The Regulation and Quality Improvement Authority

Inspection Report

15 May 2025

Northern Health & Social Care Trust

Dementia Intensive Care Unit
Inver 4
Holywell Hospital
60 Steeple Road
Antrim
BT41 2RJ

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: Northern Health and Social Care Trust (NHSCT)	**Responsible Individual:** Ms Jennifer Welsh, Chief Executive, NHSCT
Person in charge at the time of inspection: Ashleigh Moss	**Number of registered places:** 20
Categories of care: Mental Health (MH) Dementia Intensive Care	**Number of beds occupied on day one of this inspection:** 21
Brief description of the accommodation/how the service operates: Inver 4 provides care and treatment to patients who have a diagnosis of dementia and require an admission for assessment and treatment in a Dementia Intensive Care Unit (DICU). The ward is situated in Holywell Hospital. It has a mix of single occupancy rooms and dormitory style sleeping areas. Male and female sleeping areas are separate.	

2.0 Inspection summary

An unannounced inspection took place on 15 May 2025 with feedback given at ward level at the end of the day. The inspection concluded with a follow up call to NHSCT Senior Management on 20 May 2025.

On the day of the inspection there were 21 patients on the ward, 17 of whom were detained in accordance with the Mental Health (Northern Ireland) Order 1986. The remaining four patients were subject to Deprivation of Liberty Safeguards (DoLS).

The inspection sought to assess the Trust's progress against the areas for improvement (AFI) identified in the Quality Improvement Plan (QIP) following the previous inspection of Inver 4, conducted on 26 April 2022. Findings from this inspection identified that six AFI's had been met, one partially met and one not met.

Five AFI have been identified in addition to the two AFI assessed as partially met or not met and stated a second time. Please refer to section 6.0 for further detail.

The inspection focused on ten key themes: environment; incident management and adult safeguarding (ASG); staffing; restrictive practices; physical health; mental health; medicines management; patient flow; patient/relative experience and governance.

Good practice was identified with regard to staff handover, daily safety brief, relative engagement, patient activities, least restrictive practices, medicines management, educational support sessions for staff and continuity of care.

Throughout the inspection staff were observed to be caring and compassionate in their interactions with patients.

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 for Health and Social Care, Supporting Good Governance and Best Practice in the HPSS, DHSSPSNI, (March 2006) 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 AFI. 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; staffing levels; senior leadership oversight; and ward environments. The inspection team also reviewed patient care records; patient discharge arrangements and governance documentation.

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

4.0 What people told us about the service

Posters were provided inviting staff, patients, relatives and visitors to speak with inspectors and give feedback on their views and experiences.

We spoke with a number of patients and relatives. Overall comments from patients and relatives were positive; relatives reported being reassured that their loved ones were safe and receiving appropriate care.

Staff we spoke with were passionate and positive about their role. Overall staff reported that they were supported by colleagues, the ward manager and members of the multi-disciplinary team (MDT).

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 to Inver 4 was undertaken on 26 April 2022, eight AFI were identified.

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 26 April 2022</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006)</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 5.3

Criteria: 5.3.1

Stated: First time

To be completed by:
31 October 2022</td><td>The Northern Health & Social Care Trust must ensure that IPC and ward cleanliness is maintained to an acceptable standard. Regular environmental cleaning and IPC audits should be completed with Senior Management Team oversight.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

This AFI has been assessed as met.

See section 5.2.1</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 5.3

Criteria: 5.3.1

Stated: First Time

To be completed by:
31 October 2022</td><td>The Northern Health and Social Care Trust must ensure the ligature risk assessment (LRA) for Inver 4 is up-to-date and includes an action plan.</td><td rowspan="2">Partially met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

The inspection found the LRA had been reviewed and was up to date.

The LRA action plan did not provide accurate details of persons responsible or target dates for completing actions.

This AFI has been assessed as partially met, it will be re-worded to consider progress made by the Trust and stated a second time.

See section 5.2.1</td></tr>
</table>

Area for improvement 3 **Ref:** 5.3 **Criteria:** 5.3.1 **Stated:** First Time **To be completed by:** 31 October 2022	The Northern Health and Social Care Trust must ensure that the handles on the windows of the newly refurbished Inver 4 are replaced with ligature free handles. **Action taken as confirmed during the inspection**: NHSCT senior managers gave a detailed account of actions taken to date with regard to securing suitable replacement ligature free handles, however, at the time of the inspection, the window handles throughout the refurbished Inver 4 had not been replaced and were not ligature free. This AFI has been assessed as not met and has been stated a second time. See section 5.2.1	**Not met**
Area for improvement 4 **Ref:** Standard 5.3 **Criteria:** 5.3.1 **Stated:** First Time **To be completed by:** 31 October 2022	The Northern Health and Social Care Trust must: 1. Implement effective arrangements for adult safeguarding in Inver 4 ward as per Adult Safeguarding Operational Procedures 2016 and ensure: a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations; b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively; c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care;	**Met**

	d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding are improved. 2. Implement an effective process for oversight and escalation of matters relating to adult safeguarding in Inver 4; this should include ward managers, hospital managers, NHSCT senior managers and /or the Executive team as appropriate. 3. Implement effective mechanisms to evidence and assure compliance with good practice in respect of adult safeguarding in the hospital.	
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.2	
Area for improvement 5 **Ref:** 5.3 **Criteria:** 5.3.1 **Stated:** First time **To be completed by:** 31 October 2021	The Northern Health & Social Care Trust should implement a robust process that ensures patients Speech and Language requirements are consistently and accurately recorded on all documents and areas applicable.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.9	

Area for improvement 6 **Ref:** Standard 5.1 Criteria: 5.3.1 **Stated:** First Time **To be completed by:** 30 April 2023	The Northern Health and Social Care Trust must review the provision of pharmacy cover in Inver 4 to facilitate timely medicines reconciliation at admission and appropriate attendance at daily safety huddles and MDT reviews. **Action taken as confirmed during the inspection**: This AFI has been assessed as met. See section 5.2.3	**Met**
Area for improvement 7 **Ref:** Standard 4.1 and 5.1 Criteria: 4.3, 5.3.1 **Stated:** First Time **To be completed by:** 31 October 2022	The Northern Health and Social Care Trust must review and strengthen the governing arrangements in Inver 4 ward with regard to Adult Safeguarding (ASG) as follows; 1. Undertake a look back audit exercise over a six-month period to ensure all relevant incidents have been referred to the ASG team in line with regional protocol. 2. Implement a mechanism for the governance oversight and review of ASG, to establish themes, trends and patterns. This information should be used to drive improvement and shared with all relevant staff including all ward staff. **Action taken as confirmed during the inspection**: This AFI has been assessed as met. See section 5.2.2	**Met**
Area for improvement 8 **Ref:** Standard 5.3 Criteria: 5.3.1 **Stated:** First Time **To be completed by:** 31 October 2022	The Northern Health & Social Care Trust must ensure that patient mealtimes in Inver 4 are effectively and safely managed to prevent overcrowding of the dining room area while patients are eating and drinking. **Action taken as confirmed during the inspection**: This AFI has been assessed as met. See section 5.2.9	**Met**

5.2 Inspection findings

5.2.1 Environment

The inspection sought to assess the ward environment against the Royal College of Psychiatrists Standards for Older Adult Mental Health Services, 5th Edition, December 2019 to determine if it was conducive to the delivery of safe, compassionate and therapeutic care. The Inver 4 (the ward) environment was found to promote the delivery of compassionate and therapeutic care whilst improvement was required in relation to environmental safety and the general presentation of the ward.

The entrance corridor to the ward was well presented with photos of ward activities and items crafted by patients and staff. Information about the ward was displayed for relatives / visitors. The ward décor was of a good standard with contrasting colours and easy read signage.

The layout of the ward was dementia friendly with provision of regular resting points and safe access to an outdoor space. It was evident that patient comfort had been considered during the refurbishment of the ward with several quiet areas available for patients and/or visitors. A low stimulus area is located in part of the ward where there is limited space and could be disruptive to patients due to the through traffic of staff and visitors. There are limited options to re-configure this area and the Trust should be mindful of this when patients are using this space.

Small areas of torn and stained flooring were noted throughout the ward. There was evidence of regular maintenance reporting, follow up and escalation of this issue as required.

The standard of cleanliness of the ward was good and there was evidence of auditing with managerial oversight. A scheduled week long deep clean of the ward was underway on the day of the inspection. Some areas of the ward were cluttered and untidy and posed a risk to patient and staff safety. Of particular concern was the store room in which the fire extinguishers were located. This was immediately brought to the attention of the ward manager who ensured the issue was rectified promptly.

The fire risk assessment (FRA) was completed in April 2024 and detailed actions to be taken. Testing of fire detection systems was being carried out during the day of the inspection as part of the FRA review. A fire drill and an evacuation plan had been completed within the previous 12 months. There was good Senior Management Team (SMT) oversight of systems and documentation with three monthly Mental Health Fire Safety and Evacuation Planning and Sub Group Meetings.

Oxygen cylinders were stored in the clinical room however there was no signage on the door indicating oxygen storage. The FRA did not reflect these findings. An AFI has been identified in regard to fire safety.

LRAs assess all ligature points in the ward environment at least annually, detailing actions and mitigations where risks are identified to ensure staff are aware of the risk points and their management to maintain patient safety.

A LRA was completed in July 2024. The action plan did not provide accurate details of persons responsible for specific actions or target dates for completion. The majority of risks identified on the LRA did not have a programme of works detailed to address them in a timely manner. Senior management provided an update on actions taken to date to address the non-anti-ligature window handles. Where it has not been possible to complete works the Trust should ensure alternative mitigations have been considered and are detailed in the LRA. Discrepancies were noted in the existing control measures of the LRA, namely the frequency of visual checks on all patients varied throughout the LRA, not all furniture was anti-ligature in style and all beds were profiling beds and not fixed beds as described in the LRA. The Trust should review these discrepancies and revise the LRA accordingly.

Risk assessments and care plans for the use of profiling beds were not made available when requested.

At the point of entry to the ward a sign was in place advising that no plastic is permitted on the ward. Whilst the LRA states “no plastic bags are used in the ward apart from Clinical Waste Bags”, bins and dani-centres containing plastic bags/aprons were located throughout the ward which could be accessed by patients. The Trust should review their policy on the use of plastics in wards to ensure it is in keeping with the **Use of plastic bags on mental health in-patient wards, PHA Safety and Quality Alert 2018** and **Learning Matters Risk of plastic bags on mental health inpatient units, HSC Learning Matters, Issue 10 Jan 2020**.

An AFI has been identified in regard to ligature risk.

5.2.2 Incident Management and Adult Safeguarding (ASG)

Adult Safeguarding is a term used for activity which prevents harm from occurring and which protects adults at risk where harm has occurred or, is likely to occur without intervention. ASG arrangements and process should be managed in accordance with the Northern Ireland Adult Safeguarding Partnership, Adult Safeguarding Operational Procedures, September 2016, which sets out what is required to provide a safe environment and what actions and responses are required to be taken where adults may be at risk of harm or abuse.

A Designated Adult Protection Officer (DAPO) was aligned to the service to provide support and guidance to staff as required. Staff were aware that the ward manager was identified as the ASG Champion.

A “mustard box” was available to staff which contained a copy of the Regional ASG Policy, ASG processes and contact details for the DAPO and Adult Protection Gateway Team (APGT). This included details of who to contact outside of office hours.

A sample of DATIX incidents for the previous six weeks were reviewed (DATIX is the Trust’s electronic information system for recording incidents). DATIX recording contained good detail about the incidents and actions taken, including steps taken by staff to de-escalate situations, use of the low stimulus area and rotation of staff. Incidents were graded consistently and in line with Health and Social Care (HSC) Risk Matrix.

ASG incidents were reviewed by suitably trained members of the ward management team and screened appropriately. There was evidence that trends, themes and patterns were being considered when ASG referrals were made.

Senior Nurse meetings to discuss ASG incidents were held weekly with systems in place for escalation to SMT. There was good oversight of ASG by SMT, which included senior leadership walk rounds, analysis of themes and trends in the Safety and Quality Booklets, 5 weekly MDT meetings and monthly Patient Safety Incident Forums.

Staff compliance with ASG training requires significant improvement. Availability of ASG training is limited and staff have encountered difficulty in securing places. Despite this staff demonstrated good knowledge and understanding of the ASG process, including what actions to take should an incident occur that met the threshold for an ASG referral. The Assistant Director, Professional Social Work Lead and Head of Adult Safeguarding have agreed to provide additional support sessions for staff until availability of formal training improves. An AFI in relation to mandatory training for staff is discussed further in 5.2.3.

5.2.3 Staffing

Staffing levels were determined using the Telford model, a tool to assist in defining the required level of staffing based on patient acuity. All inpatient wards are required to have a mechanism for responding to low/unsafe staffing levels, when they fall below a minimum agreed level. Staff demonstrated knowledge of the agreed procedure to follow when this occurred. The ward had low staffing vacancies.

The Trust endeavoured to achieve the minimum safe staffing level for every shift with bank and agency staff booked in advance to cover staffing shortages. This supported continuity of care and consistency for patients.

The ward operates a MDT approach to care and treatment which includes nurses, social workers (SW), speech and language therapist (SLT), occupational therapist (OT), technical instructors (TI), psychiatrist, pharmacist and medical staff. There was evidence of positive working relationships within the MDT and arrangements were in place to cover allied health professionals leave with support from other areas of the hospital.

There is no aligned pharmaceutical support for the ward and this was identified as an AFI at the previous inspection. Assurances were provided by the ward manager that the current pharmaceutical support to the ward is adequate and the lack of aligned support does not negatively impact patient care.

Staff compliance with mandatory training requires significant improvement. Mechanisms were in place to monitor and review training compliance and identify deficits. However, these were not sufficiently robust to drive improvement. An AFI has been identified in regard to oversight of mandatory training compliance.

5.2.4 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 in the ward included detention under the Mental Health Order (Northern Ireland) 1986; locked exit doors; the use of medicines prescribed on a 'when required' basis; bed alarms; the use of physical interventions and levels of enhanced observations.

On one occasion inspectors observed enhanced observations being completed were not sufficiently robust and had the potential to compromise patient safety. When patients are in receipt of enhanced observations, it is imperative that staff are vigilant at all times. This matter was brought to the attention of the ward manager and addressed immediately.

There was good evidence of preventative and proactive strategies to minimise the use of restrictive practices. For instance, a low stimulus area and staff rotation were frequently used before consideration was given to the use of physical or chemical restraints and locked door considerations were in place for patients admitted on a voluntary basis. Overall, Staff were observed managing restrictions in a compassionate and caring manner.

5.2.5 Physical Health

The Trust has embedded A Picture of Health? Bridging the Gap between Physical and Mental Health Healthcare in Mental Health Hospitals (NCEPOD, May 2022). Patients' were assessed by a doctor within six hours of admission and had a physical health check within 72 hours of admission.

Appropriate physical health risk assessments such as Malnutrition Universal Screen Tool (MUST), National Early Warning Score (NEWS) and Pressure Ulcer Risk Primary or Secondary Evaluation Tool (PURPOSE-T) were in place for each patient. Physical health needs beyond the remit of on-site medical staff were sourced via referral to the appropriate specialism.

A number of patients were on a modified diet; this was noted in patient care plans. Information available in the ward dining area correlated with patient clinical notes regarding the speech and language therapy advice for eating, drinking and swallowing needs.

There was evidence that falls risks had been considered and appropriate actions had been taken to minimise risk to patient safety. These included post fall protocols in relation to anti-coagulant therapy, Central Nervous System (CNS) checks and follow up scans as required.

5.2.6 Mental Health

Patient documentation evidenced individualised care and treatment arrangements to meet the specific needs of the patients. This included regular MDT reviews to determine effectiveness of interventions. The assessment, planning, delivery and review of care and treatment was completed in collaboration with patients and their relatives. Care plans were reviewed regularly and updates/changes in care were shared during the daily handover.

The majority of patients (81%) were detained under the Mental Health Order (Northern Ireland) 1986, and a system was in place for ease of access to each patient's detention forms and the date for renewal. Appropriate documentation was available for patients subject to Deprivation of Liberty Safeguards (DoLS).

Voluntary patients were made aware of the locked doors policy at the point of admission and this was reflected in their care plans.

5.2.7 Medicines Management

The clinical room was clean and tidy, however, due to limited space it was difficult to access some emergency equipment. This was discussed with the ward manager and a member of nursing staff; assurances were given by the ward manager this would be rectified. An AFI has been made in regard to access to emergency equipment.

Fridge temperature checks were completed on the majority of days. Emergency equipment checks were completed by a staff member from another area in the hospital. These were recorded consistently for the most part, however, consideration had not been given to periods of leave and checks during these times were missed. These issues were discussed with the ward manager who gave assurances they would be addressed.

The defibrillator machine was charged with electrode pads attached. The adhesive cover on the pads was intact, however the external packaging had been opened. The Trust should seek assurances that the integrity of the pads has not been compromised by the open packaging.

Following the implementation of Encompass, medication was managed through an electronic prescribing and recording system. The ward introduced individual picture cards with the patient's photograph, personal details and a QR code which is scanned prior to all medication administration. This is an alternative to the wrist band patient identification system and can help to reduce medication errors and safety concerns.

Medication was stored appropriately, records evidenced appropriate prescribing and administration, including maximum dose of specific medications over 24 hours.

Robust systems were in place for the recording of Pro Re Nata (PRN) medicines. There were clear parameters specified on medicine kardexes to direct the administration of PRN medicines including the indication for the medicine, the minimum frequency intervals and the maximum daily dose. In instances where more than one PRN medicine was prescribed, it was clear which medicine was first and second line.

5.2.8 Patient Flow

The Royal College of Psychiatrists (2011) recommends that bed occupancy should average 85%. The majority of inpatient mental health services across the region are frequently over occupied, with a number of patients assessed as delayed in their discharge.

There were a number of patients delayed in their discharge. A lack of specialist community placements to meet the complex needs of patients was identified as a barrier to timely discharge. It was positive to note that additional SW support has been utilised to support more timely discharge and the ward is represented at the Regional Bed Management Meeting.

The ward has provision for 20 patients. There were 21 patients on the day the inspection commenced. Additional patients are accommodated in a communal bay in a "contingency space". There was insufficient provision of screens and/or curtains to ensure each patients privacy and dignity was maintained. Inspectors were required to intervene on one occasion to ensure dignity was maintained for all patients. This matter was discussed immediately with the ward manager who took swift action with the staff involved. An AFI has been identified in regard to patient privacy and dignity.

5.2.9 Patient / Relative 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 support and observe patients during mealtimes (Royal College of Psychiatrists Standards for Older Adult Mental Health Services, 5th Edition, December 2019).

Mealtimes were co-ordinated in line with 'Mealtimes Matter', a regionally agreed framework to maximise service user safety and ensure a high quality experience always occurs at every meal, drink and snack time. The mealtime experience was observed to be organised and relaxed. A Dysphasia Champion was in attendance throughout. A staff member was assigned at each table where they effectively observed and supported patients in a compassionate manner. The food appeared appetising and choice was available to patients. Some patients enjoyed their meal at different times and in different environments more suited to their preference/needs.

Information relating to patients International Dysphagia Diet Standardisation Initiative (IDDSI) was available, providing assurance that patients were receiving a diet appropriate to their needs. It was good to see patient IDDSI levels were also recorded on the daily handover and safety brief.

The ward benefits from a part time OT and two TI staff, the Trust has experienced difficulty accessing cover for an extended period of OT leave. Despite this shortage a wide and varied range of activities was available to patients with support from TI staff. Arts and crafts made by patients contributed to a colourful and stimulating ward environment.

We sought the opinion of a number of patients and relatives. Patients spoke highly of the staff and care they received. Relatives opinions for the most part were positive and staff were highly praised. Some relatives we spoke to valued and commended the accessibility and support of the ward Psychiatrist. The ward manager reported hosting "family parties" as a means of engaging relatives and including them in social events with the patients.

Information on patient advocacy and "how to make a complaint" was available to patients and relatives/visitors at the point of entry to the ward.

It is commendable that a number of staff from the ward have been nominated by management for recognition, within the Trust, of their skills and care practice.

5.2.10 Governance

Governance arrangements were reviewed through the examination of relevant documentation, discussions with the ward manager and members of the MDT. There were good systems evident with communication mechanisms to support escalation of risk, analysis of themes and trends as well as evidence of outcomes and actions being shared.

A range of meetings at senior management level were available for review.

At ward level, the daily safety brief and handover in addition to a range of other meetings promoted good communication and patient safety.

SMT visits were recorded with action plans included but there was limited evidence of follow up to the actions required. The Trust should put in place robust mechanisms to ensure compliance with SMT visit action plans.

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	7

* The total number of AFI includes two that have been stated for the second.

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 5.3 **Criteria:** 5.3.1 **Stated:** Second Time	The Northern Health and Social Care Trust should ensure the ligature risk assessment (LRA) for Inver 4 is reviewed for accuracy and consistency. The action plan should include accurate details of persons responsible and target dates for completion of actions. Ref: 5.2.1
To be completed by: 31 July 2025	**Response by registered person detailing the actions taken**: The Trust has completed an updated audit and is assured that this accurately reflects the ligature points with mitigations in place for identified risks. The action plan has identified owners and timescales to ensure completion and this has been discussed at staff meeting and will continue to be raised as a standing agenda item to ensure that all relevant staff at ward level are aware of the ligature risks in their ward and the relevant mitigations. Ligature Risks are also identified as part of the Senior Leadership night visit agenda.
Area for improvement 2 **Ref:** 5.3 **Criteria:** 5.3.1 **Stated:** Second Time	The Northern Health and Social Care Trust should ensure that the handles on the windows of the newly refurbished Inver 4 are replaced with ligature free handles. Ref: 5.2.1
To be completed by: 28 November 2025	**Response by registered person detailing the actions taken**: The Trust has completed a minors works request for the replacement of the window handles with viable options in the appraisal and costing of same with a timeline for completion requested from the Trusts Estate Services. Meetings have been arranged with the HOS, Estates, Fire Officer and Health and safety in relation to progress of a solution on the option for replacing the window handles. progress updates will be provided accordingly.

Area for improvement 3 **Ref:** Standard 5.3 **Criteria:** 5.3.1 **Stated:** First time **To be completed by:** 30 June 2025	The Northern Health and Social Care Trust should ensure appropriate signage is in place indicating the areas where oxygen is stored. The fire risk assessment should be updated to reflect this change. Ref: 5.2.1
	Response by registered person detailing the actions taken: The NHSCT acknowledges the current signage that was being utilised across the inpatient wards was not sufficient within Inver 4 as Service Users would tend to pull this off. The Trust has therefore requested that the Fire Safety Advisor ascertain a more sturdy signage that can be placed on the Clinical Room door more securely.The Ward Manager has requested that the fire risk assessment be reviewed and updated accordingly with all amendments

Area for improvement 4 **Ref:** Standard 5.3 **Criteria:** 5.3.1 **Stated:** First time **To be completed by:**	The Northern Health and Social Care Trust should put in place a robust governance assurance mechanism to ensure risks associated with ligatures are addressed. Ref: 5.2.1 **Response by registered person detailing the actions taken:** The Trust has completed an audit and is assured that the ward has an up to date ligature risk assessment which accurately reflects the ligature points with mitigations in place for identified risks. Ligature risks identified and control measures in place are discussed at staff meetings as a standing agenda item to ensure that all relevant staff at ward level are aware of the ligature risks in their ward and the relevant mitigations. Ligature Risks are also identified as part of the leadership walkaround agenda. Meetings have also been arranged with the HOS, Estates, Fire Officer and Health and safety in relation to progress of works Ligature risk assessments will be updated including control measures to mitigate against identified risks.
Area for improvement 5 **Ref:** Standard 5.3 **Criteria:** 5.3.3 **Stated:** First time **To be completed by:** 30 September 2025	The Northern Health and Social Care Trust should ensure robust governance arrangements are in place to ensure effective oversight of mandatory training compliance. Ref: 5.2.3 **Response by registered person detailing the actions taken:** All staff are advised of the need to remain compliant with mandatory training. A monthly table is collated across inpatient services which is forwarded to the Head of Service and nursing Services Manager for information; any training deficits are raised with the Ward Manager to address with the team. Staff training compliance is also monitored via the Governance team who issue reminders to teams regarding training updates required. Staff training compliance is also a standing item on the Senior management monthly Workforce and Engagement meeting chaired by the Divisional Director. The lead nurse for Nurse Education & Learning for division also drives this work ensuring compliance across all the wards with mandatory training. The introduction of the new training system (LearnHSCNI) enables staff to view their training compliance and book onto relevant/mandatory training as necessary. Managers can also use this new system to view training compliance across their staff team.

	The NHSCT are also using the new Optima E-Rostering Health system which has the capacity to upload the Training skills appropriate for all staff. When staff are nearing their renewal date there will be an alert on the system to enable Ward Managers the capacity to address this at staff supervision and follow up that they have booked the appropriate training in a timely manner. This system will ensure that one system is utilised across the inpatient wards and it will enable Service Managers to review training figures and address any outstanding issues with relevant ward managers Staff across all wards are actively working to achieve full compliance against all mandatory training with a view to completion by the proposed deadline of 30/09/2025.
Area for improvement 6 **Ref:** Standard 5.3 **Criteria:** 5.3.1 **Stated:** First time **To be completed by:** 30 June 2025	The Northern Health and Social Care Trust should ensure emergency equipment is stored in a suitable area and is accessible at all times. Ref: 5.2.1
	Response by registered person detailing the actions taken: The NHSCT has ensured that the Emergency Equipment has now been relocated to the first cupboard on entry to the Clinical Room of Inver 4 and is now accessible at all times. Signage has been placed on the door to ensure all staff can locate this equipment in the event of an emergency. This information has been communicated to all staff working within Inver 4 via Staff Handover Sheet. Equipment is checked and signed for daily (suction machine, defibrillator and oxygen cylinders). An audit regarding the contents of emergency bags is also carried out monthly by the ECT team..
Area for improvement 7 **Ref:** Standard 5.3 **Criteria:** 5.3.3 **Stated:** First time **To be completed by:** 15 May 2025	The Northern Health and Social Care Trust should ensure patient privacy and dignity is maintained at all times. Ref: 5.2.8
	Response by registered person detailing the actions taken: The NHSCT acknowledge that all patients privacy and dignity should be maintained at all times. At the time of the Inspection, there was a 21st bed in situ in Inver 4.

	Unfortunately there was no curtains or screens available around the patients bed area at that time due to the mobile screens in place being constantly knocked over by patients. The Trust has since removed the bed from the ward and Bed Management have agred that the ward has only capacity for 20 Patients. Any decisions to increase bed capacity will be made by Head of Service and/or Assistant Director level and SPPG will be informed. Nurses carry out regular health and wellbeing checks on all the patients within their ward at regular intervals (Half hourly and more frequent depending on acuity and identified risks) and ensure patient care is provisioned on an individualised person centred approach. This person centred approach accounts for the identified needs, risk and associated management plans for each individual patient as well as helping to support the maintenance of their privacy and dignity. It is acknowledged that the ward environment can also impact on our service users privacy and as such the Trust recognises the value of both staff and service user input when redesigning ward environments. There has been and continues to be extensive staff and service user involvement in the design of the new Mental health facility Birch Hill at every stage of the project to ensure that feedback from staff who work at ward level and who are familiar with ward environments is considered and integrated in the design of the ward environment across the new build to ensure it meets the needs of patients' safety and dignity. There is also a Complex Dementia Acute Care Pathway Review Group which has been established to lead on the development of an evidence based model of care and review of the operational policy in Dementia inpatient services to support staff to deliver safe and effective person centred care focused on measurable outcomes.

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

The Regulation and Quality Improvement Authority
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