Inspection Report

23 - 30 July 2025

Southern Health and Social Care Trust
Inpatient Learning Disability Ward

Dorsy Assessment and Treatment Unit
Bluestone Unit
68 Lurgan Road
Portadown
BT63 5QQ
Telephone number: 028 2836 0665

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: Southern Health and Social Care Trust (SHSCT)	**Responsible Individual:** Mr Steve Spoerry Interim Chief Executive Southern Health and Social Care Trust
Person in charge at the time of inspection: Joe Walker Assistant Director	**Number of registered places:** Nine
Categories of care: Learning Disability (LD) Assessment and Treatment	**Number of beds occupied on the day of this inspection:** Five

Brief description of the accommodation/how the service operates:

Dorsy Assessment and Treatment Unit (Dorsy) is a Mental Health and Learning Disability (MHLD) facility managed by the Southern Health and Social Care Trust (the Trust). Dorsy is situated within Bluestone Unit, located on the grounds of Craigavon Area Hospital.

Dorsy provides the Trust's acute in-patient service for adults aged 18 years and over with a learning disability who require assessment and treatment in an acute psychiatric care setting. The ward environment is designed to include a low stimulus environment with access to a seclusion room when clinically indicated.

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 to Dorsy commenced on 23 July 2025 and concluded on 30 July 2025 with feedback to the Trust's Senior Management Team (SMT). The inspection team consisted of three care inspectors and a senior inspector.

Prior to the inspection, information received by RQIA indicated concerns in relation to incident management, adult safeguarding and delays in patient discharge.

A focused inspection was undertaken to evaluate the Trust's progress in addressing the areas for improvement (AFI) identified during the last inspection as set out within the Quality Improvement Plan (QIP). The inspection also reviewed the Trust's

arrangements for the management of incidents, adult safeguarding, and patient flow, with particular attention to processes supporting the safe discharge of patients.

The inspection methodology was structured around seven thematic areas; environment; adult safeguarding (ASG) and incident management; staffing; patient experience; restrictive practices; patient flow; and governance. Each theme was assessed to determine the safety, quality and effective delivery of care and treatment provided.

Good practice was identified in several areas, including the early identification and reporting of adult safeguarding concerns, the effective multi-disciplinary team (MDT) approach to patient care, the availability of advocacy services, and the governance structures supporting oversight and accountability

The recommendations arising from a Serious Adverse Incident (SAI) were reviewed as part of the inspection methodology. Inspectors found evidence that the Trust had implemented a number of the recommendations; however, further work is required to ensure full implementation of all of the SAI recommendations made. This is discussed in more detail within sections 5.2.1 and 5.2.7 of this report.

Some patients remained in hospital while assessed as medically fit for discharge, due to limited availability of suitable community placements. This led to longer hospital stays in environments not designed for residential care. Staff remained committed to securing community placements and were doing their best to minimise the impact of extended stays on patient well-being.

Throughout the inspection, staff were observed to engage with patients in caring, compassionate and person-centred manner. Inspectors reviewed progress against the five areas for improvement (AFI) identified in the previous quality improvement Plan (QIP). Of these, four had been met, and one had not been met.

Two new AFIs were identified during this inspection. These relate to the Trust's oversight of ligature risk assessments (LRA) and fire risk assessments (FRA). Further detail is provided in Section 5.2 of this report.

In total, the QIP arising from this inspection identifies three AFIs.

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 within services are measured against 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 and safety of health and social care 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.

During this inspection, the team directly observed the experiences of patients and staff, including their interactions and engagement. Inspectors also reviewed staffing levels, leadership and oversight arrangements, the ward environment, clinical documentation, governance records, and patient flow processes. Feedback was gathered from both patients and staff to inform our assessment of the quality and safety of care and treatment.

4.0 What people told us about the service

Posters and easy read questionnaires were provided to invite staff, patients, and relatives to speak with inspectors and share their views and experiences.

Staff who spoke with inspectors were observed to be passionate and positive about their roles. Overall, they reported feeling supported by colleagues within the multi-disciplinary team (MDT), and that members of the senior management team (SMT) were accessible, supportive, and visible on the ward.

Staff highlighted concerns regarding the ward's capacity to function fully as an acute assessment and treatment unit. They reported that delayed patient discharges had resulted in patients being cared for in an environment not appropriately aligned to their assessed needs.

It was not possible to obtain completed questionnaires from patients. Patient experience is referenced in Section 5.2.5.

One relative questionnaire was received post-inspection. While a high level of satisfaction with the care provided was indicated, concerns were expressed in relation to the sensory stimulation provided. This is referenced further in Section 5.2.5.

No visitors were present on site at the time of the inspection.

5.0 The inspection

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

Areas for improvement from the last inspection on 13 May 2024		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 5.3.3 **Stated:** Second time	The Southern Health and Social Care Trust must ensure all staff have an annual appraisal completed as part of their ongoing professional development.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.7	
Area for improvement 2 **Ref:** Standard 5.3.1 **Stated:** First time	The Southern Health and Social Care Trust must review the current use of the seclusion and low stimulus environment to provide assurance that it meets the needs of the patients and maintains patient safety.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.1	
Area for improvement 3 **Ref:** Standard 5.3.1 **Stated:** First time	The Southern Health and Social Care Trust must review the disengagement strategy and the use of seclusion in the patient's own living area to ensure it is in line with the Regional Policy on the use of Restrictive Practices in Health and Social Care Settings (November 2023) which states that seclusion in hospital must only be used *'in a room or*	**Met**

	suite specifically designed for this purpose **Action taken as confirmed during the inspection**: This AFI has been assessed as met. See section 5.2.2	
Area for improvement 4 **Ref:** Standard 5.3.1 **Stated:** First time	The Southern Health and Social Care Trust must review the grading of incidents to take account of the HSC Regional Risk Matrix to include the potential impact or consequences and the cumulative impact of repeat incidents. **Action taken as confirmed during the inspection** This AFI has been assessed as met. See section 5.2.3	**Met**
Area for improvement 5 **Ref:** Standard 5.3.3 **Stated:** First time	The Southern Health and Social Care Trust must ensure that bespoke training is provided to ensure staff have the skills and knowledge to meet the needs of the patient group. This AFI has been assessed as not met See section 5.2.4	**Not met**

5.2 Inspection findings

5.2.1 Environment

The inspection assessed the ward environment against the Royal College of Psychiatrists' Standards for Acute Inpatient Learning Disability Services (5th edition, April 2024), to determine whether it supported the delivery of safe, therapeutic, compassionate care.

Dorsy provides a bright spacious environment, with a number of therapeutic areas. To meet individual patient needs, a pod style model of care is in place, providing patients with their own bedrooms and adjoining day spaces. Access to therapeutic and outdoor areas is restricted due to patient safety and compatibility concerns. The restrictions in place are linked to difficulties in securing appropriate long-term placements for patients who no longer require active treatment. This is further referenced in Section 5.2.6.

Previous concerns regarding the seclusion room being used as a bedroom had been addressed and the associated AFI met.

Overall cleanliness was generally acceptable, although a bathroom and an activity room required attention. Some furniture was damaged, presenting potential fire and infection risks. These matters were brought to the immediate attention of the ward manager. The Trust should implement a process to identify and replace damaged furniture promptly.

Dorsy has an internal courtyard and enclosed garden, providing therapeutic opportunities for patients. The Trust has plans to further develop these areas, which should be progressed in a timely manner.

The Fire Risk Assessment had not been updated since November 2022 and there was no evidence of review following a fire incident in December 2024, which met the threshold for Serious Adverse Incident (SAI) investigation.

While the Trust had completed a Fire Safety Incident Report and had implemented four of the recommendations arising from the SAI, it was not clear that all staff were aware of the recommendations made. This matter was brought to the attention of the senior management team. Staff should have ready access to an up to date FRA and a clear understanding of the associated mitigations and controls to maintain safety for all. The Trust should implement a process to ensure that this information is effectively cascaded to all staff and that all recommendations are clearly recorded and actioned in a timely manner.

Personal Emergency Evacuation Plans (PEEPS), which guide staff of the level of assistance each patient requires to safely evacuate in an emergency, were in place for four of five patients The Trust must ensure that PEEPs are completed for all patients and are kept under regular review.

An area for improvement (AFI) has been identified in relation to fire safety.

The Ligature Risk Assessment (LRA) included mitigations and actions, however several actions were outstanding with limited evidence of review or escalation to senior management. A new risk was identified during the inspection and communicated to the SMT. Post inspection assurance was provided this risk was being addressed.

An AFI has been identified regarding timely review and escalation of ligature risk.

5.2.2 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 for the safe and ethical management of restrictive intervention, restraint, and seclusion.

Restrictive practice is the term used to describe any intervention that restricts or limits a person's freedom of movement. This may include locked doors, enhanced/prescribed patient observations; physical interventions, the use of 'as required' (Pro Re Nata (PRN)) medication, rapid tranquillisation, CCTV monitoring and seclusion.

Restrictive practices including locked exit doors, enhanced observations, physical restraint, and PRN medication were in use within Dorsy, with each instance supported by a documented rationale within patient care plans.

Review of care plans evidenced that restrictive practices considered patients' human rights. Reviews were undertaken daily during safety huddles and weekly at MDT meetings. It was also evidenced that patients had appropriate disengagement strategies recorded in their care plans and that seclusion was not being used in the patients' own living areas. Previous concerns regarding these restrictive practices had been adequately addressed and were assessed as met.

All patients had a Positive Behaviour Support (PBS) plan in place. PBS is a structured, person-centred approach to supporting people who may present with behaviours that challenge, providing staff with clear guidance on proactive and responsive strategies.

The PBS plans reviewed were comprehensive and informative; however, they would benefit from being more concise and easier to navigate, ensuring that key information about patients' daily routines and structured activities is readily accessible. Incorporating learning from incident reviews would also enhance their effectiveness. The Trust should review PBS plans to ensure they remain current and accessible, include key information on patients' daily structure, routines, and activities, and continue to support consistent, person-centred care.

5.2.3 Adult safeguarding and incident management

Adult Safeguarding (ASG) refers to measures that prevent harm and protect adults at risk where harm has occurred or, is likely to occur without intervention. ASG arrangements on the ward were managed in accordance with the Northern Ireland Adult Safeguarding Partnership Operational Procedures, (September 2016), which sets out the required actions to provide a safe environment and respond effectively to adults at risk of harm or abuse.

ASG information, detailing the referral process and contact details for the Adult Protection Gateway Team, including details for the Regional (out of hours) Emergency Social Work Service (RESWS) was available on the ward.

Staff demonstrated good knowledge of ASG processes and adherence to Regional Policy, recording referrals on the Trust's electronic system for recording incidents (DATIX). Staff were well informed about protection measures for patients, and safeguarding training compliance was 100%.

Prior to the inspection, intelligence indicated delays in securing CCTV footage. The Trust advised that processes had since been revised to ensure timely retrieval of footage for investigative purposes.

A review of incidents over the previous three months found grading to be consistent with the Regional Risk Matrix; however, a significant number of patient-on-staff incidents were noted. The Trust should review the grading of repeated incidents to ensure appropriate escalation and mitigation of risk.

While incidents are reviewed daily during morning MDT huddles, there was limited evidence of operational oversight or trend analysis to identify recurring themes and promote learning. Staff reported they were offered debrief opportunities and access to occupational health or psychology support following incidents. The Trust should enhance governance processes to ensure effective analysis of incident trends, with learning identified, shared and embedded to support continuous improvement.

5.2.4 Staffing

Dorsy operates an MDT approach to care and treatment including nursing, social work, occupational therapy (OT), psychiatry, medical, physiotherapy, pharmacy and psychology staff. Nursing staffing levels are determined by the use of the Telford Model, a tool that assists in ensuring appropriate staffing based on patient acuity.

Sufficient staff were on duty, with agency staff being utilised to cover shortfalls. Although agency staff were not block-booked, efforts were made to maintain continuity by using the same agency staff where possible. Arrangements were in place to ensure agency staff had the appropriate skills and knowledge prior to placement in Dorsy.

An escalation policy provides guidance on the management of staff absence /shortages. Staffing shortfalls and challenges were recorded on DATIX, enabling senior management to analyse patterns and trends.

Staff expressed frustration that the ward was not operating as commissioned. There was cognisance of this by senior management and mitigations were in place to support staff to maintain their clinical skills.

Staff training records were reviewed. While compliance with corporate mandatory training was good, this was not consistently reflected in other areas, including e-learning and specialist training such as Working with Adults with Autism, Understanding Behavioural Distress, and PBS. This was identified at the previous inspection, and an area for improvement will be restated in this report.

5.2.5 Patient Experience

Patient experience was observed to be positive during the inspection. Staff engaged with patients in a caring, compassionate, and person-centred approach, demonstrating respect for individual preferences and needs. Patients were supported to participate in daily activities and therapeutic programmes where appropriate.

One relative questionnaire was received, indicating a high level of satisfaction with care, although concerns were raised about limited sensory stimulation. The Trust is recommended to review this aspect of patient care plans with the patient / relative and/or patient advocate to ensure appropriate sensory experiences are provided.

A range of leaflets and information was available for patients and relatives including adult safeguarding, the Trust's mission and values and information for new patients. However, information on advocacy services, the Mental Health Order (MHO), and the complaints process was lacking. The Trust should ensure key information is freely available and accessible to patients and their families.

Records and observations demonstrated that patients had access to structured activities, with good engagement. Positive examples included money management, shopping and laundry activities to prepare for discharge. Community based activities such as bus trips and visits to sensory gardens were also facilitated where possible by ward staff. Where patients declined activities, records should reflect that alternative options were offered where appropriate.

Overall, patient interactions and engagement were consistent with good practice, and patients appeared supported, safe, and treated with dignity.

5.2.6 Patient Flow

At the time of the inspection, Dorsy was operating at 55% occupancy, with remaining beds closed to admissions due to the operating model described in Section 5.2.1. This model of care has reduced the number of commissioned beds for acute assessment and treatment available within the Trust and regionally.

Patients with complex autism and learning disabilities are living in hospital, a clinical environment not designed or equipped for long-term residential care. The absence of appropriate community-based accommodation has significant implications for patients' quality of life and recovery. It increases the risk of institutionalisation and limits opportunities for individuals to develop independent living skills and experience enriched lives with the right level of support in the community.

Patient compatibility issues further restricted access to therapeutic activities and outdoor spaces, which may contribute to distress and behaviours that challenge, increasing risk for both patients and staff. Although alternative care options were being explored, progress in securing suitable community placements has been limited since the last inspection.

Records and discussions with senior staff demonstrated sustained oversight and collaboration between hospital and community learning disability teams, with continued efforts to identify and secure suitable, and where necessary bespoke, placements for each patient.

The Trust acknowledged these challenges and their impact on patients, providing assurances that all reasonable steps were being taken to mitigate the risks and secure more appropriate community care arrangements. Escalation to service commissioners, the Strategic Planning and Performance Group (SPPG) and the Department of Health (DoH) had taken place.

5.2.7 Governance

Governance arrangements were generally effective. Patient needs were communicated through handovers, daily safety huddles, safety briefs, and ward meetings. MDT records demonstrated detailed care discussion with active input from families and advocates.

While some learning from the fire-related SAI had been shared, not all recommendations had been fully implemented or embedded, and SAI learning was not consistently reflected on team meeting agendas. The Trust should ensure that all SAI recommendations are fully actioned, monitored and reviewed in practice to promote service wide learning.

MDT minutes provided comprehensive records of discussions and care provided, reflecting a holistic approach to patient needs and the involvement of families and advocates where appropriate.

Staff appraisal processes were in place with 93% of staff having completed a current appraisal. The AFI identified at the previous inspection has been assessed as met.

Overall, governance arrangements provided effective oversight and accountability at ward level, supporting safe and coordinated care delivery. Continued focus is required however to ensure that learning from incidents is fully embedded across the service to strengthen assurance and sustain improvement.

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).

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

	Standards
Total number of Areas for Improvement	3*

*The total number of areas for improvement includes one that has been stated for a second time.

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:5.3.3 **Stated:** Second time **To be completed by:** 31 January 2026	The Southern Health and Social Care Trust must ensure that bespoke training is provided to ensure staff have the skills and knowledge to meet the needs of the patient group, including Working with Adults with Autism, Understanding Behavioural Distress, and PBS. Ref: 5.2.4
	Response by registered person detailing the actions taken: Ward Sister will work towards increasing compliance of Best Practice training as per training matrix on a month by month basis. Training matrix has been updated and this will be shared with staff. It has been acknowledged the training requirements for nursing staff have increased. Ward Sister will continue to address training

	in supervision and with the assistance from Ward Support Officer ensure a training schedule is developed.
Area for improvement 2 **Ref:** Standard 5.1 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 31 January 2026	The Southern Health and Social Care Trust should ensure: All Fire Risk Assessments are up to date and completed by appropriately trained personnel. Previous actions should be updated to reflect progress or escalation to senior management. Ref:5.2.1
	Response by registered person detailing the actions taken: The Fire Officer is aware of the date of review for the Fire Risk Assessment. They continue to advise that the current Fire Risk Assessment remains valid until the next review is completed. Ward Sister will review actions on Fire Risk Assessment and ensure appropriate follow up/ escalation as required and record. Outstanding PEEP on day of inspection has now been completed. FRA will be discussed at safety briefs and be made accessible to all staff. SAI recommendations to be shared at next staff meeting 08/12/25.
Area for improvement 3 **Ref:** Standard 5.1 Criteria:5.3.1 **Stated:** First time **To be completed by:** 31 January 2026	The Southern Health and Social Care Trust should ensure: That ligature risk assessments are reviewed and updated to reflect current risks. Where residual risks remain following mitigations these should be escalated to senior management. Ref: 5.2.1
	Response by registered person detailing the actions taken: Ward Sister has raised a job request for the identified ligature. This room is identified as ‘green’ as it has controlled access as well as staff supervision at all times. All patients are currently on 1:1 observations which is another control measure.

	Ward Sister to ensure that any actions/progress/completion of risk are documented on the Ligature Risk Assessment including dates job requests are raised and any follow up.

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

The Regulation and Quality Improvement Authority
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