The Regulation and Quality Improvement Authority

Inspection Report

25 April 2023 – 6 June 2023

South Eastern Health & Social Care Trust

Ward 27 Ulster
Ulster Hospital
Upper Newtownards Road
Dundonald, Belfast
BT16 1RH
Tel No: 028 9048 4511

Ward 27 Downshire
Downshire Hospital
53 Ardglass Road
Downpatrick
BT30 6JQ
Tel No: 028 4461 3311

Downe Acute
Downe Hospital
2 Struell Wells Road
Downpatrick
BT30 6RL
Tel No: 028 4461 3311

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: South Eastern Health and Social Care Trust (SEHSCT)	**Responsible Individual:** Ms Roisin Coulter Chief Executive
Person in charge at the time of inspection: Downe Acute: Ward Manager, Neil Morgan Ward 27 Ulster: Acting Manager, Glen Haggan Ward 27 Downshire: Deputy Ward Sister, Catriona McCartan	**Number of registered places:** Downe Acute: 25 Ward 27 Ulster: 24 Ward 27 Downshire: 6 Psychiatric Intensive Care Unit (PICU), 10 rehabilitation
Categories of care: Mental Health Acute Admission Psychiatric Intensive Care	**Number of patients accommodated in the on the day of this inspection:** Downe Acute: 26 Ward 27 Ulster: 24 Ward 27 Downshire: 9

Brief description of the accommodation/how the service operates:

The South Eastern Health and Social Care Trust (the Trust) operates three acute mental health admission wards. Two of these wards, Downe Acute and Ward 27 Ulster, provide assessment and treatment for people aged between 18 and 65 with acute mental health needs. Ward 27 Downshire provides both psychiatric intensive care and rehabilitation for people aged between 18 and 65. All three wards provide for male and female patients.

Patients are admitted either on a voluntary basis or in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).

Downe Acute is situated on the ground floor of Downe Hospital and patients are accommodated in single occupancy ensuite bedrooms.

Ward 27 Ulster is situated on the first floor of the care of the elderly complex at the Ulster Hospital. Patients are accommodated in single occupancy ensuite bedrooms and multi-patient dormitories.

Ward 27 Downshire is situated within the grounds of Downshire Hospital and has a mix of single occupancy rooms and multi-patient dormitories for patients.

2.0 Inspection summary

An unannounced inspection of The South Eastern Health and Social Care Trust (the Trust) acute mental health wards commenced on 25 April 2023 at 9am and concluded on 6 June 2023, with feedback to the Trust's Senior Management Team and representatives of the multidisciplinary team. The inspection team comprised three care inspectors and administration staff.

The inspection focused on the following eleven key themes; patients with a learning disability, environment; adult safeguarding (ASG) and incident management; staffing; physical health; restrictive practices; patient experience; patient flow; medicines management; mental health and governance.

Information received by RQIA before this inspection highlighted that a number of patients with a learning disability had been admitted and continued to be accommodated within acute mental health wards. The intelligence received raised concerns about care delivery within environments which were not designed to meet the needs of patients with a learning disability. These concerns were reviewed during this inspection and further detail is available in section 5.2.1.

This inspection also sought to assess progress made against some areas for improvement (AFI) identified in the Quality Improvement Plan (QIP) following the inspection from 20 to 30 April 2021. One AFI which was identified following the most recent inspection of Ward 27 Downshire on 13 February 2023 was also reviewed and assessed as met.

A number of AFI's have not been assessed and will be carried forward to the next inspection. One AFI was assessed as not met.

Seven new AFI's have been stated for the first time and are included in the Quality Improvement Plan (QIP). New areas for improvement relate to the application of provisions within the Mental Capacity Act (MCA), Infection Prevention and Control (IPC), ligature risk management, incident management, governance, patient flow and staff training.

3.0 How we inspect

RQIA has a statutory responsibility under the Mental Health (Northern Ireland) Order 1986 to make inquiry into any case of ill-treatment, deficiency in care and treatment, improper detention, and/or loss or damage to property. Care and Treatment is measured using the Quality Standards (2006) for Health and Social Care to ensure that services are safe, of high quality, and up to standard.

RQIA's inspections form part of our ongoing assessment of the quality of services. 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 service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

The inspection team directly observed patient experiences; staff engagement with patients; how patients spent their day; the reaction to and management of incidents; staffing levels; senior leadership oversight; and ward environments. The inspection team also reviewed patient care records; patient resettlement progress; and governance documentation.

Experiences and views were gathered from staff, patients, and their families.

4.0 What people told us about the service

Posters and easy read leaflets were placed throughout wards inviting staff and patients to speak with inspectors and give feedback on their views and experiences. No feedback was received by the end of the inspection on 6 June 2023.

We spoke with a number of patients, including patients with a learning disability, across the wards. The majority of patients reflected positively on the care they received. Some patients we spoke with expressed issues about the food at ward level. This was shared with SMT during feedback.

Relatives of patients with a learning disability were asked about their experiences of the wards and care provided. Relatives expressed their satisfaction with the knowledge and understanding of staff, their loved one's mental illness as well as their individual needs associated with their learning disability. Some relatives expressed concerns about the bed reduction within the new PICU at Downshire Hospital and also noted a lack of communication from ward staff. This was also shared with staff following the inspection and with the SMT during feedback.

5.0 The inspection

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

The most recent inspections of Downe Acute and Ward 27 Ulster took place during April 2021. The inspection undertaken at this time also included Ward 27 Downshire and Ward 12 Lagan Valley Hospital.

One Improvement Notice (IN000009) was issued to the Trust following this inspection which related to the ward environment and a mixed model of care in operation at Ward 27 Downshire.

Compliance with the Improvement Notice was confirmed at the most recent inspection of Ward 27 Downshire, undertaken on 13 February 2023. One area for improvement (AFI) was identified at this time and is included in the review of the QIP below.

It is noted that while the scope of this inspection did not include Ward 12 Lagan Valley Hospital, the AFIs identified were relevant to all four wards. Future inspection activity of Ward 12 Lagan Valley Hospital will take account of these improvement areas.

<table>
<tr><th colspan="3">Areas for Improvement (AFIs) from the inspection carried out 20 April – 30 April 2021</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).</th><th>Validation of Compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 4.1
Criteria: 4.3(b)

Stated: First time

To be completed by:
Immediately</td><td>The South Eastern Health and Social Care Trust should ensure Datix incident forms are consistently completed for over occupancy, as per Trust policy to enable data correlation.</td><td rowspan="2">Carried forward to the next inspection</td></tr>
<tr><td>Action taken as confirmed during the inspection:
This AFI was not assessed during this inspection and will be carried forward for future inspection.</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 4.1
Criteria: 4.3(i)

Stated: First time

To be completed by:
29 June 2021</td><td>The South Eastern Health and Social Care Trust must review Fire Risk Assessments which should consider increased risks when wards are over occupied regarding the additional number of patients and use of and position of contingency bed placement to ensure fire exits are accessible and unobstructed.</td><td rowspan="2">Not Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The FRAs for Downe Acute and Ward 27 Ulster did not include any references to the over-occupancy or potential for the wards to be over-occupied and the associated fire risk.

This AFI was assessed as not met and is stated for a second time.</td></tr>
</table>

Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3.1(f) **Stated:** First time **To be completed by:** 29 June 2021	The South Eastern Health and Social Care Trust must ensure there is an assurance mechanism in place to monitor environmental and mattress audits, and that items arising from the associated action plans have been completed in a timely manner. **Action taken as confirmed during the inspection:** There was insufficient evidence to provide assurance that environmental audits were taking place. Mattress audits were not reviewed as part of this inspection and this area for improvement will therefore be carried forward for review at the next inspection.	**Carried forward to the next inspection**
Area for improvement 4 **Ref:** Standard 5.1 Criteria: 5.3.1(f) **Stated:** First time **To be completed by:** Immediately	The South Eastern Health and Social Care Trust must ensure compliance with regional guidance on the use of plastic bags in Mental Health (MH) inpatient wards as noted in LL-SAI-2018-033(MH) and Learning Matters Quality 2020 Issue 8, September 2018. The Trust need to have robust assurance mechanisms in place to ensure compliance with the guidance. **Action taken as confirmed during the inspection:** This AFI was not assessed during this inspection and will be carried forward for future inspection.	**Carried forward to the next inspection**

Area for improvement 5 **Ref:** Standard 5.1 Criteria: 5.3.1 (c) and (d) **Stated:** First time **To be completed by:** 29 July 2021	In relation to Adult Safeguarding the South Eastern Health and Social Care Trust shall ensure: • all staff fully understand how to recognise the potential for safeguarding; • there is timely completion and submission of adult safeguarding referrals; • interim protection plans are appropriately developed and implemented • referrals are screened appropriately and escalated in a timely fashion • there is identification of trends and shared learning to prevent similar safeguarding incidents reoccurring • all staff across the multi-disciplinary team know where ASG referrals are stored on the system and the status of each referral at any given point in time. • each ward has an adult safeguarding champion	**Met**
	Action taken as confirmed during the inspection: ASG arrangements for all three wards were reviewed and found to be well managed. Further detail is recorded in section 5.2.2 of this report.	
Area for improvement 6 **Ref:** Standard 5.1 Criteria: 5.3.1(c) **Stated:** First time **To be completed by:** 29 June 2021	The South Eastern Health and Social Care Trust should review the CCTV policy to ensure patient's privacy, dignity and human rights are upheld when contingency beds are placed in undesignated sleeping areas where CCTV cameras are used.	**Carried forward to the next inspection**
	Action taken as confirmed during the inspection: During this inspection there were no patients accommodated within undesignated sleeping areas where CCTV cameras are in use. This AFI was therefore not assessed during this inspection and will be carried forward	

Areas for improvement from the last inspection on 13 February 2023 to Ward 27 Downshire		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 5.1 **Criteria:** 5.3.1 (a) (c) **Stated:** First time **To be completed by:** 31 May 2023	The South Eastern Health and Social Care Trust must ensure that identified patients resettled in the community have their legal status reviewed and Deprivation of Liberty Safeguards (DoLS) applications progress where appropriate. The Trust is required to provide RQIA with written confirmation when patients' legal status is regraded.	**Met**
	Action taken as confirmed during the inspection: The Trust provided assurance to RQIA in writing that all patients resettled to the community had their legal status reviewed. Details of DoLS applications and pending dates for panel hearings confirmed the required progress had been made.	

5.2 Inspection findings

5.2.1 Patients with a Learning Disability

RQIA received information and notifications (Early Alerts) leading up to this inspection which highlighted that a number of patients with a learning disability had been admitted and continued to be accommodated within acute mental health wards. The intelligence received raised concerns about care delivery within environments which were not designed to meet the needs of patients with a learning disability. Inspectors sought to assess the quality of care and treatment provided to patients with a learning disability, and to determine any identifiable impact on the patients accommodated.

It is acknowledged that inpatient services for people with a learning disability across Northern Ireland continue to experience a number of challenges that impact on the availability of hospital based care. Admissions to Muckamore Abbey Hospital, the regional inpatient service for people with a learning disability, were significantly restricted at the time of this inspection and Lakeview Hospital was closed to admissions due to challenges presented by a lack of consultant psychiatry availability for people with a learning disability. Recruitment and retention of permanent staff remains a challenge across the sector for inpatient learning disability services.

Taking into consideration these challenges, some patients with a learning disability were admitted to acute mental health wards until such times as they were able to be transferred to a more suitable inpatient facility or discharged back into the community. It is also acknowledged that a number of patients with a learning disability required care and treatment of their mental health needs and their admission to an acute mental health facility was appropriate.

Information received by RQIA prior to this inspection highlighted further challenges for the Trust in finding suitable community placements for patients with a learning disability. Where community placements had not been secured, more than 30% of patients were delayed in their discharge, creating increased pressure on a system which was already experiencing over-occupancy due to increased demand for acute mental health beds.

Through redeployment of knowledgeable and experienced staff from community teams for learning disability, the Trust were taking appropriate steps to achieve care continuity and familiarity for patients during their stay in hospital. Care observed throughout the inspection was found to be safe, compassionate and delivered to a good standard. Staff knew the patients and were responsive to their individual needs. It was positive to note the supports from community learning disability services in place for patients with a learning disability with evidence of effective use of positive behaviour support (PBS).

Patients with a diagnosis of learning disability were accommodated in side rooms, some with adjoining rooms used as dining rooms and lounge areas. This enabled the patients to benefit from additional space and privacy.

Consultant psychiatrists review their patients on a weekly basis. Following the review, an email is sent to staff on the ward detailing any changes to the patient's care and treatment. However, this may be delayed for several days following the review and therefore there is a delay in implementing any recommended changes. This process should be reviewed to ensure that any delay is minimised and changes are implemented in a timely manner.

Records reviewed outlined Positive Behavioural Support (PBS) plans and PBS input where appropriate for patients with a learning disability across all three wards. There was evidence that PBS staff visited the ward to review and contribute to these plans. It was pleasing to note that all staff, including agency staff were knowledgeable of the PBS plans for each of the patients with a learning disability.

The outcome of this inspection showed that patients with a learning disability were receiving safe, effective and compassionate care within the acute mental health wards and that they were receiving appropriate care and treatment. However, it is acknowledged that the needs of patients with a learning disability would be better met in a learning disability facility with suitably trained and skilled staff to aid their recovery and possibly facilitate a quicker discharge.

5.2.2 Environment

Each of the three ward environments were inspected to determine if they were conducive to the delivery of safe, therapeutic; and compassionate care for the patients accommodated.

All patients were observed to move freely around the ward spaces with staff support where indicated.

The wards were bright and spacious with adequate quiet spaces for patients.

Stairwells and alcoves on Ward 27 Ulster should not be used for storage of equipment and other items. This was highlighted in Fire Risk Assessments (FRA) in 2021 and 2022. The Trust need to identify alternative storage arrangements that will not be a trip hazard in the event of an emergency evacuation. This matter was raised with the ward manager during the inspection and with the SMT during feedback. Assurances were given by SMT that this issue, which is already identified as an action from the FRA, would be addressed as a matter of urgency.

During an inspection in April 2021 it was brought to the attention of SMT that patients were smoking in the stairwell of Ward 27 Ulster, despite staff identifying and encouraging the use of alternative smoking areas. This practice has continued as evidenced during this inspection with the result that the flooring was damaged with cigarette burns and the area was not clean. This was discussed with the ward manager. Assurances were received from the ward manager that additional resource would be secured from patient experience services to better manage the cleanliness of the area and staff would encourage patients to use the designated smoking areas.

The fire risk assessments (FRA) for all three wards were available and Personal Emergency Evacuations Plans (PEEPs) were in place for most patients. Confirmation was received following the inspection that the outstanding PEEPS had been completed. On Ward 27 Ulster FRA action plan an action to address staff training was noted. See section 5.2.11 of the report in relation to mandatory training.

There was variation in the standard of environmental cleanliness across the three wards; the cleanliness of Ward 27 Downshire and Downe acute was of a good standard however Ward 27 Ulster required improvement. This was shared with the SMT during feedback. It was recommended that this deficit is addressed through provision of additional cleaning resource. An area for improvement has been made in relation to IPC.

There was an inconsistent approach to the completion of Ligature Risk Assessments (LRA) across each of the three wards. Ward 27 Ulster and Ward 27 Downshire did not have a completed LRA available for review. This was discussed with nurses in charge of the wards immediately and SMT during feedback. An area for improvement has been made in relation to ligature risk assessments.

During a walk round of the environment in Ward 27 Ulster a number of ligature risks were identified which exposed patients to risk. These risks were highlighted to the ward manager and prompt action was taken. Ligature risks were mitigated for patients, where necessary, through the implementation of 1:1 and general observations.

The Trust must complete a review of the LRA to ensure consistency across all three wards and include the additional ligature risks identified. Assurances were provided by SMT that action would be taken to address the ligature risks and the SMT were asked to submit a completed LRA to RQIA. Updated copies of the Ligature Risk Assessments for Ward 27 Ulster and Ward 27 Downshire were submitted to RQIA post inspection. Revised LRAs were reflective of the ligature risks identified by inspectors.

5.2.3 Adult Safeguarding and Incident Management

ASG arrangements for all three wards were reviewed and found to be well managed. ASG is the term used for actions which prevent harm from taking place and protects adults at risk (where harm has occurred or is likely to occur without intervention).

There is a Designated Adult Protection Officer (DAPO) aligned to all wards within the Trust. ASG processes and contact details for the DAPO were clearly displayed within the staff office and this also included contacts for ASG personnel during out of hours.

A sample of ASG incidents were reviewed. Staff at ward level had good knowledge of what constituted an ASG incident and were aware of the actions to take should an incident occur that met the threshold for an ASG referral to be made. Protection plans were in place and well documented. A file containing the details of ASG referrals, their current status and trends and themes was available to staff.

ASG training across all three wards was not up to date. See section 5.2.11 of the report in relation to mandatory training.

A review of incidents, spanning a six-month period across all three wards, was completed. There were inconsistencies in the application of the HSC Regional Risk Matrix grading with a number of incidents not being correctly graded to reflect the cumulative impact of repeated incidents involving the same patient/s. These inconsistencies have the potential to expose patients to repeated harm and risk. When cross referencing the incident data with the ASG referral information it was noted that a number of ASG incidents had not been recorded on DATIX.

A robust mechanism is not in place for quality assurance of incident management and there were inadequate measures in place to mitigate against recurring incidents. The Trust should review the current arrangements to ensure a robust response to incident management is developed, appropriate audit processes are implemented and regular audit practice undertaken. This was discussed with the SMT at feedback. An area for improvement has been identified in relation to incident management.

5.2.4 Staffing

The staffing arrangements across the three wards was reviewed through analysis of the staffing rotas, discussions with staff, observation of staff on shift and review of the staffing model. Staffing levels were determined using the Telford model, which is a tool to assist staff in defining staffing levels based on patient acuity. The calculations are based on individual patient need and consider levels of support required. This contributes to the delivery of safe and effective patient care.

The staffing challenges being faced by the Trust as a result of the ongoing workforce issues across the health and social care system in Northern Ireland were acknowledged. At the time of the inspection staffing levels were adequate to meet the needs of patients on the days of the inspection.

The majority of patients with a learning disability who are nursed outside of specialist Learning Disability Services require individualised staffing arrangements to meet their needs and keep them safe. There was evidence across the wards that Learning Disability Services had made arrangements for block booked agency staff to carry out enhanced observations for patients with a learning disability. This was positive to note as it enhances continuity of care for patients and enables patients to get to know staff.

Substantive staff employed across all three wards displayed competence to look after patients with a learning disability and were able to identify that their skills were transferable.

Staff in charge of wards did not always have prior knowledge of which agency staff were available on each day. However, agency staff booked by the Learning Disability Services through the Trust Bank Office had systems in place to ensure that agency staff were suitably trained. The communication arrangements in place for the management of staff to support patients with learning disability requires review.

Following a number of incidents on Ward 27 Ulster, the management team had been proactive in supporting staff by ensuring Psychology staff were available, to provide reflective practice sessions.

5.2.5 Physical Health

A sample of electronic patient records (MAXIMS), evidenced the physical health care needs of patients were appropriately assessed on admission, regularly monitored and care plans were in place for patients with long-term health conditions. Blood monitoring regimes were in place on all three wards with evidence of follow up as required.

Access to medical staff was timely and there were clear arrangements for patients to access their identified Consultant Psychiatrist. Weekly multi-disciplinary team (MDT) meetings were held for each patient on the ward.

The Malnutrition Universal Screening Tool (MUST), used to identify adults who are malnourished and/or at risk of malnutrition (undernutrition) was also in use for all patients nursed on the ward.

Patients were appropriately referred and assessed by Speech and Language Therapy (SLT) and individualised dysphagia guidelines were in place where required. These were consistent with the International Dysphagia Diet Standardisation Initiative (IDDSI) and available to all staff including domestic service staff.

Dysphagia/Swallow Awareness training across all three wards was not up to date despite choking incidents occurring. The importance of maintaining up to date training for staff was discussed with the manager/nurse in charge and highlighted as a matter of priority. See section 5.2.11 of the report in relation to mandatory training.

Braden scales (in relation to care of pressure areas) and National Early Warning Score a tool used for identifying acutely ill patients were in place. Records relating to pressure area care and wound management were satisfactory and appropriate referrals were made to the Tissue Viability Nurse.

Trust should implement the twelve key recommendations in relation to the quality of physical healthcare delivered in mental health inpatient settings which were issued by the Department of Health (DoH) in February 2023. Acknowledging that poor mental health can often be accompanied by a deterioration in physical health, these recommendations which have been drawn from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) *Report: A Picture of Health? Bridging The Gap Between Physical And Mental HealthCare In Mental Health Hospitals*, aim to improve the quality of physical healthcare in mental health inpatient settings. This was discussed with SMT during feedback and they advised they are working closely with Strategic Planning and Performance Group (SPPG) to implement the new guidance.

5.2.6 Restrictive Practices

Restrictive practices in place across the three wards included locked doors, levels of enhanced observation of patients and the use of bed rails. All restrictions had been assessed and were found to be proportionate to the risk and were regularly reviewed at MDT meetings.

The use of bed rails was risk assessed to ensure appropriate and safe usage.

Enhanced observation records highlighted that medical staff did not review all patients daily as directed by the Trust policy. Patients who had prescribed enhanced observations had a care plan in place. The Trust should strengthen its governance arrangements in relation to the oversight of enhanced observations to include the frequency of medical review and to ensure individual restrictions through observations continue to be necessary.

Staff in Downe Acute were not able to describe appropriate actions to take if voluntary patients requested to leave the ward and were deemed not safe to do so. There was no evidence of care plans in place that indicated that a patient's human rights had been considered in relation to the locked doors. An area for improvement in relation to locked door restrictions has been identified.

Discussions took place around the *Regional Policy on the use of Restrictive Practices in Health and Social Care Settings and regional operational procedure for the use of Seclusion Northern Ireland March 2023* into existing policies. SMT gave assurances at feedback that the Trust is working closely with the SPPG to embed this new policy into the existing policy and procedure.

5.2.7 Patient Experience

Staff were courteous, respectful and providing care and treatment in a dignified manner. Staff spoken with were knowledgeable of the patients' care and treatment needs.

Patients on prescribed enhanced observations appeared relaxed.

Some patients told us that they had mixed views on selection of meals and the menu can be quite repetitive. It is recommended the Trust review patient satisfaction with meal choices. This was highlighted to the Trust during feedback.

Relative feedback is a valued part of our inspection process. Contact information for relatives was requested but not all wards provide this information. This is disappointing as relatives are often an important advocate for the patient and their views and experiences could not be fully reflected during this inspection. This matter was highlighted with SMT during inspection feedback. The Trust must ensure that there are systems in place to enable RQIA to make contact with relatives as part of the inspection process.

Inspectors were however able to speak with one relative during their visit at Ward 27 Downshire and a second relative was spoken with via a telephone call following the inspection of this ward. One relative spoke highly of the staff and the care provided. They reported that staff maintain good contact, they provide information following incidents however they would like more two-way communication when they visit the ward. This feedback was shared with the nurse in charge following the inspection. Another relative informed us that they felt that if they had any concerns they would be acted upon by staff and that Ward 27 Downshire was a great place but they conveyed some concerns about the reduction of beds on one ward. These views were shared with SMT during feedback.

Staff from different disciplines engaged with patients in a caring manner and there were some examples of patient and staff interactions which displayed warmth, compassion and a therapeutic relationship.

Patient peer advocates were available and positioned centrally on each of the three wards to ensure they were accessible to all patients. Information and leaflets were available on noticeboards for patients. Patient peer advocates informed us that they support patients with any concerns/complaints they have. They also help all patients by signposting these concerns/issues to the appropriate department.

Patient peer advocates did not highlight any concerns in relation care and treatment being delivered to any patient being nursed on any of the wards visited.

The patient dining experience was well coordinated and there was a peaceful and relaxed ambience. Dining room tables had a variety of condiments available for patients. All patients exercised choice as to where and how they dined.

All patients were able to discuss their care, treatment and levels of observations. No concerns were raised.

5.2.8 Patient Flow

As stated previously, RQIA received a number of Early Alerts relating to admission of patients with a learning disability to acute beds thus limiting the number of beds available to admit patients with a mental illness. At the time of the inspection six patients with a mental health diagnosis were waiting on an acute bed and six patients with a learning disability were accommodated across the three wards.

The Trust has its own designated bed management team for the acute mental health inpatient wards. This team liaises with ward staff in relation to bed occupancy and discharge arrangements. However, the ward managers, nurses in charge and bed management team informed us that they have no role or input to the discharge or resettlement of patients with a learning disability.

It is recommended that a co-ordinated approach is adopted with Services for people with a Learning Disability to monitor bed availability in the region. This will ensure patients with a learning disability are discharged to an appropriate bed within learning disability settings and make available beds for patients with a mental illness. This was discussed with SMT at feedback. An area for improvement has been identified in relation to patient flow.

Review of records evidenced visits by community learning disability service staff to review patients with a learning disability whilst they are on acute mental health wards.

5.2.9 Medicines Management

Prescribed and administered medicines are documented on patients' kardexes. A sample of medication kardexes highlighted the administration of medicines prescribed on a 'when required' basis was infrequent and only after all other distraction techniques had been unsuccessful. First line and second line medications were clearly recorded. Rapid tranquilisation was not required at the time of this inspection.

Clinical rooms across all wards were locked in accordance with policy and procedure. It was noted that the clinical room of Ward 27 Ulster had empty medication packages and patient leaflets on the floor and would benefit from a more robust cleaning regime. The ward manager must ensure that the treatment room is routinely cleaned and maintained to a clinical standard. This was discussed with the ward manager and SMT at feedback. As discussed in section 5.2.2 of the report an area for improvement in relation to IPC has been made.

5.2.10 Mental Health

Patients detained under the MHO have a number of legal forms which require completion by appropriate persons. There was good practice in relation to oversight of the MHO detention forms for each patient detained. A summary sheet was in place for each patient and clearly identified when their next form review was due.

Review of electronic records in relation to mental health evidenced entries for all patients, for example, risk assessments, care plans, daily records completed by staff and records of weekly MDT involvement and review. Care records were well completed and organised. There were entries from all members of the MDT and progress notes were completed contemporaneously.

An Occupational Therapy (OT) weekly ward based planner was displayed and patients participated in both morning and afternoon sessions. These sessions were open to all patients, should they wish to attend.

5.2.11 Governance

Governance arrangements were assessed at ward level through a review of meeting minutes, audits and discussions with the ward managers, staff, ASG lead and there were some good oversight arrangements in place. There was evidence of a range of audits taking place, NEWS, skin bundles, falls records management, carer involvement, person centred care, 30 minute checks and individual notes with actions and learning identified.

The Trust acknowledged that the acute mental health wards within the three locations were not intended to meet the acute care and treatment needs of patients with a learning disability. However, the patients could not be accommodated in an alternative environment more suited to meet their needs. There was limited evidence of effective collaborative working between Mental Health and Learning Disability SMTs. This had the potential to impact negatively on patient care and timely discharge. A robust mechanism for the oversight of patient care and treatment is required to ensure that patients with a learning disability continue to receive safe and effective care within an acute mental health environment. See section 5.2.8 in relation to patient flow.

Staff use a daily handover record completed for both day and night duty. This was an effective communication method.

Staff informed the inspection team that members of the SMT were regularly visible on the wards and were very supportive to staff, however, we could not find formal evidence of this or assurances that the visits were focused on quality improvement audits. An area for improvement has been identified to strengthen existing governance and leadership arrangements.

The mandatory training records for all three wards were not up to date. This included, ASG, Fire Safety, Dysphagia/Swallow Awareness and Safety Interventions and other relevant training. We were advised by SMT at feedback that steps had been taken since the inspection to address some of the deficits in mandatory training. An area for improvement has been identified.

Complaints received since the last inspection were managed in line with Trust policy.

Improvement is required in the mechanisms for supporting staff. There was no evidence of routine supervision, infrequent team meetings and appraisals were not up to date. This means that staff cannot be appropriately supported to learn and develop which is particularly important at times of system pressures. The Trust should ensure that there are robust systems to support staff through adherence to the relevant Trust policies.

Key Performance Indicators (KPI) had been displayed on ward noticeboards. However, they were last updated in 2017. This information should be updated and replaced with up to date KPIs to inform staff, patients and visitors of how the ward is performing.

We were unable to gain a copy of the operational policy during the inspection to determine if it was inclusive of patients with a learning disability. We recommend that the Trust revisit this policy and ensure that it is robust in its contents to meet the needs of patients with a learning disability nursed on acute mental health wards.

6.0 Quality Improvement Plan/Areas for Improvement

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

	Standards
Total number of Areas for Improvement	12*

* the total number of areas for improvement includes one that has been stated for a second time and four which are carried forward for review at the next inspection.

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

Quality Improvement Plan	
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)	
Area for improvement 1 **Ref:** Standard 4.1 Criteria: 4.3(b) **Stated:** First time **To be completed by:** Immediately	The South Eastern Health and Social Care Trust should ensure Datix incident forms are consistently completed for over occupancy, as per Trust policy to enable data correlation.
	Action required to ensure compliance with this Standard was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 5.1
Area for improvement 2 **Ref:** Standard 5.1 Criteria: 5.3.1(f) **Stated:** First time **To be completed by:** 29 June 2021	The South Eastern Health and Social Care Trust must ensure there is an assurance mechanism in place to monitor environmental and mattress audits, and that items arising from the associated action plans have been completed in a timely manner.
	Action required to ensure compliance with this Standard was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 5.1
Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3.1(f) **Stated:** First time **To be completed by:** Immediately	The South Eastern Health and Social Care Trust must ensure compliance with regional guidance on the use of plastic bags in Mental Health (MH) inpatient wards as noted in LL-SAI-2018-033(MH) and Learning Matters Quality 2020 Issue 8, September 2018. The Trust need to have robust assurance mechanisms in place to ensure compliance with the guidance.
	Action required to ensure compliance with this Standard was not reviewed as part of this inspection and this is carried forward to the next inspection Ref: 5.1

Area for improvement 4 **Ref:** Standard 5.1 Criteria: 5.3.1(c) **Stated:** First time **To be completed by:** 29 June 2021	The South Eastern Health and Social Care Trust should review the CCTV policy to ensure patient's privacy, dignity and human rights are upheld when contingency beds are placed in undesignated sleeping areas where CCTV cameras are used.
	Action required to ensure compliance with this Standard was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 5.1
Area for improvement 5 **Ref:** Standard 4.1 Criteria: 4.3 (i) **Stated:** Second time **To be completed by:** Immediate and ongoing	The South Eastern Health and Social Care Trust must review Fire Risk Assessments which should consider increased risks when wards are over occupied regarding the additional number of patients and use of and position of contingency bed placement to ensure fire exits are accessible and unobstructed. Ref 5.1
	Response by registered person detailing the actions taken: All Fire Risk Assessments have been updated to identify the consistent location of contingency beds, thus ensuring that fire exits are not obstructed. Staff are made aware of the use of contingency beds through safety briefings and handovers.The positioning of contingency bed is a standing agenda item on ward meetings.
Area for improvement 6 **Ref:** Standard 5.1 **Criteria:** 5.3.1 (f) **Stated:** First time **To be completed by:** 30 September 2023	The South Eastern Health and Social Care Trust must ensure ligature risk assessments reflect all identified ligature risks and are kept up to date including action plans and clear timescales. Ref: 5.2.2
	Response by registered person detailing the actions taken: All wards have had their ligature risk assessments updated. In addition, senior managers have been conducting Environmental Ligature Audits, which have been completed in the Downe Acute Ward and Ward 27 UHD and Lagan Valley Ward 12.. Risks and mitigating factors are identified. There is a plan to complete the audit in Ward 27 Downshire by 30 September.
Area for improvement 7 **Ref:** Standard 5.1 **Criteria:** 5.3.1 (f) **Stated:** First time	The South Eastern Health and Social Care Trust must ensure that the general cleanliness of ward environments and their clinical areas are of an acceptable standard. Ref: 5.2.2 and 5.2.9

To be completed by: Immediate and ongoing	**Response by registered person detailing the actions taken**: A meeting with the Patient Experience Team has taken place. The needs of the individual wards have been identified and there has been an enhanced cleaning schedule agreed. Notices have been placed on the doors leading to the stairs advising patients not to smoke in the stairwells.Ward staff have been reminded to monitor these areas during the 30 min checks and to advise patients of the smoking policy. Night staff have been particularly tasked with conducting a general walk around and declutter. Ward cleanliness has been added as a standing agenda item to ward meetings.

Area for improvement 8 **Ref:** Standard 5.1 **Criteria:** 5.3.2 (c) **Stated:** First time **To be completed by:** 30 September 2023	The South Eastern Health and Social Care Trust should ensure a robust response to incident management is developed. Ref: 5.2.3
	Response by registered person detailing the actions taken: A monthly inpatient governance report is produced providing an analysis of incidents, thereby enabling the identification of patterns, trends, learning and individuals who feature in repeated incident reports. The service's Governance Team will be delivering training to staff in the use of Datix.The Governance Team also produce regular 'Top Tip' guidance to support staff in comprehensively reporting incidents. Additional resource has been identified to improve incident reviews and approvals.
Area for improvement 9 **Ref:** Standard 5.1 **Criteria:** 5.3.1 (a) (c) **Stated:** First time **To be completed by:** 30 September 2023	The South Eastern Health and Social Care Trust must ensure that all voluntary patients on Downe Acute ward have care plans in place in relation to locked doors. Ref: 5.2.6
	Response by registered person detailing the actions taken: Nursing care plans have been updated to ensure best practice in relation to caring for patients in an environment with controlled entry and exit points.In implementing the care plans, Nursing Staff ensure that article 5 of the Human rights Act, The Right to Liberty, is considered for all patients. This is discussed with patients on admission. Voluntary patients are free to leave the ward unless a risk is identifed at that time. Staff are availing of training on the application of the MHO (1986).
Area for improvement 10 **Ref:** Standard 4.1 and 5.1 **Criteria:** 4.3, 5.3.1 **Stated:** First time **To be completed by:** 30 September 2023	The South Eastern Health and Social Care Trust must review governance oversight arrangements for all wards in relation to the environmental walk around. Ref: 5.2.11
	Response by registered person detailing the actions taken: A formal report of a visit by senior manangers is completed. This report outlines the purpose of the visit, any identified issues and actions to be taken as a result. Copies of these will be avaialble in wards.

Area for improvement 11 **Ref:** Standard 4.1 **Criteria:** 4.3 (m) **Stated:** First time **To be completed by:** 31 December 2023	The South Eastern Health and Social Care Trust must ensure that all staff have completed all mandatory training appropriate to their roles and responsibilities. Ref: 5.2.11
	Response by registered person detailing the actions taken: A review of mandatory training has been completed by the Workforce Development Working Group in conjunction with representatives from the Trust's Central Nursing Team. This training matrix has been divided into role specific requirements. All Staff are aware of their training needs. This will be reflected in supervision and appraisals. Work is in progress with Central Nursing to have all training registered on Healthroster, which will facilitate audits to identify training gaps. Training will be impacted due to the development and roll-out of encompass until early 2024.
Area for improvement 12 **Ref:** Standard 8.1 **Criteria:** 8.3 (i) **Stated:** First time **To be completed by:** Immediate and ongoing	The South Eastern Health and Social Care Trust must ensure that the bed management team within acute mental health liaises regularly with Services for people with a Learning Disability to monitor bed availability in the region. Ref: 5.2.8
	Response by registered person detailing the actions taken: Representatives from Senior Management from within both Adult Mental Health Services and Disability Services meet on Tuesday mornings to discuss the needs of each patient with a learning disability who are currently admitted to an adult mental health bed. Patient Flow is also represented at these meetings. Patient Flow attend a Daily Huddle at 4pm with all Trusts where the pressures and bed availability is discussed and clarified.

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