance and support to staff through the development of Positive Behaviour Support (PBS) plans which provide key information for staff. Grab sheets based on a traffic light system enable staff to identify when a patient is becoming distressed and ensure early interventions to support the patient are implemented.

PBS staff review incidents and provide an overview of distressed behaviours experienced by patients. This allows analysis of the data for any emerging trends or themes which trigger distress which can lead to improved outcomes for patients by staff amending care plans.

A Clinical Psychologist supports the ward three days per week which is a valuable resource which supports PBS staff in the development of PBS plans.

The Activity co-ordinator provides a range of therapeutic activities for patients depending on patient choice.

5.2.8 Patient experience

Posters and easy read patient leaflets were provided inviting patients and relatives to talk to the inspection team to express their views and opinions. We spoke to a number of patients and family members.

Comments from patients and family members were predominantly positive, with relatives commenting positively on the care their relatives received and said that the staff were dedicated, caring and compassionate.

Families spoke of good communication from staff and that the Consultant contacted them weekly to provide an update following the MDT meeting.

There is a 'Have Your Say Meeting' for patients to contribute to improvements and a relatives' forum is due to recommence in June 2024 for relatives to meet informally with staff. A 'You said we Did' board in the visitors' room had a number of suggestions for improvements. These were being worked on by staff where feasible. Relatives highlighted some areas for improvement they would like to see to improve the facilities at Dorsy, including access to facilities in the local community which had been discussed with staff.

The Trust should consider how to gain the views and opinions of patients who do not wish to or are unable to attend meetings.

It was positive to see that an easy to read information booklet is provided to patients on admission detailing the purpose and expectations of Dorsy.

Staff spoke positively and compassionately regarding patients and observations of interactions with patients were positive and caring.

5.2.9 Medication Management

The treatment room was neat and tidy and daily checks of emergency equipment were being completed. Medication was stored appropriately including those that required refrigeration.

Medication records evidenced first and second line medication to be used with maximum doses over 24 hours recorded.

The use of PRN medication, which is medication that is prescribed on an 'when required' basis was reviewed. It was positive to note that CALM cards were in use, these detail actions that must be used to manage a patients distress prior to administration of medication.

Medication audits identified a reduction in PRN medication use which was positive to see.

5.2.10 Governance

Governance arrangements were reviewed through the examination of documentation, discussions with the ward manager, deputy manager and lead nurse. Inspectors also spoke with members of the MDT.

Dorsy's Operational Policy was due for review in June 2023 and remains overdue. The Trust provided assurances during feedback that this is scheduled to be reviewed although no date for completion was given.

There was evidence of good working relationships between MDT members and ward team. All members of the team highlighted the current ward challenges in relation to patient compatibility and impact the lack of community placements was having upon Dorsy's ability to function as an assessment and treatment unit.

The ward has a daily safety huddle attended by members of the MDT to review any significant events or concerns including staffing arrangements. This provides effective communication between members of the MDT and early identification of emerging risks for escalation.

Minutes of the ward operational meeting were examined. These evidenced that key performance criteria and incident analysis to identify themes and trends was reviewed and shared with staff.

Mental Health Governance meetings include the ward manager, lead nurse and members of the Senior Management Team take place. These offer opportunities to discuss and share information which in turn is shared with staff through team meeting minutes.

The ward has developed a system for recording senior leadership walk rounds and outcomes, however this is not yet fully embedded in practice.

6.0 Quality Improvement Plan/Areas for Improvement

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

	Standards
Total number of Areas for Improvement	Five

The total number of areas for improvement includes one that has been stated for a second time and four stated for a first time.

Areas for improvement and details of the Quality Improvement Plan were discussed with ward manager and senior members of the Bluestone team as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

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

Area for improvement 1 **Ref:** Standard 5.3.3 **Stated:** Second time **To be completed by:** 29 November 2024	The Southern Health and Social Care Trust must ensure all staff have an annual appraisal completed as part of their ongoing professional development. Ref: 5.2.5
	Response by registered person detailing the actions taken: The Dorsy Ward Sister has composed an Appraisal schedule and audit, to ensure all staff receive their annual appraisal in a timely manner. As these are completed, this will be evidenced on this schedule. All available staff will have their appraisal completed by Dec 24. There continues to be progressive improvement towards compliance.
Area for improvement 2 **Ref:** Standard 5.3.1 **Stated:** First time **To be completed by:** 31 July 2024	The Southern Health and Social Care Trust must review the current use of the seclusion and low stimulus environment to provide assurance that it meets the needs of the patients and maintains patient safety. Ref: 5.2.1
	Response by registered person detailing the actions taken: The Dorsy Ward Sister maintains oversight of weekly audits for Seclusion and LSE and any actions that arise from these. All use of such restrictive practices is raised via DATIX and discussed at MDT and CLT weekly governance debrief meetings. The service user currently availing of this space continues to refuse moving to a designated bedroom, as such there have been improvements to ensure not only safety but also dignity. The patient has been provided with a bedside locker for personal items and CCTV has been discontinued in this area, daily therapeutic and purposeful activities continue to be offered.
Area for improvement 3 **Ref:** Standard 5.3.1 **Stated:** First time **To be completed by:**	The Southern Health and Social Care Trust must review the disengagement strategy and the use of seclusion in the patient's own living area to ensure it is in line with the Regional Policy on the use of Restrictive Practices in Health and Social Care Settings (November 2023) which states that seclusion in hospital must only be used *'in a room or suite specifically designed for this purpose'.*

31 July 2024	Ref:5.2.2
	Response by registered person detailing the actions taken: Disengagement strategy continues to be reviewed weekly at MDT. It is also reviewed when required for any changes that need to be made. Bluestone will review the use of the term "Seclusion" when this occurs outside of a designated Seclusion Area. This review will be in line with the regional Seclusion guidance. Staff will receive support, education and training in respect of this. Oversight of Datix will allow us to idnetifty any incidences of the term "seclusion" being used outside of the designated area. The trust has the SELT process which can be utilised to review any such cases for learning opportunities.

Area for improvement 4 **Ref:** Standard 5.3.1 **Stated:** First time **To be completed by:** 31 July 2024	The Southern Health and Social Care Trust must review the grading of incidents to take account of the HSC Regional Risk Matrix to include the potential impact or consequences and the cumulative impact of repeat incidents. Ref: 5.2.4 5.2.5
	Response by registered person detailing the actions taken: All incidents recorded take account of the HSC Regional Risk Matrix. The Regional Impact Table is also accessible via the DATIX DIF1 (reporter) form to assist reporters in their grading of the incident. Staff reporting an incident record the "actual" harm. The incident reviewer/approver then reviews the actual harm grading submitted by the reporter and also enters a "potential" harm grading using the Risk Matrix (calculating likelihood x consequence) in the DIF2 form. The “potential harm” calculation can be affected by considering and applying the frequency of multiple incidents of the same type irrespective of their severity grading. Both actual and potential harm gradings are included in live Datix Dashboards and monitored over time at ward, unit and Directorate Senior Leadership Team levels. Dorsy will assure that the analysis of repeat incidents will be reflected in risk gradings.
Area for improvement 5 **Ref:** Standard 5.3.3 **Stated:** First time **To be completed by:** 31 July 2024	The Southern Health and Social Care Trust must ensure that bespoke training is provided to ensure staff have the skills and knowledge to meet the needs of the patient group. Ref: 5.2.5
	Response by registered person detailing the actions taken: Dorsy maintains a best practice training matrix as well as a mandatory training matrix. Bespoke training has already been commenced by the MDT which includes their roles/responsibilities. MCA level 3 and 4 training has been organised and will take place in September specifically for Dorsy team. Some of the current best practice training includes: ASD awareness: 65% of available have staff completed Trauma 1: 78% of available staff have completed Communication: 61% of available staff have completed Epilepsy Awareness: 78% of available staff have completed. Mandatory Training: Safety Intervention training: 92% of available staff completed Dysphagia: 79% of available staff completed Basic Life Support: 67% of available staff completed

	Dorsy's Ward Sister continues to have oversight of the training matrix and ensures staff compliance with this.

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

The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

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