The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Older People's Inpatient Mental Health Service

Provider: Western Health and Social Care Trust

Date of Inspection: 3 June 2025 – 24 July 2025

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

1.0 Service information

Organisation Provider: Western Health and Social Care Trust (WHSCT)	**Responsible Person:** Mr Neil Guckian, Chief Executive Officer, WHSCT
Person in charge at the time of inspection: Mr John-Paul McGinley Assistant Director of Community & Older People's Services	**Number of commissioned beds:** 40
Categories of care: Over 65 Functional Mental Health and Dementia Assessment and Treatment	**Number of beds occupied on the day of the inspection:** 35
Brief description of the accommodation/how the service operates: Western Health and Social Care Trust (The Trust) deliver Older People's Inpatient Mental Health Services at two locations, Tyrone and Fermanagh Hospital (T&F) (Omagh) and Waterside Hospital (Derry/Londonderry). There are four wards operating within the Trust's Older People's Inpatient Mental Health Service. Two provide assessment and treatment for patients aged over 65 years with acute mental health needs, while the remaining two provide assessment and treatment for patients aged over 65 years living with dementia. All wards offer a mix of dormitory-style accommodation and single bedrooms. Patients are admitted to the four 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 commenced on 3 June 2025, and concluded with feedback to the Trust on 24 July 2025. The on-site element of the inspection was carried out by a multi-disciplinary team comprising care, pharmacy and estates inspectors, alongside a sessional consultant psychiatrist.

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. Key lines of enquiry were established following review of a range of intelligence received by RQIA, which included Early Alerts, Serious Adverse Incidents (SAI), whistleblowing information and the previous inspection findings.

Prior to the inspection, RQIA received whistleblowing intelligence highlighting concerns regarding patient care and safety, staffing levels and supports, and ward environment. Following immediate escalation to the Trust, RQIA received assurances there was no evidence to substantiate the patient safety concerns outlined within the intelligence. The inspection confirmed the Trust were taking appropriate action to investigate and address the concerns raised.

The inspection sought to assess the Trust's progress against the areas for improvement (AFIs) identified in the Quality Improvement Plan (QIP) following the previous inspection of Waterside Hospital on 7 June 2022 and Tyrone and Fermanagh Hospital on 22 August 2022. Findings from this inspection identified fifteen AFIs had been met, one was partially met and three AFIs were not met. Further detail can be found in Sections 5.1 and 6.0 of this report.

A review of recommendations identified in Serious Adverse Incident (SAI) reports relevant to the Older People's Inpatient Mental Health Service found that most were embedded in practice, with plans in place to embed the remaining recommendations.

Since May 2025, the Trust has been implementing Encompass, a Health and Social Care programme that creates a single digital record for every citizen in Northern Ireland. The introduction of Encompass intends to support continuity of care and communication between services, improving accessibility of patient care documentation. While in the early stages of implementation, the Trust acknowledged the benefits of the programme in promoting continuity of care and communication between services.

Good practice was identified in relation to the delivery of bespoke care and treatment to patients who had complex physical healthcare needs, comprehensive and person centred patient care documentation, and effective communication with relatives.

Eleven new areas for improvement were identified, and are reported on in further detail in Section 6.0 of this report.

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 inviting staff, patients and relatives to share their views and experiences with inspectors were displayed throughout the service.

Inspectors spoke with a number of patients, relatives, staff members and the independent advocate. Overall, comments from patients and relatives were positive. Relatives reported good communication with staff at all levels and commended the standard of care and treatment their loved ones received. Patients reported satisfaction with the care and treatment provided.

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

Staff we spoke with were positive about their roles and demonstrated commitment to providing high-quality care. Some staff expressed concern that ongoing staffing pressures were affecting the service's ability to consistently deliver, effective care and treatment. These concerns were raised, with Senior Trust representatives, who acknowledged the challenges and outlined plans to address staffing pressures.

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 Waterside Hospital and Tyrone and Fermanagh Hospital were undertaken separately.

The previous inspection of Waterside Hospital undertaken on 7 June 2022, identified eleven areas for improvement (AFIs), and are included in the review of the Quality Improvement Plan (QIP) below.

The previous inspection of Tyrone and Fermanagh Hospital undertaken on 22 August 2022, identified eight AFIs, and are included in the review of the QIP below.

Areas for improvement from inspection of Waterside Hospital on 7 June 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 4.3 (b, d, e) **Stated:** Second time	The Western Health and Social Care Trust must ensure formal monthly staff meetings are convened to ensure staff are provided regular updates and are offered opportunity to raise and discuss matters in relation to day-to-day practice. Records should be	**Met**

	retained on the ward for staff reference and for future inspection. **Action taken as confirmed during the inspection**: This AFI has been assessed as met. Ref: 5.2.10.	
Area for Improvement 2 **Ref:** Standard 4.3 (j) **Stated:** Second time	The Western Health and Social Care Trust must determine the requirement to have pharmacy support on Wards 1 and 2. This review should consider any impact on patient outcomes. **Action taken as confirmed during the inspection**: This AFI has been assessed as met. Ref: 5.2.9	**Met**
Area for Improvement 3 **Ref:** Standard 4.3 (j) **Stated:** First time	The Western Health and Social Care Trust should ensure where appropriate staff can refer patients to the relevant Trust psychology service, based on patients' assessed needs. The Trust should consider some bespoke training for ward staff in relation to psychological formulating and care planning. **Action taken as confirmed during the inspection**: Psychology service is not available within the Older People's Inpatient Mental Health Service. This AFI has been assessed as not met; the AFI has been re-worded to clarify the action required. Ref: 5.2.5	**Not met**
Area for improvement 4 **Ref:** Standard 4.3 (m)	The Western Health and Social Care Trust must ensure that all staff currently working on the ward have received up to date mandatory training.	

Stated: First time	**Action taken as confirmed during the inspection:** Training records did not evidence staff having received up to date mandatory training. This AFI has been assessed as not met and has been stated a second time. Ref: 5.2.3	**Not met**
Area for improvement 5 **Ref:** Standard 5.3 **Criteria:** 5.3.1 **Stated:** First time	The Western Health and Social Care Trust must ensure that any increase in fire risk, is continuously reviewed and assessed by the Trust's fire safety advisor(s) with assurances provided that risk is being managed safely.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. Ref: 5.2.1	
Area for improvement 6 **Ref:** Standard 5.1 **Criteria**: 5.3.1 (f) **Stated:** First time	The Western Health and Social Care Trust must ensure compliance with regional guidance of the use of plastic bags in Mental Health (MH) inpatient wards and Learning Matters Quality 2020 Issue 8, September 2018. The Trust need to have robust assurance mechanism in place to ensure compliance with the guidance in conjunction with IPC team.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. Ref: 5.2.1	

Area for improvement 7 **Ref:** Standard 5.3 **Criteria:** 5.3.1 **Stated:** First time	The Western Health and Social Care Trust must ensure the ligature risk assessments for Waterside Ward 1 and Ward 2 are disseminated to all staff and includes an action plan. The Trust must also ensure that all staff have a working knowledge of the ligature risks and management. **Action taken as confirmed during the inspection:** This AFI has been assessed as met. Ref: 5.2.1	**Met**
Area for improvement 8 **Ref:** Standard 5.3 **Criteria:** 5.3.1 **Stated:** First time	The Western Health and Social Care Trust must: 1. Implement effective governance arrangements for adult safeguarding arrangements to ensure compliance with regional Adult Safeguarding guidance and addresses the following AFI: 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; d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding are improved; e) ensure regular audit of adult safeguarding referrals and incidents; 2. Implement an effective governance process for oversight and escalation of	**Partially met**

	matters relating to adult safeguarding in Ward 1 and 2. 3. Implement effective mechanisms to evidence and assure compliance with good practice in respect of Adult Safeguarding in the hospital. 4. 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 some improvement in relation to ASG practices. However, reporting of ASG incidents remained inconsistent across the service. ASG incidents were reviewed and screened by suitably trained staff. Protection plans, implemented appropriately and maintained at ward level. The governance arrangements in place to oversee ASG were not sufficiently robust to ensure compliance with the ASG operational procedure or provide opportunities for learning and development. This AFI has been assessed as partially met and has been reworded and stated a second time. Ref: 5.2.2	
Area for improvement 9 **Ref:** Standard 4.1 **Criteria:** 4.3 **Stated:** First time	The Western Health and Social Care Trust must implement a staffing model to determine staffing levels, which must address patient acuity and the changing needs of patients. The Trust must also ensure nursing students are rostered as supernumerary while on ward placements.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. Ref: 5.2.3	

Area for improvement 10 **Ref:** Standard **Stated:** First time	The Western Health and Social Care Trust must review governance oversight arrangements of Ward 1 and Ward 2 in relation to environments. SMT should make a formal record evidencing all quality assurance visits and any actions arising from the visit. This record should be available on the ward and shared with all relevant staff.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. Ref: 5.2.10	
Area for improvement 11 **Ref:** Standard **Stated:** First time	The Western health and Social Care Trust must ensure there are robust procedures in place for the safe and efficient discharge of patients from hospital care and patient flow within the ward.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. Ref: 5.2.8	

Areas for improvement from inspection of Tyrone and Fermanagh Hospital on 22 August 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 4.1 **Criteria:** 4.3 **Stated:** First time	The Western Health and Social Care Trust must implement an evidence based staffing model to determine staffing levels, which must address patient acuity and the changing needs of patients.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. Ref: 5.2.3	

Area for Improvement 2 **Ref:** Standard 5.3 **Criteria:** 5.3.1 **Stated:** First time	The Western Health and Social Care Trust must ensure that compliance with fire safety measures, are continually reviewed and assessed by the Trust's fire safety advisor(s) with assurances provided that all risks are being managed safely.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. Ref: 5.2.1	
Area for Improvement 3 **Ref:** Standard 5.1 **Criteria:** 5.3.1 (f) **Stated:** First time	The Western Health and Social Care Trust must ensure compliance with regional guidance of the use of plastic bags in Mental Health (MH) inpatient wards 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 in conjunction with IPC team.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. Ref: 5.2.1	
Area for improvement 4 **Ref:** Standard 5.1 **Criteria:** 5.3.1 **Stated:** First time	The Western Health and Social Care Trust must expedite the estates work to address safety issues identified in relation to external doors.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. Ref: 5.2.1	
Area for improvement 5 **Ref:** Standard 5.1 **Criteria:** 5.3.1 **Stated:** First time	The Western Health and Social Care Trust must ensure ligature risk assessments for both wards are up to date. An action plan should include clear timescales to determine when ligature points requiring removal or replacement will be completed.	**Met**
	Action taken as confirmed during the inspection:	

	This AFI has been assessed as met. Ref: 5.2.1	
Area for improvement 6 **Ref:** Standard 8.1 **Criteria**: 8.3 (i) **Stated:** First time	The Western Health and Social Care Trust must ensure that the information pertaining to patient admission and discharge is accurately reflected within patient flow documentation.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. Ref: 5.2.8	
Area for improvement 7 **Ref:** Standard 4.1 and 5.1 **Criteria:** 4.3, 5.3.1 **Stated:** First time	The Western Health and Social Care Trust must review governance oversight arrangements of Oak ward and Ash ward in relation to the environment. SMT should make a formal record evidencing all quality assurance visits and any actions arising from the visit. This record should be available on the ward and shared with relevant staff.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. Ref: 5.2.10	
Area for improvement 8 **Ref:** Standard 4.1 **Criteria:** 4.3 (m) **Stated:** First time	The Western 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: Training records did not evidence staff having received up to date mandatory training. This AFI has been assessed as not met and has been stated a second time. Ref: 5.2.3	

5.2 Inspection findings

5.2.1 Environment

The inspection sought to assess ward environments against the Royal College of Psychiatrists Standards for Older Adult Mental Health Services, 5th Edition, December 2019 (RCP Standards) to determine if they were conducive to the delivery of safe, compassionate and therapeutic care. Overall, the ward environments were typically compliant with these standards; however, improvement was required in relation to the governance and oversight of environmental safety.

Each ward presented as bright, spacious, and maintained to an acceptable standard of cleanliness. Environments were dementia friendly with provision of regular resting points, contrasting colours, and easy read signage. Seating in one ward was in a poor state of repair, affecting patient accessibility and comfort. An AFI has been identified, regarding the seating available to patients.

All wards had access to outdoor spaces. Patients in Waterside Hospital required staff supervision in accessing these areas, in line with environmental safety risk assessments and as an interim arrangement until planned estates, works to address identified risks were completed. The Trust is encouraged to prioritise and progress these works in a timely manner.

Fire risk assessments (FRA) which seek to assess and review compliance of fire safety measures, had been undertaken within the previous 12 months. However, the associated action plans did not demonstrate the actions taken to address identified risks. In one ward, several fire doors required review by the Trust's Estates department, as highlighted within the FRA action plan. In addition, a number of fire doors were observed to be wedged open. Following escalation to Senior Management representatives, assurances were received that the Estates department had reviewed the fire doors identified, and monitoring measures implemented.

Fire safety checks across both sites were completed and records were maintained appropriately. Safety issues previously identified with the external doors at the Tyrone and Fermanagh hospital site had been addressed following the previous inspection.

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

Ligature Risk Assessments (LRA) are carried out at least annually to assess all potential ligature points in the ward environment, identify associated risks and outline mitigations, ensuring staff are aware of the risk points and how to manage them to maintain patient safety. LRAs were available on each ward and showed evidence of regular review. However, the action plan, while in place, was not accessible to ward staff. Action plans should be accessible to all staff to ensure they are appropriately informed of the actions and mitigations required to maintain patient safety.

The Trust had taken steps to comply with regional guidance on the use of plastic bags in mental health inpatient units. Lockable bins were in place in three wards to restrict patient access, and

bins had been ordered for the fourth ward. However, plastic Personal Protective Equipment (PPE) remained accessible to patients, and Health and Safety risk assessments had not specifically addressed this. The risk to patient safety was raised with senior staff, and immediate action was taken. During feedback, senior management confirmed that PPE and other plastic were no longer accessible to patients.

The Trust's governance and oversight arrangements of environmental safety and associated risk assessments require strengthening to ensure identified risks are managed appropriately, and addressed in a timely manner. An AFI has been identified.

Ward environments should have a mechanism in place to enable patients, staff and visitors to summon assistance when required. While a nurse call system was in place across the service, it was not available outside of the WC's and bathrooms in one ward. An AFI has been identified to enhance the accessibility of a nurse call system in all patient areas.

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).

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 were displayed in the nurses' station in each ward.

While some improvements to ASG practices had been made since the last inspection, the reporting of ASG incidents remained inconsistent across the service, with staff seeking advice before progressing a referral. When staff hesitate to initiate the appropriate safeguarding actions and depend on advice from the Adult Protection Gateway Team (APGT) before proceeding, this creates uncertainty and increases the risk of delays in implementing necessary safeguards, potentially leaving the patient without adequate protection. During feedback, the Trust provided assurance that immediate action had been taken to ensure all ASG incidents were being reported immediately and in line with the Northern Ireland Safeguarding Partnership, Adult Safeguarding Operational Procedures, September 2016.

ASG incidents reported were reviewed by suitably trained members of the Senior Management team and appropriately screened. Incidents that met the threshold for onward referral to the Adult Protection Gateway Team (APGT) were submitted in accordance with regional procedures. Protection plans were maintained at ward level and available to all staff.

Overall, governance arrangements across the service were not sufficiently robust to monitor compliance with the Adult Safeguarding Operational Procedures or to identify opportunities for learning and improvement. ASG audits did not facilitate the identification or analysis of emerging themes or trends. The AFI identified following the previous inspection of Waterside Hospital was assessed as partially met and has been stated for a second time.

DATIX incidents were reviewed (DATIX is the Trust's electronic system for recording incidents). The DATIX records contained an appropriate level of detail and demonstrated consistent grading in line with the HSC Risk Matrix. However, with the exception of one ward, a high proportion of incidents had not been reviewed or approved in a timely manner.

This increases the potential for delays in escalating risk to the appropriate level and in identifying early learning to prevent similar incidents occurring.

Where incidents had been reviewed, records indicated repeated learning points and limited evidence of post-incident debriefs taking place. There was also limited evidence of a mechanism to collate and analyse incident data across the service to support the identification of emerging themes or trends and ensure necessary learning and actions were implemented.

An AFI has been identified in regard to the governance and oversight of incident management.

5.2.3 Staffing

Staff at all levels were observed delivering care and treatment in a caring and compassionate manner and demonstrated good knowledge and understanding of patients' individual needs.

Staffing levels were determined using the Telford model, a tool designed to assist in defining the required level of staffing based on patient acuity. The Trust acknowledged that a review of the current staffing model was required to ensure that the staffing levels determined, appropriately reflected patient acuity. At the conclusion of the inspection, this review had commenced in collaboration with Workforce Development.

All inpatient wards are required to have a mechanism for responding to low or unsafe staffing levels when they fall below an agreed minimum. There was variation across the service in relation to compliance with Trust procedure. The Trust should revisit the procedure for responding to low or unsafe staffing levels with all staff and monitor adherence.

In response to staff vacancies, the Trust had booked Trust employed bank staff and agency staff in advance to help maintain safe staffing levels. On occasions where safe staffing levels could not be achieved, other members of the Multi-Disciplinary-Team (MDT) were reallocated to provide cover. This reallocation was found to have an impact on patient experience. Further detail is provided in Section 5.2.4.

Each ward operated a MDT approach to care and treatment incorporating nursing staff, nursing assistants, occupational therapists, therapeutic nurses, therapeutic assistants, dementia companions, psychiatry and medical staff. The MDT resource within the service did not include psychology representation and had only limited representation from pharmacy. Further reference is made in Sections 5.2.5 and 5.2.9.

Training records evidenced low compliance with mandatory training requirements. While Trust representatives reported actual compliance levels as higher than those recorded, the oversight arrangements for mandatory training were not sufficiently robust to provide assurance that staff are appropriately equipped to undertake their duties competently and safely.

AFIs identified following the previous inspections of Waterside Hospital and Tyrone and Fermanagh Hospital in relation to staff training were assessed as not met. These have been subsumed into a single AFI and stated for a second time.

5.2.4 Patient Experience

Patients should expect to have their meals in 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 (RCP Standards).

Observations across each ward showed that meal times were organised and relaxed, allowing staff to effectively support and observe patients in a compassionate manner. Food appeared appetising, with choices available to patients, and refreshments and snacks were also accessible outside of mealtimes.

Mealtimes were co-ordinated in line with the regionally agreed framework 'Mealtimes Matter'. A Mealtime Coordinator oversaw the mealtime experience on each ward. Information relating to patients' Recommended Eating Drinking and Swallowing (REDS) requirements was available for patient experience and nursing staff, providing assurance that patients were receiving food and fluids at the appropriate level in accordance with the International Dysphagia Diet Standardisation Initiative (IDDSI).

The availability of meaningful and therapeutic activity varied across the service. The temporary closure of the therapeutic hub at Waterside Hospital, along with the occasional reallocation of therapeutic staff to maintain safe staffing levels on the wards, was found to interrupt the delivery of therapeutic activities. During feedback, the Trust confirmed that the therapeutic hub in Waterside hospital had become operational. The Trust is encouraged to keep under review the impact on patient experience and outcomes, when therapeutic staff are reallocated to other duties.

The introduction of Dementia Companions within the Dementia Assessment and Treatment wards since the last inspection, had enhanced the experience of patients living with dementia in the Tyrone and Fermanagh hospital. The Trust reported that additional Dementia Companions were being appointed, which was expected to enhance the delivery of therapeutic activities for patients living with dementia across the service.

5.2.5 Mental Health

Patient documentation evidenced individualised care and treatment arrangements to meet patients' specific needs. This included regular MDT reviews to assess the effectiveness of interventions.

Patients did not have access to psychological services and limited progress had been made since the last inspection to provide bespoke training for staff in relation to psychological formulation and care planning. As highlighted within the RCP Standards, psychology input is an essential component within older people's acute mental health and dementia services. It contributes to the assessment and formulation of patients' psychological needs, supports the MDT to implement appropriate non-pharmacological interventions and contributes to reducing distress, behaviours that challenge and the use of restrictive practices. Where psychology is not present within the MDT, services are more likely to rely on pharmacological or restrictive approaches. Patients may experience increased levels of distress and staff may face challenges in delivering personalised, trauma-informed care. An analysis of patient experience,

communication and incidents involving patient distress would support the Trust to determine any deficiency in service provision by not having access to psychological services. The impact of the continued absence of psychology within this service needs to be determined and action taken to ensure that patient care is not being compromised.

The AFI identified following the previous inspection of Waterside Hospital has not been met and has been reworded to clarify the action required.

The process of leave planning had been reviewed following a recommendation within a SAI report, evidencing a robust risk management process in collaboration with patients and relatives prior to and following planned leave.

At the time of inspection, over 50% of patients were detained under the MHO for assessment and or treatment. Prescribed forms for patients detained under the MHO were in place, but there was limited evidence that their rights as a detained patient had been explained to them. The Trust should review the monitoring arrangements in place to ensure all detained patients have had their rights under the MHO explained to them.

5.2.6 Physical Health

Patients' were assessed by a doctor and received a physical health check within 72 hours of admission, which is in line 'A picture of Health'- A review of the quality of physical healthcare provided to patients admitted to a mental health inpatient setting. Physical health concerns identified on admission or during the patients' stay were followed-up with appropriate investigations and treatment, as demonstrated within patient care records. There was evidence of referral and collaborative working with other specialities where the patients' needs were beyond the remit of on-site medical staff including, Tissue Viability, Speech and Language Therapy and Palliative Care.

Patient documentation demonstrated individualised assessment and care planning to address identified physical healthcare needs. Physical health risk assessments such as Falls, Malnutrition Universal Screen Tool (MUST), and National Early Warning Score (NEWS), were in place and reviewed as appropriate for each patient.

Staff demonstrated sound knowledge and understanding of patients' individual physical healthcare needs and the measures in place to address these appropriately. Medical staff were readily available to patients and staff across the service.

5.2.7 Restrictive Practice

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, enhanced levels of observations, use of PRN ('when required') medications, the use of physical interventions; and the use of falls sensor technology.

Preventative and proactive strategies were in place to minimise the use of restrictive practices across the service. Patient care documentation demonstrated that restrictive practices were, appropriately recorded and implemented based on individual assessed need and risk. For patients admitted on a voluntary basis, records confirmed that patients had received information in relation to the locked door policy and access arrangements.

The Mental Capacity (Northern Ireland) Act 2016 requires Deprivation of Liberty Safeguards (DoLS) to be in place for patients who are not detained under the MHO, lack capacity, are under continuous supervision or control, and are not free to leave the ward. There was limited evidence of a clearly defined process for the implementation of DoLS across the service, and patient care documentation did not consistently reflect care and treatment amounting to a deprivation of liberty for those subject to DoLS. An AFI has been identified with regard to the implementation and management of DoLS within the service.

5.2.8 Patient Flow

The Regional Bed Management Protocol for Acute Psychiatric Beds (Regional Mental Health Acute Bed Management Network, January 2022), requires each Trust to have a designated manager or team responsible for coordinating day-to-day bed management issues. The Trust advised they were exploring options to implement a dedicated resource to oversee the co-ordination of bed management within the service. In the interim, a single point of contact, allocated on a rota basis, oversaw co-ordination of bed management and demonstrated effective oversight of related issues.

The service maintained accurate patient flow data in respect of admissions, discharges, length of stay and delayed discharges. At the time of inspection, a number of patients were experiencing delay in their discharge, which the Trust attributed to a lack of specialised community placements. Trust representatives discussed the potential to undertake a scoping exercise to assess the availability of community placements within the Trust area. RQIA recommend the Trust undertake this exercise to support its efforts to reduce the number of patients experiencing delays in their discharge.

Discharge planning arrangements were discussed at weekly MDT meetings and included the involvement of patients, their relatives, the community mental health team and patient advocates as appropriate.

5.2.9 Medicines Management

Medicines were supplied by Altnagelvin Hospital (Waterside Hospital) and Omagh Hospital (Tyrone and Fermanagh Hospital). The consultant pharmacist (for older people) provided clinical support on a monthly basis to Dementia Assessment and Treatment wards prior to the implementation of Encompass. Since May 2025, clinical support has been limited to ad hoc on-site support and via telephone call on request. A weekly medicine order was completed by a pharmacy technician. A business case to secure funding for onsite pharmacist and pharmacy technician support across the service should be progressed.

Arrangements were in place for the safe management of medicines during patient admission and discharge. As part of the admission process, the admitting doctor obtained details of medicines prescribed pre-admission, which were then reviewed by a consultant psychiatrist.

At Waterside Hospital, this review was completed the following day, while at the Tyrone and Fermanagh Hospital, reviews were undertaken twice weekly. There was no clinical pharmacist review of medicines at admission; however, staff confirmed that a pharmacist could be contacted by telephone when necessary. Arrangements were in place to ensure patients had a continuous supply of their medicines at discharge, along with any necessary advice and written information.

The Trust has transitioned to Encompass, with medicine records maintained electronically. The majority of records were maintained to a satisfactory standard with medicine entries, dosage regimes and the patient's allergy status appropriately recorded. Review of the records of administration indicated that patients were administered their medicines as prescribed. Nurses were familiar with the arrangements for ensuring timely administration of prescribed medicines, including time-critical medicines. Staff had recorded the reason for any omitted doses.

At weekly patient case reviews, the MDT considered medication changes, any use of PRN ('when required') medicines and additional information such as blood tests, physical health checks and the use of high dose antipsychotics. Staff reported that the use of PRN ('when required') medicines was also reviewed during daily ward rounds at Waterside Hospital.

The Regional Rapid Tranquillisation Policy was in place, and nurses were aware of its content. Nurses advised that staff and patient debriefing took place as soon as was practical after an incident where rapid tranquillisation was needed. A report of the use of rapid tranquillisation was recorded on a Trust incident form (DATIX).

The management of medicines prescribed to be administered 'when required' to manage behaviours of concern and distressed reactions as part of a de-escalation/behavioural management strategy was reviewed. Most patient records had clear parameters to direct the administration of medicines prescribed on a 'when required' basis. This included the indication for the medicine, the minimum frequency intervals and the maximum daily dose. However, in instances where more than one medicine was prescribed, it was not always clear which medicine was first, second or third line and care plans were not in place for all patients. The reason for and outcome of administration of these medicines was recorded in the patient case notes. An AFI has been identified in relation to patient records and care planning.

Controlled drugs were safely and securely stored and controlled drugs registers were maintained. Discrepancies in the controlled drug register were noted in both Waterside Hospital and Tyrone and Fermanagh Hospital. For two liquid medicines, the quantity in stock did not correlate with the running balance recorded in the controlled drug register. These recording errors had not been identified by staff, which indicated that a physical check of the quantity of controlled drugs held in stock was not routinely carried out during reconciliation procedures. An AFI has been identified.

On one ward in Tyrone and Fermanagh Hospital, the medication room door was observed to be unlocked during the inspection. While one ward in Waterside Hospital, the medicine trolley had an open shelf containing some external medicines, liquid medications and injections. Medicines must be stored securely to prevent unauthorised access and risk to patients. This was escalated to ward management during the inspection and AFI has been identified.

A number of medicines intended for single patient use, for example, inhalers and insulin pen devices were not individually labelled to denote ownership. This means that these medicines

may be administered to more than one patient, which is not in accordance with Infection Prevention and Control Standards. Other medicines, for example eye preparations and some liquid medicines, with a reduced expiry date once opened, did not include the date of opening. In addition, some medicines remained in use after their expiry date had been exceeded. An AFI has been identified in relation to the governance arrangements of medicines management.

The management of medicines requiring cold storage was reviewed. A review of refrigerator temperature records on one ward in Waterside Hospital evidenced gaps in the recording of maximum and minimum temperatures. Guidance was provided on how to accurately monitor the refrigerator temperature, including the need to reset the thermometer each day after recording the maximum, minimum and current temperatures. It was agreed that this would be shared with all nurses and monitored through the audit process.

Resuscitation trolleys were readily accessible and records were available of the daily audit of contents and expiry dates.

There was evidence that nursing staff were knowledgeable regarding the Trust medicines management policy and procedures and the medication needs of individual patients. The consultant pharmacist advised that the Trust's Medicine Code and ward procedures for the management of controlled drugs were due to be reviewed.

The management of medication related incidents was discussed with the consultant pharmacist and nursing staff, who advised that incidents were investigated, reported and that any learning identified and resultant changes in practice were shared with all staff to prevent a recurrence.

In addition to the quarterly controlled drug audit, senior ward staff advised that they complete a medicines management self-audit tool monthly. A sample of completed audits was submitted to RQIA for review. The issues noted at this inspection had not been identified. It was agreed that ward management would oversee the audit procedures.

Training records reviewed indicated that mandatory medicines management training was not always up to date and reviewed in line with Trust procedures. An AFI in relation to mandatory training was identified in Section 5.2.3.

5.2.10 Governance

Governance arrangements were reviewed through the examination of relevant documentation and discussions with ward managers, the interim Head of Service, the Dementia Service Improvement Lead, the Assistant Director and members of the MDT.

Regular staff meetings were held across the service as far as practicable, providing updates to staff and opportunities to raise and discuss matters in relation to day-to-day practice.

There was evidence of effective governance arrangements with regard to patient care documentation and environmental cleanliness. Senior Management meetings and associated minutes demonstrated oversight of ward performance against Key Performance Indicators (KPIs) and indicated actions required to drive improvement.

Quality assurance visits undertaken by Senior Management took place in two of the four wards. However, visit records did not provide evidence of effective oversight of environmental safety or review actions identified from previous visits.

Governance arrangements overseeing ASG and incident management require strengthening regarding the collation and analysis of incident data and monitoring of the implementation of learning and actions.

RQIA issued correspondence to the Trust in December 2022 following the identification of variances in the management of incidents and ASG across Trust directorates, and urged the Trust to continue to develop robust lines of communication between all Trust directorates, taking every opportunity to drive improvement through the sharing of learning, across all services. The inspection identified robust lines of communication to support the dissemination of learning across directorates had not been sustained. An AFI has been identified concerning communication between Trust directorates.

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	13

* the total number of areas for improvement includes two that have been stated for a second 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 (m) **Stated:** Second time **To be completed by:** Immediately	The Western Health and Social Care Trust must review governance arrangements to ensure effective oversight of staff mandatory training compliance. Ref: 5.2.3 & 5.2.9 (revised to provide clarity)
	Response by registered person detailing the actions taken: The training matrix across the 4 wards have been reviewed and revised to now include two rather that four training matrix, one for the northern sector and one for the southern sector. We now have more structure around core mandatory, mandatory and desirable training needs for all grades of staff. All training is now a standing item agenda on our monthly In-patient Governance and Business meetings.

	Staff training is also a standing item agenda on the Ward Manager's monthly staff meetings in each sector. We are in the process of completing a Dementia training needs analysis which will determine any future Dementia training needs for our staff. We have recently appointed a Business Support Officer who is assisting both the Senior Management Team and the Ward Manager's with oversight in this area for improvement.
Area for improvement 2 **Ref:** Standard 5.1 Criteria: 5.3.1 (a, c) **Stated:** Second time **To be completed by:** 14 January 2026	The Western Health and Social Care Trust must implement effective governance and oversight arrangements of Adult Safeguarding practice to ensure compliance with The Northern Ireland Adult Safeguarding Partnership, Adult Safeguarding Operational Procedures, September 2016. Governance and oversight arrangements should seek to ensure: • Staff are adequately supported and trained to fulfil their roles and responsibilities under the ASG operational procedure. • Robust mechanisms are in place to monitor compliance with the Operational procedures and identify opportunities for learning and development. Ref: 5.2.2 (Revised to provide clarity)
	Response by registered person detailing the actions taken: A process mapping exercise is currently being undertaken jointly with the WHSCT Adult Safeguarding Team Head of Service and Principal Social Worker across all four wards. This will inform future pathways and determine the level of support required to address this area for improvement. Further bespoke training has now been arranged for the southern sector staff. Bespoke training needs and ASG support will be further reviewed following the process mapping. Mandatory Adult Safeguarding level 2 training is recorded on training matrix. We have developed a template to record and monitor Adult Safeguarding data across the four wards. This will help to identify volume of referrals within a 12 month rolling period and identify themes, patterns and analysis of referrals to assist with ongoing quality improvement initiatives.

	The Senior Management Team and Adult Safeguarding Team now undertaking bi-monthly Adult Safeguarding Governance and Oversight meetings to review all adult safeguarding concerns within our OPMH In-patient wards.
Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3.1 (e) **Stated:** First time **To be completed by:** 14 January 2026	The Western Health and Social Care Trust must strengthen their governance and oversight of environmental safety by establishing a robust mechanism for ongoing monitoring, review and timely management of environmental risks within patient areas. Ref: 5.2.1
	Response by registered person detailing the actions taken: Since this inspection, the Health and Safety Inspections for Ward 1, Ward 2 and Ash and Oak Villas that were commenced in 2023 have been reviewed and updated following completion of capital infrastructure works in financial years 2023 / 2024 and 2024 / 2025. The vast majority of identified risks have been successfully completed and the few remaining minor outstanding issues are being progressed in the new financial year. All three Health and Safety reports are included for discussion in our monthly Governance and Business meeting attended by the Senior Management Team and both Ward Manager's. Since commencement of the monthly Ligature risk assessments in April 2022, these continue to be completed monthly. There is also environmental safety sweeps being undertaken on three occasions per 24 hours of each ward area. We have revised our morning huddles and have separated into two huddles, one for wards and one for community. This allows more time in the mornings to focus on clinical issues, including environmental risks. The Senior Manager Assurance and Accountability template has been revised to include environmental risks. The Senior Management team attend and co-chair the quarterly Mental Health Environmental Safety Group alongside our colleagues in Adult Mental Health and Learning Disability. This forum identifies and discusses risks and shared learning.

Area for improvement 4 **Ref:** Standard 5.1 Criteria: 5.3.2 (a, c) **Stated:** First time **To be completed by:** 14 January 2026	The Western Health and Social Care Trust must implement effective governance and oversight arrangements of incident management to ensure: • A robust mechanism is in place to collate and analyse incident data. • Timely review of incidents. • Identified actions and learning are implemented. Ref: 5.2.2
	Response by registered person detailing the actions taken: Following the feedback meeting with RQIA on 24 July 2025, the following day the Senior Management Team agreed a process for weekly monitoring, review and closure of appropriate Datix. This process has been effective in ensuring governance and oversight arrangements in respect of incident management and the weekly meetings continue. A weekly Learning Newsletter has been developed as part of this process to ensure learning is shared with all staff across our Older People's Mental Health In-patient areas.
Area for improvement 5 **Ref:** Standard 4.1 Criteria: 4.3 (a, b) **Stated:** First time **To be completed by:** 14 January 2026	The Western Health and Social Care Trust should establish robust communication pathways between directorates to ensure learning is consistently shared and used to drive improvement. Ref: 5.2.10
	Response by registered person detailing the actions taken: This area for improvement requires the WHSCT Corporate Management Team input to progress successfully. This area for improvement has been shared and discussed within our own directorate Governance Meeting.
Area for improvement 6 **Ref:** Standard 5.1 Criteria: 5.3.1 (f) **Stated:** First time **To be completed by:** 14 April 2026	The Western Health and Social Care Trust must ensure a nurse call system is available and accessible in all patient areas across the service. Ref: 5.2.1
	Response by registered person detailing the actions taken: This area for improvement will be progressed through a capital infrastructure business case for the 2026 / 2027 financial year.
Area for improvement 7 **Ref:** Standard 6.1	The Western Health and Social Care Trust should review the impact (if any) of the absence of inpatient psychology provision

Criteria: 6.3 (c) **Stated:** First time **To be completed by:** 14 April 2026	on patient outcomes and identify any associated risks to the quality and safety of care. Ref: 5.2.5
	Response by registered person detailing the actions taken: As a starting point within this area for improvement, the weekly multidisciplinary template will be updated on Encompass to include the clinical need for psychology input for each patient. The appropriate referrals will be made to the Older People's Mental Health Psychological Therapies service. The outcomes of referral triage will be monitored on a weekly basis and this will determine appropriate action if required. Any rejection for Psychological input from the service will be datixed appropriately.
Area for improvement 8 **Ref:** Standard 5.1 Criteria 5.3.1 (f) **Stated:** First time **To be completed by:** 14 January 2026	The Western Health and Social Care must review furniture provided for patient use; ensuring furniture is fit for purpose and meets the specific needs of patients. See 5.2.1
	Response by registered person detailing the actions taken: We secured money in 2025/ 2026 to procure new furniture for Wards 1 and 2 Waterside Hospital. The new furniture order is currently being finalised and we hope to have this progressed within the next two months.
Area for improvement 9 **Ref:** Standard 5.1 Criteria: 5.3.3 (f) **Stated:** First time **To be completed by:** 14 January 2026	The Western Health and Social Care Trust must implement governance arrangements to ensure effective oversight of the implementation of Deprivation of Liberty Safeguards in compliance with The Mental Capacity (Northern Ireland) Act 2016 and associated Code of Practice. See 5.2.7
	Response by registered person detailing the actions taken: For this area for improvement the weekly multidisciplinary case conference template will be updated on Encompass to include MHO/ MCA considerations. We have included MHO/ MCA for discussion in our morning huddle template.

<table>
<tr><td rowspan="2">Area for improvement 10

Ref: Standard 5.1
Criteria: 5.3.1 (a, f)

Stated: First time

To be completed by:
Immediately</td><td>The Western Health and Social Care Trust must ensure, were medicines are prescribed for the management of behaviours of concern and distressed reactions:
A care plan is in place
The care plan and prescription record clearly indicate which medicine is prescribed first, second and third line.
Ref: 5.2.9</td></tr>
<tr><td>Response by registered person detailing the actions taken:
The Ward Manager/ Nurse in charge/ Named Nurse/ Associate must all ensure on a daily basis that a care plan is in place for the management of behaviours of concern and distressed reactions for each patient.

The Consultant Psychiatrist and ward medical team must ensure that all medications prescribed clearly indicate first, second and third line use.

The Clinical Lead Psychiatrist of Old Age will share this area for improvement at the following forums to ensure this is shared will all prescribers;
OPMH medical interface team meeting.
Weekly post graduate education session.
All clinical supervisors.
Med Ed West.
All care plans and medication prescriptions to be discussed weekly at the multidisciplinary case conference meeting.

The Senior Management Team assurance visit will collate a snapshot of this area for improvement.</td></tr>
<tr><td rowspan="2">Area for improvement 11

Ref: Standard 5.1
Criteria: 5.3.1 (f)

Stated: First time

To be completed by:
24 October 2025</td><td>The Western Health and Social Care Trust must ensure that a physical check of controlled drugs is routinely carried out during reconciliation procedures.

Ref: 5.2.9</td></tr>
<tr><td>Response by registered person detailing the actions taken:

Senior management will ensure that all staffs controlled drug competencies are up to date and revisit Standard Operating procedure CD38: Reconciliation of CD Stock Balance. This document is within the Share-point link shared with both Ward Managers for onward dissemination amongst ward staff.

Pharmacy Memo February 2020 :Dealing with CD liquid discrepancies is also being shared with all staff via the Ward</td></tr>
</table>

	Managers. This includes CD Liquid reconciliation good practice points.
Area for improvement 12 **Ref:** Standard 5.1 Criteria 5.3.1 (f) **Stated:** First time **To be completed by:** Immediately	The Western Health and Social Care Trust must ensure that medicines are stored securely to prevent unauthorised access and risk to patients. Ref: 5.2.9
	Response by registered person detailing the actions taken: All medications are required to be stored securely across our OPMH inpatient wards. It is the responsibility of all registrants to ensure that this area for improvement in maintained at each shift. The Senior Management Team assurance visit will collate a snapshot of this area for improvement. All registrants have been requested to update their Medicines Management training. Medicines Management training is a mandatory training requirement on our training matrix. The Western Trusts medicine code has been shared with Ward Managers again for dissemination to all ward staff. Particular reference is directed towards chapter 9 – storage and security of medicines.
Area for improvement 13 **Ref:** Standard 5.1 Criteria 5.3.1 (f) **Stated:** First time **To be completed by:** Immediately	The Western Trust must implement effective governance arrangements of medicine management to ensure: • Appropriate labelling of medicines intended for single patient use • Appropriate management of medicines with a reduced expiry date once opened. Ref: 5.2.9
	Response by registered person detailing the actions taken: The following points have been confirmed and agreed with Pharmacy: • Staff can request labelled products from pharmacy for appropriate labelling of medicines intended for single patient use.

	• Items dispensed from the main pharmacy will indicate the expiry date for (liquids/ eye drops/ insulin pens/inhalers) at the point of dispensing. • Those items with a limited expiry taken from general stock will require staff to check the outer manufacturers packaging. All outer packaging will indicate if expiry is shortened on opening. Staff can annotate date of first opening or date of expiry. All of the above has been shared with both Ward Managers.

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

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