The Regulation and Quality Improvement Authority

Inspection Report

29 April – 23 May 2024

Belfast Health & Social Care Trust

Acute Mental Health Inpatient Centre
Belfast City Hospital
Belfast
BT9 7YG
Telephone number: 028 9032 9241

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

1.0 Service information

Organisation/Registered Provider: Belfast Health and Social Care Trust (BHSCT) (the Trust) **Responsible Individual:** Dr. Cathy Jack Chief Executive, BHSCT	**Registered Manager:** Hazel Walsh, Service Manager
Person in charge at the time of inspection: Orla Tierney, Co-Director, Mental Health & CAMHs, BHSCT	**Number of registered places:** 80 Ward 1: 14 Ward 2: 20 Ward 3: 20 Ward 4: 6 (PICU) Ward 5: 20
Categories of care: Mental Health (MH) Acute Admission Psychiatric Intensive Care (PICU)	**Number of patients accommodated on the first day of this inspection:** 83 Two patients were accommodated in contingency spaces. One patient was on leave.

Brief description of the accommodation/how the service operates:

The Adult Mental Health Inpatient Centre (AMHIC) is located on the site of Belfast City Hospital and managed by the Belfast Health and Social Care Trust. There are five wards within AMHIC. Wards 2,3 and 5 provide assessment and treatment for patients with acute mental health needs aged between 18 and 65 years old. Ward 1 provides assessment and treatment for patients over 65 years old, and Ward 4 (PICU) provides psychiatric intensive care for patients who require this level of support.

Wards 1,2,3 and 4 are mixed gender. Ward 5 is a male only ward. All wards consist of single occupancy bedrooms with ensuite bathroom facilities.

Patients are admitted either 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 29 April 2024, and concluded with feedback to the Trust on 23 May 2024. The inspection team comprised four care inspectors, an assistant director, a senior inspector, an estates inspector and estates assistant, RQIA's sessional Consultant Psychiatrist and administrative support.

The inspection focused on the following eleven themes; incidents; adult safeguarding; environment; staffing arrangements; mental health; physical health; restrictive practices; patient experience; governance; patient flow; and medicines management. These themes were established following review of a range of intelligence received by RQIA which included Early Alerts, Serious Adverse Incidents, engagement with key stakeholders and the previous inspection findings.

The inspection findings identified concerns regarding the management of adverse/serious adverse incidents. These concerns relate to the limited action, taken by the Trust following incidents, to promote patient safety. The Trust's oversight and governance arrangements require to be strengthened to ensure incident management processes are effective with timely action taken to minimise risk and demonstrate a proactive approach to promoting safe care. The incidents involved, ligature, choking and fire safety.

As a result of the concerns, a meeting was arranged with Senior Trust Representatives on 7 August 2024 with the intention of issuing an Improvement Notice due to failure to comply with the following Standard:

The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (DoH, 2006).
Quality Standard 5.1 Safe and Effective Care Theme 2:
Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.
Criteria 5.3.1: Ensuring Safe practice and the Appropriate Management of Risk; and Criteria 5.3.2: Preventing, Detecting, Communicating and Learning from Adverse Incidents and Near Misses

Having analysed the Trust's action plan and considered the information provided by the Trust at the meeting, RQIA determined that the patient safety risks associated with ligature risks had not been sufficiently mitigated and as a result, RQIA determined to serve an Improvement Notice **(IN000019)** to the Trust on 16 August 2024. The date for compliance with the Improvement Notice is 17 February 2025.

The enforcement policies and procedures are available on the RQIA website.

Enforcement notices are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

3.0 How we inspect

RQIA has the authority under the Mental Health (Northern Ireland) Order 1986 and The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland Order) 2003 to conduct this inspection.

RQIA also has a statutory duty under Article 86 of the Mental Health (Northern Ireland) Order 1986 to keep under review the care and treatment of patients and to make inquiry into any case of ill-treatment, deficiency in care and treatment, improper detention, and/or loss or damage to property.

The quality and delivery of care is assessed against the Department of Health Quality Standards for Health and Social Care, Supporting Good Governance and Best Practice in HPSS, (2006).

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the service is performing at the time of the inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

In preparation for this inspection, information about the service was reviewed and used to inform the Key Lines of Enquiry (KLOEs) for this inspection.

Patient care and staff/patient interactions were observed. A range of documents were examined on site to include but not limited to patient care documentation, policies and procedures and governance information.

Posters and leaflets were placed throughout the ward inviting staff and patients to speak with inspectors and feedback on their views and experiences.

4.0 What people told us about the service

We spoke with a number of patients and staff and asked for their views. We also met with the Carers' Advocate.

The majority of patients spoke positively about their care and treatment and how it had supported their recovery. Patients also said their experience of the ward was positive. Any concerns raised by patients were addressed during the inspection.

Staff spoke positively about their ward teams and felt supported by individuals from the Senior Management Team. A number of staff were concerned about changes to the ward environment to meet the needs of patients admitted who had an Intellectual Disability. It was evident that additional support from Community Learning Disability services was available for patients in AMHIC who had an Intellectual Disability. Senior Managers were aware of these concerns and mechanisms were in place to support staff with caring for patients with these additional needs.

Patient advocacy was available through the Trust Patient Engagement Officer who was accessible at ward level, at specified times. Leaflets and information on how patients could access other advocacy services was available on each ward.

The Carers' Advocate reported that the majority of relatives/carers gave positive feedback about the ward, the staff and the care and treatment delivered to patients.

Feedback from what people told us about the service was shared with senior 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 last inspection to AMHIC was undertaken on 04 May 2021; six areas for improvement were identified.

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 04 May 2021</th></tr>
<tr><th colspan="2">Action required to ensure compliance The Quality Standards for Health and Social Care DoH (March 2006).</th><th>Validation of compliance</th></tr>
<tr><td>Area for improvement 1

Ref: Standard 5.1
Criteria: 5.3.1 (f)

Stated: Second time

To be completed by:
4 June 2021</td><td>The Belfast Health and Social Care Trust should ensure that evidence based risk screening tools:

• Should be completed in accordance with the Trust's policy/procedures and in line with best practice guidance;
• Are accurately completed to support the patient's physical health care needs such as: Braden Scale, MUST, fluid balance and fluid management charts;
• Inform care plans and are reviewed regularly.

Action taken as confirmed during the inspection:
This AFI has been met.</td><td>Met</td></tr>
</table>

Area for improvement 2 **Ref:** Standard 5.3 Criteria: 5.3.1 (f) **Stated:** First time **To be completed by:** 4 June 2021	The Belfast Health and Social Care Trust should audit supplementary care records to assure themselves that they are completed accurately. **Action taken as confirmed during the inspection**: There was limited evidence to support regular auditing of patient care records. It is acknowledged that a response has been received from the Trust in relation to future auditing plans and schedules. This AFI has been partially met and as a result of the information obtained from the Trust will be reworded and stated for a second time. See section 5.2.5, 5.2.9	**Partially met**
Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3.1(e) **Stated:** First time **To be completed by:** 25 May 2021	The Belfast Health and Social Care Trust should address the following in relation to fire safety: • Ensure each wards fire risk assessment is accessible at ward level; • Ensure fire risk assessments are maintained as a “live document” which is updated and reflects when recommendations are actioned, by whom and on what date; • Ensure each fire risk assessment is updated to reflect the changing risks when wards are over occupied; and • Ensure all patients who may need one have a personal emergency evacuation plan (PEEPS) completed. **Action taken as confirmed during the inspection**: This AFI has been met.	**Met**

Area for improvement 4 **Ref:** Standard 5.1 Criteria: 5.3.3 (b) **Stated:** First Time **To be completed by:** 4 June 2021	The Belfast Health and Social Care Trust should ensure: • Patient care plans reflect their individual care needs; and • Care plans are shared with the patient; and evidence that the patient is in agreement with the planned care. **Action taken as confirmed during the inspection**: Some care plans were generic in nature and not all patients had signed their care plans. This AFI has not been met and will be stated for a second time. See section 5.2.5	**Not met**
Area for improvement 5 **Ref:** Standard 5.1 Criteria: 5.3.1 (c) and (d) **Stated:** First time **To be completed by;** 4 June 2021	The Belfast Health and Social Care Trust should undertake a review of their Adult Safeguarding (ASG) arrangements to ensure: • All referral forms are completed in full with appropriate, accurate detail; • That interim protection plans are appropriately developed implemented and recorded; • Referrals are screened by ward and deputy ward managers and escalated to the DAPO/adult safeguarding team in a timely manner in line with regional and Trust timeframes; • Staff can easily access information that informs them at what stage in the process ASG referrals are; • Progress notes reflect ASG incidents; • ASG incidents and referrals feature on safety briefs and PIPA meetings as a standing item; and • Effective audit and assurance of adherence to Trust procedures and Adult Safeguarding Operational Procedures 2016. **Action taken as confirmed during the inspection**: There was limited evidence available to confirm satisfactory progress with achieving	**Not met**

	this AFI. APP1 forms were completed in full however protection plans were not always available. Screening arrangements were in place, however for those ASG referrals that met the threshold, the stages of the investigation were not available to those who required it, nor was it included in the patient records. ASG was discussed at safety and MDT meetings. There had been no audit completed for the Trust to assure managers that all staff were adhering to the Regional procedures. This AFI has not been met and will be reworded to reflect progress and stated for a second time. See section 5.2.2	
Area for improvement 6 **Ref:** Standard 5.1 Criteria: 5.3.3 (d) **Stated:** First time **To be completed by:** 4 October 2021	The Belfast Health and Social Care Trust should ensure a consistent approach to recording is applied throughout the unit for all disciplines ensuring that: • There is a shared understanding of where to store records that cannot be updated or stored on Paris; • Templates used are consistent across all wards (in particular for PIPA and safety briefs/handovers and MDT meetings); and • Records are signed and dated and in line with professional and Trust standards.	**Not met**
	Action taken as confirmed during the inspection: There is an inconsistent approach to recording and storage, with different wards using different templates. There were discrepancies noted in all wards in relation to signing and dating records. This AFI has not been met and will be reworded to reflect changes in the Trust's electronic recording system and stated for a second time. See section 5.2.9	

5.2 Inspection findings

5.2.1 Incident Management

Incidents Involving Ligatures

A number of inpatient deaths have occurred in acute mental health inpatient facilities across Northern Ireland. These include incidents where patients have completed suicide, using doors/door handles as ligature points. Regional learning and recommendations were issued following some of these incidents with the aim to reduce risks for patients.

The most recent Ligature Anchor Point Survey (LAPS), completed in AMHIC April 2024, identified that the internal doors and door handles were a risk to patients. The LAPS recommended replacement of the door handles and that consideration should be given to replacing the doors, which could be used as an anchor point. It is recognised that the risks associated with the doors are included in the Directorate and Corporate Risk registers and are discussed at a monthly divisional governance meeting. Additionally, all incidents that meet the threshold are discussed at the Collective Leadership Team meeting. Despite these actions there are insufficient mitigations in place to reduce the risk associated with the current doors. An example of one element of post incident learning and mitigation, is to increase the frequency of patient observations. This however has not been implemented.

Sadly, in 2020 there was a patient death in AMHIC in which a bedroom door handle was used as a ligature point. The Trust identified the internal doors in the AMHIC wards, with the exception of ensuite bathroom doors, as a ligature risk, five years ago. Despite this limited progress has been made.

During the Intention to serve an Improvement Notice Meeting on 7 August 2024, Trust representatives provided an account of the actions progressed to date, in response to the concerns identified by RQIA during the inspection. RQIA were informed that the Trust have released some capital funding to commence a programme of replacement of the doors/door handles in AMHIC. However, the available funding is limited in terms of the number of doors that can be replaced. The information provided to RQIA indicates that the funding available will only permit doors/door handles to be replaced in one of the wards. AMHIC has five acute mental health inpatient wards.

Having considered all of the information provided by the Trust, RQIA determined that the actions taken and proposed do not provide the necessary assurance that the risks are being managed sufficiently to ensure the delivery of safe care to patients admitted to AMHIC. Therefore, an Improvement Notice was issued with the aim of supporting the Trust to replace the door/door handles in AMHIC, review the mitigations to manage the risks until such times as the doors/door handles are replaced and ensure effective governance processes are implemented.

Choking Incidents

There have been a number of patient deaths as a result of choking in acute inpatient facilities across Northern Ireland. In 2023 a patient died in AMHIC as a result of a choking incident. A Level 1 Serious Adverse Incident (SAI) investigation has been completed and the Trust are finalising the report. Following the incident, the Trust made recommendations which focused on staff training. At the time of the inspection, there was insufficient evidence that the recommendations had been implemented and for the period of RQIA's review of incidents (January to March 2024), there had been a further 13 incidents related to choking.

During the meeting on 7 August 2024, the Trust provided an action plan which provided some assurance on the Trust's actions and intentions with regard to the management of choking.

Fire Related Incidents

There have been 12 fire setting incidents in AMHIC since the new facility opened. Information displayed at the entrance to wards, illustrates items considered to be contraband in line with the Trust's Search Policy for AMHIC. Lighters are a listed contraband item, however, during the inspection a number of patients had access to personal lighters. An observable mitigation had been implemented (Ciglow) to reduce the fire risk associated with patient access to lighters, as described in the Trust's action plan submitted to RQIA on 11 March 2024. Despite this mitigation, patients continued to have access to lighters and therefore the risk of fire setting remained.

During the meeting on 7 August 2024, the Trust provided an action plan which provided some assurance on the Trust's actions and intentions with regard to the management of fire related incidents. An area for Improvement relating to fire has been included in the QIP.

Assessing Risk and Learning from Incidents

There was limited evidence on Datix recordings that cumulative risk was taken into consideration when grading the outcome of incidents. The inspection team reviewed incidents in AMHIC between January and March 2024, relating to self-harm/suicide. A large number of these involved patients using ligatures. Each of the incidents had been recorded with no evidence that previous incidents of a similar nature had been reviewed or considered when assessing the level of risk presented by individual patients. This was reflected in the outcome of the risk grading and may determine incidents not being escalated to senior management as they do not meet the threshold for escalation. This has potential to impact negatively on patient outcomes.

There was limited evidence of a mechanism for sharing learning following incidents. Learning identified from choking incidents had not been cascaded effectively to ward staff and actions to be taken post incident had not been fully implemented.

The system in place for effective oversight of mandatory training was not robust. Some training identified from incidents was made mandatory, however, the uptake of this training was poor. The Trust should ensure that there are robust governance arrangements in place to ensure effective oversight of mandatory training compliance.

An area for improvement in relation to incident management was identified.

5.2.2 Adult Safeguarding

Each ward had a Social Worker identified as the Designated Adult Protection Officer (DAPO) with oversight of Adult Safeguarding for that ward. An Adult Safeguarding (ASG) information board was displayed in all the main offices providing information to staff. ASG incidents and referrals were a feature on daily safety briefs and Purposeful In-Patient Admission (PIPA) meetings as a standing item.

There was good adherence to ASG procedures, ASG referrals were completed comprehensively, screened and escalated appropriately to the DAPO/ASG Team in line with regional and Trust timeframes. Good practice was identified with regards to the recording systems in place in two of the wards which identified patients involved in the ASG process and gave a brief synopsis of the ASG issues. It is recommended the Trust share these practices across all wards.

Gaps were identified in the process after the ASG referral was screened. Operational staff were not kept up to date on the stages of the investigation and not all staff were informed of the protection arrangements in place for patients. Patients' daily progress notes were not kept up to date with ASG actions and decisions and staff did not have access to the specific ASG documentation. This has the potential to place patients at risk of additional safe guarding. This was raised with members of Senior Management and assurances were received following the inspection that this issue has been addressed and a robust system is now in place.

There was no evidence of audit by Senior Management of ward level ASG processes. This was identified during the previous inspection of AMHIC and an AFI was identified. This inspection showed some improvement however, the AFI had not been fully met. As a result, the AFI stated at the last inspection has been reworded and stated for a second time.

5.2.3 Environment

The Acute Mental Health Inpatient Centre (AMHIC) is a standalone facility located within the grounds of the Belfast City Hospital. The five wards interconnect with a reception area in a circular layout with a well maintained outside area in the centre which contains a relaxation pod.

All wards operate locked doors at the point of entry and patients required the assistance of staff to both enter and leave the ward environment. A patient booklet is available to patients at the point of admission which includes information on the restrictions in place.

The ward environments were bright and spacious. A number of private spaces were available to patients, including the centre's relaxation pod.

The standard of cleaning throughout was good and there were no malodours. Some wards would benefit from redecoration.

Patients are accommodated in single occupancy ensuite bedrooms which they have opportunity to personalise. Patients can lock and unlock their bedroom doors as they wish. All ensuite bathroom doors have been removed as they have been assessed as being a ligature risk. The Trust should consider additional options, to those currently in place, to enhance patient privacy and dignity.

A Fire Risk Assessment (FRA), completed in November 2023, was available for review. The FRA had not been updated to evidence the actions taken by the Trust to address the recommendations contained within it. Fire safety is discussed in more detail in section 5.2.1. Fire safety and risk checks had not been completed in accordance with Trust policy and faults and defects had not been rectified in a timely manner. Governance oversight of fire safety requires improving.

It was positive to note that patients with mobility needs had Personal Emergency Evacuation Plans (PEEPS) in place. It would be good practice to consider PEEPS for patients who may also need assistance due to their presenting mental health needs and those patients diagnosed with an intellectual disability.

There have been longstanding problems affecting the supply of water, which has an impact on patient experience and safety. These include automatic activation of showers when not in use, leaks, environmental damage and intermittent supply in some toilets. Assurances were given by Senior Management during formal feedback that the necessary agencies had been contacted to progress repairs and resolution of the issues.

5.2.4 Staffing

There was a good system in place to assist the Trust to identify safe staffing levels. Staffing levels are determined using the Telford model, which is a tool used to assist staff in ensuring appropriate staffing levels are in place, based on patient acuity. Patient acuity has the potential to fluctuate in any of the five wards and there was evidence on staff rotas that staffing had been adjusted in response to this. The inspection identified that patients who, at times, present with dysregulated behaviours had an impact on the staffing resource for the other patients.

The Trust aimed to achieve the minimum safe staffing level for every shift, however this was not always possible. There was a reliance on Trust bank staff or redeploying staff across the five wards. Additionally, a small number of agency staff, who were familiar with patients and the environment were booked in advance to support continuity of care. Staffing shortages were escalated appropriately.

AMHIC operates within a multidisciplinary team (MDT) model of care with a number of allied health professionals (AHP) contributing to the MDT. These include Psychiatry, Psychology, Pharmacy, Nursing, Medical, Speech and Language Therapy, and Occupational Therapy.

Access to the pharmacy service was not equitable across the five wards. Nursing staff in wards with no pharmacy support advised they complete the management of medicines tasks that are undertaken by pharmacy staff available on other wards. This can result in reduced capacity for patient contact by nursing staff. The Lead Pharmacist advised that an options paper has been drafted to review the current pharmacy compliment. The Trust should review the level of pharmacy support available to ensure adequate support is available in all wards.

Staff training records evidenced that the majority of staff in three of the five wards had not received an appraisal within the last 12 months, however most staff across all wards had received at least one supervision session within that time frame.

An area for improvement has been made in relation to the level of pharmaceutical support available across all wards.

5.2.5 Mental Health Care

Patients had access to a MDT and assessed needs and care provided was documented. Care plans sampled were up to date, regularly reviewed, reflective of the current treatment plan and provided guidance to those directly caring for the patient. Detailed care plans, specific to individualised mental health needs, were available for the majority of patients. Voluntary patients were aware of the locked doors policy and this was reflected in their care plans.

There was limited evidence of regular auditing of patient care documentation. This was identified during the previous inspection and an AFI was made. This inspection showed this AFI has been partially met and as a result of the information obtained from the Trust will be reworded and stated for a second time.

Some care plans were generic in nature and require attention to accurately reflect individualised need. It is important for patients to be invovled in planning their care. Evidence of patient involvement in their care plans was inconsistent. Where evidence was not available, the reason was not always documented. On occasions where it was documeted, for example “patient too unwell to sign”, there was no evidence of staff revisting the care plan with the patient at a time when they had capacity to be in involved. This was identified during the previous inspection and an AFI was made. This inspection showed the AFI had not been met. As a result, the AFI stated at the last inspection has been stated for a second time.

It was positive to observe bespoke care and treatment being delivered to individuals with Intellectual Disabilities with support provided by the community learning disability team.

There was good oversight of the use of the Mental Health (Northern Ireland) Order 1986 when patients were detained. Patients were provided with information about their detention and leaflets explaining their rights were available at ward level. Patients were informed of their right to a referral to the Mental Health Review Tribunal for Northern Ireland.

5.2.6 Physical Health

Patients’ physical healthcare needs were met, in the main, by on-site medical staff. Patients were seen by a Doctor and had a physical health check within 72 hours of admission. Good practice was evidenced in blood testing, medication reviews by Consultant Psychiatrists, anti-biotic therapy, and anti-psychotic blood monitoring.

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

It was positive to note that patients who were considered delayed in their discharge had been supported to attend appointments and clinics at other hospitals to receive care for ongoing physical health conditions which could not be managed in AMHIC. This is good practice.

5.2.7 Restrictive Practice

Restrictive practices in use included locked doors to manage entry to and exit from the ward; levels of patient observations; the use of medicines prescribed on a "when required" basis; the use of physical interventions; patient searches; and the use of seclusion in one ward. Although staff had limited knowledge of Regional Policy on the use of *Restrictive Practices in Health and Social Care Settings and Regional Operational Procedure for the use of Seclusion Northern Ireland March 2023* it was evident that restrictions had been risk assessed, were proportionate to the level of risk and applied in accordance with this policy.

The Trust Seclusion Policy was not in line with Regional Policy and was not up to date. The unit has one seclusion room located within PICU which has CCTV recording in place. The CCTV captures views which compromise patients' privacy and dignity. The Trust must review the areas covered by CCTV to promote patients' privacy and dignity.

Senior management and ward level staff were unsure about the duration of retention of CCTV recordings. The Trust must ensure all staff involved in the management of CCTV footage are familiar with the required footage retention time frames as directed within Policy.

An area for improvement has been identified in relation to updating the Trust Seclusion Policy in line with Regional Policy, the protection of patients' privacy and dignity in seclusion and the management of CCTV footage.

5.2.8 Patient Experience

The majority of patients spoke positively about their care and treatment and of the staff delivering it.

Staff were observed delivering compassionate care, however, there were times when staff did not always respond in a timely manner to patients requesting to speak with them at the office, causing frustration for patients. This observation was not evident across all wards. The observations undertaken during the inspection were raised with both the ward's leadership team and Trust Senior Management were also informed on day one of the inspection. It was positive to see improvements the following day.

Mealtimes Matter is a regionally agreed framework to maximise service user safety and ensure a high quality experience always occurs at every meal, drink and snack time. 'Meal Time Matters' literature was displayed in the majority of wards. Several dining experiences were observed over a number of days. Staff were in attendance and a meal time coordinator had been identified in some of the wards. Catering staff displayed warmth and kindness in their interactions with patients and had very good knowledge of patients' dietary requirements, likes and dislikes. These staff should be highly commended.

The food looked appetising and there was good variety available at most meals. On the first day of the inspection there was not enough food for all patients to have a meal in one of the wards. This was raised immediately with Senior Management and assurances were given that meals would be provided to those patients who had not received a meal. The Trust should explore options for patients ordering their meals in advance to ensure there is enough of each food choice.

The Carers' Advocate reported that no complaints had been received from families in relation to the care and treatment delivered to their relatives and the majority of relatives spoke positively about the staff and the care for patients. The Carers' Advocate advised that regular events are held for relatives, including social outings and support groups, which they reported were well attended.

Patient advocacy information was available to patients at the point of admission and was displayed throughout the ward. Minutes of patient forum meetings were displayed in patient communal areas. Information on "how to make a complaint" was easily accessible to patients at the entrance of each ward and is included in the patient booklet.

5.2.9 Governance

There were governance systems in place to monitor performance and improve outcomes for patients.

Morbidity and Mortality (M&M) Meetings allow services to review the quality of care that is provided to patients and identify any opportunities for improvement. There are monthly M&M Meetings in AMHIC. Learning and change in service provision from this meeting cascades into the monthly Operational Meeting.

Parallel to this process are weekly Collective Leadership Team (CLT) meetings and a monthly Divisional Meeting. The M&M and Operational Meetings feed in to the Divisional Meeting. These processes aim to provide an assurance that incidents and complaints are reviewed at an appropriate level.

Senior management visits to wards were recorded on a "visiting pyramid" sheet. These records were not consistently completed and did not detail what checks/actions were carried out during the visit.

Concerns were identified in relation to sharing outcomes from senior management to ward level staff with regard to both local and regional incidents. Ward staff at various levels were not familiar with some regional or local shared learning, including that which related to incidents which occurred in AMHIC. See section 5.2.1.

A schedule of ward based audits was in place, however, this was not always adhered to. There was no evidence of senior management oversight of the audit schedule.

Recording and storage of records was inconsistent between wards. Templates used for PIPA, safety briefs/handovers and MDT meetings varied across all wards. It is recommended the Trust implement standardised recording templates and incorporate good practices from across individual wards. This was identified during the previous inspection and an AFI was made. This inspection showed the AFI had not been met. As a result, the AFI stated at the last inspection has been reworded to reflect changes in the Trust's electronic recording system and stated for a second time.

An area for improvement has been identified in relation to records of senior management visits to wards.

5.2.10 Patient Flow

The Royal College of Psychiatrists (2011) recommends that acute bed occupancy should average 85%. Inpatient Mental health services across the region are frequently over occupied, with patients assessed as delayed in their discharge and patients waiting for admission for assessment and treatment.

There was a good system in place for the identification of challenges with bed flow. The service gathers data with respect to patients' admission/discharge and monitors length of patient stays. This data is discussed daily at senior management level. Patient flow data provided during the inspection was detailed and informative.

Bed flow data indicated AMHIC had been over occupied for the majority of the previous 12 months with contingency spaces in use the majority of time. A contingency space is an additional area that may be utilised in the ward to accommodate a patient bed at times of over occupancy. There is a system in place for decision making with regards to patient admissions. When no beds are immediately available, patients are placed on a waiting list, some of whom require to remain in Emergency Departments. It is recognised that factors contributing to delayed patient discharges are impacting on the availability of beds for patient admissions across the region.

A regional bed management system promotes a regional approach to the prioritisation of appropriate and timely admissions. When no beds are available in AMHIC, the Trust implement the Regional Bed Management Protocol for Acute Psychiatric Beds, January 2022.

Ward 4 (PICU) provides psychiatric intensive care for patients who require this level of support. Patients should remain in PICU for the least amount of time necessary, with transfer to a less intensive ward when the patient's mental health has sufficiently improved. The impact of the high demand for the AMHIC service has resulted in PICU adopting a discharge planning role and at times discharging patients directly. This is not in keeping with usual PICU practices and may not adequately prepare patients for discharge.

5.2.11 Medicines Management

Clinicians highlighted the importance of having clinical pharmacy as part of the MDT in every ward to ensure safe and effective interventions. However, lack of available funding has affected this provision limiting pharmacy support to two of the five wards.

Medication reconciliation is one aspect of the role of pharmaceutical staff. A review of a number of medication kardexes evidenced inaccuracies in recordings for some Pro Re Nata (PRN) medications. These inaccuracies were brought to the attention of the ward managers and were rectified immediately by medical staff.

Whilst there was no specific data indicating direct patient harm resulting from the lack of pharmacy provision, it is a concern that three wards do not meet the requirements of a full MDT. See section 5.2.4.

6.0 Quality Improvement Plan/Areas for Improvement

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

	Standards
Total number of Areas for Improvement	10*

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

Whilst recommendations were made during Feedback to the Trust, AFI were not specifically identified at that time. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Quality Standards for Health and Social Care (DHSSPSNI March 2006)	
Area for improvement 1 **Ref:** Standard 5.1 Criteria: 5.3.1 **Stated:** Second time **To be completed by:** 31 October 2024	The Belfast Health and Social Care Trust should ensure effective audit and oversight of patients care documentation. Ref: 5.2.9
	Response by registered person detailing the actions taken: Since June 2024, Encompass is now operational within the BHSCT for all patients records. The Mental Health Senior professional nurse has set up a working group to look at auditing of patients documentation across the Mental Health Division on Encompass. AMHIC will be part of this group and will consist of a Multi-disciplinary Team - ASM, Nurse Development Lead, Ward Sisters/ Charge Nurses. Group to consider including medical input as well as service user experience.

Area for improvement 2 **Ref:** Standard 5.1 Criteria: 5.3.3 **Stated:** Second time **To be completed by:** 31 October 2024	The Belfast Health and Social Care Trust should ensure: • Patient care plans reflect their individual care needs; and • Care plans are shared with the patient and evidenced that the patient is in agreement with the planned care. Ref: 5.2.5
	Response by registered person detailing the actions taken: AMHIC have set up a working group to review all care plans on Encompass. This working group includes the Nurse Delopment Lead, Ward Sisters/ Charge Nurses. MyCare scope to send to patients from Encompass. Transformational Leads and Service User Representatives will be in this working group. Supporting patients with the MyCare app going forward.
Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3.1 **Stated:** Second time **To be completed by;** 31 October 2024	The Belfast Health and Social Care Trust should undertake a review of their Adult Safeguarding (ASG) arrangements to ensure: • That interim protection plans are appropriately developed implemented and recorded; • Staff can easily access information that informs them at what stage in the process ASG referrals are; • Progress notes reflect ASG incidents, and the information is carried forward in subsequent recordings to ensure risks are managed and learning is embedded; • Effective audit and oversight of ward level adult safeguarding processes. Ref: 5.2.2
	Response by registered person detailing the actions taken: Every ward now has a live tracking system in place for all safe guarding investigations. The Band 7 and Band 6 have access to this and the DAPO and Ward Sister/Charge Nurse will maintain oversight. The Protection plans are on the ward daily safety briefs which the DAPO will audit. The DAPO continues to meet with ASG for MH and Divisional Social Worker to feed into regional development of ASG on the Encompass system.

	Adult safeguarding on monthly Morbidity and Mortality (M&M) and Operational meeting agendas.
Area for improvement 4 **Ref:** Standard 5.1 Criteria: 5.3.3 **Stated:** Second time **To be completed by:** 31 October 2024	The Belfast Health and Social Care Trust should ensure a consistent approach to recording is applied throughout the unit for all disciplines ensuring that: • There is a shared understanding of where to store records that cannot be updated or stored electronically; • Templates used are consistent across all wards (in particular for PIPA and safety briefs/handovers and MDT meetings) sharing good practice across the unit; and • Records are signed and dated and in line with professional and Trust standards. Ref: 5.2.9
	Response by registered person detailing the actions taken: AMHIC have set up a working group to review all templates used for safety brief, PIPA and MDT meetings to ensure consistency across all wards. This working group includes the Nurse Delopment Lead, Ward managers, Deputy Ward Sisters/Charge Nurses and ASM. The working group will be Multi-Disciplinary. Audit of notes for signatures will form part of the review of Encompass documentation.
Area for improvement 5 **Ref:** Standard 5.1 Criteria: 5.3 **Stated:** First time **To be completed by:** October 2024	The Belfast Health and Social Care Trust should put in place a robust governance assurance mechanism to ensure risks associated with Fire are addressed. This includes fire risk assessment, actions arising from the FRA and environmental checks. Ref: 5.2.1
	Response by registered person detailing the actions taken: See AMHIC Action Plan point 2.0 Fire Risk A detailed Fire Risk Assessment and Action plan has been commenced by AMHIC in collaboration the the NIFRS, local Fire Safety Officers and the senior team in AMHIC. This plan will minimise the risk of fires being started in AMHIC while ensuring that the Human Rights, dignity and privacy of patients is upheld

Area for improvement 6 **Ref:** Standard 5.1 Criteria: 5.3 **Stated:** First time **To be completed by:** 31 October 2024	The Belfast Health and Social Care Trust should ensure that: • Recommendations/learning identified from adverse incidents is disseminated to the appropriate staff. • There is a mechanism in place to assure the Trust that recommendations/learning have been embedded and practice improved. • The governance system considers cumulative risk has been considered when assessing incidents. Ref: 5.2.1
	Response by registered person detailing the actions taken: See AMHIC Action Plan Point 4.0 Strengthening Governanace Processes - embedding learning to all levels of staff The Senior Team have developed a plan to improve the disemmination of information across all wards and to every level of staff as far as is practicable. All wards now consider accumulated risk when analysing incidents and a threshold is in plae for this
Area for improvement 7 **Ref:** Standard 5.1 Criteria: 5.3 **Stated:** First time **To be completed by:** 31 October 2024	The Belfast Health and Social Care Trust should review the level of pharmaceutical support available to ensure effective use of the current resource across all wards in AMHIC. Ref: 5.2.4
	Response by registered person detailing the actions taken: A new lead pharmacist (Band 8b) took up post in February 2024 and the contraction of services was subsequently reviewed with all services reinstated across Wards 2-5 on the 20th May 2024. A full service is provided for all clozapine patients and discharges across AMHIC. A business case to secure additional pharmacy resource is in development.

Area for improvement 8 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 31 October 2024	The Belfast Health and Social Care Trust should ensure robust governance arrangements are in place to ensure effective oversight of mandatory training compliance. Ref: 5.2.1
	Response by registered person detailing the actions taken: There is a shared record for all wards mandatory training matrix. ASM reviews at managerial supervision with ward managers. Staff Training is on individual staff records on E roster and alerts on Eroster when essential training lapsed. (Nursing) Mandatory training matrix shared at Divisional Governance monthly meeting.
Area for improvement 9 **Ref:** Standard 5.1 Criteria: 5.3 **Stated:** First time **To be completed by:** 31 August 2024	The Belfast Health and Social Care Trust should ensure: • the Trust Seclusion Policy is in line with regional Policy and is up to date. • patients recorded by CCTV whilst in seclusion have their privacy and dignity protected. • CCTV footage is managed in line with Regional Policy. Ref: 5.2.7
	Response by registered person detailing the actions taken: AMHIC using the Regional policy "Use of restrictive practices in health and social care setting" (March 2023). The Trust seclusion policy is due for review in Novement 2025, however in light of this suggested AFI, the Trust will review the Regional Policy for Seclusion and consider the guidance around CCTV "Use of CCTV in a Period of Seclusion 11.97 The use of CCTV for a period of seclusion within a hospital setting is to enhance the safety of all involved. The use of CCTV must not replace staff presencelxxxvi. Where organisations use CCTV, staff must refer to individual organisational policies for guidance. Data protection requirementslxxxvii related to the use of CCTV must be incorporated in organisational policies for use of CCTV and guide decision-making for each individual use of CCTV for monitoring a period of seclusion. This will include a Data Protection Impact Assessmentlxxxviii that outlines the necessity, fairness and proportionality of the decision to use CCTV to monitor a period of seclusion. In addition to the above, each organisation that uses CCTV to monitor a period of seclusion should consider and outline how the proposed

	processing meets the seven key principles under the UK GDPR. " Remote control access for CCTV camera to be requested in the interim. This will allow staff to pause at times when the patient's privacy and dignity may be potentially comprised. Any CCTV audio that we are rquired to review retrospectively, a set of permissions must be adhered to, before this can be viewed. BHSCT CCTV policy in draft and currently being progressed. Good Management Good Records guidance states that CCTV images must be kept for as long as is necessary, informed by the purpose for which the recording was collected. A Regional Information Governance consultation has agreed a general 28 day period is reasonable, unless the need for a longer period can be justified. The data will then be permanently erased unless required for evidential purposes e.g. potential legal claims from slips/falls, assaults on staff/visitors etc.
Area for improvement 10 **Ref:** Standard 5.1 Criteria: 5.3 **Stated:** First time **To be completed by:** 31 October 2024	The Belfast Health and Social Care Trust should ensure senior management visits to wards are recorded in detail to reflect checks /actions completed during the visit, including the actions taken in response to outstanding Estates Department works. Ref: 5.2.9
	Response by registered person detailing the actions taken: Fortnighly meetings with senior estates team and AMHIC senior management have been established. Six weekly meetings with Fire and Estates staff alongside the ASM, Ward Sisters/ Charge Nurses.

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