The Regulation and Quality Improvement Authority

Inspection Report

1 - 2 June 2023

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:** Six
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. 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 1 June 2023 and concluded on 2 June 2023 with feedback provided to the Southern Health and Social Care Trust (the Trust) senior management team (SMT) before leaving the hospital site. The inspection team consisted of two care inspectors, a senior inspector and administration staff. An associate fellow from RQIA observed the inspection process on the morning of day one.

The inspection focused on ten key themes including, environment, incident management and adult safeguarding (ASG), staffing, physical healthcare, restrictive practices, patient experience, governance, medication management, patient flow and mental health. Each theme was assessed to determine safe and effective delivery of care and treatment.

The inspection also assessed progress made against six areas for improvement (AFI) identified during the most recent inspection carried out on 5 April 2022. Four AFIs were assessed as met. Two AFIs were partially met and will be restated for a second time in the Quality Improvement Plan (QIP) found at the back of this report.

The QIP includes four new AFIs identified from this inspection. Areas that require improvement are in relation to the ward environment, adult safeguarding and incident management and staffing.

During the inspection staff were observed to be caring and compassionate in their interactions with patients. Areas of good practice were identified in relation to multidisciplinary team (MDT) working, medication management, speech and language therapy support and recreational and therapeutic activities for 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. To do this we gather and review information we hold about the service, examine a variety of relevant records, meet and talk with staff and management, observe practices throughout the inspection and engage with patients and relatives. Our reports reflect performance at the time of our inspection, highlighting both good practice and any areas for improvement (AFI). 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 the ward environment. The inspection team also reviewed patient care records; and governance documentation.

4.0 What people told us about the service

Posters and leaflets were placed throughout the ward inviting staff and patients to speak with inspectors and feedback on their views and experiences.

We spoke with patients, relatives and staff on their experiences of the ward. One relative met with us during the inspection and five patients' families were telephoned to ascertain their views of the care provided. Comments were generally positive with any issues raised being followed up by the inspection team during the inspection. Patient experience is discussed further in Section 5.2.6.

Relatives stated the care was good especially from regular staff, they were made to feel welcome at meetings and that there was good communication with the ward and MDT staff.

5.0 The inspection

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

The last inspection to Dorsy Assessment and Treatment Unit was undertaken on 5 April 2022; six areas for improvement (AFI) were identified.

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 05 April 2022</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 5.3

Criteria: 5.3.1

Stated: First time

To be completed by:
12 May 2022</td><td>The Southern Health and Social Care Trust must ensure all environmental safety assessments are up to date and completed in conjunction with the Trust’s relevant Health and Safety department and all remedial actions stated in the risk assessments are followed up within the time frames specified. Assessments that require to be updated are the Fire Risk Assessment (FRA) and Ligature Risk assessment.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The environmental safety assessment was updated in October 2022.

The Fire Risk Assessment (FRA)and Ligature Risk Assessment (LRA) were reviewed annually and remedial actions were being followed up within the specified time frames</td></tr>
<tr><td>Area for improvement 2

Ref: Standard 5.1

Criteria: 5.3.1

Stated: First time

To be completed by:
1 November 2022</td><td>The Southern Health and Social Care Trust must review the use of the extra care suite and the seclusion room within it, to ensure it meets the needs of patients and maintains patient safety with consideration to:
• the appropriateness of the seclusion room door;
• the extra care suite environment; and
• the purpose / rationale for the use of the extra care suite in line with the seclusion policy</td><td>Met</td></tr>
</table>

	Action taken as confirmed during the inspection: The use of the extra care suite and seclusion room have been reviewed. A protocol to reflect the rationale for seclusion and the steps staff are required to take when the extra care suite and seclusion room are utilised has been developed as an addendum to the policy. The Trust should ensure there is a system in place to provide assurance that all staff are aware of this protocol. The Trust has confirmed that the seclusion room door meets the standard 7.2.35 and 7.2.36 of the *National Minimum Standards for Psychiatric Intensive Care in General Adult Services (2014)*.	
Area for improvement 3 **Ref:** Standard 5.1 **Criteria:** 5.3.1 **Stated:** First time **To be completed by:** 1 November 2022	The Southern Health and Social Care Trust must ensure a formalised physical health care pathway is implemented that will include health screening, any follow up required and a process for anti-psychotic monitoring.	**Met**
	Action taken as confirmed during the inspection: A physical healthcare pathway which includes health screening has been implemented. The pathway includes a process for anti-psychotic monitoring led by the ward pharmacist.	
Area for improvement 4 **Ref:** Standard 4.1 **Criteria:** 4.3 **Stated:** First time **To be completed by:** 1 November 2022	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: • that staff with responsibility for patients' income and expenditure have been appropriately trained for this role; • systematic reviews of the procedures and controls in place at	**Partially Met**

	ward level are undertaken by the Trust; and • receipt books are provided to allow members of staff to receipt monies deposited at the ward on behalf of patients and to record details of absent receipts.	
	Action taken as confirmed during the inspection: There was evidence staff have received training to support increased awareness and better understanding of their responsibilities for the management of patient's monies. Receipt books were held at ward level however receipts were not always provided when monies were deposited by family members on behalf of patients. Systematic review of the procedures and controls at ward level were not evident. This AFI has been stated for a second time and reworded to take account of the progress made.	
Area for improvement 5 **Ref:** Standard 5.1 **Criteria**: 5.3.1 **Stated:** First time **To be completed by:** 14 August 2022	The Southern Health and Social Care Trust should review the pharmacy resource to enhance the effective management of medicines.	**Met**
	Action taken as confirmed during the inspection: A pharmacist is employed two days per week for Dorsy which is having a positive impact on the management of medicines.	
Area for improvement 6 **Ref:** Standard 4.1 **Criteria:** 4.3 **Stated:** First time **To be completed by:** 1 November 2022	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; • Themes, trends, and learning identified from the dataset and adult safeguarding incidents are shared with all the relevant staff, including ward staff.	**Partially Met**

	• 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. There was evidence that incidents and adult safeguarding were being reviewed at senior management governance meetings where themes and trends were identified, however there was limited assurance that themes, trends, and learning identified from the dataset and adult safeguarding incidents was being shared with all the relevant staff, including ward staff. Senior leadership walk rounds of the ward were not being recorded and there were no outcome reports available to identify actions or improvement required. This AFI has been stated for a second time.	

5.2 Inspection findings

5.2.1 Environment

Dorsy presented as a pleasant environment with sufficient provision of quiet spaces to meet the needs of the patients accommodated. Patients had access, with supervision, to a number of outdoor spaces including a garden. The gardens require some attention to make for a more pleasant space for patients to enjoy and relax.

The visitors' room, which is accessible via the main entrance to the ward, is a relatively small room with a large office desk which makes it less appealing for patients to relax when they have family visits. The décor could also be improved to offer patients and visitors a pleasant space to spend time together.

Details of advocacy organisations, Human Rights information, how to complain, what constitutes adult safeguarding, how to report a concern and health promotion information was available for patients and visitors on an information board mounted at the entrance to the ward. The patient activities information displayed was provided in easy to read format, and staff photos were mounted to promote familiarity of staff with patients and their families. The use of a suggestion box encourages visitors and patients to share their experience of the ward and make suggestions for improvement.

Nursing supplies were stored in a bathroom which continues to be in use for patients. This is not conducive to a therapeutic bathing experience and presents a health and safety hazard for staff and patients. An unused bedroom was also being used for storage. This was discussed with management during the inspection. The Trust should review and monitor the storage arrangements in place to ensure the bathroom and bedroom spaces are utilised as intended and do not present safety issues for patients or others. An AFI has been identified in relation to appropriate storage arrangements that do not compromise safety.

Not all patient areas were maintained to an acceptable standard of cleanliness. This was raised with the ward manager and a deep clean of the affected areas was completed. The most recent environmental cleanliness audit took place during March 2022. The Trust should ensure that environmental audits are completed regularly in line with Trust policy and ensure an acceptable standard of cleanliness is maintained at all times.

The Fire Risk Assessment (FRA) and Ligature Risk Assessment (LRA) had been reviewed and were up to date. Personal Emergency Evacuation Plans (PEEPs) which inform staff of the level of assistance a patient needs to safely evacuate in an emergency had not been completed. This was discussed with the ward manager and written communication received post inspection confirmed PEEPs were in place for all patients. The Trust should implement a system to ensure that PEEPS are in place at all times.

A number of lounge chairs in the corridors were in a poor state of repair. This was raised with the ward manager who advised that new furniture had been ordered although there was no date for delivery. The Trust must expedite this request and review the risks associated with the continued use of these chairs as a matter of urgency.

As a result of a serious adverse incident which occurred in March 2022, a patient sustained a serious injury from the seclusion room door. The use of the seclusion room and extra care suite had been reviewed by the senior management team (SMT) and a protocol had been developed for the safe use of the seclusion room in conjunction with the Trust's seclusion policy. The Trust should continue to ensure that the system in place to provide assurance that all staff are aware of this protocol and actions required to minimise the risk of injury is robust, and that all risks associated with the safe operation of seclusion room are added to the environmental risk register.

There was no clock visible from the seclusion room. The absence of a visible clock from this area was noted during a previous inspection in July 2017. This must be addressed by the Trust in accordance with *Royal College of Psychiatrists Quality Network for Learning Disability Services (QNLD), Standards for Inpatient Learning Disability Services, Fourth Edition, 2021*. The seclusion room and the adjoining external courtyard area would also benefit from redecoration and introduction of calming colour tones.

Funding has been secured to relocate the sensory room to an alternative, more appropriate space. There remains no known timescale for this improvement and this should be addressed.

5.2.2 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.
Staff at ward level demonstrated good understanding and knowledge of what constituted an ASG incident. This was confirmed during discussion with the Designated Adult Protection Officer (DAPO). It was evident that staff were knowledgeable through their adherence to the *Adult Safeguarding Prevention and Protection in Partnership Policy (July 2015)*. ASG information was available at ward level.

APP1 referral forms were completed to a good standard and where patients were at risk of harm protection plans were in place. Appropriate oversight and governance arrangements to monitor safeguarding concerns were evident from the records reviewed and discussions with the DAPO. ASG incidents were discussed as part of the MDT governance meetings, minutes of which were available on the ward.

Datix incident reports (Datix is the Trust's electronic system for recording incidents) for the six-month period prior to the inspection were reviewed. Incident reports were completed to a good standard and the majority of incidents had been graded appropriately. A number of incidents of challenging behaviours were recorded. Staff have the opportunity for a debrief following an incident. The Trust should consider the cumulative impact of incidents and provide additional support to patients and staff where needed.

Incidents and adult safeguarding concerns were reviewed at senior management governance meetings which take place on a quarterly basis. It was not clear how this information was collated and shared with ward staff to improve practice. An AFI has been identified to address the Trust's sharing of information and learning from ASG incidents with staff.

5.2.3 Staffing

Staffing levels were determined using the Telford model, which is a tool to assist staff in defining staffing levels based on patient acuity.

The MDT staffing complement was appropriate to meet the needs of patients consisting of consultant psychiatrist, two-part time community psychiatrists, junior medical staff, occupational therapist, speech and language therapist, behaviour support therapists, pharmacist, physiotherapy, activities staff and nursing staff. There was evidence of collaborative MDT working through the daily safety huddle, MDT and discharge planning meetings.

The ward manager reported challenges in obtaining suitably qualified staff for the ward where a number of vacant staff nurse posts remain. An escalation process provides guidance to staff on how to manage staffing shortages including how to book agency staff for the ward. A new agency staff framework has been implemented and requires time to embed. Where staffing levels were reduced these were recorded through the Datix reporting mechanism.

Staff spoke of the challenges of recruiting qualified staff and patient acuity. It was positive to note that a whole team approach was used to support patients and to ensure their needs were met. Staff reported morale was good, although staffing levels and incidents can impact this. Staff said they felt supported and listened to by senior management.

Not all staff had access to a personal alarm to summon assistance in the event of an emergency. This had the potential for delays in staff response which could place staff and patients at risk.
This was discussed with senior management during inspection feedback. Assurances were provided that steps were being taken to address this shortfall. An AFI has been identified in relation to the provision of personal alarm devices.

The staff training matrix was reviewed for mandatory training and e-learning. The overall training compliance for staff requires improvement. Staff had limited knowledge regarding the Mental Capacity Act (MCA) and not all staff had completed the appropriate level of MCA training. The Trust must ensure all staff have completed all mandatory training within the required timeframes and that there is effective oversight of this.

The Trust should ensure that relevant training is provided for staff to enable them to effectively support the patients in their care and an appraisal system is implemented. An AFI has been identified.

5.2.4 Physical Health

A physical health care pathway was in place to monitor patients' health, with evidence of ongoing referral to medical specialists and health professionals as required, however, physical healthcare documents were not readily accessible to all members of the MDT. The Trust should review access arrangements to ensure all members of the MDT have access.

Records reflected that patients' physical health needs were being met. Risk assessments such as Braden, the Malnutrition Universal Screen Tool (MUST) and National Early Warning Score (NEWS) were in place for each patient and reviewed in accordance with identified risks. It was positive to note that patients had been assessed for and prescribed medication to manage pain on a "when required" basis.

Patients with swallowing difficulties had been assessed by a speech and language therapist with the outcome of the assessment available to staff. There was evidence that appropriate action had been taken following reported choking incidents. Staff compliance with dysphagia training requires improvement. The *RQIA Review of the Implementation of recommendations to prevent choking incidents across Northern Ireland (May 2022)* recommends this training is mandatory. An area for improvement has been made.

A dietician and physiotherapist are available by referral to support patients' nutritional and mobility needs. Healthy eating is promoted and patients are supported to prepare meals in preparation for discharge.

Patients oral hygiene needs are monitored by staff and support given where required. Patients are referred for dental treatment as required to the dental clinic at Craigavon Area Hospital.

5.2.5 Restrictive Practice

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

Restrictive practices in place within Dorsy ward include detention as prescribed under The Mental Health (Northern Ireland) Order 1986, locked doors, levels of observation, the use of PRN medication and prescribed physical interventions. All restrictions sampled were risk assessed, found to be proportionate to the level of risk identified and had been explained to individual patients and their family representatives. Staff demonstrated good awareness of what may constitute a restriction, they knew that the least restrictive option available should be used to manage the risk identified and were aware that all restrictions in place for patients should remain subject to regular review.

Patient care plans were detailed including consideration of patients Human Rights and were reviewed and updated by the patients named nurse following the daily MDT safety huddle and weekly MDT meetings where the level of risk had increased or decreased. A Safety Cross recording tool was in use to record when specific restrictions were used for each patient. A Safety Cross is a tool designed in the shape of a cross to collate key safety information over a defined period. This enables staff to identify and evaluate the frequency of specific restrictions and update care plans.

Deprivation of Liberty Safeguards (DoLS) are a set of checks that are part of the Mental Capacity Act (NI) 2016. The DoLS procedure protects a person receiving care whose liberty has been limited by checking that this is appropriate and is in their best interests. DoLS were not in place for patients accommodated on a voluntary status. This was discussed with management, who acknowledged that further training was required. An AFI has been identified to improve the application of the DoLS framework.

5.2.6 Patient Experience

Posters and patient leaflets were placed throughout the ward inviting patients and staff to approach the inspection team to express their views and experiences. We spoke with patients, and eight members of staff.

There was opportunity for family members of patients to speak with us in person on site or by telephone. Feedback from families was generally positive. Where any concerns had been raised they were followed up during the inspection. Good communication with the MDT was highlighted by families in that they were made to feel welcome at meetings, their views were respected and the care provided to their family member by staff was compassionate.

Information was available on the ward and in the entrance foyer regarding advocacy services with the patients' advocates attending the MDT meetings.

A weekly activity planner and bespoke individual activity plans were in place to enhance patients' quality of life and prepare for discharge. During the inspection patients were observed participating in a range of activities including cookery, smoothie making, art, and basketball.

A monthly meeting called, 'have your say' encourages patients to share their views with regards to the care provided in Dorsy and make suggestions for change. Staff interactions with patients were observed to be respectful, courteous and compassionate.

The mealtime experience was observed, with a variety of food options available, all of which appeared appetising. There was a relaxed atmosphere through lunch and staff were available should patients require assistance. Independence was promoted through the use of specialist plates and plate guards.
It was positive to note that a meal time co-ordinator and speech and language therapist helped supervise mealtimes with a safety pause conducted before meals are served. This is in line with *Mealtimes Matter*, a regionally agreed framework to maximise patient safety and ensure a high-quality experience always occurs at every meal, drink and snack time.

Care Opinion, an online platform to share care experiences, is used for relatives and patients to provide feedback on the quality of the service. The results of these were available on the ward. Inspectors noted that the majority were positive and complimentary of the staff and care provided.

5.2.7 Patient Flow

There were six patients accommodated within Dorsy ward at the commencement of inspection and seven by the close of inspection on 2 June 2023. Five patients had experienced delays in their discharge due to a lack of suitable community placements and delays in the recruitment and training of suitably qualified staff to enable patients to safely transition to a successful community placement. A number of community placements have since been identified and these were being progressed.

The ward has a fortnightly discharge planning meeting attended by the MDT, senior managers from Bluestone, advocacy services and family members who wish to attend. Future placements and discharge planning related matters were discussed at these meetings. Inspectors noted good partnership working with community teams, relatives and advocates to progress discharge planning.

5.2.8 Medicines Management

A dedicated pharmacist provides medicines management support two days per week. This includes support to the MDT team in relation to safe and effective administration of medication.

Medicines were stored in the treatment room, which was clean and well-organised, with medications stored appropriately, including those that required refrigeration. A controlled drug audit is conducted quarterly by the pharmacist. Where compliance issues were identified these were investigated, discussed at governance meetings and any learning shared with staff.

The use of PRN medication, which is medication that is prescribed on an as and when required basis, was reviewed. It was positive to note that distraction techniques were utilised as an alternative prior to the administration of PRN medication with the use of CALM cards available to support staff. Medication audits indicate a reduction in the use of PRN medication for some patients. Medication records evidenced first and second line medication to be used when required with maximum daily doses and minimum dosage intervals recorded.

Monitoring of patients' blood results for specific medications was being completed and antipsychotic monitoring medication pathways were in place. Easy to read information on medications was provided for patients which is good practice.

Medicines and oxygen for emergency use were checked and found to be in date.

5.2.9 Mental Health

During the admission process patients are assessed by medical staff, which includes an assessment of their mental state. Patients mental health is monitored by their Consultant and MDT team with early identification of changes being discussed at the daily MDT safety brief and weekly meetings. Individual risk assessments and care plans were in place to offer guidance to staff on how best to support patients with their mental health needs.

A weekly MDT ward round meeting where patients, relatives and advocates are actively encouraged to attend is held to discuss care and treatment and actions and goals are discussed and reviewed holistically.

Behaviour support therapists provide guidance to staff in relation to positive behaviour support (PBS) for patients. This includes the development of PBS care plans and a 'grab sheet', which is a summary of key PBS information for staff. The summary PBS sheets are based on a traffic light system to enable staff to identify when a patient is becoming distressed and ensure early interventions are provided to support the patient and minimise any distress. There was evidence of collaborative working between the nursing staff and the PBS staff to promote positive outcomes for patients.

Clinical psychology had input in patient care; they attended case reviews and weekly MDT meetings.

Activity co-ordinators provide a range of therapeutic activities for the patients and this was evidenced during our observations of care. This had a positive impact on the patients well-being and reduced distress.

5.2.10 Governance

The governance arrangements were reviewed through the examination of documentation and discussions with the ward manager and deputy manager. Inspectors also spoke with representatives from the SMT and senior nursing staff. There was evidence of good working relationships between MDT members and ward staff.

The Operational Policy describes clear admission criteria for the ward. The model of care promotes a biopsychosocial model. This holistic approach takes into account the physical, psychological, and social factors for persons with learning disability, and promotes an integrated approach to treatment options offered by the multi-disciplinary team (MDT).

There is a daily MDT safety huddle each morning to review any significant events or concerns including staffing arrangements. This allows for effective communication and consistent care and treatment to be delivered with escalation of risks. Staff spoke positively of the benefits of this meeting.

Data was collected relating to safety interventions; this is discussed at governance meetings to identify patterns and trends. Evidence to demonstrate how this information is used to inform best practice was not available for inspection. It is recommended that the Trust reviews how the collation of data can be used to drive improvement.

Staff reported that senior management visit the ward regularly, however there were no records when visits happened or what the outcomes were. The Trust should put in place arrangements for the recording of senior management/leadership visits to wards, to include the purpose of the visit and the outcome. An AFI has been identified.

The management of patients finances at ward level was reviewed. Sufficient funds were held at ward level for patients. Individual cash balance logs were maintained with receipts obtained for any money spent. Cash receipt books were available in the ward, however, receipts were not always provided when cash was deposited by relatives. The Trust should assure themselves that robust governance arrangements are in place to ensure patients monies are appropriately managed and accounted for, with receipts provided to families. An AFI has been identified.

An accreditation process was underway as part of the Quality Network Learning Disability. This is a quality initiative to improve the management processes and standards of care in the ward. The Trust is hopeful Dorsy will attain accreditation with the Royal College of Psychiatrists. A number of carers were given questionnaires as part of this initiative. Comments were mainly positive with staff being described as 'exceptional' and 'very helpful'.

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	6

The total number of AFI s includes two that have been stated for a second time and four stated for a first time.

AFIs and details of the Quality Improvement Plan were discussed with the 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/Areas for Improvement	
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)	
Area for improvement 1 **Ref:** Standard 4.1	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

Criteria: 4.3 **Stated:** Second time **To be completed by:** **4 September 2023**	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. Ref: 5.1 and 5.2.10
	Response by registered person detailing the actions taken: A review of the process of the management of money and valuables has been completed by the Lead Nurse and a receipt book has been provided for Dorsy staff to issue receipts. Weekly and monthly audits of the updated procedure will be undertaken. The audit will also capture where a family member refuses or does not wait for a receipt.
Area for improvement 2 **Ref:** Standard 4.1 **Criteria:** 4.3 **Stated:** Second time **To be completed by:** 4 September 2023	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; • 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. Ref: 5.1, 5.2.2 and 5.2.10
	Response by registered person detailing the actions taken: The Lead consultant, lead nurse and ward manager currently meet fortnightly to discuss incidents and identify themes and trends which are then brought to the current monthly Dorsy governanace meeting. A separate Operational meeting will be organised for Dorsy chaired by the Lead Nurse. This will allow for the sharing of information directly with ward staff. The Directorate collective leadership team review on a weekly basis all incidents reported within Dorsy and actions are generated following this review. Dorsy is reviewing the template for recording Leadership walkarounds, to include the date and time of the visit, purpose and comments/actions agreed. The role of the current monthly Dorsy Governance

	Meeting is also being reviewed as is the format of the governance reports/dataset. This review will include consideration of incorporating Dorsy Governance information within the overarching Acute (Bluestone) Governance meeting. This will allow for the wider analysis of trends and identification and sharing of learning across the whole of the Bluestone site. The MHD Governacne Coordinator is meeting with the Head of Service and Bluestone/Dorsy ward managers on 18/09/2023 to discuss their existing incident profiles, datix dashboards and strutctured early learning processes.
Area for improvement 3 **Ref:** Standard 5.3.1 **Stated:** First time **To be completed by:** 4 September 2023	The Southern Health and Social Care Trust must ensure storage arrangements are reviewed and risk assessed to provide safe therapeutic spaces for patients. Ref: 5.2.1
	Response by registered person detailing the actions taken: The ward are undertaking a declutter and re-organisation of current space. The bathroom has been cleared and is now useable by the patients. Estates services are looking at off-site storage for all wards in Bluestone, as current storage in each of the wards is limited.

Area for improvement 4 **Ref:** Standard 4.3 **Stated:** First time **To be completed by:** 4 September 2023	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. Ref: 5.2.3
	Response by registered person detailing the actions taken: A new supply of alarms have arrived and have been allocated to all new nurses starting post over the next number of weeks. Dorsy permanent staff all have alarms, swipes and keys. There are currently 10 additional alarms for agency, bank staff and students. A system has been put in place to reduce the likelihood of temporary staff leaving the unit with an alarm
Area for improvement 5 **Ref:** Standard 5.3.1 **Stated:** First time **To be completed by:** 4 September 2023	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. Ref: 5.2.3 5.2.4 5.2.5
	Response by registered person detailing the actions taken: Bespoke In House Adult Safeguarding training dates have been arranged for Dorsy staff. Once completed, the Lead Social Worker will be delivering in-house sessions on a rolling programme. Adult Safeguarding e-learning is currently at 74%. Dysphasia training is in progress - an e-learning link has been circulated and to date 37% of Dorsy staff have completed the training. Deprivation of Liberty Safeguards training: MCA 2 and 3 untrained staff: 75% compliance MCA 3 AND 4 trained staff: 55% compliance. Lead Nurse will monitor training compliance
Area for improvement 6 **Ref:** Standard 5.3.1	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

Stated: First time **To be completed by:** 4 September 2023	continual supervision and are not free to leave that DoLS are put in place. Ref:5.2.5
	Response by registered person detailing the actions taken: Patients admitted to Dorsy who are not detained under the Mental Health Order (MHO), will have their capacity assessed and MCA considered. Staff are undergoing essential training to support and understand this process. Deprivation of Liberty training: MCA 2 and 3 untrained staff: 75% compliance MCA 3 AND 4 trained staff: 55% compliance. An MCA in-house training programme is being developed. A meeting is taking place with the Lead Social Worker to review training needs. Lead Nurse will monitor training compliance and improvement

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