The Regulation and Quality Improvement Authority

Inspection Report

5 April – 14 April 2022

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)	**Registered Manager:** Dr. Maria O'Kane, Chief Executive Officer; SHSCT (The Trust)
Person in charge at the time of inspection: Mrs. Jennie-Lee Simms Lead Nurse, Mental Health (SHSCT)	**Number of registered places:** 10 bedded inpatient facility
Categories of care: Learning Disability (LD) Assessment & Treatment	**Number of patients accommodated in the ward on the day of this inspection:** Day One: Seven patients Day Two & Three: Eight patients
Brief description of the accommodation/how the service operates: Dorsy Assessment and Treatment Unit 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 ward on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).	

2.0 Inspection summary

In September 2021 the Trust's Medical Director requested a meeting with RQIA to inform us of concerns relating to care and treatment identified in the Dorsy Unit. This meeting was held with the Trust's Medical Director and Assistant Director of Systems Assurance on 21 September 2021. At this meeting the Trust highlighted a significant number of concerns relating to patient care and treatment, staffing arrangements, adult safeguarding, incident management, leadership and the culture on the ward.

Following this meeting the Trust also submitted a comprehensive report to RQIA on 26 September 2021. This report included all the concerns identified and the actions to be taken to address the concerns. The Trust agreed to keep us up to date with progress and agreed to submit subsequent action plans for our review and assurance.

In order to afford the Trust time to achieve the actions and improve care and treatment, RQIA determined to schedule an unannounced inspection at a time when RQIA could measure and assess progress had been made.

An unannounced inspection to Dorsy Assessment and Treatment Unit commenced on 5 April 2022, at 09:00 and concluded on 14 April 2022 with feedback to the Trust's Senior Management Team (SMT). The unit was inspected by a team comprising of care, pharmacy and finance inspectors and supported by a psychiatric ADEPT fellow on behalf of RQIA's clinical lead.

The inspection focused on eleven key themes: environment; care and treatment; restrictive practices; physical healthcare; resettlement and delayed discharge arrangements; staffing; incident management and adult safeguarding (ASG); management of patient finances; medicines management; governance and leadership as well as patient, staff and family engagement. Each theme was assessed to determine safe and effective delivery of care and treatment. The inspection also assessed progress with respect to areas for improvement (AFI) identified during a previous inspection undertaken on 25 – 26 July 2016.

The inspection identified good practice in relation to patient experience through the provision of therapeutic and recreational activities and significant improvements to the unit have created a more therapeutic and pleasant space for patients. There was a good Multidisciplinary Team (MDT) approach to discharge planning with ongoing involvement from the patient's community teams.

The inspection also evidenced improvements in staff morale and an increase to the multi-disciplinary compliment.

All AFIs made from the previous inspection (25 – 26 July 20217) were assessed as met. A total of six AFIs have been identified, all been stated for the first time. Areas that require improvement relate to the environment, restrictive practices, physical healthcare; management of patient finances, medicines management and governance and leadership.

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 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 how the service was performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

4.0 What people told us about the service

Posters were placed throughout the ward to notify staff, patients and relatives that an inspection had commenced if they wished to approach us with any feedback they may have, or alternatively, to complete an electronic questionnaire. Hard copy questionnaires were also placed on the wards inviting patients and relatives to complete and post them to us.

Three patients told us they were satisfied with their care and treatment; and a total of three patient questionnaires were returned, all detailing positive feedback. A total of seven staff interviews were conducted, ensuring a combination of substantive and agency staff of different grades and disciplines. Lastly, we contacted patient's families to hear about their views in relation to the quality of care being delivered in Dorsy ward (further details on patient/staff and family engagement can be viewed in Section 5.2.11 of this report).

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 25-26 July 2017; seven areas for improvement were identified.

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 25 and 26 July 2017</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Mental Health Order (Northern Ireland) 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: Quality Standard 5.3.1 (a)

Stated: First time

To be completed by:
25 October 2017</td><td><u>Comprehensive risk assessments</u>

Comprehensive risk assessments were not reviewed in accordance with Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Comprehensive risk assessments were available, reviewed, up to date and aligned with Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010.</td></tr>
</table>

Area for Improvement 2 **Ref:** Quality Standard 8.3 (a) **Stated:** Third time **To be completed by**: 25 January 2018	<u>Extra care suite (this area is used for seclusion)</u> The following was observed in this area. There was no bed. There were safety hazards, particularly in the bathroom facility. Walls and floors are not of a seamless construction. Walls were not painted a calm, definitive colour and the room required to be repainted. (A minor works request has been submitted). The door opened inward with the potential hazard that a patient could use the bathroom door to hold the exit door open. There was no clock for the patient to view.	**Met**
	Action taken as confirmed during the inspection: A bed was available within the seclusion room and the safety hazards highlighted had been removed. The construction of the walls and flooring was safe and the walls had been painted. The bathroom door has been removed. A clock was not available but this was actioned during the inspection. This AFI has been assessed as being met, however, further AFI's in relation to the seclusion room have been identified.	

Area for Improvement 3 **Ref:** Quality Standard 5.3.3 (f) **Stated:** Second time **To be completed by:** 15 September 2017	<u>Psychology and behaviour support services</u> There was no psychological care / intervention plans in place. There was no evidence of any functional behaviour assessments in the care documentation reviewed. The four behaviour management plans reviewed were; not patient centred or easily understood, too complex, and focused mainly on risky behaviours with little consideration given to the overall assessed needs of the person. Patients who required support with their communication would not have understood the content of their plans. These plans were not easily interpreted by the range of staff that was required to implement them. There was a brief formulation documented in each patient's behaviour management plan. However, this did not link in with the functions of the behaviour and there was limited reference to the formulation in the actual behaviour management plan. It was documented, for example, that a patient had anxiety. However there was no further mention of anxiety in the management plan. None of the staff working on the ward had received any training in proactive ways to support people who present with behaviours that are challenging.	**Met**
	Action taken as confirmed during the inspection: Two full-time Behavioural Therapists now work in the unit. These therapists contribute to the MDT assessment and link in with patient's families to obtain baseline assessments, from which they formulate positive behaviour support plans. PBS plans were person centred and individualised. All patients at the time had either a full completed PBS plan whilst others had short interim plans as they were still undergoing assessment and formulation.	

	PBS training for staff is underway with additional dates allocated.	
Area for Improvement 4 **Ref:** Quality Standard 5.3.3 (f) **Stated:** Second time **To be completed by:** 15 September 2017	<u>Care documentation</u> Due to the high volume of records maintained for patients who have been receiving learning disability services for many years, there was no concise summary of each patient's psychiatric history, behavioural difficulties, treatments, therapies prescribed and their therapeutic benefits. The patients' family history, developmental history and social functioning could not be readily established. It was also difficult to establish the nature and efficacy of any psychological interventions that had been tried over the years. There were records that were out of date and non-essential information contained in each patient's care documentation. This made it difficult to review the patients' journey. The records of the ward rounds were inconsistently completed with the agreed actions, the responsible person and a timeframe for achievement. The minutes of the therapeutic meetings provided a description of the patient's week. There was no documented evidence of a review of the therapeutic goal and intervention from the previous week.	**Met**
	Action taken as confirmed during the inspection: Since the previous inspection on 26-27 July 2017 the Trust have adopted the use of PARIS. PARIS is an electronic system that manages information to support the care delivery process – from initial referral, assessment and an agreed care plan. The information on the PARIS system was up to date and relevant to meet the needs of the patient. All disciplines input into the weekly MDT	

	meeting with each providing an entry for discussion and any proposed actions or outcomes.	
Area for improvement 5 **Ref**: Quality Standard 5.3.3 (f) **Stated:** First time **To be completed by:** 15 September 2017	<u>Psychology service</u> There were two part time associate psychologists working on the ward. The associate psychologists were based in the community. The consultant clinical psychologist indicated that they do not see any patients but attended the therapeutic meetings one half day per week. The associate psychologists stated they were asked to work beyond their role and remit and could not provide interventions to meet the assessed needs of the patients as they were not trained to do so. Care and treatment was therefore not provided in accordance with NICE Guidelines (Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges May 2015). Patients did not have access to any evidenced based psychological therapies, for example: psychosis, trauma, anger management, attachment, obsessive compulsive disorder, autism or forensics. Patients with forensic requirements did not access care despite the consultant clinical psychologist being dual qualified as a forensic psychologist.	**Met**
	Action taken as confirmed during the inspection: A consultant clinical psychologist was available in the unit 16 hours per week. The psychologist and the PBS therapists form part of the MDT and attend the weekly MDT meeting. There was evidence that the psychology and positive behaviour services were a valuable resource; supporting patients with PBS plans	

	and psychological therapies such as Dialectical Behavioural Therapy (DBT).	
Area for improvement 6 **Ref**: Quality Standard 5.3.3 (f) **Stated:** First time **To be completed by:** 15 September 2017	<u>Model of care</u> Inspectors could not determine what model of care was used to underpin this service. Inspectors recommend that training needs analysis and work force review is completed following the trust's decision on the model of care.	**Met**
	Action taken as confirmed during the inspection: The Southern Health and Social care Trust have adopted the biopsychosocial model of care which looks at the interconnection between biology, psychology and socio-environmental factors. A full multi-disciplinary team is available and appropriate skill mix on the unit allows for the delivery of this bio-psycho-social model. There is a good culture of positive behaviour support on the unit.	
Area for improvement 7 **Ref**: Quality Standard 5.3.1(e) **Stated:** Second time **To be completed by:** 15 May 2017	<u>Environment</u> Inspectors noted on review of the incidents that the exit door beside the extra care suite was broken and reported to the trust estates department on 13 February 2017. The door remained unsecure. It was noted that a patient on enhanced observations had absconded through the same door. There was no evidence that the delay in carrying out this remedial work was recorded on the ward risk register.	**Met**
	Action taken as confirmed during the inspection: The door has been repaired and in working order.	

5.2 Inspection findings

5.2.1 Environment

We reviewed the physical environment of Dorsy to assess if the ward was safe and conducive to the delivery of safe, therapeutic and compassionate care. Dorsy ward is a bright and vibrant ward with a therapeutic ambiance. There were a number of quiet/relaxation areas and several outdoor garden spaces for the patients to avail of and to facilitate patient's visitors.

The Trust shared a copy of the Imagination Project which outlined their journey to improvement to enable a more therapeutic environment within Dorsy. There was clear evidence of significant improvements to the physical environment of the ward in comparison to the previous six months where the ward was sparse and lacked evidence of patient engagement projects.

The standard of environmental cleaning of clinical and non-clinical areas throughout the ward was good. There was evidence of good governance around environmental checks such as environmental, hand hygiene and mattress audits as well as infection prevention and control audits.

On review of the Fire Risk Assessment (FRA) and ligature risk assessment, both were found to be out of date. This was escalated to the Nurse in charge (NIC) and the senior management team (SMT) during the inspection and an AFI has been identified in relation to this.

There was good compliance with mandatory fire training and several staff had completed the nominated fire officer training course. Staff had a good knowledge of ligature risks and were able to identify potential increase in risk for individual patients.

A seclusion room and extra care suite is available in Dorsy. We were concerned that the door to the seclusion room was heavy and had the potentiality to cause harm to patients and staff. It is recommended that the Trust urgently review this door, to consider the appropriateness of it for the patients.

The extra care suite was observed as small and not in keeping with the National Association of Psychiatric Intensive Care Units (NAPICU) standards 2015. The location of the extra care suite could compromise patient privacy and dignity. An area for improvement has been identified recommending that Trust review the extra care suite environment.

5.2.2 Care and Treatment

During the inspection, staff were observed treating patients with compassion and respect whilst delivering care and treatment in a committed and kind manner.

There was a multidisciplinary approach to care and treatment with a good focus on the delivery of a behaviour support model in a therapeutic environment.

The range of activities on offer complimented the care and treatment and also enhanced the behaviour support model.

There were two activity co-ordinators who cover a range of shifts including evenings and weekends. Staff spoke highly of the valuable contribution they make to the delivery of care. There was evidence of a high level of therapeutic engagement with patients during the course of the inspection.

Two full-time behavioural therapists covering a variety of shifts including evenings and weekends provide positive behaviour support for patients on the ward. These therapists contribute to the MDT assessment and link in with patient's families to obtain baseline assessments, from which they formulate positive behaviour support plans.

Care and treatment was reviewed by the MDT on a weekly basis or earlier as required. Patient risks were reviewed at a daily safety huddle.

Each patient had access to the advocacy service contact details for the advocacy services were displayed throughout the ward. As a result of Covid-19 most of the advocacy support is provided via phone call or zoom. Advocates are involved in the weekly MDT meetings and also discharge planning meetings.

5.2.3 Restrictive Practices

Restrictive practices are the term used to describe any intervention that restricts a person's freedom of movement. Restrictive practices include locked doors; enhanced/prescribed patient observations; physical intervention; rapid tranquilisation; seclusion. Prohibiting personal items is also considered a restrictive practice.

Restriction practices that were in place had been risk assessed and were proportionate to the level of risk. Decision making regarding restrictive practices and in keeping with best practice guidance and involved patient's relatives, when appropriate patients and advocates.

Patient's care records reflected detailed recording and a plan of care for any restrictions and evidenced consideration of the patient's human rights. Restriction practices were reviewed regularly by the patient's named nurse or sooner were the level of risk had increased or decreased. There was also evidence of restrictions being reviewed at the weekly MDT meetings.

Staff demonstrated a good awareness of restrictive practices and there was evidence that physical interventions were used as a last resort and de-escalation techniques are prioritised to support patients. Quality improvement (QI) initiatives to reduce restrictions were ongoing.

A reducing restrictive practices Quality Improvement project audit was available for review; this included information regarding the use of physical intervention, seclusion and the extra care suite environment. However, it was challenging to find any themes or trends' emerging from this project and this information was not shared with ward staff. It is recommended that establishing themes and sharing information with staff will enhance this project further.

We met with staff and reviewed the use of the extra care suite. We also reviewed the operational policy for seclusion. We could not determine the rationale for use of this area as an extra care area and we were concerned that staff were using this area to support patients and were unclear of the purpose of its use.

We shared our concerns with the SMT and recommend the Trust should review this area re appropriateness in line with the seclusion policy. An AFI has been identified.

5.2.4 Physical Healthcare

The arrangements for managing patients physical health care needs was reviewed. Patients had access to medical staff at all times during their stay. Physical health assessments occurred on admission and care plans reflected assessed needs of the patients. Each patient had an up to date screening tool in relation to skin care (Braden) and nutrition (Malnutrition Universal Screening Tool (MUST)) completed.

On review of patient's records we could not evidence a physical health care pathway was in place, whilst we could evidence some physical health monitoring in relation to bloods and electrocardiograms (ECG) at the point of admission, we could not evidence any follow up or onward referrals. The oversight of health screening requires strengthening and a formal process is recommended for anti-psychotic monitoring. The SMT have reported that there is a plan to introduce a physical health monitoring proforma that will capture all this information. An AFI has been identified.

5.2.5 Resettlement / delayed discharge

The processes in place to manage resettlement and support delayed discharges was reviewed. Five out of the eight patients in the unit were delayed in their discharge, and had a discharge plan in place. Contributing factors for delays in discharge were the adaptations required to physical environments and the recruitment and training of staff to enable patients to safely move to their new home in the community.

Fortnightly discharge planning meetings were held and there was good established links with the community teams. There was evidence of MDT involvement and consideration had been given to patient safety, support mechanisms and the location of family and friends.

Although the majority of patients in Dorsy were delayed in their discharge, there was a mechanism in place to ensure discharge was progressing. The challenge for the Trust is sourcing an appropriate and safe placement in the community that meets the individualised needs of each patient.

5.2.6 Staffing

In line with best practice guidance 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 consider levels of support required. This contributes to the delivery of safe and effective patient care.

We reviewed the staffing arrangements for Dorsy. At the time of the inspection the Trust were recruiting to fill the ward manager vacancy. In the interim, the ward has been managed by three band 6 deputy ward managers supported by the lead nurse for mental health.

The Trust has recently appointed a lead nurse for learning disability; however, it will take time for them to embed into this role. It was also positive to observe that all registrants were Registered Learning Disability Nurses.

Staffing levels were good with only some deficits on staffing rotas. Staff had a good knowledge and understanding of the escalation process to obtain additional staff when these deficits occurred. The Trust block booked agency and utilised bank staff to cover deficits which afforded consistency and positive working relationships between the teams.

Nursing staff spoke about how staff morale had improved significantly in the past six months and attributed this to the lead nurse for mental health and SMT support.

A review of the staff training matrix reflected that staff were compliant with mandatory training and there was evidence of up to date supervisions and appraisals in place for staff.

The MDT staffing compliment was good, comprising of consultant and junior doctors, nursing, behaviour therapists, social work, activity workers and dedicated psychology input. The recruitment of occupational therapy and speech and language therapy is underway. Patient advocates are also included in the MDT. There was evidence of good MDT working.

5.2.7 Incident Management & Adult Safeguarding

Incidents were managed in line with Trust policy and procedure. Patients care records and risk assessments were reviewed and updated accordingly following an incident by the MDT. The DATIX records were comprehensive and detailed the actions taken during and following an incident. The grading of incidents was appropriate.

As stated in Section 5.2.6 of this report the Trust have appointed behavioural therapists who are in the process of undertaking Positive Behaviour Support (PBS)training for staff. The Trust should consider a review of the impact of the behaviour therapist role and PBS training in relation to any reduction of incidents within the ward. This would be an opportunity to demonstrate patient outcomes and promote shared learning across other Trusts.

In relation to adult safeguarding (ASG), staff were adhering to the regional Adult Safeguarding Operational Procedures, Adults at Risk of Harm and Adults in Need of Protection, (Sept 2016). All ASG were appropriately referred and staff had a good knowledge and understanding of the safeguarding process. Protection plans were in place and reviewed regularly by the MDT. We observed good communication via handover sheets of ASG referrals and protection plans and also viewed easy read documentation available to support patients to understand the ASG process. Contact details for the adult safeguarding team were on display for patients and relatives.

During the course of the inspection we met with the social worker and the head of service for adult safeguarding. They provided assurance of the governance arrangements in place in relation to ASG; with a very clear program of audit identifying themes and trends for referrals. It was challenging to evidence that this learning was shared with ward staff. An AFI has been identified and will be added to an overarching area for improvement relating to section 5.2.10.

5.2.8 Management of Patients Finances

The management of patient's finances was reviewed. Sufficient monies were held at ward level to ensure that purchases could be undertaken by, or on behalf of, patients.

A sample of purchases undertaken on behalf of patients was reviewed. The records were up to date at the time of the inspection and in line with Trust policy. Receipts were available for most patients.

There was no official receipt book available for staff to issue a receipt when monies were deposited in the ward on behalf of patients or to record details of purchases when no receipts were returned.

Checks on patients' monies held in the safe were undertaken twice daily (during the handover of morning and evening shifts). Members of staff are required to record when the checks have taken place, this was not always consistently recorded.

A review of records showed that when monies were received from the Trust's cash office, the amount received was recorded at ward level. There was no corresponding record retained from the cash office to confirm the amount deposited at the ward.

A review of staff training records highlighted that staff had not received training in the management of patient's finances at ward level. Additionally, there was no evidence of Trust governance for the ward, such as the oversight of the controls in place for the management of patients' finances. An AFI has been identified to strengthen the management of patient's finances.

5.2.9 Medicines Management

Medication management was reviewed during the inspection to determine if medicines were managed safely and effectively.

There was evidence that patients were administered their medications as prescribed and kardexes were well maintained.

Ward based pharmacy support was limited and this had an impact on the timeliness of medicines reconciliation for newly admitted patients. Priority was given to those patients who were prescribed clozapine or other high-risk medicines. The reduced pharmacy resource also impacted on the ability to undertake some audits such as quarterly audits of controlled drugs and kardex audits.

It was positive to note a weekly PRN medication usage audit had commenced as part of a reduction project, which indicates the unit's commitment to reducing restrictive practices.

There was evidence that medicine administration records were completed to a satisfactory standard. The records indicated that patients were administered their medicines as prescribed and staff recorded the reason for any omitted doses. Nursing staff co-ordinated the medicine ordering and stock control processes.

Nursing staff had knowledge of critical medicines and the need for their timely administration. Medicines were stored safely and securely in locked cupboards with medication areas being clean, tidy and organised.

Controlled drugs were safely and securely stored. Reconciliation stock checks were completed at shift handovers however there was no evidence of a quarterly audit on the management of controlled drugs.

Regional care pathways and appropriate arrangements were in place for both Clozapine and Lithium treatments including blood monitoring. Clozapine was held as a stock medicine on the ward with no additional checks to ensure that it was being administered as prescribed. The clozapine supply arrangements in the SHSCT mental health wards is at variance with what happens in both the community as well as in other HSC MH wards across the region, there should be a risk assessment in place with the rationale for working outside of the usual procedures in place in the rest of the Trust.

Areas for improvement have been identified in relation to medicines management in Dorsy that will strengthen the pharmacy service within the ward and drive improvement.

5.2.10 Governance & Leadership

Governance and leadership oversight was good and there was evidence of cohesive teams with good working relationships between ward staff and the lead nurses to promote the delivery of safe and effective care. The SMT were aware of the challenges within the ward such as a vacant ward manager position and compatibility issues with patients who are delayed in their discharge. Staff confirmed that senior management are visible within in the ward and that the SMT are approachable.

A review of the governance arrangements for Dorsy ward was completed through a range of meetings with the SMT and examination of documentation relating to governance within the Trust to include a weekly data set and a range of minutes of meetings to include Dorsy Oversight, Bluestone governance meeting. The Dataset is a robust reporting mechanism that captured a wide range of themes to include delayed discharge, bed occupancy, incident management, staffing, restrictive practices and family engagement. This report was numerically informative; however, there was no evidence of a thorough discussion to inform outcomes regarding analysis of incidents, identifying trends and themes to reduce reoccurrence and cascading information to all relevant staff including staff working on the ward. An AFI has been identified.

All staff spoke positively about the level of support from SMT particularly the lead MH nurse in the absence of a ward manager. While, ward staff described that members of the SMT were available by phone and visible on the ward, there was no documentation supporting regular leadership walk arounds, schedules of visits or any outcome reports following a visit to the ward. An AFI has been identified.

5.2.11 Patient, Staff & Family Engagement

Family Engagement
Families spoke highly of the care and treatment being delivered to their relatives, reiterating that the nursing staff have a great knowledge and understanding to enable them to meet the needs of their loved ones.

Many families spoke highly of the level of therapeutic engagement on offer in the ward and that the patients enjoy going out on outings. Several families highlighted that they are well informed in relation to any incidents or changes in treatment plans and felt assured that the MDT involved them in any decision making.

Any family concerns highlighted during the inspection the Trust had knowledge of and were already taking the appropriate action to address.

Patient Engagement
We received three completed questionnaires and spoke with three patients during the inspection. Patients told us they were treated with dignity and respect and that staff were knowledgeable on how to support them in all aspects of their care. Patients were aware of the advocacy services available to them.

Patients spoke positively about the staff, the MDT and they felt involved in their care and treatment.

Patients liked their bedrooms and the food with several stating they liked to participate in activities with the activity worker.

An effective patient advocacy service was available and was involved in MDT discussions relating to patient care and treatment.

Staff Engagement
We spoke with a range of staff from different grades and also ensured we spoke with substantive and agency staff. Staff spoke openly about challenges they endured during a time when the acuity of the patients was greater and there were different management structures in place.

All staff talked about the morale improving and feeling a sense of 'hope.' Staff felt much supported by the lead nurse and SMT stating they had access to training opportunities and clinical supervision.

There was a sense of pride when discussing patient care and treatment with staff, conveying dedication and team work to deliver best outcomes for patients.

7.0 Quality Improvement Plan/Areas for Improvement

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

	Standards
Total number of Areas for Improvement	6

Six areas for improvement have been identified which have all been stated for the first time.

Areas for improvement and details of the Quality Improvement Plan were discussed with representatives from the SMT, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)	
Area for improvement 1 **Ref:** Standard 5.3 **Criteria:** 5.3.1 **Stated:** First time **To be completed by:** 12 May 2022	The Southern Health and Social Care Trust must ensure all environmental safety assessments are up to date and completed in conjunction with the Trusts 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. Ref: Section 5.2.1
	Response by registered person detailing the actions taken: All relative assessments have been updated, inclusive of FRA and LRA

Area for improvement 2 **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 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 Ref: Section 5.2.1
	Response by registered person detailing the actions taken: Planning application is being composed and will be lodged allowing the Division to have planning approval in readiness to build the extension in Financial year - 23/24. This would involve commissioning a design team up work stage 2 and need approx. £30k of revenue funding. CAG application to be worked up with planning for this tital capital investment. Advice sought from RQIA in regards to door types (seclusion) that would be more appropriate for LD environments. QI in process in regards to seclusion and ECS, inclusive of appropriateness, purpose, process, policy and recording.
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. Ref: Section 5.2.4
	Response by registered person detailing the actions taken: A Physical Health Care Pathway, namely 'Don't just screen - intervene' has commenced in Dorsy as a QI

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 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. Ref: Section 5.2.8
	Response by registered person detailing the actions taken: Training is ongoing, Dorsy have had a transition of staffing over recent weeks, inclusive of a number of newly qualified RLDNs and a ward manager. Finance is a standing agenda item on ward meetings and ward rounds, both processes oversee reviews. Dorsy will be moving to full implementation of the Purposeful inpatient Admission QI that will provide a real time analysis, accountability and assurance. Receipt books are to be installed at ward level.
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. Ref: Section 5.2.9
	Response by registered person detailing the actions taken: A newly appointed 0.5 WTE pharmacist has been appointed to Dorsy. Investment and demography requests have been submitted to Finance, which endeavours to permit the further growth of the Bluestone Pharmacy resource.

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. • The Trust should develop a method of recording regular leadership walk arounds, schedules of visits or any outcome reports following a visit to the ward. Ref: Sections 5.2.3, 5.2.7 and 5.2.10
	Response by registered person detailing the actions taken: Bluestone have appointed a lead Social worker worker who provides an overview and analysis of Safeguarding and incident data, inclusive of themes and trends. Forums are in-situ in regards to oversight, discussion, information flow and learning. Scrutiny of incidents by MHD Collective Leadership Team, the monthly Dorsy Governance Group continues, Weekly incident review meeting, Senior team meeting, Ward managers meeting, Ward meetings and Team talks/communication folders to discuss incident activity. A record is now held of all Leadership Walks inclusive of themes and outcomes and this is also embedded in the oversight dataset. Dorsy Oversight meetings continue - fortnightly data analysis, with a set focus on incident/trend analysis and quality improvement assurances.

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

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