Inspection Report

18 November – 2 December 2024

South Eastern Health & Social Care Trust

Dementia and Over 65 Functional Care

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 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:** Ward 11 Lagan Valley: 16 Downe Dementia: 10
Categories of care: Dementia Assessment and Treatment Functional Mental Health over 65	**Number of beds occupied on the day of this inspection:** Ward 11 Lagan Valley: 17 Downe Dementia: 10
Brief description of the accommodation/how the service operates: **Ward 11 Lagan Valley** provides assessment and treatment to male and female patients with dementia and patients over 65 years with a functional mental illness. The two patient groups are accommodated in different parts within the ward and have separate day, dining and bedroom areas. The bedrooms have a mix of single occupancy and dormitory style sleeping arrangements. **Downe Dementia** ward provides assessment care and treatment to male and female patients with dementia. It has single occupancy ensuite bedrooms and is situated on the ground floor of Downe Hospital. Patients are admitted to both wards on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).	

2.0 Inspection summary

An unannounced inspection to the South Eastern Health and Social Care Trust's (The Trust) Inpatient Mental Health Services for Dementia and over 65 Functional Care commenced on 18 November 2024, and concluded with feedback to the Trust on 2 December 2024. The inspection team comprised two care inspectors, RQIA's sessional Consultant Psychiatrist and administrative support.

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 Ward 11 Lagan Valley on 23 March 2018 and Downe Dementia on 21 November 2022. Findings from this inspection identified that twenty AFI's had been met, two partially met and two not met.

One AFI has been identified in addition to the four AFI's assessed as partially met or not met and stated a second time. Please refer to section 5.1 and 6.0 for further detail.

Recommendations identified in Serious Adverse Incident (SAI) reports relevant to the Trust's Inpatient Mental Health Services for Dementia and over 65 Functional Care were also reviewed during the inspection and found to be embedded in practice.

The inspection focused on the following ten themes: environment; adult safeguarding (ASG) 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 with regard to the involvement of families in the planning and delivery of care and treatment, minimisation of restrictive practices, and incident management. Areas that require improvement are in relation to the Trust's governance and oversight of environmental safety and Adult Safeguarding.

Throughout the inspection staff were observed to be caring, compassionate and person centred 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 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; 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 and relatives to speak with inspectors and give feedback on their views and experiences.

We spoke with a number of patients, relatives, staff and the Alzheimer's Society independent advocate. Overall comments from relatives were positive; they reported being reassured that their loved ones were safe and receiving appropriate care.

The independent advocate was complimentary of the service provided to patients and relatives and reported positive working relationships with the Multi-disciplinary team (MDT).

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

5.0 The inspection

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

The previous inspections of Ward 11 Lagan Valley and Downe Dementia were undertaken separately.

Ward 11 Lagan Valley previous inspection was undertaken on 23 March 2018, nine areas for improvement (AFI's) were identified and are included in the review of the Quality improvement plan (QIP) below.

Downe Dementia previous inspection was undertaken on 21 November 2022, fifteen AFI's were identified and are included in the review of the QIP below.

Areas for improvement from inspection of Ward 11 Lagan Valley on 23 March 2018		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)		**Validation of compliance**
Area for Improvement No. 1 **Ref:** Quality Standard 5.3.1 (f) **Stated:** Second Time	<u>Self-harm and ligature risk assessments</u> All beds in the ward were profiling beds which were required for patients admitted to the dementia ward side of the unit because of their physical needs. However, it was unclear why all the beds on the over 65 functional mental health side of the ward were profiling beds. All patients who were admitted to the functional mental health side did not have a clinical need for this type of bed.	**Met**

	The patient risk assessment flow chart for the use of a profiling had been updated however it did not identify the use of a static bed for patients as a least restrictive option to manage patients at risk. Ligatures were assessed as part of the general risk assessment. Each section of the ward was assessed as high, medium or low. In relation to self-harm the over 65 functional mental health ward was highlighted as red. Anti- ligature work was not completed in full. It was also recorded that one of the control measures was staff have Applied Suicide Intervention Skills Training (ASIST) training. All staff had not received training in suicide prevention strategies.	
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.1, 5.2.3 and 5.2.6	
Area for Improvement No. 2 **Ref** Quality Standard 5.3.1 (f) **Stated:** First Time	<u>Response time from Estates Department</u> Staff reported to the inspector that there were sometimes delays in response times from the Estates Department to job requests submitted in relation to door closures.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.1	

Area for Improvement No. 3 **Ref** Quality Standard 5.3.1 (f) **Stated:** Second Time	<u>Environmental Safety</u> There was no environmental health and safety audit completed for Ward 11 although the inspector was informed that Ward 11's environmental health and safety assessment is scheduled for 10 April 2018. **Action taken as confirmed during the inspection**: This AFI has been assessed as met. See section 5.2.1	**Met**
Area for Improvement No. 4 **Ref:** Quality Standard 6.3.1(a) **Stated:** First Time	<u>Occupational therapy resource</u> There was no ward based occupational therapist assigned to Ward 11. **Action taken as confirmed during the inspection**: This AFI has been assessed as met. See section 5.2.3	**Met**
Area for Improvement No. 5 **Ref:** Quality Standard 6.3.1 **Stated:** Second Time	There was a limited occupational therapy activity budget of £50 between three services. This limited community living activities **Action taken as confirmed during the inspection**: This AFI has been assessed as met. See section 5.2.4	**Met**
Area for Improvement No. 6 **Ref:** Quality Standard 5.3.3 (c) **Stated:** Second Time	<u>Staff meetings</u> Attendance at staff meetings was low. The minutes reviewed evidenced that seven staff attended in October 2016, four staff attended in November 2016 and ten staff attended that meeting January 2017. Attendance was only from nursing staff.	**Met**

	The following was not included in the team meeting agenda: Learning from incidents / accidents. Up to date evidence based practice, new guidelines etc. Feedback from any courses / study days attended by staff this would enable shared learning and encourage service improvement.	
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.10	
Area for Improvement No. 7 **Ref:** Quality Standard 6.3.2 (g) **Stated:** Second Time	<u>Patient / relative experience</u> There was no information displayed in relation to patient and relative experience.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.4	
Area for Improvement No. 8 **Ref:** Quality Standard 5.3.1 (a) **Stated:** Second Time	<u>Person centred goals</u> It was unclear in the occupational therapy documentation if patient's goals had been achieved. Although OT documentation was not assessed on this inspection it has been brought forward for review at the next inspection of Ward 11. Nursing care plans were not goal orientated. Goals were recorded as interventions with no time frame recorded and the inspector found it difficult to establish if the interventions were effective.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.5	

Area for improvement No. 9 **Ref**: Quality Standard 5.3.1 (a) **Stated:** Second Time	<u>Patient recording system</u> There were two systems for recording patient information. Some information was recorded in patient's paper files and some on the electronic recording system (MAXIMS).	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 2.0	

Areas for improvement from the last inspection of Downe Dementia on 21 November 2022		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 5.1 Criteria: 5.3.1 (a) **Stated:** Third time	The South Eastern Health and Social Care Trust must ensure that all patients with dementia have an individualised evidenced based risk screening tool completed.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.5	
Area for Improvement 2 **Ref:** Standard 5.1 Criteria: 5.3.1 (a) **Stated:** Third time	The South Eastern Health and Social Care Trust should ensure that appropriate risk assessments are completed for profiling beds and the use of bed rails.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.6	

Area for Improvement 3 **Ref:** Standard 5.1 Criteria 5.3.1 (a) **Stated:** Third time	The South Eastern Health and Social Care Trust must review the approach to recording and analysis of distressed behaviours. Staff should be supported to develop the skills, knowledge and expertise to analyse behaviours, determine why the behaviour has occurred and develop person specific support plans that aim to reduce the person's distress.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.5	
Area for improvement 4 **Ref:** Standard 5.1 Criteria: 5.3.1 (a) **Stated:** Third time	The South Eastern Health and Social Care Trust must ensure that a medication audit of the kardex is completed as part of the quality assurance process.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.9	
Area for Improvement 5 **Ref:** Standard 4.1 Criteria: 4.3 (j) (m) **Stated:** Third time	The South Eastern Health and Social Care Trust must ensure that all staff currently working on the Downe Dementia ward have received up to date mandatory training and it is recorded in a format that easily identifies staff training requirements.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.3	
Area for Improvement 6 **Ref:** Standard 5.1 Criteria: 5.3.1 (c) **Stated:** First time	The South Eastern Health and Social Care Trust must implement effective governance arrangements for adult safeguarding to ensure compliance with regional Adult Safeguarding guidance. The Trust must ensure:	**Partially met**

	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) 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; d) ensure regular audit of adult safeguarding referrals and incidents; e) ensure that all staff including SMT have completed the appropriate level of ASG training for their roles and responsibilities.	
	Action taken as confirmed during the inspection: The inspection found ASG incidents were addressed in line with regional Adult Safeguarding guidance. Staff demonstrated knowledge and understanding of their role and responsibilities in regard to Adult Safeguarding and had completed training appropriate to their level. There was limited evidence of regular audit of adult safeguarding referrals and incidents. 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 5.2.2	
Area for Improvement 7 **Ref:** Standard 5.1 Criteria: 5.3.2 (a) (c) **Stated:** First time	The South Eastern Health and Social Care Trust must ensure there are robust quality assurance systems in place to review and analyse incidents to determine any patterns or emerging themes and take appropriate action to ensure patient safety.	**Met**

	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.2 and 5.2.10	
Area for Improvement 8 **Ref:** Standard 5.1 Criteria: 5.3.1 (a) (c) **Stated:** First time	The South Eastern Health and Social Care Trust must ensure that the fire risk assessment is up to date and available for inspection. • Personal Emergency Evacuation Plans must be completed and kept under regular review to ensure the safe evacuation of patients in an emergency. • All fire safety checks must be completed as detailed in Trust policy and records maintained for inspection. • Fire training must be completed in line with Trust policy for fire safety training.	**Partially met**
	Action taken as confirmed during the inspection: While Fire risk assessments had been reviewed within the last year, one ward did not evidence actions taken to address identified risks. Personal Emergency Evacuation Plans were in place and reviewed regularly. Fire safety checks at ward level were found to be completed and records maintained appropriately. 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	
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 a ligature risk assessment for Downe Dementia ward is completed and disseminated to all staff. The risk assessment should include clear actions to mitigate identified risks. All staff must have a working knowledge of the ligature risks and how these are managed.	**Not met**

	Action taken as confirmed during the inspection: Ligature risk assessments while in place, did not specify ligature risks present in the ward environments. Actions and mitigations therefore did not effectively inform staff of ligature risks in the ward environment and their management. This AFI has been assessed as not met and has been stated a second time. See section 5.2.1	
Area for Improvement 10 **Ref:** Standard 5.1 Criteria: 5.3.1 (c) **Stated:** First time	The South Eastern Health and Social Care Trust must ensure compliance with regional guidance for the use of plastic bags in Mental Health (MH) inpatient wards and Learning Matters Quality 2020 Issue 8, September 2018. A robust assurance mechanism must be implemented in conjunction with the Trust's IPC team to ensure compliance with the guidance.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.1	
Area for Improvement 11 **Ref:** Standard 6.1 Criteria: 6.3.2 (a) **Stated:** Third time	The South Eastern Health and Social Care Trust must undertake a review of the dining experience to ensure that patients have their meals in an appropriate environment that supports their dignity.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.4	

Area for Improvement 12 **Ref:** Standard 5.1 Criteria: 5.3.1 (a) **Stated:** First time	The South Eastern Health and Social Care Trust must ensure that care plans and risk assessments, are person centred and contain sufficient detail for staff to deliver safe, effective and compassionate care.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.5 and 5.2.6	
Area for Improvement 13 **Ref:** Standard 5.1 Criteria: 5.3.1 (a) (c) **Stated:** First time	The South Eastern Health and Social Care Trust must ensure that ward staff have an understanding of Deprivation of Liberty Safeguards (DoLS) and where voluntary patients are subject to continual supervision and are not free to leave that DoLS are put in place.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.7	
Area for Improvement 14 **Ref:** Standard 5.1 Criteria: 5.3.3 (b) (e) (f) (g) **Stated:** First time	The South Eastern Health and Social Care Trust must ensure that a comprehensive quality assurance system with robust audits to monitor operational effectiveness, patient safety and ward performance is developed and the outcomes of these shared with staff to promote improvement in practice. These should include auditing of incidents, care planning documentation and medication.	**Not met**
	Action taken as confirmed during the inspection: There was limited evidence a comprehensive quality assurance system was in place to improve operational effectiveness and patient safety. This AFI has been assessed as not met and has been stated a second time. See section 5.2.1, 5.2.2 and 5.2.10	

Area for Improvement 15 **Ref:** Standard 5.1 Criteria: 5.3.3 (c) **Stated:** First time	The South Eastern Health and Social Care Trust must ensure that staff have access to support processes which focus on a culture of learning and include regular staff meetings, staff debriefs following incidents, and regular supervision.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.10	

5.2 Inspection findings

5.2.1 Environment

The inspection sought to assess the ward environments against the Royal College of Psychiatrists Standards for Older Adult Mental Health Services, 5th Edition, December 2019 to determine if they were conducive to the delivery of safe, compassionate and therapeutic care. Each ward environment was found to be conducive to the delivery of compassionate and therapeutic care whilst improvement was required in relation to oversight of environmental safety.

Both wards presented as warm, spacious and welcoming with quiet areas available to patients. Cleanliness was generally of an acceptable standard, with identified areas of concern followed up and addressed during the inspection. Each ward would benefit from redecoration, which the Trust confirmed is planned. Maintenance issues were appropriately reported and addressed in a timely manner.

Environments were dementia friendly with provision of regular resting points, contrasting colours, easy read signage and safe access to outdoor green space. It was positive to observe some patients had chosen to personalise their bedrooms.

The communal bath in Ward 11 Lagan Valley was not operational. This was raised with the Trust who confirmed they were in the process of replacing it. RQIA would encourage the Trust to expedite this process to enable patients to be able to utilise their preferred means of attending to personal care needs.

Fire risk assessments (FRA) had been reviewed within the previous 12 months. There was some variation in practice in respect of governance and oversight of FRA action plans; Ward 11 Lagan Valley's FRA did not evidence actions taken to address identified risks. Additionally, there was limited evidence to provide assurance that the Trust's Estates department and Senior Management Team (SMT) had effective oversight of priority actions within the FRA. The Trust must ensure FRA's and associated action plans are addressed in a timely manner and updated to reflect actions taken.

Fire safety checks at ward level were completed and records maintained appropriately.

Personal Emergency Evacuation Plans (PEEPs), inform staff of the level of assistance a patient needs to safely evacuate in an emergency. PEEPs were in place for all patients and evidenced regular review.

The AFI identified following the previous inspection of Downe Dementia in regard to fire safety was assessed as partially met and has been reworded to consider progress made by the Trust and stated for a second time.

Ligature Risk Assessments (LRA) assess all ligature points in the ward environment at least annually, identifying actions and mitigations where risks are identified to ensure staff are aware of the risk points and their management to maintain patient safety. LRAs were available in each ward however they did not specify all the ligature points present in the wards. This is important in order to be able to effectively inform staff of the ligature risks, actions and mitigations required to maintain patient safety. The AFI identified following the previous inspection of Downe Dementia was assessed as not met and has been stated a second time.

Lockable bins were in place to restrict patient access to plastic bags in Ward 11, evidencing compliance with the regional guidance on the use of plastic bags in mental health inpatient units. In Downe Dementia lockable bins were not evident in the dining area or bathrooms resulting in patients requiring support and supervision from staff when accessing these areas. RQIA would encourage the Trust to consider placement of lockable bins across the ward to allow patients the opportunity to access these areas without staff support where appropriate.

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 Safeguarding Partnership, Adult Safeguarding Operational Procedures, September 2016.

A Designated Adult Protection Officer (DAPO) was aligned to the service to provide support and guidance to staff as required. ASG processes and contact details for the DAPO and Adult Protection Gateway Team (APGT) were clearly displayed in the nurses' station. This included details of who to contact outside of office hours. 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. Staff compliance with ASG training was 81.5%.

ASG incidents were reviewed by suitably trained members of the Ward Management team and screened appropriately. Incidents which met the threshold for onward referral to the APGT were referred in accordance with regional procedures. Protection plans were maintained at ward level, available to all staff and reviewed regularly by the MDT.

There was limited evidence of regular audit of ASG incidents and referrals. SMT communicated plans to strengthen leadership oversight of ASG processes to include audits which is important to evidence trends in incident analysis. Previous inspection findings resulted in an AFI being identified in relation to governance arrangements for ASG. This AFI has been assessed as partially met and has been reworded to consider progress made by the Trust and stated for a second time.

A sample of DATIX incidents for the previous six months were reviewed (DATIX is the Trust's electronic information system for recording incidents). DATIX recording contained good detail about the incidents and actions taken and incidents were graded consistently and in line with HSC Risk Matrix.

An effective process was in place for sharing learning from incidents, the inspection findings validated learning identified and adequate mitigations implemented to reduce the risk of similar incidents occurring.

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. Staff demonstrated knowledge of the agreed procedure to follow when this occurred. Staffing levels were determined using the Safe Care model, a tool to assist staff in defining the required level of staffing based on patient acuity. The Trust endeavoured to achieve the minimum safe staffing level for every shift, however this was not always possible due to staffing vacancies. A system was in place to ensure that Trust bank and agency staff familiar to the wards were booked in advance in order to maintain safe staffing levels.

Each ward operated a MDT approach to care and treatment including; nursing, nursing assistants, social work, occupational therapy, occupational therapy assistants, psychiatry and medical staff. There was evidence of positive working relationships within the MDT resulting in effective communication and close working.

Staff demonstrated sound knowledge and understanding of the patients' holistic needs within their care and spoke about patients in an empathic and compassionate manner.

Training available to staff included, a range of health and safety training; adult safeguarding training; swallow awareness training; ligature rescue training; Mental Capacity Act training; and dementia capable care. Additional training sessions and information was also provided following identification of learning from incidents.

While there was good compliance with mandatory training, the mechanism to monitor and review training compliance was not sufficiently robust to maintain effective oversight. An AFI has been identified in regard to oversight of mandatory training compliance.

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

The mealtime experience was observed to be organised and relaxed, allowing staff to effectively support and observe patients in a compassionate manner. The food appeared appetising and choice was available to patients. Outside of mealtimes, refreshments and snacks were also available. It was positive to note that the mealtime experience in Downe dementia ward had improved greatly since the previous inspection.

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, providing assurance that patients were receiving the appropriate level within the International Dysphagia Diet Standardisation Initiative (IDDSI).

Patients engaged in a range of therapeutic and recreational group and individual activities provided by ward staff and outside agencies which sought to promote social inclusion, routine and structure. Community based activities were arranged and facilitated by the Occupational Therapy Service and nursing staff. Inspectors observed patients engaging in a dance therapy group session facilitated by an outside organisation and supported positively by ward staff.

Information about the staff team, advocacy services, activities and topic of the month was available in each ward. Ward 11 Lagan Valley displayed additional information useful to patients and relatives including; ward performance, ASG, mechanism for carer and patient feedback and Mental Capacity Act. RQIA recommends this practice is replicated in Downe Dementia to ensure consistent information is made available to patients and relatives across the wards.

5.2.5 Mental Health

Patient documentation evidenced individualised care and treatment arrangements to meet the specific needs of the patient. 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.

Patients' life stories booklets and Pool Activity Level Assessments (PALS) provided valuable information to support staff to communicate effectively with patients and reduce patients distress, however, this information was not always evident in the patient's care plan. It is recommended that the Trust consider supporting documentation during the care planning stage.

Effective oversight of MHO Prescribed forms was evidenced for patients who were detained. Over 80% 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. Where physical health concerns were identified on admission or during the patients' stay, there were appropriate follow up investigations and treatment evident within patients' documentation. If patients' needs were beyond the remit of on-site medical staff, referral and liaison with other specialities was also evidenced.

Physical health risk assessments such as Falls, Malnutrition Universal Screen Tool (MUST), National Early Warning Score (NEWS) and Pressure Ulcer Risk Primary or Secondary Evaluation Tool (PURPOSE-T) risk assessments were in place and reviewed as appropriate for each patient.

Profiling beds were provided based on clinical need and relevant risk assessments were documented. It was positive to note that a previous recommendation from a serious adverse incident in ward 11 had resulted in staff developing a revised falls protocol and was available for staff in the ward.

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 included locked exit doors; levels of enhanced observations; the use of medicines prescribed on a 'when required' basis; the use of physical interventions; and bed rails.

Preventative and proactive strategies were in place to minimise the use of restrictive practices across the service such as falls sensor technology. Restrictive practices were documented appropriately and based on assessed need and risk. Locked door considerations were in place for patients admitted on a voluntary basis.

An appropriate system was in place for patients who were not detained under the MHO but were under continuous supervision or control and not free to leave the ward through Deprivation of Liberty Safeguards under the Mental Capacity Act (Northern Ireland) 2016.

5.2.8 Patient Flow

At the time of the inspection there were no patients awaiting admission or delayed in their discharge.

A lack of specialist community placements to meet the complex needs of patients was identified as a potential barrier to timely discharge as was found in the previous inspection of Downe Dementia. The Trust had recently commenced the pilot Dementia Behaviour Outreach Service (DBOS) in the Lisburn area to support and maintain community placements.

Discharge planning arrangements were discussed at the weekly MDT meeting and sought to include the patient, relatives and patient advocates.

5.2.9 Medicines Management

The clinical room in each ward was neat and tidy, emergency equipment checks were completed within the appropriate timeframes.

Following the implementation of Encompass, medication was managed through an electronic prescribing and recording system. Medication was stored appropriately, records evidenced appropriate prescribing and administration, this included maximum dose of specific medications over 24 hours. Controlled drugs were checked at each shift changeover.

The medication audit tool used prior to the implementation of Encompass requires to be reviewed and updated to reflect the new electronic medication system.

5.2.10 Governance

Governance arrangements were reviewed through the examination of relevant documentation, discussions with ward managers, the assistant director and members of the MDT.

The Governance report ensured effective leadership oversight of incident management through detailed analysis which identified emerging patterns and trends. There was evidence that learning and actions to mitigate recurring incidents and promote patient safety was communicated with ward teams through staff meetings and learning guides.

To facilitate the implementation of Encompass some audits had been temporarily suspended. While some audits had continued, ward staff access to performance data following completion was limited, making it difficult to effectively monitor ward performance.

The inspection identified limited governance and leadership oversight of ASG (see section 5.2.2) and environmental safety (see section 5.2.1). Previous inspection findings resulted in an AFI being identified in relation to the development of a comprehensive quality assurance system. The AFI has been assessed as not met and has been stated a second time.

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	5*

* the total number of areas for improvement includes four that have been stated for a second time.

Whilst recommendations were made during Feedback to the Trust, AFI's 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 5.1 Criteria: 5.3.1 (c) **Stated:** Second time **To be completed by:** 02 March 2025	The South Eastern Health and Social Care Trust must implement effective governance arrangements for adult safeguarding to ensure compliance with regional Adult Safeguarding guidance. The Trust must ensure regular audit of adult safeguarding referrals and incidents. Ref 5.2.2
	Response by registered person detailing the actions taken: The early Indicators Audit has commenced in the Downe Dementia Unit with a plan to replicate this in Ward 11. This audit will help us to identify any potential quality of service issues when risk of harm has been identified and allow for support to be provided to the service at an early stage. In addition to the above audit, now that amalgamation has taken place, the monthly governance reports that are completed by the wards will be sent to the MH DAPO for collation, thematic review, reporting and escalation as required. The role of the MH DAPO includes oversight and governance of all safeguarding activity carried out by our services. An educative and supportive component to this role also ensures that staff able to carry out their roles with confidence.
Area for improvement 2 **Ref:** Standard 5.1 Criteria: 5.3.1 (a) (c) **Stated:** Second time **To be completed by:** 02 December 2024	The South Eastern Health and Social Care Trust should review oversight arrangements of Fire Risk Assessments to provide assurance action plans are maintained and reviewed in an appropriate and timely manner. Ref: 5.2.1
	Response by registered person detailing the actions taken: In collaboration with the Trust Fire Safety Officer, an annual fire safety evacuation exercise is carried out with all staff. Both wards have annual fire safety inspections and have evacuation and shelter plans updated. Recruitment has commenced for a facilities manager who will ensure oversight of fire risk assessments, weekly checks,

	reviews and actions, and to ensure actions are completed in a timely manner and documents updated, in conjuction with the Ward Manager. Oversight from the Senior Management Team and the Estates Department will be provided to ensure that all actions are taken in a timely manner. Each ward aim to have all staff trained in fire warden, this will ensure there is a fire warden on each shift.
Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3.1 (a) (c) **Stated:** Second time **To be completed by:** 02 March 2025	The South Eastern Health and Social Care Trust must ensure that a detailed ligature risk assessment of ward environments is conducted at least annually to identify all ligature points. Action plans and mitigations must be put in place where risks are identified, and staff must be made 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 Building Safer Wards. An audit has been designed to look at wards and part of this is reviewing the environment. It is essential to maintain a Dementia enabling environment so this will be taken into consideration at all reviews. Inpatient wards update the ligature generalised risk assessment annually or more often as required. These have been reviewed accordingly. This will now be with oversight through ward manager meetings and as part of the facilities managers role. Ligature Improvement work on both wards has been agreed and works have commenced. Further to this, a new Ligature audit tool is now used by a Core Group across Inpatient Wards to ensure consistency and appropriate escalation. This core group consists of a Governance Nurse, Nurse Lead, Positive Practices and Safety Interventions Lead, Facilities Manager and a Medical representative. This audit will be completed on both wards.

Area for improvement 4 **Ref:** Standard 5.1 Criteria: 5.3.3 (b) (e) (f) (g) **Stated:** Second time **To be completed by:** 02 March 2025	The South Eastern Health and Social Care Trust must ensure that a comprehensive quality assurance system with robust audits to monitor operational effectiveness, patient safety and ward performance is developed and the outcomes of these shared with staff to promote improvement in practice. These should include auditing of incidents, care planning documentation and medication. Ref: 5.2.10
	Response by registered person detailing the actions taken: Due to the recent amalgation of services both wards are now under the Adult Direcorate structure and will have access to governance support. Ward Managers now attend 6 weekly inpatient governance meetings led by the Clinical Nurse Governance Lead. Reports are generated and shared at these meetings. which includes reviews on incidents, shared learning and identifies themes This will ensure oversight of operational effectiveness, patient safety and ward performance. The Clinical Governance Nurse Lead continues to work 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 one single documentation KPI which has adopted the PACE framework. A Pilot has commenced in a ward within Acute Mental Health for the data input into the new Formic data system with an eventual plan to roll out across each ward and the development of the KPI Dashboard in this area.
Area for improvement 5 **Ref:** Standard 4.1 Criteria: 4.3 (m) **Stated:** First time **To be completed by:** 02 March 2025	The South Eastern Health and Social Care Trust must review the governance and oversight arrangements in place to monitor staff training compliance to provide effective assurance that all staff are compliant with mandatory training requirements. Ref: 5.2.3
	Response by registered person detailing the actions taken: Job plans have been provided to both Ward Managers. This will help ensure Ward Managers and Deputy Ward Managers have protected time to review their teams training compliance once a week, as well as reviewing individual staff training needs during supervision with staff. When wards have high acuity/staff shortages they will utilise bank shifts to ensure staff can be released to attend training. Bespoke training will be

	utilised where possible to try and faciliate training as close to the wards as possible to ease attendance. LMS and Healthroster have reporting functionality in terms of compliance with training, however it was identified a composite training spreadsheet was needed and is currently in development for completion by the Ward Manager as a live document. There is a current review ongoing of corporate, directorate, service and professional mandatory training.

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