The Regulation and Quality Improvement Authority

Inspection Report

4 – 12 May 2021

Belfast Health and Social Care Trust

Acute Mental Health Inpatient Centre
Belfast City Hospital
Belfast
BT9 7YG
Telephone number: 028 9032 9241

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: Belfast Health and Social Care Trust (BHSCT)	**Responsible Person:** Dr Cathy Jack Chief Executive, BHSCT
Person in charge at the time of inspection: Mr. Johnny Killough, Assistant Service Manager.	**Number of commissioned beds:** Ward 1: 14 Ward 2: 20 Ward 3: 20 Ward 4: 6 Ward 5: 20
Categories of care: Mental Health (MH) Acute Admission Psychiatric Intensive Care	**Number of beds occupied in the wards on the day of this inspection:** Ward 1: 14 Ward 2: 20 Ward 3: 20 and one patient on leave Ward 4: 7 Ward 5: 20 and one patient on leave

Brief description of the accommodation/how the service operates:

There are four Mental Health acute admission wards across the Belfast Health and Social Care Trust (the Trust). These are based in the Adult Mental Health Inpatient Centre (AMHIC) on the site of Belfast City Hospital. Three of these wards provide assessment and treatment for patients with acute mental health needs aged between 18 and 65 years old, one ward provides assessment and treatment for patients over 65 years old. Patients are admitted either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO). The fifth ward (ward 4) on this site provides psychiatric intensive care for patients who require this level of support.

Ward 2 is a female ward, Ward 3 is a mixed gender ward, Ward 4 is a mixed gender Psychiatric Intensive Care Unit (PICU), Ward 5 is a male ward, and Ward 1 is a mixed gender ward for adults over 65 years old. All wards consist of single bedrooms with ensuite bathroom.

2.0 Inspection summary

An unannounced inspection to the MHLD acute admission wards across the Trust commenced on Tuesday 04 May 2021 at 9:00 am and concluded on Wednesday 12 May 2021 with feedback to the senior management team.

The inspection was carried out by a combination of care and pharmacy inspectors with input from RQIA's Clinical Lead.

This inspection forms part of a series of inspections to the acute mental health inpatient services across all five Health and Social Care (HSC) Trusts in Northern Ireland. These inspections are being undertaken following our review of information and intelligence, highlighting significant pressures across three HSC Trusts as a result of ongoing bed pressures in acute mental health inpatient services in Northern Ireland. Best practice guidelines recommend that bed occupancy should be at 85%. At present demand for acute mental health inpatient beds in Northern Ireland has increased significantly and occupancy levels have escalated to over 100%. On occasions there have been no commissioned beds reported as being available across Northern Ireland, leading to decisions to admit patients to contingency beds or in some cases to support patients to sleep on settees or chairs until such times as a bed becomes available. This series of inspections aims to identify whether over occupancy is impacting the safe delivery of patient care and treatment. This series of inspections also aims to share good practice between Trusts to manage over occupancy and to support regional wide improvements.

This inspection focused on eleven key themes: patient flow; environment; restrictive practices; management of incidents/accidents/adult safeguarding; patient comfort; care and treatment; staffing; medicines management; governance and leadership; patient engagement; and staff engagement. Each theme was assessed by inspectors to determine if over occupancy was affecting the delivery of safe care. Additionally, any areas for improvement identified during or since the last inspection that directly impacted over occupancy were reviewed.

This inspection identified that the Trust's acute mental health inpatient wards were frequently over occupied. We determined that the over occupancy presented some challenges but had a minimal impact on the ability of staff to deliver safe and effective care to patients.

Strong governance and assurance, effective leadership, and clear communication mechanisms were other important factors in supporting the delivery of safe care at times when the service was over occupied. Staffing levels were safe and staff were routinely observed providing a high standard of care and treatment. Incidents and accidents were managed well and in line with Trust policy and ward environments were clean, tidy and conducive to the delivery of care.

Patients told us they were treated with dignity and respect and felt that staff actively listened to them and attended their needs. Patients were observed being supported by compassionate staff who took all necessary steps to maintain their dignity, privacy and comfort at all times. All staff advised that they would be happy for a close family member to be cared within this service.

Effective leadership in most wards and at senior management level has enabled the Trust to deliver a safe and compassionate service whilst embedding a least restrictive approach to supporting people with mental illness.

A total of six areas for improvement (AFIs) were identified one of which has been stated for a second time. Areas that require improvement relate to physical health care needs, auditing of supplementary care records, fire safety, care plans, adult safeguarding and record keeping.

3.0 How we inspect

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

The information obtained is then considered before a determination is made on whether the service is operating in accordance with the relevant legislation and quality standards.
Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the Trust to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

4.0 What people told us about the service

Questionnaires were placed on the wards inviting patients and relatives to complete these and post them to us. Posters were placed throughout wards inviting staff to complete an electronic questionnaire.

There were no patient questionnaires returned however seven interviews took place with patients who all indicated that they were satisfied their care was safe and effective, that they were treated with compassion and that the service was well led.

There was no staff questionnaires returned however there were 21staff interviews conducted. Staff responses indicated that they felt patient care was safe, effective, that patients were treated with compassion and that the service was well led. All staff indicated that they felt supported in their roles and that the senior management team were visible on wards and responsive.

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 of AMHIC was specific to Ward 4 and was undertaken on 13 - 20 August 2019. Three areas for improvement were identified.

<table>
<tr><th colspan="3">Areas for improvement from the last inspection to Ward 4 on 20 August 2019</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Mental Health (Northern Ireland) 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).</th><th>Validation of compliance</th></tr>
<tr><td>Area for improvement 1

Ref:
Standard 5.3.1 (f)

Stated: First Time</td><td>The Trust’s SMT shall ensure that evidence based risk screening tools are in place and accurately completed to support the patient’s physical health care needs, eg; Braden Scale, MUST, fluid balance and fluid management charts. Where needs are identified care plans should be completed to reflect the need and reviewed regularly. These should be completed in accordance with Trust policy/procedures and in line with best practice guidance.</td><td rowspan="2">Not met</td></tr>
<tr><td></td><td>Action taken as confirmed during the inspection:

In some of the patient records examined, fluid balance charts, Braden Scale and MUST screening tools were not present, incomplete or inaccurate and the wards monthly audits of compliance for Braden and MUST completion identified low scores for March 2021 and May 2021. (see Section 5.2.6 for further information.)

This area for improvement has not been met and has been stated for the second time.</td></tr>
</table>

Area for improvement 2 **Ref**: Standard 5.3.3 (d) **Stated:** First Time	The senior management shall ensure that when a patient is assessed as requiring support with their activities of daily living such as personal care, a care plan should be completed that details the specific support the patient requires.	**Met**
	Action taken as confirmed during the inspection: Care records were examined and it was evident that when a patient was assessed as requiring support with their activities of daily living, such a personal care, a care plan was completed which detailed the specific support required.	
Area for improvement 3 **Ref**: Standard 5.3.3 (d) **Stated:** First Time	The senior management team shall ensure that daily nursing progress records are contemporaneous and accurately reflect care delivery.	**Met**
	Action taken as confirmed during the inspection: Daily nursing progress notes reviewed were contemporaneous and accurately reflected care delivery.	

5.2 Inspection Findings

This inspection focused on eleven key themes. Each theme was assessed by inspectors to determine if over occupancy was having an impact on the delivery of safe care.

- Patient Flow
- Environment
- Restrictive practices
- Management of Incidents/Accidents/Adult Safeguarding (ASG)
- Patient comfort – human rights, privacy and dignity
- Care and treatment
- Staffing
- Medicines management
- Governance and Leadership
- Patient engagement and
- Staff engagement

5.2.1 Patient Flow

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

We reviewed these systems and processes to determine their effectiveness in managing the increased demands on these services.

The Trust is commissioned for 80 beds across its acute mental health inpatient services. It was evident on the days of the inspection that the Trust was operating over the recommended 85% acute bed occupancy recommended by The Royal College of Psychiatrists. This recommendation had been set as operating a service with high levels of bed occupancy may affect patient care, as directing patients to the bed most suitable for their care is less likely to be possible.

Discussion with senior Trust staff identified that the Trust were using settees as extra beds. At the time of the inspection one patient was sleeping on a settee. (Please see Section 5.2.5 entitled Patient Comfort for how this impacted patient dignity). In two wards patients had been transferred to acute hospitals for additional medical treatment and their beds had been allocated to new admissions. This approach to bed management has the potential to cause delayed discharges in another part of the health and social care system. One patient, whose needs did not require it, was receiving care and treatment in the extra care suite in PICU to avoid the use of a contingency settee and to afford the patient privacy and dignity.

The recruitment of a Bed Capacity Network Coordinator to the mental health acute inpatient admission wards has been positive in establishing a more coordinated and collaborative approach to patient flow within the Trust area and across the region. This individual is responsible for coordinating all bed management plans which includes, the number of beds available, occupied beds, patients allocated on leave, patients supported on observations and patients that are identified for potential discharge. An important aspect of this role is the engagement through a regional network with other Trusts which supports the understanding and subsequent coordination of bed pressures across the region. In addition to the Bed Capacity Network Coordinator the Trust also has two additional staff dedicated to work as part of the patient flow team.

The Bed Capacity Network Coordinator advised that the home treatment team worked in collaboration with the patient flow team to explore all options to avoid admission to hospital where possible. This approach ensures patients who can be treated at home with enhanced support are, thus avoiding an admission to hospital which ultimately reduces pressure on beds. Therefore when a patient requires admission to an acute mental health bed, assurances can be given that all alternatives to a hospital admission were considered and explored.

Patient flow is being impacted by the closure of Muckamore Abbey Hospital (the regional learning disability hospital) since August 2018. As a result patients with a learning disability who require assessment and treatment due to a decline in their mental health are being admitted to AMHIC.

The Trust have embarked on a quality improvement project "Needs Extra Management Options" (NEMO) to develop new care pathways to improve the patient journey and reduce the number of patients delayed in their discharge; four pathways had been developed with associated tools to support staff. It was evident that this project had supported patient flow and resulted in a shared accountability between hospital and community teams. Formulation meetings occur twice weekly to discuss delayed discharges and potential discharges with community care managers invited to attend. A pathway has also been developed for out of area admissions. It was noted that planning for discharge began at the start of the patient's admission. This was an excellent initiative which demonstrated a positive impact to patient flow.

During focus group discussions consultants reported that facilitating early discharge also creates risks with some patients being discharged home before they are ready. Consultants felt a burden of responsibility in making difficult decisions and having to have exceptionally difficult conversations with family members.

On review of Trust governance systems it was positive to note that the Trust were collating their own data in relation to length of stay, admissions, discharges, delayed discharges and out of Trust admissions. The patient flow team had good oversight of patient profile across all wards, and meetings with the team highlighted the complexities of patients.

Compliance with the Regional Bed Management Protocol for Acute Psychiatric Beds (Aug 2019) was examined. This regional guidance was developed by the Social Care Commissioning Lead for acute mental health in collaboration with the five Trusts in Northern Ireland. It was developed to guide the Trusts in managing psychiatric beds to ensure patients are admitted to an appropriate facility to meet their individual needs in a timely manner. Additionally the Trust have developed their own localised policy to further support decision making around patient flow, this remains in draft form. We determined the Trust was compliant with this policy.

The Trust operates a number of patient information systems including the PARIS IT system and Purposeful Inpatient Admission (PIPA) model; both contain bed management information and functions. The PIPA information is noted at ward level on a white board and reflects admissions, discharges and length of stay at a glance. PIPA meetings occur daily and enable daily multi-disciplinary discussion about patients' care and treatment. The bed capacity network coordinator attends the PIPA meeting every morning to support patient flow and discuss staffing levels based on patient needs.

It was evident that over occupancy was having an impact on the Trusts ability to meet the needs of all patients; however, they were delivering quality care whilst managing demand on services in circumstances beyond their control.

5.2.2 Environment

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

AMHIC is a purpose built facility which opened in 2019. All patient rooms are single occupancy with ensuite bathrooms. A number of interview rooms were available to accommodate visitors. Patients also had access to well-maintained outdoor gardens, which were enclosed within the forecourt of the building.

The hospital was clean, tidy, free from excess clutter, with clinical and support areas being well managed throughout. Environmental cleaning was carried out to a high standard.

Environmental audits confirmed good oversight of these areas. Domestic Supervisors carry out daily spot checks and action any deficits immediately.

A review of a selection of documents including minutes of meetings; risk assessments; audits of the environment; staff's Infection Prevention and Control (IPC) practices; and staff training records confirmed good governance measures were in place to support staff and promote IPC in all of the wards. Covid-19 general risk assessments were completed and information to guide staff, patients and visitors on the Covid-19 safety measures to be taken was displayed in each area.

Staff were knowledgeable on IPC practices and good compliance with IPC practices was observed in relation to hand hygiene, equipment cleaning, use of personal protective equipment (PPE); and the management of linen and waste.

The arrangements for fire safety were reviewed. In the main fire safety was being effectively managed. We identified a number of areas were fire safety could be enhanced. These included retaining up to date fire risk assessments at ward level, recording and evidencing the actions which have been taken to address recommendations made in fire risk assessments, ensuring fire risk assessments are updated when wards are over occupied and ensuring personal emergency evacuation plans are completed to identify measures to be taken for patients requiring assistance in the event of an evacuation.

We determined that over occupancy did not impact on the Trust's ability to provide an environment that was safe and conducive for the delivery of care. An area for improvement has been made with regard to fire risk assessments.

5.2.3 Restrictive practices

The management of restrictive practices across the five inpatient wards was reviewed to determine if over occupancy was having an impact on the use of restrictive practices.

Restrictive practices in use included locked doors; level of observations and physical intervention. We determined that restrictions which were in place had been risk assessed and were proportionate to the level of risk in keeping with best practice guidance.

Patient care records reflected detailed recording and a plan of care for any restrictions. There was evidence that consideration had been given to the patient's human rights including deprivation of liberty safeguards. Care plans however were generic and not individualised to patients. The care plans reviewed had not been signed by patients and all stated that the patient had declined to sign. There was no evidence that patient's care plans had been shared with them during their stay in hospital. This does not support collaborative care planning. An area for improvement has been made.

Any planned restriction was reviewed weekly by the patient's named nurse or sooner where the level of risk had increased. Changes in the patients risk status leads to a review with the multi-disciplinary team (MDT) and there was evidence that the increasing risks were further assessed and individually managed. MDT meetings evidenced discussion around reducing restrictions through the use of unescorted leave, home leave and time of the ward.

The PIPA model was embedded in the Trust to ensure reviewing and planning of the person's hospital stay on a daily basis, reducing the time they spent there and helped support them to leave as soon as they are well enough. It was positive that all wards were observed to have effective systems in place to promote good communication and sharing of information between staff through the PIPA information boards, daily safety brief and handover sheets.

Over occupancy was observed to increase restrictive practices as additional patients admitted to wards were required to sleep on settees in areas not designated for sleeping and use alternative bathroom facilities in the absence of ensuite facilities. As a result these patients had to be placed on 1:1 observations due to ligature risks in the environment, including when they used the bathroom. The requirement for 1:1 observations in both areas is restrictive and impacts on privacy and dignity; however it is acknowledged that measures taken were in the interests of safety and were observed to be as least restrictive as possible.

At times of over occupancy some patients who did not need this level of support were placed in PICU. This may also include patients who were not detained under the Mental Health Order (NI) 1986. Prior to admission Trust staff would explain to patients that the only available space for them would be in PICU. Staff would outline the restrictive nature of PICU and gain the consent of patients prior to their admission and advise that as soon as an alternative bed became available in the acute wards patients would be transferred to an open ward.

Staff in PICU reported it was difficult to manage an additional patient who did not require this level of support in a high risk intensive care environment. Patients who were admitted to PICU during times of over occupancy are allocated a bed in the extra care area. However, when the extra care area is used to accommodate a patient during times of over occupancy, this depletes the ward of a resource allocated and risk assessed for de-escalation and restrictive practices which include physical intervention and rapid tranquilisation. Staff reported there were no other suitable areas to support such practices as this would impact on safety, patient privacy and dignity.

The PICU seclusion room has been used infrequently since opening two years previous. Policy and procedures pertaining to seclusion were available along with evidence that staff had attended relevant training. A review of patient care records evidenced safe use of seclusion which was risk assessed, used for the least amount of time and proportionate to the level of risk.

One ward had a number of profiling beds to support additional physical care needs for the over 65's patient group. As a result of over occupancy there are occasions when profiling beds are being used for patients who don't require this type of bed. As profiling beds pose a significant ligature risk patients are subjected to restrictive practices in the form of 1:1 enhanced observations.

Staff demonstrated a good awareness of restrictive practices and confirmed that physical intervention was used as a last resort and de-escalation techniques were prioritised to support patients. It was evident that the leadership across all of the wards promoted a least restrictive approach to care. Weekly governance meetings and review of data evidenced good governance around use of restrictions. The 'Safety Cross' project was in place across the wards; this is a regional tool for collecting data about the use of restrictive practices (this project is linked to the regional Towards Zero Suicide Patient Safety Collaborative). Staff had completed MAPA (Management of Actual or Potential Aggression) training across all wards.

It is evident that over occupancy impacts on restrictive practices however it is acknowledged that this is outside the Trusts' control and has been identified within the wider over-occupancy regional issues.

5.2.4 Management of Incidents/ Accidents and adult safeguarding

Incidents recorded on the Trust's electronic reporting system, Datix, from January to April 2021 were reviewed to determine if there was an increase in number or complexity of incidents as a result of over occupancy. From our review it was determined that there was no direct correlation between increase in incidents and over occupancy despite all wards being over occupied at one time or other during this period.

There was good awareness and processes in place for the reporting and managing of incidents and accidents. Overall incidents were generally appropriately graded. We noted some variance between wards with some wards grading incidents based on the cumulative effect of incidents involving the same patients and other wards did not. We reviewed the Trust's procedure for grading an incident which came into effect in January 2018 and is next due review in January 2023. The policy directs staff to grade the incident on the perceived outcome of the incident at the time. This may prohibit consideration of repeated incidents of a low risk nature being graded higher. During discussion with the Trust's senior management team (SMT) we were assured that staff were adhering to the policy which was designed to grade each incident separately.

The SMT advised that cumulative risks resulting from repeated incidents are discussed during the weekly live governance meetings. The SMT acknowledged that they need to develop a means of evidencing the discussion at these meetings. Overall there was evidence that SMT have good processes in place to review incidents which included live governance, collective leadership team and monthly governance meetings.

During the feedback session representatives from the SMT shared how these processes of reviewing incidents enabled them to identify trends which have led to quality improvement work around detained patients who attempt to leave hospital without permission known as Absconding without Leave (AWOL).

Following each incident an update was noted against the relevant patient's comprehensive risk assessment (CRA). However due to a flaw on the patient electronic recording system (PARIS) updates were not easily identified. This was also discussed with SMT representatives who acknowledged this as an issue. Under the current PARIS system there was no work around available to address this issue however SMT reported that they hope the new electronic ENCOMPASS (a Health and Social Care (HSC) wide initiative that will introduce a digital integrated care record to Northern Ireland.) will have this capability.

In most cases incident reports clearly identified when an adult safeguarding incident had occurred. Staff demonstrated good knowledge of what constituted an adult safeguarding concern and were able to make referrals appropriately. There was a notable difference in the number of concerns relating to the management of ASG referrals on one ward. The SMT confirmed they were aware of these concerns and as a result had commissioned an audit and investigation. The SMT are currently in the process of devising an action plan to address any recommendations arising from the and our inspection findings.

A review of all adult safeguarding referrals from 01 January to 29 March 2021 evidenced a lack of detailed recording and identified the following concerns regarding the adult safeguarding processes:

- There was no live system to update ward staff regarding what stage the ASG had reached
- Ward manager/deputy ward manager screening ASG referrals were outside of the Trust's policy timeframe on occasions
- A copy of the referral was not always retained at ward level in the patient file
- A number of APP1 referral forms were incomplete or had conflicting information. Some did not evidence any interim protection plan
- The details of the incident requiring an APP1 referral form did not always correspond to what was recorded on the daily progress notes
- Protection plans and ASG incidents were not always recorded in ward safety brief and PIPA meetings which would have enabled further protection for the patients
- Details of referrals are not being adequately collated to identify and support learning
- There was no evidence of auditing or analysis of incidents to support safeguarding prevention

We met with the DAPO for the hospital and the Assistant Service Manager (ASM) to raise our concerns regarding ASG. Representatives of the Trust's SMT agreed that the current system was not sufficiently effective and did not provide assurances of adherence to the ASG policy and procedures. The Trust's SMT confirmed that they were aware of the issues and were in the process of developing a plan to address the concerns. As a result we determined not to escalate this matter further. An area for improvement in relation to ASG has been made.

5.2.5 Patient comfort

Patient care practices were observed to determine if patient comfort had been impacted by over occupancy.

Patients, within the commissioned bed numbers, had their own bedroom with ensuite bathroom. We observed a female patient on 1:1 enhanced observations being cared for in a room that was a non-designated bedroom and generally used for patient interviews. The staff member was seated outside the room observing the patient and the door was open. The location of the room and positioning of the settee did not take into consideration the patient's dignity, privacy or associated noise. We advised staff to put up a mobile screen to protect the patient's dignity and prevent other patients who used this corridor from having direct sight line into the room. This was actioned immediately.

All settees and seating were made of fabric capable of being wiped and although not ideal for patients to sleep on they were fit for purpose. Patients who were admitted during times of over occupancy were informed of sleeping arrangements in non-designated areas prior to their admission.

Some locks on patient room doors were broken due to a flaw in the specification of the door; the ASM advised that building contractors have been contacted and repairs requested. Staff reported patients can easily gain entry to each other's rooms and this increases the risk of aggression between patients. This was evident in the review of Datix incidents. The Trust mitigate this risk by encouraging all patients to ensure their doors are closed and by addressing any issues that arise during the general observation checks.

The Trust has plans to seek alternative doors. Further information about the replacement of doors is noted in Section 5.2.11 of this report.

Patient safety risks at door entrances were identified by the Trust and measures to reduce risks were to be implemented weekly. We identified gaps in these checks from 21 October – 4 December 2020 on one ward. This was discussed with members of the SMT at Trust feedback who confirmed that they had introduced a monthly audit to assure compliance.

There were good arrangements in place for patient safety during admission with high risk items removed and stored safely with the patients consent.

At all times, staff were observed treating patients with kindness and respect whilst delivering care and treatment in a committed and compassionate manner. Staff were observed maintaining a respectful distance during 1:1enhanced observations and knocking doors prior to entering patient rooms.

Overall, staff were taking all necessary steps, to the best of their ability, within the resources available to them, to maintain the dignity, privacy and comfort of patients when wards were operating over and above their commissioned beds.

5.2.6 Care and treatment

Patient records were reviewed to determine if over occupancy was impacting on the care and treatment of patients.

Each patient had paper care records and a computerised PARIS care record. Patients had an admission assessment completed by a doctor and nurse in line with Trust policy and had comprehensive risk assessments completed to reflect their individual needs. Care plans were in place for assessed needs. Some of the care plans were generic in nature and were not personalised to the individual.

Staff presented as knowledgeable with respect to the patients they were caring for.
There was evidence of MDT input, ongoing treatment plans and contact with the patients' key workers. Liaison with acute secondary and highly specialised physical health care services was noted when patients had an underlying physical health care condition.

In some of the patient records examined, fluid balance charts, Braden Scale (Braden scale is a risk screening tool for pressure sores) and Malnutrition Universal Screening Tools (MUST) were not present, incomplete or inaccurate and the wards monthly audits of compliance for Braden and MUST completion identified low scores for March 2021 and May 2021. Assurances were provided that the patients whose fluid balance required monitoring were capable of monitoring their own fluid balances (as they normally do this when they are at home) and that patients were also reviewed regularly by their consultants in charge of their physical health care needs and the consultants were content with their fluid management. The low monthly compliance scores were discussed with the deputy ward manager and doctors responsible for overseeing patients' physical health care. An area for improvement with respect to these matters was made during the previous inspection of Ward 4. As a result of the issues identified during this inspection we have stated this AFI for the second time.

A further area for improvement has been made for the Trust to undertake an audit of supplementary records.

Issues with dating, signing and duplication of records were identified. Information was being missed as a result of two separate record keeping systems (computer and paper) and there were inconsistencies between PIPA reports and safety brief records across the wards. To ensure consistency and improve governance a standard template should be developed and used throughout AMHIC. An area for improvement for record keeping has been made. The template for the daily PIPA report was comprehensive and could be further enhanced with the addition of a section for safeguarding/incidents.

Overall, we determined that patient care and treatment was not being compromised as a result of over occupancy.

5.2.7 Staffing

Staffing was reviewed to determine if safe staffing was being maintained when wards were over occupied.

Ward Managers across all wards were knowledgeable about their funded staffing positions, staffing and skill mix. They had clear knowledge of staff absences, vacant positions, and plans in place to recruit permanent staff and reported that there had been a recent review and reset of staffing across all wards. All wards used a patient acuity (patient care requirements) tool to assist in determining safe daily staffing levels. PIPA boards were displayed on each ward and included patient acuity levels and required levels of observation. On review of required staffing levels it was noted these were increased in accordance with increased patient acuity and observation levels.

Ward managers attended a daily morning meeting to review each ward's staffing levels, patient acuity levels and observation requirements – this meeting informed where additional staff were needed and, if required, staff would be deployed across AMHIC. Staff advised that this was extremely helpful and promoted a culture of collective working. The skill mix across wards had recently been reviewed and as a result there were plans in place to increase the compliment of health care assistants in one ward and transfer registered nurses to another ward.

Each ward in AMHIC has a dedicated occupational therapist, and access to physiotherapy and speech and language therapy staff and dietitian input as required.

There was an increase in staffing pressures when over occupancy occurred due to the requirement for increased patient observation levels. Challenges in recruitment, staff absence, and the Covid-19 pandemic were identified as factors that have impacted staffing. A recruitment drive was underway within the Trust and interviews for nursing staff were being held at the same time as the inspection. The compliment of deputy ward managers has increased and has strengthened support and leadership within AMHIC.

There were good governance systems in place to monitor staffing levels. Ward staff complete a DATIX incident form to escalate low staffing levels to the Trust's SMT. Assurance was given that staffing levels were reviewed by the SMT across the unit on a daily basis. It was acknowledged that the Trust were taking all necessary steps to monitor and review their processes to assist in maintaining adequate staffing levels and whilst they have a drive on recruitment it is recognised that recruitment and retention of staff has been identified as a wider regional and national issue.

We determined that over occupancy was contributing to staffing pressures.

5.2.8 Staff Views

We met with and spoke to a number of staff to seek their views regarding the impact of over occupancy on the delivery of patient care.

Staff reported the standard of patient care was high, patient centred and there was a culture of respect for patients and staff. All staff advised they received good support from their managers who were knowledgeable and approachable. Managers were visible throughout the unit and staff described the delivery of care as compassionate. New staff reported feeling at ease.

Staff reported clear mechanisms for feedback and learning from incidents and audits via staff meetings (which could be accessed virtually), debriefs, incident review meetings, emails, minutes, clinical supervision and verbal communications. Staff reported there were weekly reflective practice sessions facilitated by psychologists and felt this was extremely helpful.

Staff support mechanisms included the Trust's online 'B Well' staff health and wellbeing service, occupational health, and a walking club for staff initiated by staff from one of the wards. Staff stated they had up to date supervision and appraisals and reported good communication and support between peer networks.

All staff described recent improvements within their area of work, including the daily PIPA meeting which has helped share staff across the unit. A quality improvement project was ongoing on one ward in conjunction with speech and language therapy. A stop and pause approach at meal times had been adopted to ensure patients receive the correct diet consistency meal in line with their assessed need. Staff welcomed this initiative and reported it had improved patient safety at meal times.

Focus groups were held with junior and senior doctors to determine if over occupancy impacted their delivery of care. All doctors reported the impact of patients sleeping on settees and the associated increase in workload. The lack of beds in PICU resulted in the inappropriate transfer of patients to an acute admission wards that would be better cared for in an intensive care unit. Despite these pressures which at times doctors reported impacted staff morale, they also reported they have a great team and they consider the standard of care they provide to be excellent.

Doctors also reported additional pressures on the acute mental health inpatient beds following the closure to admissions of Muckamore Abbey Hospital in August 2018. Doctors advised that there is a lack of expertise amongst the staff team to effectively manage this cohort of patients. This challenge is greater when wards are over occupied. The challenges arise as mental health staff require additional training to be skilled up to nurse patients with a learning disability in particular to understand their communication needs. Discussions with SMT confirmed that input from learning disability in-reach teams was in place to provide additional support to these patients.

We determined over occupancy was impacting on staff pressures however all staff were confident that patients still received a high standard of care despite the challenges.

5.2.9 Patient Views

We spoke with patients to determine if over occupancy was affecting the delivery of their care.

Patients told us they were treated with dignity and respect and that staff actively listened to them and attended their needs. Patients advised staff involved them in all aspects of their care and they each had opportunity to attend meetings about their care. Patients were aware of the advocacy services available to them.

Some patients reported that there was not enough staff or that it was difficult to locate them. Patients found it difficult to know if there was anyone in the ward office when they knocked the door and did not know if they had been heard.

All patients were aware of the activities available to them, but few participated. Patients recognised that the ward manager wore a red uniform and deputies were in dark blue uniforms. Some patients reported that they were not always certain who their named nurse for the shift was. This was discussed with members of the SMT during feedback.

A Trust Patient Satisfaction survey was ongoing at the time of the inspection. The individual conducting the survey confirmed that they had received similar feedback from patients regarding the lack of staff or patients being unable to locate staff.

Most patients reported feeling well cared for and were observed to be supported by compassionate staff. Overall the experience of patients was not affected by over occupancy.

5.2.10 Medicines management

Medicines management was reviewed to determine if patient medicines was effectively being managed at times of over occupancy.

There was evidence that satisfactory systems were in place for medicines management on all wards. Medicines were being managed safely and patients were being administered their medicines as prescribed.

Pharmacy support was provided on the wards by two full time pharmacists and a full time pharmacy technician. They were supported on site by the Trust lead mental health pharmacist. Staff were complimentary of the pharmacy support provided to the wards and the contribution to the safe management of medicines. The clinical pharmacists' support to the wards includes medicines reconciliation for newly admitted patients, attendance at the daily PIPA multidisciplinary team meetings, attendance at the multidisciplinary patient case reviews and in patient discharge planning. The pharmacy technician co-ordinates the medicine ordering and stock control processes, including reviewing the expiry dates of medicines. The Trust lead mental health pharmacist participates in the medicines management aspects of restraint training for the healthcare staff.

The Trust lead mental health pharmacist performed a kardex completion audit in March 2021. The results were presented to the AMHIC audit group and the recommendations were circulated to all medical staff and clinical pharmacists in AMHIC. Recommendations were planned to be reviewed after six months.

The nursing staff were very knowledgeable regarding the medicines management processes and the medication needs of individual patients.

Arrangements were in place for the safe management of medicines during the patient admission and discharge processes. Details of pre-admission medicines prescribed were routinely obtained as part of the admission process. Arrangements were in place to manage medicines when patients were discharged from the wards to ensure a continuous supply of their medicines and to ensure they were given any necessary advice.

Kardexes were maintained in a satisfactory manner on each of the wards; with medicine entries, dosage regimes and the patient's allergy status appropriately recorded. The good practice of highlighting critical medicines and the dates for medicines prescribed, for example, at twice weekly or weekly intervals was acknowledged. In most instances, the medicines kardex had been signed by the pharmacist to confirm that medicines reconciliation had been carried out. The medicine administration records were generally completed to a high standard. The records indicated that patients were administered their medicines as prescribed. Staff recorded why a medicine was omitted. Staff exhibited knowledge of escalating to the prescriber in instances where patients refused medicines.

At patient case reviews, the multidisciplinary team consider medication changes, the use of 'PRN' medicines and additional information, such as blood tests, physical health checks and the use of high dose antipsychotics.

Staff demonstrated a good knowledge of critical medicines and the need for their timely administration. Staff were familiar with the arrangements for ensuring timely supply of prescribed medicines, including medicines required during out of hours periods.

On all wards there were clear parameters specified on the medicine kardexes to direct the administration of medicines prescribed on a "when required" (PRN) basis as part of a behavioural management strategy. This included the indication for the medicine, the minimum frequency intervals and the maximum daily dose. In instances where more than one PRN medicine was prescribed as part of a behavioural management strategy, it was clear which medicine was first, second and third line. On four wards the reason for and outcome of administration was evidenced in the patient daily notes, on one ward this recording was inconsistent.

The Trust Rapid Tranquillisation Policy was in place and staff were aware of its' content. Posters of the policy were displayed in ward treatment rooms. Staff advised that staff and patient debriefing took place as soon as was practical after an incident where rapid tranquillisation was needed. A report of the use of rapid tranquillisation was made on a Trust incident form. Staff confirmed that the frequency of a patient's use of these medicines was monitored and reviewed at the daily PIPA meetings and at the multidisciplinary patient case reviews.

The Trust Rapid Tranquillisation Policy directs staff to prescribe oral and intramuscular (IM) doses of medicines separately on the kardex. However, the usual practice was for oral and IM routes of administration to be prescribed as a single entry on the kardex. This matter had been highlighted at the recent kardex completion audit and the Trust's lead mental health pharmacist indicated that he planned to review this matter in more detail at a future audit.

Regional care pathways were in place for both clozapine and lithium. Clozapine was supplied weekly to the wards on a named patient basis. Arrangements were in place for regular review and monitoring of clozapine and lithium treatments, including blood monitoring.

Where the combined antipsychotic medication dose prescribed exceeded the recommended maximum daily dose limit, a high dose antipsychotic monitoring sheet was in place.

A good standard of storage and stock control of medicines was observed across all wards. Medicines were stored in locked cupboards and medicine areas were clean, tidy and organised. The temperature ranges of the medicine refrigerators were appropriately maintained and monitored. Resuscitation trolleys were stored safely and daily trolley audit records were observed.

Limited use of controlled drugs requiring safe custody was observed on the wards. Controlled drugs were safely and securely stored and the controlled drugs registers had been appropriately maintained. Reconciliation stock checks were completed at shift handovers. A Trust pharmacist carried out a quarterly audit on the management of controlled drugs on each ward.

5.2.11 Governance and leadership

Governance and leadership was reviewed to ensure effective mechanisms of communication, senior decision making and escalation arrangements when admitting patients when wards are over occupied.

At ward level there was evidence of cohesive teams with good working relationships between the ward manager and their staff to promote the delivery of safe and effective care. There was good multidisciplinary working across all disciplines.

There was clear evidence of positive leadership from the senior management team; staff told us that the ASM was visible and approachable at all times.

Robust governance systems were in place to support bed management. The Trust collates their own data in relation to length of stay, admissions, discharges, delayed discharges and out of Trust admissions. The Trust was able to articulate the impact of this data and how it is used to inform bed management discussion and decision making regarding admissions to hospital. The decision to admit patients to wards when they are over occupied was considered and only agreed as a last resort when risks to patients were high and no other treatment pathway was available in the community. Arrangements were in place for reporting and escalating over occupancy within the Trust and at regional level. There was a significant quality improvement piece of work done to facilitate discharges with the development of Woodstock Bank which has led to better outcomes for patients regarding their length of stay. Woodstock Bank is a new nine bedded unit that was created to accommodate patients who were delayed in their discharge and had no home to return to. It provides medium term accommodation for patients and also provides support to service users between 8am and 8pm.

There was a range of meetings held to support patient flow; we observed a daily huddle to discuss beds attended by the patient flow team, ward managers and ASM. There was a fortnightly MDT delayed discharge meeting to discuss individual patients that were delayed in their discharge. This enabled meaningful discussion with care managers to plan for discharge and to identify solutions such as supported living opportunities at the point of admission. This was identified as an example of good practice.

The SMT were aware of the bed pressures across the Trust and the impact over occupancy had on patient and ward risk. Information was provided to RQIA by the ASM specifically around restrictive practices for all wards.

There is a weekly report on the use of MAPA which provides a detailed analysis of the type of physical restraint used, low, medium or high level holds and whether or not rapid tranquilization was used and the number of incidents involving the same patient were categorised.

Governance structures within the Trust had been reviewed and strengthened and there are clear escalation processes in place to support sharing of information through a range of meetings to include a weekly governance meeting were weekly statistics in relation to incidents and safeguarding referrals are discussed. The ASM told us how the learning from other inspections in other wards across the Trust had been shared and has drove improvement in AMHIC.

We reviewed the action plan arising from the outcomes of two Serious Adverse Incident investigations. Four areas for improvement were identified relating to; the management of ligature risks in relation to doors and the replacement of doors, fire safety, and smoking in the unit. The Trust had put appropriate mitigations in place to manage; the ligature risks, fire safety risk and smoking. The Trust was in the process of sourcing appropriate alternative replacement doors. Plans were underway for members of the Trust's design team and contractors to visit Edinburgh to view the proposed new doors to assess if they would meet their requirements. However, due to the travel restrictions arising from the Covid-19 pandemic they were unable to proceed with the visit. The divisional nurse lead advised that this visit would proceed as soon as travel restrictions eased.

6.0 Conclusion

On reviewing our inspection findings it was evident that over occupancy was having an impact on the environment, restrictive practices, staffing and patient comfort. Staff also discussed the challenges and pressures they faced, however it was clear that this was not compromising the delivery of safe and effective care.

Based on the inspection findings and discussions held, we are satisfied that this service is providing safe and effective care in a caring and compassionate manner. Six areas for improvement were identified that will support the Trust to deliver improved outcomes for patients and staff.

7.0 Quality Improvement Plan/Areas for Improvement

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

	Standards
Total number of Areas for Improvement	**6***

Six areas for improvement have been identified which includes one that has been stated for a second time.

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with representatives from the SMT as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).	
Area for improvement 1 **Ref:** Standard 5.1 Criteria: 5.3.1 (f) **Stated:** Second time **To be completed by:** 4 June 2021	The Belfast Health and Social Care Trust should ensure that evidence based risk screening tools: • Should be completed in accordance with the Trust's policy/procedures and in line with best practice guidance; • Are accurately completed to support the patient's physical health care needs such as: Braden Scale, MUST, fluid balance and fluid management charts; • Inform care plans and are reviewed regularly. Ref: 5.1
	Response by registered person detailing the actions taken: Trust response The Trust acknowledges that this remains an issue. An audit calendar has been developed to ensure that risk screening tools and care plans including those in relation to physical health needs are audited and any resulting action plans are completed. The Nurse Development Lead and Assistant Service Manager will have overall oversight and wards will be held to account.

Area for improvement 2 **Ref:** Standard 5.3 Criteria: 5.3.1 (f) **Stated:** First time **To be completed by:** 4 June 2021	The Belfast Health and Social Care Trust should audit supplementary care records to assure themselves that they are completed accurately. Ref: 5.2.6
	Response by registered person detailing the actions taken: Trust response An audit calendar has been developed to ensure that supplementary care records are audited and any resulting action plans are completed. The Nurse Development Lead and Assistant Service Manager will have overall oversight and wards will be held to account.
Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3.1(e) **Stated:** First time **To be completed by:** 25 May 2021	The Belfast Health and Social Care Trust should address the following in relation to fire safety: • Ensure each wards fire risk assessment is accessible at ward level; • Ensure fire risk assessments are maintained as a "live document" which is updated and reflects when recommendations are actioned, by whom and on what date; • Ensure each fire risk assessment is updated to reflect the changing risks when wards are over occupied; and • Ensure all patients who may need one have a personal emergency evacuation plan completed. Ref: 5.2.2
	Response by registered person detailing the actions taken: Trust Response A fire folder containing the fire risk assessment is now held in the main multidisciplinary team office of each ward. Trust Action - The Assistant Services Manager will meet with Ward Sisters/Charge Nurses and Fire Wardens within Acute Mental Health Inpatient Centre (AMHIC) to review their fire folders on a six monthly basis. - Fire safety will be added as a standing agenda item to AMHIC's monthly governance meeting. - Any patient requiring a personal emergency evactuation plan will have one completed as part of the admission process.

Area for improvement 4 **Ref:** Standard 5.1 Criteria: 5.3.3 (b) **Stated:** First Time **To be completed by:** 4 June 2021	The Belfast Health and Social Care Trust should ensure: • Patient care plans reflect their individual care needs; and • Care plans are shared with the patient; and evidence that the patient is in agreement with the planned care. Ref: 5.2.3
	Response by registered person detailing the actions taken: Trust response Monthly audits of patient documentation including care plans continue. Any remedial action to be taken is discussed with relevant staff member. AMHIC endeavour to include patients in the care planning process although some patients are reluctant to do so. As stated in the main body of the report, a note is made to say that the patient refused to sign. Attempts to include patient involvement is evidenced throughout patient documentation e.g. during the minutes of meetings and discussions highlighted in the patient's records.

Area for improvement 5 **Ref:** Standard 5.1 Criteria: 5.3.1 (c) and (d) **Stated :** First time **To be completed by;** 4 June 2021	The Belfast Health and Social Care Trust should undertake a review of their Adult Safeguarding (ASG) arrangements to ensure: • All referral forms are completed in full with appropriate, accurate detail; • That interim protection plans are appropriately developed implemented and recorded; • Referrals are screened by ward and deputy ward managers and escalated to the DAPO/adult safeguarding team in a timely manner in line with regional and Trust timeframes; • Staff can easily access information that informs them at what stage in the process ASG referrals are; • Progress notes reflect ASG incidents; • ASG incidents and referrals feature on safety briefs and PIPA meetings as a standing item; and • Effective audit and assurance of adherence to Trust procedures and Adult Safeguarding Operational Procedures 2016. Ref: 5.2.4
	Response by registered person detailing the actions taken: Trust Response The Assistant Services Manager has met with both the Adult Safeguarding Lead and Senior Social Worker within AMHIC. An action plan has been developed and implemented in AMHIC which will help ensure that the above area for improvement is addressed: - - Adult safeguarding awareness sessions now take place for all staff within as part of their local induction. - All medical staff are invited to Level 2 adult safeguarding training - All senior managers have received level 3 adult safeguading training - There has been an increase in the amount of staff trained as Investigating Officer within adult safeguarding processes - The Assistant Services Manager and Senior Social Worker in AMHIC audit two adult safeguarding files per month. Any issues arising from the audit are discussed at AMHIC's monthly safeguarding meeting. - Adult safeguarding is a standing agenda item on ward governance meetings and both AMHIC's Operational and M&M meetings - ASP3s and safety plans are now recorded on PARIS under safeguarding casenote which make it more easily identifiable for staff. - Adult safeguarding information is now on each ward's PIPA board. Trust Action

	- Adult safeguarding will be incorporated into the monthly notes audit. - Adult safeguarding to be incorporated onto safety briefing documentation across the Unit.
Area for improvement 6 **Ref:** Standard 5.1 Criteria: 5.3.3 (d) **Stated:** First time **To be completed by:** 4 October 2021	The Belfast Health and Social Care Trust should ensure a consistent approach to recording is applied throughout the unit for all disciplines ensuring that: • There is a shared understanding of where to store records that cannot be updated or stored on Paris; • Templates used are consistent across all wards (in particular for PIPA and safety briefs/handovers and MDT meetings); and • Records are signed and dated and in line with professional and Trust standards. Ref: 5.2.6
	Response by registered person detailing the actions taken: Trust response The Trust is aware of the above issue. PIPA templates are all similar and a designated template management team has been put in place. All versions of templates will be disseminated through said team to help ensure consistency. The Belfast Trust is working with the rest of the region in the development of the You in Mind documentation and moving towards the implementation of Encompass. Trust Action - A quality improvement initiative is being undertaken in relation to ensuring the uniformity of all safety briefs and handovers and associated documentation across AMHIC. - The monthly file audit template will be reviewed and updated to ensure that signatures are recorded against case notes.

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