Unannounced Inspection Report
21 January 2021

Belfast Health & Social Care Trust

Type of Service: Mental Health and Learning Disability Hospital
Erne Ward
Muckamore Abbey Hospital
1 Abbey Road
Antrim
BT41 4SH
Tel No: 028 9504 2087

Membership of the inspection team

Wendy McGregor	Acting Assistant Director, Improvement Directorate, Regulation and Quality Improvement Authority
Carmel Treacy	Inspector, Hospital Programme Team, Regulation and Quality Improvement Authority
Lorraine O'Donnell	Inspector, Hospital Programme Team, Regulation and Quality Improvement Authority
Stephen O'Connor	Inspector, Independent Health Care Team, Regulation and Quality Improvement Authority

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Erne is a ward within Muckamore Abbey Hospital (MAH). MAH is a Mental Health and Learning Disability Hospital managed by the Belfast Health and Social Care Trust (the Trust). The ward provides inpatient care to male adults 18 years and over who have a learning disability and require rehabilitative care and treatment in a psychiatric care setting. Patients are admitted to the ward from other wards in MAH either on a voluntary basis or in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).

The ward provides a service to people with a Learning Disability from the Belfast Health and Social Care Trust (BHSCT), the Northern Health and Social Care Trust (NHSCT) and the South Eastern Health and Social Care Trust (SEHSCT).

On the day of the inspection, there were nine beds operational in Erne ward, eight patients were accommodated on the ward and one patient was on a period of extended leave.

3.0 Service details

Responsible person: Dr Cathy Jack Belfast Health and Social Care Trust	**Position:** Chief Executive Officer
Category of care: Acute Mental Health & Learning Disability	**Number of beds:** 9
Person in charge at the time of inspection: Ward Manager	

4.0 Inspection summary

An unannounced inspection was undertaken to Erne on 21 January 2021. The inspection commenced at 05:00hrs and finished at 17:00hrs. Feedback from the inspection was delivered to the Trust's senior management team (SMT) on 26 January 2021.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Mental Health (Northern Ireland) Order 1986 and the DHSSPSNI Quality Standards for Health and Social Care (March 2006).

We undertook this inspection in response to intelligence we received about Erne ward on 18 January 2021. We examined a number of areas to support our findings including; decision making and patient risk management, supporting patients who present with challenging behaviours, attending to patient's personal care needs, medical intervention following an incident, privacy and dignity of patients, management of continence, staffing, staff morale, infection prevention and control (IPC) and the ward environment.

On review of the information received, we determined that the concerns regarding neglecting to attend to a patient's personal care needs and providing an appropriate level of medical intervention after an incident met the threshold for onward referral to the Trust's Adult Safeguarding Gateway team for investigation under the Northern Ireland Adult Safeguarding Partnership: Adult Safeguarding Operational Procedures (2016). These referrals were made by us on 18 January 2021 and we have attended the subsequent Adult Safeguarding strategy meetings. We will continue to attend the strategy meetings and receive updates as the investigation progresses.

The previous Quality Improvement Plan (QIP) generated from the inspection of Erne on 24 October 2017 was reviewed during the previous inspections of the entire hospital site undertaken on 15 April 2017 and 27 October 2020. We will continue to monitor progress with that QIP during forthcoming multi-disciplinary team hospital inspections.

We were pleased to see good practice in relation to:

- how nursing staff were observed treating patients with dignity and respect;
- how patients were being listened to and asked for their consent and opinion;
- adherence to good hand hygiene;
- the level of information and signage about social distancing due to Covid-19 displayed; and
- an evidence of a culture of openness and transparency among staff.

We were concerned that:

- some incidents were inappropriately graded on the incident recording system (DATIX);
- there was a lack of debriefing for staff following incidents;
- there were a limited number of staff trained in a Learning Disability speciality;
- whilst mattress audits were being completed, there was no record of what actions were being taken to address issues found;
- whilst IPC support was available to the ward, there were no formal records of visits or outcomes retained by the IPC team or the ward;
- the ward staffing levels were not sufficient to allow time for staff supervision/appraisals and ward meetings;
- there were issues with working relations between agency and permanent Trust staff; and
- there was the potential for patient comfort and safety to be compromised because environmental issues were not being addressed in a timely manner.

4.1 Inspection outcome

Total number of areas for improvement	8

There were eight new areas for improvement arising from this inspection. These are detailed in the QIP.

Details of the QIP were discussed with the senior management team (SMT) at a feedback session on 26 January 2021. The timescales for implementation of these improvements commence from that date. Findings of our inspection are outlined in the main body of the report.

This inspection did not result in enforcement action.

5.0 How we inspect

Prior to the inspection, a range of information relevant to the ward was reviewed. This included the following records:

- previous hospital inspection reports;
- QIPs returned following previous hospital inspections;
- Serious Adverse Incident (SAI) notifications;
- information about complaints; and
- other relevant intelligence received by RQIA.

The ward was assessed using an inspection framework. The methodology underpinning this inspection included; discussions with patients, day and night staff, members of the Multi-Disciplinary Team (MDT) and domestic support staff; observations of practice; and review of relevant documentation. Records examined during the inspection included nursing care records; medical records; senior management governance reports; minutes of relevant meetings; duty rotas; and Datix incidents.

Posters informing patients and staff of our inspection were displayed while our inspection was in progress.

We invited staff to complete an electronic questionnaire during the inspection. No questionnaires were received by RQIA.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection of MAH from 27-28 October 2020

The previous Quality Improvement Plan (QIP) generated from the inspection of Erne on 24 October 2017 was reviewed during the previous inspections of the entire hospital site undertaken on15 April 2019 and 27 October 2020. We will continue to monitor progress with the entire hospital site QIP during forthcoming multi-disciplinary hospital inspections.

6.2 Inspection findings

6.2.1 Decision making and patient risk management

The information we received prior to the inspection alleged that some patient's risk management plans were not fully implemented and that some decisions were taken without a full MDT discussion. We reviewed care records, risk assessments and care plans relating to four patients. There was evidence of frequent MDT involvement and informed decision making at the daily Purposeful Inpatient Admission (PIpA) meetings. The PIpA model provides a good multidisciplinary review of each patient and involves shared decision making around care and treatment issues and risk assessments. Risk assessments were updated in a timely fashion and appropriately reflected the discussion and decision making when risks had changed. There was good input from the MDT with the Speech and Language Therapy and Occupational Therapy service also involved in decision making.

We observed the handover from night staff to day staff and were satisfied that patient's risk management plans were shared and discussed with all staff on commencement of their shifts.

We found evidence that staff were adhering to patient's risk management plans and patients were appropriately prescribed enhanced observation levels in order to maintain their safety. We determined that the general focus of staff on the ward was to maintain patient safety, with less attention being given to engaging patients with therapeutic and leisure activities as detailed in patient's positive behaviour support plans (PBS). (See section 6.2.2 for more detail)

6.2.2 Support of patients who present with behaviours that challenge

On review of the patient's records and discussions with the multi-disciplinary team we found that there were appropriate onward referrals to other primary health care services and good monitoring of physical health by the hospital's General Practitioner (GP) and medical staff if patient's presented with any changes to their behaviours.

The majority of staff on duty did not have Learning Disability speciality training. We determined that this was having an impact on the implementation of patient's positive behaviour support (PBS) plans. We raised this issue with the behaviour support staff and the hospital SMT who told us of plans to train agency staff in the use of PBS plans. The PBS nurse attends the ward to undertake assessments, review patients and support staff with the implementation of PBS plans and is also involved in patient resettlement work supporting service users who have moved to the community.

SMT told us that the PBS policy is currently under review and will be adopted as a framework within the hospital and become more embedded in practice.

All of the patients in Erne present with very complex challenging behaviours and there has been a noted deterioration in some patients' behaviours recently. The Trust should progress the training of agency staff in PBS plans as soon as possible to benefit both patients and staff. The Trust should also review the resource allocation of PBS nursing staff to enable support to be provided to patients currently residing in the hospital and those undergoing resettlement to the community. The additional support and training would support the decrease of the risks/incidents which result from behaviours that challenge. An area for improvement has been made.

During our inspection in October 2020 we made an area for improvement regarding family involvement in patient care planning. The records we reviewed identified improvement in this area and evidenced family being informed when incidents had occurred. Ward staff and the SMT outlined ongoing family engagement work to improve communication with families in these areas. This will be reviewed on the next inspection.

6.2.3 The privacy and dignity of patients

The information we received prior to inspection alleged that patients' privacy and dignity was not always maintained. We spent time observing staff delivering care to patients, some of whom were extremely distressed for prolonged periods of time. Throughout our observation patients were being treated with dignity and respect and were being listened to.

In one patients' area the bathroom door had been removed, resulting in privacy not being maintained during personal care. This area was only accessed by the patient and staff. The patient recently moved to this area, following MDT agreement. It was envisaged that the move would provide the patient with a quieter space and reduce the number of recurring incidents, as the patient previously shared an area with another patient. The rationale for this move was appropriate, however, the new environment had not been fully adapted to meet the patient's needs. As this patient displayed challenging behaviours they required reinforced doors, the non-reinforced doors had been removed and had not been replaced with reinforced doors at the time of this inspection. The ward manager, PBS nurse and SMT agreed to ensure the doors were replaced as a matter of urgency. This will be reviewed at the next inspection.

6.2.4 Management of continence

Information received prior to the inspection alleged that some staff were not appropriately managing the continence needs of some patients. We reviewed care records of four patients who required support with their continence needs. All records included a continence assessment and care plan and evidenced that patients were being supported with their continence needs. There were no malodours evident in the ward and there was no evidence to support inappropriate management of patients continence needs.

6.2.5 Infection Prevention Control (IPC)

The information we received prior to the inspection alleged that there was poor compliance with IPC measures by staff. We reviewed the ward environment and observed staff who demonstrated good hand hygiene and the use of Personal Protective Equipment (PPE). Staff also demonstrated good knowledge on the management of waste.

We reviewed the IPC and environmental cleanliness audits and determined that the scores for both were good. Staff told us that IPC team support is available to the ward. The IPC team confirmed they last visited the ward on 19 January 2021. The IPC team told us they did not complete any formal records of their visits to the ward. We determined that records of these visits were required to highlight any actions required following their visit. An area for improvement has been made.

Hospital Support services were only available during office hours. Outside of these hours there is a reliance on nursing staff to undertake some cleaning tasks, mainly in relation to mopping bathroom floors following patient use. In those areas we found cleaning equipment left with used water in place. Staff awareness of the IPC management of cleaning equipment, disinfectant dilution rates and procedures to follow when removing blood requires improvement. The ward manager assured us that this would be addressed.

An appropriate amount of signage was displayed throughout the ward reminding staff, patients and visiting staff about the importance of social distancing due to the ongoing Covid-19 pandemic. A designated isolation area was available should a patient begin to show signs of being infected with Covid-19. If the patient returns a positive Covid-19 test result, they are supported as per the hospital policy and temporarily transferred to a ward identified for patients who are Covid-19 positive. A Track and Trace system was in place at the main entrance of the ward. During the day we noted staff enter and exit the building from doors throughout the building which did not have a Track and Trace system in place making oversight of people entering and exiting ward difficult. An area for improvement has been made.

6.2.6 Ward environment

The information we received prior to inspection alleged that elements of the ward environment did not adequately provide a safe and comfortable environment for patients. An environmental check found poor temperature control in some areas in the ward. The water running from many of the hand washing sinks took a prolonged period of time to run warm and in some sinks remained cold. There were no working handwashing facilities in three bathrooms and nursing staff confirmed that staff and patients access water from the bath taps to facilitate hand hygiene in these areas. These issues had been reported to the estates department and we determined they had not been addressed in a timely way.

We observed much wear and tear throughout the ward; enamel chipped on a bath, chipped paint on some doors and walls, stained floor covering and damaged furniture. Some areas were cluttered and disorganised and following discussion with ward manager were addressed. There were items stored in boxes on the floors of store rooms making it difficult to clean effectively. These issues were highlighted to the ward manager and domestic supervisor and addressed by them on the day of the inspection. We observed a build-up of lime scale on some taps and there was dust and debris on items in the domestic store. The internal and external window glass required cleaning. An area for improvement has been made to address the above findings.

The ward environment was difficult to navigate and could cause issues for staff who were not familiar with the ward layout. Patient accommodation was spaced out throughout the entire ward with some patients having their own “pod” area. These areas were often reached through a series of self-locking doors. Staff highlighted to us that there have been episodes of accidental seclusion because staff were unfamiliar with the geography of the ward, and had on occasions left a specific area of the ward without realising the exit door they had used automatically locked behind them. We found evidence that when this had occurred it was, for a very short period of time and they had been reported as an incident and referred to the Adult Safeguarding team. The SMT told us they were aware of the issue and some actions had been taken action to address the problem including posters displayed reminding staff to be vigilant about the potential for accidental seclusion of patients. We have asked the Trust to keep this issue under careful review.

6.2.7 Staffing

The information we received prior to the inspection led us to review ward staffing arrangements and determine if patient needs were being met including patients’ prescribed enhanced observation levels. We were content that the model of staffing was in the main, known to staff, being achieved and had effective escalation arrangements when this wasn’t the case. These systems were effective in addressing the deficit in staffing levels on the ward on a daily basis.

The current ward manager has been acting up into the role since September 2020 and the two supporting deputy ward manager posts were vacant. The SMT told us that one of the deputy ward manager posts had been recruited and the Trust was waiting on pre-employment recruitment checks being completed.

We were informed about recruitment challenges across the region and the Trust’s rolling recruitment advert for registered nurses and health care assistants. On a positive note three registered nurses and fifteen health care assistants had recently been recruited for the hospital.

Staff we spoke with told us that staff appraisals, supervision and staff/ward meetings had not been taking place for a prolonged period of time. Whilst, in the main there were enough staff to meet the needs of patients’ there was insufficient staff to facilitate additional staff development and peer support requirements such as clinical supervision sessions, appraisals and staff/ward meetings. An area for improvement has been made.

It was positive to note that over the Christmas holidays and, in light of the resurgence of Covid-19 cases in the community and on the site, staffing was, on the whole well managed.

6.2.8 Staff morale

The information we received prior to the inspection alleged poor morale amongst agency staff as a result of being treated less favourably.

Permanent and agency staff told us that the ward manager and assistant services manager were very supportive, listened to any concerns they raised, were visible on the ward and complete regular walk arounds. Staff also said they are well supported by other members of the MDT.

It was good to observe on arrival to the ward at 05.00hrs the hospital site night sisters, supporting ward staff as some patients were particularly unsettled.

We reviewed staff duty rotas and determined that the ward is reliant on both agency staff and staff from other wards, 60% of the staff on duty were agency staff. We spoke with Trust staff and agency staff. Agency staff said they felt welcomed by the hospital; part of the team and morale was good however this was not the case for Trust staff who told us they felt morale was low amongst permanent staff. As a result of discussions with Trust staff and agency staff we determined that further work is needed to address the reasons for low morale amongst Trust staff. These findings were shared with the SMT at the inspection feedback.

6.3 Other findings

6.3.1 Incident management

We reviewed all Datix incidents from 01 October 2020 to 21 January 2021 and found many of the incidents had been graded as low and reflected the outcome of the incident in many cases and not the inherent risk. We saw that the frequency with which some types of incidents occurred, for example assaults on staff, was not reflected in the grading of the risk. We determined that this reduced the opportunity for the Trust to identify action and share learning to prevent or reduce the likelihood of similar incidents occurring. We saw evidence that some incidents were being discussed through various governance systems but we determined that low grade risks were not always escalated for review at a more senior governance level. An area for improvement has been made.

Staff told us that there was no debriefing structure in place following incidents and subsequently the opportunity for staff learning was being missed. Improvements are required in providing the opportunity for debriefing for all staff involved in the management of incidents. An area for improvement has been made.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the SMT, as part of the inspection process, on 26 January 2021. The timescales for implementation of these improvements commence from the date of the inspection feedback.

The Trust should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further action. It is the responsibility of the Trust to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas for improvement

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

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

The Trust must ensure the following findings are addressed:

Support of patients who present with behaviours that challenge

Area for improvement 1 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) (a) (5.3.3) (d) **Stated:** First Time **To be completed by:** 26 July 2021	The Belfast Health and Social Care Trust shall ensure all patients on Erne ward have appropriate and timely access to the positive behaviour support service. **Ref:** 6.2.2
	Response by the Trust detailing the actions taken: The Positive Behaviour Support service is part of the Psychological Therapies Service in Muckamore Abbey Hospital. It has increased staff capacity, with employment of an additional 4 permanent Behaviour Support Practitioners (Band 6) which include a dedicated behaviour therapist allocated to Erne Ward. They work within a multi-discplinary team to provide PBS consultation, training, assessment, intervention and direct practice leadership support to Erne Ward staff and patients. In addition, a pilot workforce development strategy was implemented in 2019 with the introduction of a new Behaviour Assistant Band 4 pschology graduate role, to primarily support ward staff and MDT staff with the implementation of PBS strategies and support. This included support in assessment and implementation of of individual patient PBS plans, as well as supporting the facilitation of patient engagement in meaningful activity within the ward and offsite, as part of the overall improvement of quality of life consistent with the aim of PBS approach. There is an alloation of one Behaviour Support Assistant per ward, although flexibility and responsiveness of service is provided when possible. At times in the last year, following reallocation of some resource to meet patient need, Erne Ward has had the support of two Behaviour Assistants to facilitate patient activities. The service has recently been impacted due to staff sickness and redeployment of some staff to an acute situation in one of the Trust's community 24/7 facilities. This situation is beginning to stablise and resolve with the planned return of staff from sick leave and the recruitmnet of a further 3 Behaviour Support Assistants in May 2021, one of which will be allocated to Erne Ward. Additional PBS staff resource has also been allocated to Erne Ward specifically focusing on and supporting resettlement work.

Area for improvement 2 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) (a) (5.3.3) (d) **Stated:** First Time **To be completed by:** 26 July 2021	The Belfast Health and Social Care Trust shall ensure that all staff working on the ward have the skill and knowledge to effectively support patients who present with behaviours that challenge, including implementation of each patient's positive behaviour support plans. **Ref:** 6.2.2
	Response by the Trust detailing the actions taken: Clinical psychology and the hospital Senior Manager Team (SMT) have recently held several meetings to review the implementation of PBS as an organistional framework on the hospital site. The meetings have included discussion relating to a PBS training strategy to incorporate induction processes and PBS awareness for new staff including agency staff. Clinical Psychology have provided the SMT with a proposal for PBS training to develop staff skills and knowledge to effectively support patients who present with behaviours that challenge and to increase capacity for PBS implementation within the hospital system. Clinical psychology have also provided the SMT with a reference of resources for ongoing CPD activity in relation to PBS for staff within the hospital. A primary area of focus identified was to revisit site wide PBS training. A training schedule has been developed and a number of sessions are being delivered to a range of staff across site in May and June 2021. The sessions are facilitated by behaviour therapy and clinical psychology staff. Clinical psychology have shared with the Nurse Development Lead, the BHSCT Learning Disability induction programme for staff for consideration as a source of reference for development of the hospital induction programme. Erne Ward has an allocation of a Behaviour Support Therapist and a Behaviour Assistant to support the implementation of PBS within the ward. This includes practice leadership and modelling to support staff development of their knowledge and skills to effectively support patients who present with behaviours that challenge. Consultation and psychological formulation is also provided by psychology as and when required, following referral. This has included facilitation of team psychological formulation sessions with staff by clinical psychology and behaviour support staff, to promote a psychological understanding of patient need. Training for individual PBS plans has commenced. The PBS team have provided ward staff with a written copy of the PBS plan and an associated 'grab sheet', which provides the key information and supports strategies for each patient for staff reference - there is also a shared computer file where the documents are stored and updated.

	The BHSCT has a Positive Behaviour Support Policy which was implemented in Muckamore Abbey Hospital in November 2017. It has been agreed that Clinical Psychology will lead on a policy review with consultation and then a policy relaunch across site.
	Infection Prevention Control (IPC)
Area for improvement 3 **Ref:** Standard 5.1 Criteria 5.3.1 (f) **Stated:** First Time **To be completed by:** 26 July 2021	The Belfast Health and Social Care Trust shall ensure the Trust IPC team record all visits to wards in MAH. Actions arising from the visit should be shared with the ward manager, disseminated to appropriate ward staff and actioned accordingly. This may include sharing any actions with the Trust's estates department. **Ref:** 6.2.4
	Response by the Trust detailing the actions taken: The Infection Prevention and Control Team (IPCT) retain a record of the date of each IPCT visit completed which was provided at the time of the inspection. During a ward visit the IPC Nurse will review the management of any patients known or suspected of having an IPC risk. The IPC Nurse will also use this time to observe the environment, patient equipment, clinical practices and speak with staff to see if they have any questions or concerns. Any concerns noted by the IPC Nurse is raised with the Ward Manager or nurse in charge at the time of the visit for action. The IPC Nurse will use their professional judgement as to the level of escalation to relevant parties, for example if the PCSS manager or Estates lead for the site or senior managers should be contacted to have the issues actioned immediately. The IPC Nurse will also determine if a formal audit is required which will follow the already established escalation process within the Trust to drive improvement. All estates issues must be reported by the Ward Manager through established processes.

Covid-19 Track and Trace	
Area for improvement 4 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First time **To be completed by:** 26 July 2021	The Belfast Health and Social Care Trust shall ensure a robust track and trace system is in place in Erne ward which takes account of its multiple entrances and exits. **Ref:** 6.2.4
	Response by the Trust detailing the actions taken: A robust track and trace system has been implemented within Erne Ward. Signage has been displayed at all entrances and exits informing visitors that they must report to the nursing station and ask for the person in charge. The person in charge will ensure that the visitor has signed into the signing in book to maintain a record and audit of all people who have attended the ward each day. This process has been communicated to all staff within the ward.
Environmental Issues	
Area for improvement 5 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First time **To be completed by:** 26 July 2021	The Belfast Health and Social Care Trust shall ensure that all patients in Erne ward have access to a comfortable, clean, and warm, living area. This should include robust audits of the ward environment and timely repair of broken items by the Trust's estates department. **Ref:** 6.2.5
	Response by the Trust detailing the actions taken: Job requests to Estates Services have been submitted for outstanding work and the Ward Manager and the Estates Services team are working together to progress these jobs in a safe, timely and patient centred way. The process for job requests is being reviewed to ensure work is requested in a timely manner, that there is good ongong communication with the Estates Services team and that there is a plan for work to be completed with minimal disruption to patients. Job requests are being overseen and coordinated by a member of the administration team - all planned upcoming repair and maintence work is discussed at weekly planning meetings to ensure work happens in a timely manner. As part of the audit processes for the hospital site, the Assistant Service Managers will implement environmental audits across wards, this will include auditing wards outisde their own areas, by carrying out walk arounds to review the environment and

	living conditions. A review of all patient placements across site has commenced to ensure that patients are living on the ward best suited to their needs.
Staffing Levels	
Area for improvement 6 **Ref**: Standards 4.1 Criteria 4.3 (l) **Stated:** First time **To be completed by:** 26 July 2021	The Belfast Health and Social Care Trust shall ensure that staffing levels allow for staff clinical supervision sessions, staff appraisals and the facilitation of regular ward/staff meetings. **Ref:** 6.2.6
	Response by the Trust detailing the actions taken: There is now a permanent Ward Manager and Deputy Ward Manager in place for Erne Ward. Recruitment exercises continue across site for nursing and healthcare staff. An exercise is underway to bring all appraisals up to date. A schedule has been developed for clinical supervisions and regular ward meetings. The Assistant Service Manager will monitor this to ensure that appraisals take place within the required timesframes, that supervisions are up to date and that regular ward meetings are happening.

<table>
<tr><th colspan="2">Incident Management</th></tr>
<tr><td rowspan="2">Area for improvement 7

Ref: Standard 5.1
Criteria 5.3 (5.3.2) (a)(c)

Stated: First Time

To be completed by:
26 July 2021</td><td>The Belfast Health and Social Care Trust shall ensure that a robust system is in place to ensure that all incidents are graded appropriately to reflect the inherent risk rather than the outcome. The system should include audits of incidents and implementation of learning arising from the audits.

Ref: 6.3.1</td></tr>
<tr><td>Response by the Trust detailing the actions taken:
The Ward Manager will review the grading of incidents when approving them for the ward, they will ensure that each incident is graded in line with the Trust's grading matrix. The Governance and Quality Manager will support the ward by auditing incidents to ensure they are graded appropriately and organise Incident Management and Approval Training for the staff who have yet to avail of this.

The Ward Manager will receive a monthly incident report from the Business Support Manager - this report will shows trends and patterns. The incident report will be discussed at MDT ward meetings to ensure that appropriate action is taken based on any patterns or learning being identified through analysis of incidents. As part of the review of incidents the MDT will consider if the inherent risk has increased due to the volume, pattern, or detail of incidents.</td></tr>
<tr><th colspan="2">Debriefing System</th></tr>
<tr><td rowspan="2">Area for improvement 8

Ref: Standard 5.1
Criteria 5.3
(5.3.2)(a)(b)(c)

Stated: First Time

To be completed by:
26 July 2021</td><td>The Belfast Health and Social Care Trust shall ensure that a local incident debrief policy and procedure is implemented so that:

• learning arising from incidents is shared across MDT’s and across the MAH site in a timely manner;
• trends are identified;
• records are maintained for all incident debrief sessions details the actions required and the persons responsible for ensuring the action is completed.

Ref: 6.3.1</td></tr>
<tr><td>Response by the Trust detailing the actions taken:
The Belfast Health and Social Care Trust shall ensure that a local incident debrief policy and procedure is implented.
A debrief Standard Operating Procedure (SOP) and recording template will be developed and implemented across the hospital site.
The Trust's 'Hot Debrief' guidance will be reissued to all staff, ward managers will discuss the guidance at their team meetings and display the guidance in areas accessible to staff.</td></tr>
</table>

	A template will be designed to support staff in recording their discussion, agreed actions and any key learning identified. The Ward manager will review all incidents that occur within the ward to establish if there are any patterns or learning, a review of any identified trends will take place at weekly MDT meetings to ientify any learning or action required from incident trends.

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

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