The Regulation and Quality Improvement Authority

Inspection Report

05 August – 10 September 2024

South Eastern Health & Social Care Trust
Inpatient Mental Health Services

Ulster Hospital
Trust Headquarters 1st Floor
Upper Newtownards Road
Dundonald
Belfast
BT16 1RH

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	**Responsible Person:** Ms Roisin Coulter, Chief Executive Officer, South Eastern Health and Social Care Trust
Person in charge at the time of inspection: Rachel Gibbs, Director of Adult Services and Prison Healthcare, South Eastern Health and Social Care Trust	**Number of registered places:** Downe Acute: 25 Ward 12 Lagan Valley: 21 Ward 27 Ulster: 24 Ward 27 PICU: 6
Categories of care: Mental Health (MH) Acute Admission Psychiatric Intensive Care	**Number of beds occupied on the day of this inspection:** Downe Acute: 24 Ward 12 Lagan Valley: 24 Ward 27 Ulster: 26 Ward 27 PICU: 7

Brief description of the accommodation/how the service operates:

The South Eastern Health and Social Trust (the Trust) inpatient mental health services are provided across three sites and consist of three mental health acute admission wards and a psychiatric intensive care unit (PICU). These wards provide assessment and treatment for people aged between 18 and 65 and are mixed gender.

With the exception of PICU all patients are admitted either on a voluntary basis or in accordance with The Mental Health (Northern Ireland) Order 1986 (MHO). All patients admitted to PICU should be detained in accordance with the MHO.

Downe Acute has single occupancy ensuite bedrooms and is situated on the ground floor of Downe Hospital.

Ward 12 Lagan Valley has a mix of single occupancy rooms and dormitory style sleeping arrangements and is situated within the grounds of Lagan Valley Hospital.

Ward 27 Ulster has a mix of single occupancy rooms and dormitory style sleeping arrangements and is situated within the grounds of the Ulster Hospital. Single rooms have ensuite bathrooms.

Ward 27 PICU has single occupancy ensuite bedrooms and is situated within the grounds of Downshire Hospital.

2.0 Inspection summary

An unannounced inspection to the South Eastern Health and Social Care Trust's Inpatient Mental Health services commenced on 05 August 2024, and concluded with feedback to the Trust on 10 September 2024. The inspection team comprised three care inspectors, an assistant director, an estates inspector, RQIA's sessional consultant psychiatrist and administrative support.

Prior to the inspection RQIA received intelligence regarding; concerns in respect to the oversight of adult safeguarding (ASG) incidents, occupancy pressures; and the standard of one of the four ward environments. These areas were reviewed during the course of the inspection.

The inspection focused on the following ten themes; environment; adult safeguarding and incident management; staffing; patient experience; mental health; physical health; restrictive practices; patient flow; medicines management; and governance. Each theme was assessed to determine safe and effective delivery of care and treatment.

Since November 2023 the Trust has been implementing Encompass, a Health and Social Care programme that creates a single digital care record for every citizen in Northern Ireland. The introduction of Encompass is intended to support continuity of care and communication between services, improving accessibility of patient care documentation. As the first of five Trusts across Northern Ireland to introduce Encompass, the Trust has encountered some challenges, these are further referenced in the body of this report.

Good practice was identified in the delivery of bespoke care and treatment to patients who had an intellectual disability, handover documentation, and the development of preventative and proactive strategies to minimise the use of restrictive practices.

Staff were observed to be compassionate in their approach to patients in their care and care and treatment delivered to patients was person centred.

ASG incidents were managed and addressed in accordance with the Northern Ireland Adult Safeguarding Partnership, Adult Safeguarding Operational Procedures, September 2016.

The inspection identified concerns regarding incident management; restrictive practices; and governance and leadership oversight within the Inpatient Mental Health Services.

Whistleblowing information received during the inspection identified issues with staff morale and the ward environment. The concerns raised correlated with the findings of this inspection in terms of environment and staff morale. Whilst the Trust had taken some action to address the concerns raised, more work is required.

The Trust's oversight of incident management requires strengthening. The inspection identified an inconsistent approach to incident reporting and management of incidents across the Trust's Inpatient Mental Health Services. The system in place for sharing learning from incidents was not robust and any learning from incidents did not inform environmental risk assessments or extant action plans.

The use of seclusion was not in keeping with the Regional Operational Procedure for the Use of Seclusion as outlined within the Department of Health (DoH) Regional Policy on the use of Restrictive Practices in Health and Social Care Settings, November 2023 (Regional Policy). A number of concerns were identified in relation to the seclusion room environment, availability of seclusion records and quality of recordings. These concerns did not provide assurance that there was effective oversight of seclusion to ensure patient privacy, dignity and comfort were maintained.

Not all ward environments were conducive to the delivery of safe, therapeutic and compassionate care. While the Trust had made attempts to improve existing environments, there was limited space to facilitate visiting and 1:1 therapeutic work in some areas; showering facilities did not meet the needs of the patient population, and gender considerations were not always evident. The level of cleanliness and delays in addressing maintenance issues in two wards raised concern.

A business proposal for a new build inpatient service was submitted to the Strategic Planning and Performance Group (SPPG) during early 2023. Acknowledging the business proposal, there remains concern that the ward environments will further deteriorate. RQIA recommends the Trust identify an alternative interim option which would better suit the needs of this patient group and meet the required standards for inpatient mental health services.

Based on the findings in respect of incident management, seclusion practices and ward environments, the inspection concluded that the governance and leadership oversight system in place was not sufficiently robust.

RQIA invited Senior Trust Representatives to attend a Serious Concerns meeting on 24 October 2024 and to provide RQIA with the Trust's action plan detailing how the Trust intended to address the concerns highlighted.

Following consideration of the information provided by the Trust, RQIA determined the Serious Concerns would be upheld. A level of assurance was provided within a revised action plan submitted by the Trust. RQIA will continue to monitor the Trust's progress against the actions detailed within the action plan and through a future inspection of the service.

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 to damage or 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 Trust 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 discharge arrangements and governance documentation.

4.0 What people told us about the service

We spoke with a number of patients, relatives and staff and asked for their views. Sixteen completed questionnaires were received from patients.

Most patients spoke positively about the care and treatment they received. However, some patients raised concerns regarding the ward environment in Ward 12 Lagan Valley and Ward 27 Ulster, specifically regarding lack of privacy and the condition of non-gender specific showering facilities.

Staff in most wards spoke positively about their teams and were supported by ward management. Staff raised concern regarding the limited space available in Wards 12 and 27 to facilitate patient visits and therapeutic work.

Staff from two wards reported lack of supervision and team meetings and dissatisfaction with how team concerns were addressed. This was brought to the attention of Senior Management (SMT) during feedback and has been included within the Trust's action plan post inspection.

Most relatives/carers spoke positively about the care and treatment their family member received. Many said they received regular communication from different members of the multi-disciplinary team (MDT) and that the staff treated their relative with compassion and empathy.

5.0 The inspection

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

The last inspection of the Trust's Inpatient Mental Health Services was undertaken on 24 April 2023. Ward 12 Lagan Valley was not included in the April 2023 inspection. The last inspection of Ward 12 Lagan Valley was undertaken on 20 April 2021.

Areas for improvement from the last inspection on 24 April 2023		
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 4.1	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.	**Not met**

Criteria: 4.3(b) **Stated:** First time	**Action taken as confirmed during the inspection**: Practice across the Inpatient Mental Health Services with regard to Datix incident reporting of over occupancy was not consistent. This AFI has been assessed as not met and will be stated a second time. See section 5.2.8	
Area for Improvement 2 **Ref:** Standard 4.1 Criteria: 4.3(i) **Stated:** First time	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. See section 5.2.10	**Partially met**
	Action taken as confirmed during the inspection: There was evidence of mattress audits completed across the service. However, there was no evidence of regular environmental audits being undertaken. This AFI has been assessed as partially met, it will be re-worded to take account of progress made by the Trust and stated a second time. See section 5.2.1 & 5.2.10	
Area for Improvement 3 **Ref:** Standard 5.1 Criteria: 5.3.1 (f) **Stated:** First time	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.	**Not met**
	Action taken as confirmed during the inspection: Lockable bins were in place across all wards restricting patient access to plastic bags. However, during the inspection bins with	

	accessible plastic bags were observed in patient areas of three wards. This AFI has been assessed as not met and will be stated a second time. See section 5.2.1	
Area for improvement 4 **Ref:** Standard 5.1 Criteria: 5.3.1(c) **Stated:** First time	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.	**Not met**
	Action taken as confirmed during the inspection: The Trust CCTV policy was reviewed 22 November 2022, however it did not evidence consideration given to the use of contingency spaces where CCTV is in place. This AFI has been assessed as not met and will be stated a second time. See section 5.2.1	
Area for Improvement 5 **Ref:** Standard 4.1 Criteria: 4.3 (i) **Stated:** Second time	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.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.1	
Area for Improvement 6 **Ref:** Standard 5.1 Criteria: 5.3.1 (f) **Stated:** First time	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.	**Not met**
	Action taken as confirmed during the inspection:	

	Ligature risk assessments did not reflect all ligature risks within the ward environment nor was there evidence that an assessment of the environment had been undertaken at least annually. This AFI has been assessed as not met and will be subsumed into a new AFI to consider additional concerns identified in relation to Ligature risk assessments. See section 5.2.1	
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.	**Partially met**
	Action taken as confirmed during the inspection: Some improvement was evidenced within one ward, and clinical areas across all four wards were of an acceptable standard. However, the general cleanliness of two ward environments remained below standard. This AFI has been assessed as partially met, it will be reworded to take account of progress made by the Trust and stated a second time. See section 5.2.1	
Area for Improvement 8 **Ref:** Standard 5.1 Criteria: 5.3.2 (c) **Stated:** First time	The South Eastern Health and Social Care Trust should ensure a robust response to incident management is developed.	**Not met**
	Action taken as confirmed during the inspection: Concerns were identified with regard to the governance and oversight of incident management. This AFI has been assessed as not met and will be stated second time. See section 5.2.2	

Area for Improvement 9 **Ref:** Standard 5.1 Criteria: 5.3.1 (a) (c) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.7	
Area for Improvement 10 **Ref:** Standard 4.1 and 5.1 Criteria: 4.3, 5.3.1 (f) **Stated:** First time	The South Eastern Health and Social Care Trust must review governance oversight arrangements for all wards in relation to the environmental walk around.	**Not met**
	Action taken as confirmed during the inspection: There was limited evidence of environmental walk around being undertaken by Senior Management across the Service. This AFI has been assessed as not met and will be stated a second time. See section 5.2.10	
Area for Improvement 11 **Ref:** Standard 4.1 Criteria: 4.3 (m) **Stated:** First time	The South Eastern Health and Social Care Trust must ensure that all staff have completed all mandatory training appropriate to their roles and responsibilities.	**Not met**
	Action taken as confirmed during the inspection: Records reviewed evidenced low compliance with regard to Infection prevention control, Mental Capacity Act, Ligature rescue and Fire drill training. This AFI has not been met and will be stated a second time. See section 5.2.3	

Area for Improvement 12 **Ref:** Standard 8.1 Criteria: 8.3 (i) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.8	

5.2 Inspection findings

5.2.1 Environment

The inspection sought to assess the ward environments against the Royal College of Psychiatrists Standards for Acute Inpatient Services for Working Age Adults, 8th Edition, May 2022, to determine if they were conducive to the delivery of safe, therapeutic and compassionate care. Two of the four ward environments were assessed as falling below these standards.

Ward 12 Lagan Valley and Ward 27 Ulster had limited space available to facilitate quiet areas for visiting and therapeutic 1:1 work with patients. Designated dining areas were not big enough to allow patients to eat in comfort and encourage social interaction.

Showering facilities were insufficient to meets the needs of the patient population and gender considerations were not in place in Ward 12 Lagan Valley. Previous inspection findings resulted in an AFI being identified in relation to the cleanliness of ward environments and their clinical areas. Clinical areas were maintained to an appropriate standard, however shared areas within Ward 12 Lagan Valley and Ward 27 Ulster were not. The AFI has been assessed as partially met and will be stated a second time.

Ward 12 Lagan Valley and Ward 27 Ulster were located on the first floor of their respective buildings, with an outdoor space located on the ground floor.

Patients continued to smoke in the ward fire exit corridors, bathrooms and sleeping areas, this concern was identified during the previous two inspections. Smoking in the ward environments areas presents risk to safety, health and wellbeing of both patients and staff. The Trust need to expedite plans to address and manage this risk. A review of both Ward 12 Lagan Valley and Ward 27 Ulster environments is required and an interim solution considered to provide assurances that both wards are conducive to the delivery of safe, therapeutic and compassionate care.

While Fire Risk Assessments (FRA) were reviewed within the last year, they did not fully address the risk presented by patients smoking in the wards. The Trust's approach to managing this risk and the supports available to patients to adhere to the non-smoking policy, were not consistently applied across the service. FRA's did not evidence actions taken to address identified risks. An AFI has been identified in regard to the Trust's oversight of Fire Risk Assessments.

Personal Emergency Evacuation Plans (PEEPs), which inform staff of the level of assistance a patient needs to safely evacuate in an emergency, were in place across the service. It is recommended that the Trust consider developing PEEPs for patients who may require assistance due to their presenting mental health needs or cognitive ability.

Ligature Risk Assessment's (LRA) identify ligature anchor points which could be used by patients to harm themselves and include the actions and mitigations in place to manage the risk appropriately. LRAs available in each ward did not include all ligature risks and there was limited evidence of annual assessment of the ward environment. Risks identified during the inspection were shared with the Ward manager or nurse in charge and action was taken to increase staff awareness. The AFI identified following the previous inspection was assessed as not met and has been subsumed into a new AFI to reflect the additional concerns identified during this inspection.

Following RQIA's April 2021 inspection the Trust was required to put in place a robust assurance mechanism to ensure compliance with the regional guidance on the use of plastic bags in mental health inpatient units. Whilst lockable bins were in place across the service to restrict patient access to plastic bags, additional bins with accessible plastic bags were observed in patient areas in three of the four wards. This patient safety risk was raised with the respective ward managers and the bins were immediately removed. The AFI from April 2021 has been assessed as not met and has been stated for a second time.

Bed pressures necessitated patients to be accommodated in contingency spaces which would normally be used as day areas. The operation of CCTV in these areas impacts patient comfort and privacy and was identified as an AFI following RQIA's April 2021 inspection. The Trust's review of the CCTV policy in November 2022, did not consider the impact of CCTV operating in contingency spaces where patients continued to be accommodated. Measures in place to conceal the CCTV lens were not a sufficiently robust mitigation to ensure patient privacy, dignity and human rights are upheld. This AFI has been assessed as not met and has been stated for a second time.

5.2.2 Adult Safeguarding and Incident Management

Adult Safeguarding (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). ASG arrangements reviewed were found to be managed in accordance with the Northern Ireland Adult Safeguarding Partnership, Adult Safeguarding Operational Procedures, September 2016.

The Trust's Inpatient Mental Health Service had a Designated Adult Protection Officer (DAPO) aligned to provide support and guidance to staff as required. ASG processes and contact details for the DAPO and Adult Protection Gateway Team (APGT) were displayed in staff offices in each ward. Staff at ward level demonstrated knowledge and understanding of the ASG process, including what actions to take should an incident occur that met the threshold for an ASG referral. Staff compliance of ASG training was 87.5%.

ASG documentation was maintained at ward level. Staff were aware of ASG referrals made, protection plans in place and investigations that were ongoing. Senior management reported challenges in maintaining oversight of ASG processes since the implementation of Encompass. The Trust should consider implementing interim measures to maintain SMT oversight of ASG processes while the Encompass issues are resolved. An AFI has been identified in relation to SMT oversight of the ASG process.

A review of 283 DATIX incidents, spanning a six-week period was completed (DATIX is the Trusts electronic information system for recording incidents).

The reporting, grading and escalation of incidents was inconsistent and a significant number of incidents were ungraded within two of the four wards. Incidents were not reviewed or approved in a timely manner by Ward and Senior level management. The process in place for sharing learning from incidents was not sufficiently robust, and learning from incidents did not inform environmental risk assessments or extant action plans.

Three fire setting incidents had occurred in the service within the eight-month period leading up to the inspection. There was limited evidence to indicate the Trust considered reporting these incidents in line with the Health and Social Care Board, Procedure for the Reporting and Follow up of Serious Adverse Incidents, November 2016. Additionally, there was limited evidence to validate learning had been identified and adequate mitigations implemented to reduce the risk of similar incidents occurring, including review of the FRA.

The previous inspection established the Trust did not have a robust mechanism in place to quality assure incident reporting / recording and there were inadequate measures in place to mitigate against recurring incidents. An AFI from the previous inspection was assessed as not met and has been stated a second time.

5.2.3 Staffing

All inpatient wards are required to have a mechanism for responding to low/unsafe staffing levels, when they fall below a minimum agreed level. Staffing levels were determined using the Telford model, a tool to assist staff in defining appropriate staffing levels based on patient acuity. The Trust aimed to achieve the minimum safe staffing level for every shift, however this was not always possible due to staffing vacancies. The practice of booking Trust bank staff and agency staff in advance was in place to maintain safe staffing levels across the wards.

Each ward operated a multi-disciplinary team (MDT) approach to care and treatment including; nursing, social work, occupational therapy, psychiatry, medical and psychology staff. Reported vacancies across disciplines impacted on the Trust's capacity to implement a consistent MDT approach across the Service. Patients in one ward had not had access to an occupational therapy (OT) service for a period of three years and some patients had been under the care of several Psychiatrists due to reliance on locum cover. Efforts to improve recruitment across disciplines including Psychiatry were in place. New OT appointments had been made including the ward which had no access to an OT service for three years.

Mandatory training for all staff was not up to date. Compliance rates for Infection Prevention Control, Ligature rescue, Mental Capacity Act and Fire Drills were low across the service. Previous inspection findings resulted in an AFI being identified in relation to mandatory training. The AFI has been assessed as not met and has been stated a second time.

5.2.4 Patient Experience

Patients should expect to have their meals within a designated dining space that is big enough to allow patients to eat in comfort, where social interaction is encouraged and where staff can engage with and observe patients during mealtimes (Royal College of Psychiatrists Standards for Acute Inpatient Services for Working Age Adults, 8th Edition, May 2022).

While mealtimes were observed to be organised and relaxed in all areas, two wards (Ward 12 Lagan Valley and Ward 27 Ulster), did not have enough seating to accommodate all patients during meal times. Patients raised this as an issue with the inspection team. We were informed the Trust were in the process of acquiring additional seating in the dining area and patients had been informed. An AFI has been identified in regard to ensuring adequate seating provision during meal times.

Mealtimes were co-ordinated in line with the regionally agreed framework 'Mealtimes Matter'. A meal time coordinator oversaw the meal time experience in each ward. Information relating to individualised Recommended Eating Drinking and Swallowing (REDS) was available for patient experience and nursing staff. This offered assurance that patients were receiving the appropriate level within the International Dysphagia Diet Standardisation Initiative (IDDSI).

The food appeared appetising and choice was available to patients who chose their meal option in advance. Alternatives were available if patients did not want to avail of the menu options for that day.

Staff were visible in communal areas across all wards and engaged with patients in a kind and compassionate manner. Patients appeared comfortable in the company of staff, including patients who had enhanced observations prescribed.

While the Trust had commenced the rollout of the Safe Wards initiative which focuses on reducing conflict and containment within mental health inpatient services, more needs to be done to offer patients purposeful activity. The availability of meaningful activity was limited across the service and staff and patients highlighted a reliance upon OT staff to coordinate and deliver activities.

Each ward displayed literature of independent advocacy services available to patients.

Information available to patients varied across the Service. Some wards provided a wide range of information including, ward booklet; advocacy; recovery college; mental health literature; and voluntary services available in the community. It is recommended the Trust ensure information made available to patients is consistent across all areas of the service.

5.2.5 Mental Health

Patient documentation evidenced individualised care and treatment arrangements were in place to meet the specific needs of the patient with regular MDT review.

Bespoke care and treatment was delivered to individuals with Intellectual Disabilities, with support provided by the community learning disability team if assessed as required. Ward staff demonstrated sound knowledge and understanding of the patients' needs and how to address these appropriately.

Patients and staff placed great value on the shared psychology resource across the service. In addition, some nursing staff had undertaken Cognitive Behaviour Therapy (CBT) and Eye Movement De-sensitisation and Reprocessing (EMDR) training to improve patient access to psychological therapies across the service.

Effective oversight of MHO Prescribed Forms was evidenced for patients who were detained. Over half of patients accommodated at the time of inspection were detained under the MHO for assessment and or treatment.

5.2.6 Physical Health

Patients' were assessed by a Doctor and had a physical health check within 72 hours of admission. Appropriate physical health risk assessments such as Malnutrition Universal Screen Tool (MUST) and National Early Warning Score (NEWS) risk assessments were in place for each patient.

A number of patients had complex physical health care needs. Most patients with physical healthcare needs had received an assessment of their needs and a care plan was in place. A small number of patients did not have a care plan in place to address their physical health needs, this was raised with ward management during the inspection. This matter is further referenced in section 5.2.10.

There was evidence of referral and liaison with other specialities where the patients' needs were beyond the remit of on-site medical staff.

5.2.7 Restrictive Practices

The Regional Policy on the use of Restrictive Practices in Health and Social Care Settings, Department of Health, November 2023 (the Regional Policy), provides the regional framework to integrate best practice in the management of restrictive interventions, restraint and seclusion.

Restrictive practices implemented across the service included locked exit doors; levels of enhanced observations; the use of medicines prescribed on a "when required" basis; the use of physical interventions and; the use of seclusion in PICU.

Preventative and proactive strategies were in place to minimise the use of restrictive practices. Implementation of the Safe Wards initiative will further support the Trust in its efforts to minimise the use of restrictive practices across the acute wards.

Governance oversight of restrictive practice documentation was not sufficiently robust and was inconsistent across the service, for example, ward exit considerations for voluntary patients was inconsistent across the wards and a small number of patients who were prescribed enhanced observations did not have all the required documentation in place. Following escalation to the respective Ward managers all required documentation was put in place for all prescribed enhanced observations.

Seclusion is the confinement of a person in a room or area from which the person is not free to leave and has a significant impact on a patient's human rights. Seclusion practices were not in line with the Mental Health (Northern Ireland) Order 1986 Code of Practice or the Regional Policy. Patient seclusion records were not readily available for inspection and were not completed in line with the recording requirements of the Regional Policy; records evidenced lack of senior management oversight during the use of seclusion and there was no evidence of care planning for patients when seclusion was required.

The Trust must review its seclusion practices to ensure effective SMT oversight of seclusion to include documentation completed in line with the Regional Policy and accessibility of documentation for inspection and review purposes.

The cleanliness and maintenance of the seclusion room was not of an acceptable standard, indicating the room was not ready for use if or when required. Several maintenance issues were identified affecting ventilation, temperature control, lighting, observation and means of two-way communication. This was raised immediately with the Lead Nurse who provided assurance appropriate actions would be taken to address this. Post inspection, during the Serious Concerns meeting, the Trust provided assurances the seclusion room was safe to use.

5.2.8 Patient Flow

The system in place to monitor patient flow within the Service included daily review of data at senior management level. Data was gathered with respect to admission/discharge and length of stay.

All admission requests with the exception of patients admitted under the MHO were managed on a daily basis by Home Treatment Teams and Hospital Liaison service. At the time of inspection there were no patients waiting to be admitted. To support effective decision making, a "bed priority tool" was used to prioritise patients in greatest need. Daily patient flow meetings held to review the admission waiting list and level of priority were considered an effective process to manage bed allocation. The bed management team within the service liaised regularly with Services for people with an Intellectual Disability to monitor bed availability in the region.

Practice across the Service with regard to DATIX incident reporting of over occupancy, as directed by Trust policy, and to enable data correlation, was not consistent. Previous inspection findings resulted in an AFI being identified in relation to DATIX incident reporting of over occupancy. The AFI has been assessed as not met and has been stated a second time.

The Trust's SMT were in the process of reviewing the admission and discharge process for Inpatient Mental Health Services in line with the Regional Bed Management Protocol for Acute Psychiatric Beds, January 2022.

5.2.9 Medicines Management

Prescribed and administered medicines were documented electronically. Review of medication records across the Service identified an inconsistent approach to recording "when required" medications. This has the potential to lead to incorrect administration of "when required" medication as prescribed.

It is recommended the Trust ensure consistent recording of first, second and third line "when required" medications across the Service.

There was evidence of regular prescribing reviews particularly of high dosage anti-psychotic medications. Clozapine and lithium pathways were followed consistently across the four wards.

5.2.10 Governance

Governance arrangements were reviewed through the examination of relevant documentation, discussions with ward managers, lead nurse, clinical services manager, assistant director and the governance and service improvement manager. Inspectors also spoke with members of the MDT.

Handovers were comprehensive, providing staff coming on shift with the appropriate information to address the needs of the patient group in each ward.

Staff meetings had been stood down for a number of months due to pressures, citing over occupancy and staffing pressures. Three wards were found to recommence staff meetings from May 2024. Staff meeting records could be improved to adequately inform staff who are unable to attend meetings.

Most ward level audits had been temporarily suspended across the service to facilitate the implementation of Encompass. This was found to impact the Trust's oversight of patient care and safety; a number of patient care documents were not in place including, locked door care plans for voluntary patients; enhanced observation documentation; and physical health care plans. An AFI has been identified in regard to ward level audits.

The inspection identified inconsistent practices across the Service with respect to, incident management; maintaining the ward environment; adherence to fire safety regulations; and sharing of information with staff. RQIA could not be assured the Trust's governance and leadership oversight of these areas was sufficiently robust.

The Trust must review their Governance systems to ensure they are sufficiently robust to oversee the monitoring of Inpatient Mental Health Services safety and quality and to drive forward improvement.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement (AFI) 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	13*

* the total number of AFIs includes 8 that have been stated for a second time.

Whilst recommendations were made during Feedback to the Trust, AFI were not specifically identified at that time. 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:** Second time **First completed by date:** Immediately **To be completed by:** 10 September 2024	The South Eastern Health and Social Care Trust should ensure DATIX incident forms are completed routinely each time a ward becomes over-occupied, as per Trust policy to enable data correlation. Ref: 5.2.2 (Revised to provide clarity) **Response by registered person detailing the actions taken:** Action Completed The Patient Flow Team oversee and report on occupancy across all wards. They check contingency bed usage daily and complete a new Datix incident each time a contingency space is used to allow better tracking of usage rather than overall occupancy figures as they are not reflective of daily changes. SMT have daily oversight of bedflow data and Datix incidents. The Trust reports Regionally on overoccupancy and Encompass reporting functionality in this area is almost finished validation.

Area for improvement 2 **Ref:** Standard 5.1 Criteria: 5.3.1(f) **Stated:** Second time **First completed by date:** 29 June 2021 **To be completed by:** 10 March 2025	The South Eastern Health and Social Care Trust must ensure there is an assurance mechanism in place to monitor environmental audits, and that items arising from the associated action plans have been completed in a timely manner. Ref: 5.2.1
	Response by registered person detailing the actions taken: The Adult Directorate is currently undergoing restructuring and as part of this process the wider business support for services is being reviewed and improved. The Divisional Business Support Manager is developing a new Facilities Management Team which will include a Facilities Manager who will oversee environmental audits, actions and recommendations, as well as Facilities Support Workers on each ward with set roles and responsibilities to include oversight of environmental audits, escalation and liaison with Support Services to remedy any issues arising in a timely manner. The Facilities Manager will liaise with the Trust Support Services Quality, Training and Performance team to ensure regular C4C environmentral audits are undertaken and dsiplayed appropriately.
Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3.1 (f) **Stated:** Second time **First completed by date:** Immediately **To be completed by:** 10 September 2024	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 a robust assurance mechanism in place to ensure compliance with the guidance. Ref: 5.2.1 (Revised to provide clarity)
	Response by registered person detailing the actions taken: Action Completed As an interim measure plastic bag checks will now form part of the 30 minute Safety Check Flowsheet whereby an Environmental check is completed each 30 minutes alongside Patient safety checks by ward staff. Extra lockable bins have been made available to each ward. In the future facilities support model, regular daily environmental checks using a set checklist has been identified as a role for the pending Facilities Management Team.

Area for improvement 4 **Ref:** Standard 5.1 Criteria: 5.3.1(c) **Stated:** Second time **First completed by date:** 29 June 2021 **To be completed by:** 10 January 2025	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. Ref: 5.2.1
	Response by registered person detailing the actions taken: Local CCTV Policy for Mental Health In-patients is under review the Head Of Service and MH Governance Lead to ensure that there is an SOP for measures to be followed when using contingency spaces in rooms where CCTV is present. As part of this review the HOS is linking with Estates to explore a more formal method of de-activating or covering over CCTV cameras when their use is contraindicated as in above recommendation.
Area for improvement 5 **Ref:** Standard 5.1 Criteria: 5.3.1 (f) **Stated:** First time **To be completed by:** 10 March 2025	The South Eastern Health and Social Care Trust must ensure a risk assessment of ward environments is conducted when required and at least annually of all ligature points. Action plans and mitigations are put in place where risks are identified, and staff are aware of the risk points and their management. All required actions should include timescales for completion and updated to reflect progress made. Ref: 5.2.1
	Response by registered person detailing the actions taken: Standards for Inpatient Wards have been reviewed Regionally as part of the Building Safer Wards Workstream. An audit has been designed to look at ward compliance to the Buliding Safer Wards Standards. This audit reviews the environment and practices including completion of GRA2 reviews. Wards update GRA2s quarterly with oversight at ward manager meetings. An Action Plan for Ligature Improvement Work is in place and a new Ligaure audit tool is now used by core group of ligature assessment staff across Inpatient Wards to ensure consistency of audit and review including appropriate escalation. The role of Facilities manager will support staff to undertake GRAs and ensure all remedial actions are adressed

Area for improvement 6 **Ref:** Standard 5.1 Criteria: 5.3.1 (f) **Stated:** Second time **First completed by date:** Immediate and ongoing **To be completed by:** 10 September 2024	The South Eastern Health and Social Care Trust must ensure that the general cleanliness of ward environments are maintained to an acceptable standard. Ref: 5.2.1
	Response by registered person detailing the actions taken: SMT have linked in with Support Services to request enhanced cleaning schedules of each of the wards. Funding is being sourced for additional Support hours to ensure general cleanliness of the ward environment. Ward managers to ensure cleanliness checks are completed as part of the 30 minute checklist and any immediate issues to be flagged with Support Services. Support services complete a quarterly audit which Ward managers have sight of for actions. In the future the Facilities Management Team will complete additional more frequent environmental and C4C audits and ensure follow up and reviews are completed where required and in a timely fashion.
Area for improvement 7 **Ref:** Standard 5.1 Criteria: 5.3.2 (c) **Stated:** Second time **First completed by date:** 30 September 2023 **To be completed by:** 10 January 2025	The South Eastern Health and Social Care Trust should ensure a robust response to incident management is developed. Ref: 5.2.2
	Response by registered person detailing the actions taken: Ward managers and Deputies have new robust Job Plans in place. These plans have been shared with ward management teams and their roles and responsbilities in day to day incident management explained. Referesher training has been rolled to all reviewers and all ward staff. As part of the Job Plan time has been built in for a daily review of incidents on the ward within the last 24 hrs to ensure earlier response and data gathering to assist with investigations. Protected time is available for managers to prioritise management roles and responsibilities. Ward Team meetings are now scheduled the week following In-patient Governance Group to ensure feedback is coming back to wards from In-Patient Governance to ward level meetings. Set agendas/ Meeting templates will ensure all key info is passed down to staff on the floor. All Team meetings have been shared with Lead Nurse, HOS and AD to ensure Senior management attendance.

Area for improvement 8 **Ref:** Standard 4.1 and 5.1 Criteria: 4.3, 5.3.1 (f) **Stated:** Second time **First completed by date:** 30 September 2023 **To be completed by:** 10 January 2025	The South Eastern Health and Social Care Trust must review governance oversight arrangements for all wards in relation to the environmental walk around. Ref: 5.2.1 & 5.2.10
	Response by registered person detailing the actions taken: The Trust are planning to employ a Facilities manager who will oversee audits, actions and recommendations. We are also looking to employ Housekeepers on each ward to create an overarching Facilities management Team with set roles and responsibilities to include oversight of environmental audits and walkarounds. In the interim Senior managers routinely attend Team meetings at ward level. The new anti-ligature audit tool now used by a Core MDT Group across Inpatient Wards. meaning each area will get a 6 monthly MDT walkaround to identify environmental ligature risks, this will also allow an opportunity to identify any other issues present during the walkaround in partnership with risk advisory team.
Area for improvement 9 **Ref:** Standard 4.1 Criteria: 4.3 (m) **Stated:** Second time **First completed by date:** 31 December 2023 **To be completed by:** 10 March 2025	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: 5.2.3
	Response by registered person detailing the actions taken: Job plans ensure ward managers and deputies to include protected time to review their teams training compliance once a week as well as reviewing individual staff training needs during monthly supervision with staff. LMS and Healthroster have reporting functionality in terms of compliance with training- however it was indified a CompositeTraining spreadsheet was needed and is currently in development for completion by the ward manager as a live document for ward teams to oversee compliance with mandatory training and pending requirements. We are implementing initiatives such a freeze week for training/ monthly focus on Mandatroy training e.g. Nov Adult Safeguarding, Dec Ch Safeguarding, Jan Fire Safety etc

Area for improvement 10 **Ref:** Standard 5.1 Criteria: 5.3 **Stated:** First time **To be completed by:** 10 March 2025	The South Eastern Health and Social Care Trust should review oversight arrangements of Fire Risk Assessments to ensure: • All risks identified are fully addressed • Fire Risk Assessments and associated risk assessments are reviewed as appropriate following incidents • Action plans are maintained and reviewed to provide assurance that risks are appropriately addressed Ref: 5.2.1 & 5.2.2
	Response by registered person detailing the actions taken: Each area carries out in collaboration with the Trust Fire Safety Officer, an annual fire safety evacuation exercise. Wards have annual Fire Safety inspections and have Evacuation and Shelter plans updated. Each area has been asked to identify a Fire Champion to ensure oversight of fire risk assessments, weekly checks, reviews and actions, and to ensure actions are completed in a timely fashion and documents updated. Each area has identified Fire Wardens with an enhanced level of training and awareness. Ward managers and Fire Champions ensure relevant risk assessments are updated accordingly post incident. A new SOP for the management of Lighters has been created and implemented across the wards in response to recent fire incidents. A local SAI review will be completed on recent fire incidents in Ward 12. A directorate-wide fire safety group is being estblished to ensure coordination of fire training, risk assessments, drills & adequate levels of fire wardens.
Area for improvement 11 **Ref:** Standard 5.1 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 10 March 2025	The South Eastern Health and Social Care Trust should re-establish ward level audits to ensure effective oversight of patient care documentation requirements. Ref: 5.2.10
	Response by registered person detailing the actions taken: Work is ongoing with the Safe and effective Care Team in the creation and validation of automated KPI audits within Encompass. Within Mental Health a KPI for Documentation is ready for testing; the person centred care, carer involvement and individual note audit have been transformed into 1 single Documentation KPI which has adopted the PACE framework. A Pilot has been agreed within one Ward for the data input into the new Formic system with an eventual plan to roll out across

	each ward and the development of the KPI Dashboard in this area. These dashboards are discussed at in-patient governance group
Area for improvement 12 **Ref:** Standard 4.1 Criteria: 4.3 (h) **Stated:** First time **To be completed by:** 10 January 2025	The South Eastern Health and Social Trust should establish a robust assurance mechanism to maintain effective SMT oversight of Adult Safeguarding processes. Ref: 5.2.2
	Response by registered person detailing the actions taken: There is a monthly inpatient governance meeting which routinely reviews safeguarding incidents / training complaince. This meeting escalates any issues to the Mental Health Management monthly governance meeting. Any issues requiring further escalation are tabled at the Directorate SMT &/or the Coprorate Governance Committee. MH DAPO/ Senior Practitioner oversees Adult Safeguarding referrals across the Wards and attends the monthly MHSCG meeting to provide updates and feedback. MH DAPO will share relevant reports with the SMT in addition to attending monthly meeting. In the interim the Wards maintain a central folder of adult safeguarding referrals and actions which can provide full oversight of active processes during SMT visits. Director of SW Chairs Adult a quarterly Safeguarding Sub committee Forum which holds an asg action plan. Development of a mental Adult Safeguarding Report to be presented to SMT and shared with Adult Safeguarding Sub committee meeting for information and/or escalation

Area for improvement 13 **Ref:** Standard 5.3 Criteria: 5.3.3 **Stated:** First time **To be completed by:** 10 March 2025	The South Eastern Health and Social Care Trust must ensure adequate seating provision for the patient population during meal times. Ref: 5.2.4
	Response by registered person detailing the actions taken: The dining rooms has been cleared of all other non-dining furniture and replaced with adequate dining tables and chairs to ensure there is adequate space for all patients

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

The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

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