Inspection Report

3 November – 18 November 2022

Gillis Memory Centre

Type of service: MHLD Facility
Address: Bluestone Unit
Craigavon Area Hospital
68 Lurgan Road
Portadown
Craigavon
BT63 5QQ
Telephone number: 028 38334444

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

1.0 Service information

Organisation/Registered Provider: Southern Health and Social Care Trust (SHSCT)	**Responsible Individual(s):** Dr. Maria O'Kane, Chief Executive Officer; SHSCT (the Trust)
Person in charge at the time of inspection: Gayle Murphy Dementia Co-ordinator	**Number of registered places:** 10
Categories of care: Dementia Care	**Number of patients accommodated in the ward on the day of this inspection:** 14 patients
Brief description of the accommodation/how the service operates: Gillis Memory Centre provides assessment, care and treatment to male and female patients with dementia. Patients are admitted either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).	

2.0 Inspection summary

An unannounced inspection of Gillis Memory Centre (Gillis) commenced on 3 November 2022 at 09:00 and concluded on 18 November 2022 with feedback to the Trust's Senior Management Team (SMT). The inspection team comprised of three care inspectors and administration staff.

From 04 May 2022 as an interim arrangement, Gillis Memory Centre was closed at St. Luke's Hospital site, Armagh and the service was relocated to the Bluestone Unit within the grounds of Craigavon Area Hospital. The move was precipitated by recruitment and retention challenges with regard to Consultant Psychiatrists of Old Age. The Trust initiated a public consultation from 03 October 2022 until 23 December 2022 to determine future inpatient dementia service provision across the Trust.

Following the transfer of Gillis Memory Centre service, patients and staff, provision for 10 dementia care beds was made within Willows ward at Bluestone Unit. The change resulted in reduced capacity to admit dementia care patients who require medical assessment and treatment from 18 to 10 and reduced Willows ward capacity to admit patients over the age of 65 with a functional mental illness from 20 beds to 10.

Intelligence received prior to the inspection indicated the conditions within Gillis had deteriorated following the transfer of this service to the Bluestone Unit. Information reported to the inspection team during the inspection of Willow ward in July 2022 also highlighted concerns in relation to communication and leadership.

RQIA has a statutory responsibility under the Mental Health (Northern Ireland) Order 1986 and the Health and Social Care (Reform) Act (Northern Ireland) 2009 to make inquiry into any case of ill-treatment, deficiency in care and treatment, improper detention and/or loss or damage to property.

The inspection focused on eight key themes including adult safeguarding (ASG) and incident management, environment, staffing, care and treatment records, physical health, restrictive practices, discharge planning and governance. Inspectors directly observed mealtime experience and care delivery.

Good practice was identified in relation to the person centred information contained within personal patient portfolios, the development of a dementia companion role and the Greatix staff recognition scheme.

Three areas for improvement (AFI) included in the Quality Improvement Plan (QIP) from the most recent inspection of Gillis on 22 February 2019 were reviewed. One AFI was assessed as no longer relevant due to the ongoing public consultation. The remaining two AFIs were assessed as met and partially met. Five new AFIs in relation to theming and trending of incidents, patient experience of the ward environment including patient dining experience, communication between staff teams, personal emergency evacuation plans and fire safety, learning from the recent move of Gillis to the Bluestone site and ligature risk management were identified following this inspection.

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 patients, relatives, staff and management and observe practices throughout the inspection.

This information is considered and triangulated before a determination is made on whether the service is operating in accordance with the relevant legislation and quality standards. Our reports reflect how services 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

Posters and patient/relative leaflets were placed throughout the ward inviting patients, relatives and staff to approach the inspection team to express their views and experiences.
We spoke with patients, a number of staff and one patient's relatives during the inspection and following the inspection other relatives were contacted by telephone.

Feedback from families was generally positive. Families described care as compassionate and noted that communication provided by nursing staff was very good; they were encouraged to attend meetings and received regular updates in relation to incidents and patients' MDT meetings. One relative described the staff as 'exceptionally good', another spoke of how well the staff knew their relative and a third stated their relative received 'wonderful care'.

No completed patient/relative questionnaires were received post inspection.

5.0 The inspection

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

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 22 February 2019</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement No.1

Ref: Standard 5.3.1 (f)

Stated: Second Time

To be completed by:
22 August 2019</td><td>The ward’s operational guidelines need to be approved by the Trust’s Executive Management Team.</td><td rowspan="2">Deferred by the Trust until conclusion of public consultation</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Due to the move of this service and the review of the model of care, the inpatient dementia service is undergoing a public consultation exercise. The operational guidelines will be developed in accordance with the future proposed model. RQIA will review the updated operational guidelines through inspection processes.

This area for improvement will be removed from the QIP.</td></tr>
<tr><td rowspan="2">Area for improvement No.2

Ref: Standard 5.3.3 (d)

Stated: First Time

To be completed by:
22 August 2019</td><td>Address the gaps identified in mandatory training for ward staff in respect of:

• Immediate life support
• Fire Safety; and
• Falls Management

Develop and implement a system to ensure that all staff has completed mandatory training in a timely manner.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Mandatory training records indicated adequate oversight arrangements to ensure training is completed in a timely manner.</td></tr>
</table>

	Gaps in training were minimal for all mandatory and eLearning training courses listed including immediate life support, fire safety and falls management training.	
Area for Improvement No.3 **Ref:** Standard 5.3.3 (f) **Stated:** First time **To be completed by:** Immediate and ongoing	Address the issues identified with the patient care records in relation to ensuring that they are indexed in accordance with Trust standards and ensure that the loose pages are secured. Develop a system of governance and oversight for patient care records to ensure records are maintained to the required standards.	**Partially Met**
	Action taken as confirmed during the inspection: Paper and electronic records were found to be well maintained and there were no loose pages. Although a system for the governance and oversight of patient care records was in place to ensure records are maintained to the required standards, there was limited evidence to confirm this was in use. This AFI is partially met and will be revised and stated for a second time in the QIP.	

5.2 Inspection findings

5.2.1 Adult Safeguarding and Incident Management

Adult Safeguarding (ASG) arrangements were reviewed. ASG is the term used for activities which prevent harm from taking place and which protects adults at risk where harm has occurred or is likely to occur without intervention.

There was a robust system in place that included SMT oversight to ensure compliance with ASG policies and procedures. Staff at ward level demonstrated good understanding and knowledge of what constituted an ASG incident; and that the Adult Safeguarding Prevention and Protection in Partnership Policy (July 2015) was being adhered to. This was confirmed during discussion with the Designated Adult Protection Officer (DAPO). Staff had attended ASG training to develop confidence in making direct referrals to the ASG team, ensuring timely reporting of concerns and implementation of protection plans. Care plans were in place for safeguarding and these were completed to a good standard with an appropriate level of detail recorded.

A review of Datix (Datix is the Trust's electronic system for recording incidents) records identified incidents were graded appropriately. Incident reports were completed to a good standard and there was a mechanism in place to ensure staff have the opportunity to debrief following an incident.

The cumulative impact of repeated incidents was not evident nor was there indication that the incidents had been analysed for patterns or themes which may inform care and lead to improved patient outcomes. Application of a rigorous approach to analysis and review would support the identification of emerging trends and themes. An area for improvement in relation to incident analysis is included in the QIP.

5.2.2 Environment

We visited Gillis to review and assess if the environment was safe and conducive to the delivery of safe, therapeutic and compassionate care and to determine suitability of the ward environment in meeting the assessed needs of the patients accommodated.

The ward presented as bright and airy with lots of natural light. The absence of window blinds however was found to cause some discomfort for patients due to the low sunlight on the day of inspection. The Trust should review and identify suitable window coverings to address this issue.

Communal spaces, including the living room, activities room and the garden spaces operate as shared areas for use by patients from both Gillis and Willow wards. We observed that bringing both groups of patients together in the one area was having an impact on patient experience due to overcrowding and noise. There is a risk that this could result in increased levels of agitation and distress for patients.

The ward footprint offers patients the option of two quiet lounge spaces off the main ward area. When the ward exceeds its capacity to accommodate patients however, one of the quiet room spaces is used to accommodate an additional patient bed. Sleeping arrangements were required within another ward due to over-occupancy issues. This arrangement is not satisfactory for patients experiencing dementia. The Trust should monitor the environment and assess the impact on patient experience, taking action to address as appropriate. An area for improvement is included in the QIP in relation to this.

Information relating to individual patient's dietary needs was appropriately recorded, consistent with care plan information and available for staff involved in serving patient meals. Patient information displayed in the main ward corridor however could compromise patient confidentiality. The Trust should review the arrangements in place to safeguard patient data from view of visitors to the ward.

The mealtime experience was an extremely busy time on the ward and lacked an organised and coordinated approach. Staff were observed supporting patients with their meal in a caring and sensitive manner however poor practice was also noted in relation to staff standing beside a patient to support them with their meal. Given our observations we recommend the Trust review the dining arrangements for both groups of patients and consider designating staff member(s) to coordinate patient meal times. RQIA also recommend that meal times are staggered to accommodate patients' needs.

This was raised during the inspection and with SMT during feedback. An area for improvement in relation to the coordination and management of patients' dining experience is included in the QIP.

In preparation for the relocation of Gillis service to the Bluestone Unit site, the Trust made some environmental adjustments to the ward environment to align with the safety requirements for patients with dementia care needs. Whilst some environmental improvements had been made, inspectors found a lack of appropriate signage to help orientate patients to their surroundings and there were no handrails to promote patient mobility.

An information board mounted at the entrance to the ward held details of advocacy organisations, how to complain, what constitutes adult safeguarding and how to report a concern, health promotion and citizens' advice.

The Fire Risk Assessment (FRA) and the associated action plan were reviewed. Fire doors were found to be propped open. This was followed up with the nurse on duty on the days of the inspection.

Personal Emergency Evacuation Plan (PEEPs) inform staff of the level of assistance a patient needs to safely evacuate in an emergency. PEEPs were not readily available for inspection, however immediate action was taken and PEEPs were developed for all patients. The level of detail should be reviewed to ensure it is adequate for safe evacuation of individual patients. An area for improvement has been identified in relation to addressing the practice of propping fire doors open and the availability of person specific PEEPs for all patients on the ward.

The Ligature Risk Assessment (LRA) provided for inspection did not include the risk presented by handrails in patient's en-suite bathrooms. The ligature risk assessment should be reviewed to include all identified ligature risk issues. An area for improvement has been included in the QIP in relation to this.

Infection Prevention and Control procedures were satisfactory however evidence of infection control audits, cleaning schedules and mattress audits was not provided for inspection. This is further referenced within the Governance section of this report.

5.2.3 Staffing

Staffing levels on the ward were determined using the Telford Model which is a tool to assist staff in ensuring appropriate staffing levels based on patient acuity.

The arrangements for staffing were reviewed and safe staffing levels were evidenced through staff discussion, daily safety brief, analysis of staff duty rotas and observation of staff on shift. There was sufficient staff on duty and agency staff were block booked to provide continuity. Patients from respective wards have a dedicated nursing staff team including individual ward managers.

A new Dementia Companion position has been created for inclusion within the staff complement for Gillis ward. This role will provide holistic, dementia informed care within Gillis and will work as a member of the multi-disciplinary team (MDT).

An escalation policy provides staff with clear guidance regarding the management of staff absence /shortages. Staffing shortfalls are not recorded on Datix, the Trust's incident management system. The Trust should consider the Datix reporting mechanism as a means of recording staffing shortages to support effective governance oversight.

The staff training matrix was reviewed for both mandatory training and e-learning. It was noted the majority of staff were compliant with training requirements and there was a clear management oversight process in place to ensure staff who were in need of updates were identified in a timely manner.

5.2.4 Care and Treatment

We reviewed the quality of record keeping in relation to patients' care and treatment plans.

Patient records were held on PARIS, the Trust's electronic system for recording and maintaining patient information.

A range of appropriate assessments were utilised to support the care planning process. Specific care plans for the management of aggression, distressed behaviours, covert administration of medication, the use of locked doors, safeguarding and 1:1 supervision were also in use. It was positive to note that efforts to manage behaviours through distraction and diversion were a first line management approach and there was evidence of observation levels being reviewed and reduced.

Inspectors found the standard of recording was in line with Nursing and Midwifery Council (NMC) standards for record keeping. Patient Centred Portfolios held additional, individualised information regarding patient's preferences and wishes. An activity programme was displayed outside the ward's activity room and staff were observed to actively engage patients with their chosen activity. Activity records were maintained to reflect patients' participation and engagement. This was noted positively.

There was no evidence of a formal care plan audit being completed. There was however evidence that care plans are reviewed on a regular basis and relevant points discussed at weekly ward managers meetings. An area for improvement has been stated for a second time in relation to care plan audits.

5.2.5 Physical health

Patients' physical health care needs were well managed and effectively addressed. Physical health checks were completed by medical staff with evidence of ongoing referral to medical specialists as required.

There was evidence that patients were referred and reviewed by the Speech and Language Therapist (SLT) and food charts were in place where food intake was required to be monitored.

Falls risk assessments were completed for all patients to determine if the patient was at risk of falls. Assessment on the appropriate use of bed rails was completed in line with patient needs with alternatives being considered where bed rails were not required or appropriate.

Appropriate physical health risk assessments such as Braden, Malnutrition Universal Screen Tool (MUST) and National Early Warning Score (NEWS) risk assessments were in place for each patient and reviewed in accordance with identified risks.

5.2.6 Restrictive Practices

Restrictive practices in use included locked doors to manage egress from the ward, levels of patient observations, the use of Pro Re Nata (PRN) medication and physical intervention. It was positive to note the use of assistive technology such as sensor mats, to reduce the use of more restrictive options. There was regular, weekly MDT review of restrictions and evidence of staff consideration of Human Rights within patient care plans. Risk assessments identified restrictions which were proportionate to the risk, the least restrictive option and used as a last resort.

There were care plans in place for the use of PRN medication. It was positive to note that distraction techniques were utilised as an alternative prior to the administration of PRN medication. Medication records evidenced first and second line medication to be used when required with maximum daily doses and intervals recorded. Patients who were receiving medication covertly had care plans in place indicating the rationale.

5.2.7 Patient Flow

During the inspection Gillis ward was operating at 140% bed occupancy. This reduced the capacity to admit patients over 65 (Willow ward) and limits the wards ability to admit patients with dementia in need of acute care and assessment.

Patients' length of stay ranged from two weeks to 15 months. Inspectors were informed that barriers to discharge included a lack of suitable community placement that could meet the complex needs of the patients. Three patients were delayed in their discharge due to a lack of specialist dementia care provision in the community.

Discharge planning meetings were held weekly to review and plan for discharge with the patient's next of kin invited. Meeting minutes reflect collaborative working between MDT professionals to coordinate discharge planning.

5.2.8 Governance

A range of minutes from meetings were reviewed including managers meetings and operational meetings and quality improvement records were reviewed to determine if effective governance arrangements were in place. Inspectors also spoke with representatives from the SMT and senior nursing staff.

There is no Band 7 ward manager in post although an appointment had been made. Appropriate arrangements were in place to offer staff leadership support in the interim.

Weekly ward manager meetings were attended by managers across the hospital site. Meeting notes lacked detail and we were unable to determine what actions were agreed to manage risks and concerns identified.

The wards operate separately with no sharing of patient risk or profile information to assure safety of patients. There was limited evidence of meetings taking place for staff from Gillis and Willow wards to discuss operational issues and identify how best these can be overcome. The Trust should review the communication arrangements between Gillis and Willow to ensure all staff have adequate understanding of patient risk issues in order to be able to intervene appropriately and provide effective support should a need arise. An area for improvement has been included in the QIP in relation to this.

Senior management walk rounds of the ward were not evident and staff were unclear in relation to the senior management structure. We were informed from a range of staff at different levels there was limited communication prior to the move to Bluestone. Staff described rushed preparations and a difficult transition. Staff morale was notably low and concern was expressed for the longer term plan for patients and staff. The Trust should undertake a review of the move of Gillis to the Bluestone site in May 2022. This must include staff views and identify what went well and where learning is required, with a view to using the outcomes to inform any further changes to the ward environment and model of care.

National Quality Improvement (NQI) reports were available for the period April to September 2022. These reports collect data in relation to omitted medicines, nutritional screening (MUST), falls, rapid tranquilisation and physical intervention. We found 100% compliance had been achieved consistently for the period.

We were informed that there is a programme of audit that will be implemented across Bluestone however the audit tools have yet to be developed. The Trust should ensure that the audit programme offers staff feedback and supports continuous improvement.

It was positive to note that a staff recognition scheme was in place called Greatix. This is a scheme that appreciates and values staff contribution to improving care and is to be commended as good practice.

6.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	0	7

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

Quality Improvement Plan

Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006). Regulations (Northern Ireland)	
Area for Improvement 1 **Ref:** Standard 5.3.3 (f) **Stated:** Second time **To be completed by:** Immediate and ongoing	The Southern Health and Social Care Trust must develop and implement a system of governance and oversight for patient care records to ensure records are maintained to the required standards. Ref: 5.1 and 5.2.4
	Response by registered person detailing the actions taken: Records audit tool in place which is utilised at each operational supervision session, focusing on an audit sample of two records per staff member, promoting discussion, learning, compliance and assurance. Supervision alongside KSF appraisal and Personal development plans to indicate/include Records management training requirements and all training in this regard will be supported/facilitated.
Area for Improvement 2 **Ref:** Standard 5.3.3 (g) **Stated:** First time **To be completed by:** 31 January 2023	The Southern Health and Social Care Trust must apply a robust audit approach to incident analysis that supports the identification of emerging trends and themes. Ref: 5.2.1
	Response by registered person detailing the actions taken: Weekly CLT Governance Forum (Multi professional leads, Governance Team, Safeguarding Team, Carers consultants with a key term of reference for oversight and analysis of incidents, severity, themes, trends and triangulation Weekly action plan is in place to promote discussion and relative quality/safety improvements from this forum. Weekly ward manager, Head of service, dementia coordinator/Lead Nurse Forum with incident analysis and improvements as a standing item Gillis has been amalgamated into the Acute Governance Forum Nursing Quality indicator audits and associated quality improvement plans occur monthly with key remedial actions identified for quality and safety improvement
Area for Improvement 3	The Southern Health and Social Care Trust must review the dining arrangements for both groups of patients with view to

Ref: Standard 6.3.2 (g) **Stated:** First time **To be completed by:** 31 January 2023	improving the coordination and management of patients' dining experience. **Ref: 5.2.2**
	Response by registered person detailing the actions taken: Gillis has implemented the Meal Time Matters QI initiative, there are two identified Meal Time Matters champions designated at shift handover whose remit includes assuring that the environment is therapeutically conducive to patient's needs, that all SALT assessed requirements are being followed (dysphagia), documentation is completed and easy read/pictorial menus are displayed for patients. Red and Yellow Meal time supervisor badges are worn. An audit programme is in place (inclusive of unscheduled audits). Instructions for ward staff and catering staff are present within the dining space. Tables have been reset, and are designated to be for either POA or Gillis. The activity room is now designated as an extra dining space for POA patients, this caters for 5 patients. Memorandum has been sent to all staff in regards to 'standing alongside' patients during mealtimes, and advising of appropriate etiquette in this regard, adherence is overseen by the Meal Time Matters Champions, Nurse in Charge and the rolling audit programme.
Area for improvement 4 **Ref:** Regulation 5.3.2 **Stated:** First time **To be completed by:** 31 January 2023	The Southern Health and Social Care Trust should monitor the ward environment to assess any impact on patient experience relating to the mixed model of care, noise levels, overcrowding of communal spaces and over-occupancy. Ref: 5.2.2
	Response by registered person detailing the actions taken: Patient experience relative to the mixed environment is continually monitored throughout each day. Overcrowding in communal areas has been reduced via the optimisation of activity rooms, the visiting room, day room and the dining room (outside of mealtimes) is utilised for reminiscence and music therapy, Outdoor spaces have been optimised via the installation of new tables and chairs. There is daily MDT led activities programme in situ.

Area for improvement 5 **Ref:** Regulation 8.3 **Stated:** First time **To be completed by:** 31 January 2023	The Southern Health and Social Care Trust shall review the communication arrangements between Gillis and Willow to ensure all staff have adequate understanding of patient risk issues in order to be able to intervene appropriately and provide effective support should a need arise. Ref: 5.2.8
	Response by registered person detailing the actions taken: Gillis now has a permanent ward manager in place. Gills and Willows staff will maintain co-representation at all staff meetings and team talks. In the scenario that a patient living with dementia is resident in Willows ward, the named nurse or delegated associate nurse will be present at all patient specific forums inclusive of MDT meetings, reviews and handovers.
Area for improvement 6 **Ref:** Standard 5.3.1 **Stated:** First time **To be completed by:** Immediate and ongoing	The Southern Health and Social Care Trust must assure itself that the practice of propping fire doors open is not common practice and all patients who require assistance in an emergency have an up to date Personal Emergency Evacuation Plan. Ref: 5.2.2
	Response by registered person detailing the actions taken: Memorandum submitted to all staff regarding the ceasing of any practice of propping open Fire Doors. This will be continually audited by ward manager. All PEEPs are in place for all patients requiring assistance with evacuation. These are centrally stored on Gillis K-Drive and all staff have access.
Area for improvement 7 **Ref:** Standard 5.3.1 **Stated:** First time **To be completed by:** 31 Jan 2023	The Southern Health and Social Care Trust shall ensure that the ligature risk assessment is kept under review and identified risks are managed to eliminate or reduce the level of risk. Ref: 5.2.2
	Response by registered person detailing the actions taken: The Gillis Ligature Risk assessment is up to date and has been amalgamated with Willows. Audit and review schedule is in place inclusive of roles and responsibilities.

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

The Regulation and Quality Improvement Authority

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