The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Inpatient Mental Health Services

Provider: Western Health & Social Care Trust

Date of Inspection: 11 March 2025 – 25 April 2025

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: 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 Doherty, Interim Assistant Director for Crisis Services. Lead Nurse (Adult Mental Health)	**Number of commissioned beds:** 62 beds
Categories of care: Inpatient Mental Health Service including provision of Psychiatric Intensive Care	**Number of beds occupied in the wards on the day of the inspection:** 68 beds

Brief description of the accommodation/how the service operates:

Inpatient Mental Health Services within the Western Health and Social Care Trust are provided at three locations, Tyrone and Fermanagh (T&F) site (Omagh), Grangewood site (Derry/Londonderry) and one service which operates outside the parameters of the T&F site.

There are five wards operating within the Trust's inpatient mental health service. Four of the five wards are gender specific and provide assessment and treatment for patients with acute mental health needs for people aged between 18 and 65. Access to Psychiatric Intensive Care (PIC) beds is made available when required and is inclusive of the bed numbers. Of the four wards, two consist of single occupancy bedrooms (Grangewood) and two wards provide dormitory-style sleeping arrangements or single bedrooms (T&F).

Patients are admitted either to these four wards on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).

One of the five wards (Rathview) is operating as a MHLD assessment Unit and can accommodate six patients with a mental illness/disorder, following assessment either by the Mental Health Liaison Service (MHLS) or the Crisis Resolution and Home Treatment Team (CRHTT). Patients are expected to stay for a maximum of seven days. This ward is mixed gendered and has single occupancy bedrooms with en-suite facilities. At the time of the inspection no patients were to be admitted to this ward under the provisions as set out in the MHO.

2.0 Inspection summary

An unannounced inspection to the WHSCT Inpatient Mental Health services commenced on the 11 March 2025, and concluded with feedback to the Trust on 25 April 2025. The inspection team comprised three care inspectors, an assistant director, a senior inspector, an estates senior inspector, RQIA's sessional consultant psychiatrist and remote administration support.

Prior to the inspection RQIA received whistleblowing intelligence regarding; concerns in relation to staffing, the use of enhanced observations, staff training the skill mix required to support patients requiring PIC. The Trust's internal investigation substantiated the matters raised through the whistle blowing process and had developed an action plan aimed at addressing the concerns and support ongoing improvement. This action plan was reviewed during the inspection.

RQIA also considered intelligence received and recommendations made from Serious Adverse Incidents (SAI), Coroner's Inquest findings and Early Alerts (EA), allowing for and undertook a review of this information as part of the inspection methodology. There was evidence to confirm that some actions arising from recommendations had been embedded in practice with processes in place to ensure implementation of all recommendations. Appropriate mechanisms were in place to monitor progress and drive improvement for patients accessing the service.

The inspection sought to assess the Trust's progress against the areas for improvement (AFI) identified in the Quality Improvement Plan (QIP) following the previous inspection of the Trust's Inpatient Mental Health services on 29 March 2021 and Rathview on 23 November 2023. The findings of this inspection identified that eight AFI's had been met, two partially met and one not met. Please refer to section 5.1 for further detail. During the inspection the Trust were preparing for the implementation of Encompass. Encompass is being implemented across all five Health and Social Care Trusts and is the Health and Social Care Programme that creates a single digital care record for every citizen in Northern Ireland.

The inspection methodology was structured around ten thematic areas. The 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.

Good practice was identified with regard to; adult safeguarding and incident management, audits, Quality Improvement (QI) initiative regarding care plans, care pathways, speech and language therapy (SLT), multi-disciplinary team (MDT) approach to patient care, training, senior management team (SMT) visibility and advocacy services available to patients. Throughout the inspection staff were observed to be caring, compassionate and person centred in their engagement with patients.

Ten AFI's have been identified from the thematic areas reviewed. Areas that require improvement are in relation to the Trust's oversight of ligature risk assessments (LRA); fire risk assessments (FRA); family/relative/stakeholder involvement; consistency around the administration of Pro Re Nata (PRN) medication; patient's rights, restrictive practices, the leave absent without leave (AWOL) policies; patient's property policy and Rathview's model of care. See section 5.2 for further detail.

The Quality Improvement Plan (QIP) identifies a total of 13 Areas for Improvement (AFIs) including ten newly identified AFIs and three restated from the previous two inspections.

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. Clinical records, patient flow arrangements and governance documentation were also reviewed. During the inspection we gathered the experiences from patients, staff and families.

4.0 What people told us about the service

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

We spoke with patients, relatives, and staff and received a number of completed questionnaires. Overall comments from relatives were positive; they reported improvements in person centred care and felt involved in all aspects of their family member's care and treatment.

The independent advocate was complimentary of the service provided to patients and relatives and reported positive working relationships with the Multi-Disciplinary Team (MDT) and their involvement in writing of Standard Operational Procedures for staff.

Staff we spoke with were passionate and positive about their role. Overall staff reported that they were supported by colleagues within the multi-disciplinary team (MDT) and members of the senior management team (SMT) were accessible and visible on the wards.

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 to MHLD Acute Mental Health Wards in Western Trust on 29 March 2021		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 5.1 Criteria: 5.3 (5.3.1) (f) **Stated:** First time **To be completed by:** 12 October 2021	The Western Health and Social Care Trust should take steps to improve their bed management processes by: • Developing a local escalation policy to manage bed pressures which supports Trust staff to effectively manage fluctuations in capacity and demand with a consistent approach; • Developing a local policy for 'on leave from inpatient care' which includes the actions to be taken if a patient who is 'on leave from inpatient care' and whose bed has been used to accommodate another patient, unexpectedly returns; • Maximising the use of their IT systems to collate data such as bed occupancy to include category of admissions and length of stay. Review and analysis of this information is integral for optimising patient flow • Working in collaboration with other bed management colleagues in other trusts to ensure a collaborative and effective approach to managing beds across the region.	**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 5.1 Criteria: 5.3 (5.3.1) (f) **Stated:** Second time **To be completed by:** 12 October 2021	The Western Health and Social Care Trust shall address the following matters in relation to infection prevention and control: • Improve the standard cleaning of sanitary wear; • Commence a programme of decluttering, and reorganisation of storage areas; • Take action to improve the cleaning and organisation of domestic cleaning equipment and stores. • Ensure mattresses are cleaned and maintained and where necessary replaced. Mattress audits should be conducted and identified issues actioned. • Robust monitoring of these areas should be in place to provide continued assurance.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met See section 5.2.1 & 5.2.3	
Area for improvement 3 **Ref:** Standard 8.1 Criteria: 8.3 **Stated:** First Time **To be completed by** 12 October 2021	The Western Health and Social Care Trust shall review the process around discharge letters in line with Trust policy to ensure discharge letters are completed within 7 days of the patients discharge.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met See section 5.2.7	

Area for improvement 4 **Ref:** Standard 5.1 Criteria: 5.3 (5.3.1) (f) **Stated:** First time **To be completed by:** 12 October 2021	The Western Health and Social Care Trust should review the management of "when required/PRN" medicines prescribed for distressed reactions in Elm and Lime wards to ensure that; • Kardexes clearly specify the indication for each medicine and if more than one medicine is prescribed, this clearly states which is first line and second line (where prescribed) • The time intervals between first and second line medicines (where prescribed) is clearly stated in the patient's kardex and/or care plan • The reason for and outcome of each administration is recorded on each occasion	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met for the wards identified. However, practice was not consistent across both sites, therefore a new AFI will be stated. See section 5.2.3	
Areas for improvement from the last inspection Rathview on 23 November 2023		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 5.1 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 12 January 2024	The WHSCT must ensure that Ligature Risk Assessments are accurate and comprehensive and completed with support from estates services personnel.	**Partially met**
	Action taken as confirmed during the inspection: This AFI has been assessed as partially met, it will be reworded to take account of progress made by the Trust and stated a second time. See section 5.2.1	

Area for improvement 2 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 12 January 2024	The WHSCT must ensure staffing levels are sufficient to keep patients and staff safe and support the delivery of effective care. Senior management must have oversight of staffing levels, especially when staffing levels are depleted.	**Met**
	Action taken as confirmed during the inspection: This AFI is assessed as met. See section 5.2.3	
Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 31 January 2024	The WHSCT must ensure there is a robust procedure for staff when an alarm is triggered from Rathview.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met See section 5.2.7	
Area for improvement 4 **Ref:** Standard 6.1 Criteria: 6.3.1 **Stated:** First time **To be completed by:** 29 March 2024	The WHSCT must ensure there is a formal pathway for the transfer of patients from mental health acute admission wards to Rathview. This should include an assessment of the patient on arrival by the receiving nursing staff.	**Partially Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as partially met, it will be reworded to take account of progress made by the Trust and stated a second time. See section 5.2.7	

Area for improvement 5 **Ref:** Standard 5.1 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 12 January 2024	The WHSCT must ensure all patient care plans are reviewed and renewed when a patient is transferred from another ward.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met See section 5.2.7	
Area for improvement 6 **Ref:** Standard 6.1 Criteria: 6.3.1 **Stated:** First time **To be completed by:** 29 March 2024	The WHSCT must ensure Rathview patient flow information is included in the regional bed management forum.	**Not met**
	Action taken as confirmed during the inspection: Rathview bed occupancy numbers are shared with Trust patient flow co-ordinators but not with the regional bed management forum. This AFI has been assessed as not met and will be restated for the second time. Ref: 5.2.7	
Area for improvement 7 **Ref:** Standard 5.1 Criteria: 5.3.2 **Stated:** First time **To be completed by:** 12 January 2024	The WHSCT must ensure shared learning and recommendations resulting from SAIs are disseminated and implemented to the relevant wards/departments/staff across the Trust.	**Met**
	Action taken as confirmed during the inspection: This AFI has been assessed as met See section 5.2.7	

5.2 Inspection findings

5.2.1 Environment

The inspection sought to assess the ward environments against the Royal College of Psychiatrists Standards for Acute Inpatient Services for Working Age Adults, 8th Edition, May 2022 and the Royal College of Psychiatrists Standards for Psychiatric Intensive Care Units Third Edition, to determine if they were conducive to the delivery of safe, therapeutic and compassionate care. Ward environments were mainly found to be compliant with these standards and were observed to be enabling and supportive to the delivery of therapeutic and compassionate care. However, some wards were in need of refurbishment and improvements were required in respect to environmental safety.

Wards were clean and spacious with an assurance mechanism in place to monitor environmental cleanliness and compliance with Infection Prevention Control standards. Female sanitary disposal units had been removed from bathrooms to reduce risks to patient safety but this was impacting on patient dignity and Infection Prevention Control (IPC) standards. An AFI has been identified in relation to sanitary disposal equipment and IPC.

Some of the ward environments across the two sites were in need of decoration and upgrade to promote a more therapeutic space for patients and staff. We suggest the Trust devise a schedule of works in conjunction with the Estates Department to improve ward environments for patients and staff.

Ligature Risk

Ligature Risk Assessments (LRA) were completed with the support of the Estates Department, however these were not consistent across all sites and did not reflect all ligature risks identified. Ligature risk action plans did not include all the necessary mitigations to manage identified risks in all wards. Additional risks noted during the inspection were shared with the Ward manager and action was taken to address this.

Ligature sensors had been installed on single bedroom doors across all wards. However, these were not installed on dormitory doors and these doors were not listed as a ligature risk. The mitigations in place to reduce the risk were not sufficient, appropriate and robust. To enhance patient safety, ligature sensors should be installed in all areas designated for patient's sleeping as staff are not always present in these areas. The Trust should also ensure consistency in the frequency of safety checks so that the effectiveness of the sensors across the sites can be assured. An AFI from the previous inspection was assessed as partially met and has been stated a second time.

With the exception of Rathview a nurse call alert system was not available in the four other wards, resulting in patients not having a means to summon assistance. Although a system is in place to check on the well-being of patients, the Trust should identify and implement a more robust mechanism for patients to access immediate assistance when required. This is essential to promote patient safety, privacy and dignity.

The mechanism for locking entry doors for two wards (T&F) caused a delay between the door closing and locking, increasing the risk of patients leaving the ward without the knowledge of staff. Whilst there was evidence of this issue being raised and addressed for one of the wards it was brought to the attention of the Ward Manager for further escalation to Estates Department. The Trust should consider provision of signage to alert visiting relatives and professionals of the importance of ensuring the door is secured on entry and exit. This will help in managing and reducing the risk of patients going Absent Without Leave (AWOL) from the wards. AWOL is further discussed in 5.2.3.

The Trust implemented a number of changes to ward environments in response to learning and recommendations identified in SAI's. Anti-ligature en-suite doors were in place in Grangewood and modifications were made to the dual lighting system outside the bedroom doors. This system now alerts the nurses station when a staff member is present in the en-suite along with the patient.

Windows were replaced across the T&F site as recommended and although they had not been replaced at the Grangewood site, mitigations were evident with continued oversight and regular audits from the Trust which ensured these were sufficient to manage the risk.

As part of an additional recommendation from an SAI, the Trust are reviewing CCTV across the Service. Closed Circuit Television (CCTV) remains operational in a small number of different locations across the service, the Trust are planning and progressing a pilot in the use of body cameras throughout the Trust.

Fire Safety

Fire Risk Assessments (FRA) were reviewed across all of the inpatient services and were in date with the exception of Rathview. The FRA in Rathview was completed by a member of ward staff due to the unavailability of a fire officer and had not been reviewed within the last year. This was brought to the attention of the Senior Management Team (SMT) during the inspection and assurances were provided that identified fire safety risks were being managed through the action plan and efforts would be made to secure the availability of a fire officer. Improved oversight is also needed to ensure greater consistency in the recording of fire equipment checks. A new AFI has been identified in relation to FRA.

Personal Emergency Evacuation Plan (PEEPS), which inform staff of the level of assistance a patient needs to safely evacuate in an emergency, were in place for patients as required.

Grangewood site does not have a separate PICU. Provision for psychiatric intensive care is made through a mechanism for closing of an area of the ward which separates acute beds from psychiatric intensive care beds, therefore, there is no separate clinical room. Whilst there was no evidence of increased risk to patients or staff, this could create challenges when access to emergency equipment and/or medication is required in the PIC area. This was discussed with SMT during the inspection and at feedback with assurances provided that this would be monitored closely.

Paper bags were available at the front door of each ward for visitors to use. However, we noted a very small number of bins with plastic bags insitu. This was brought to the attention of the ward manager and removal of same was recommended. The Trust must ensure compliance with regional guidance on the use of plastic bags in Mental Health (MH) inpatient wards as noted in LL-SAI-2018-033(MH) and Learning Matters Quality 2020 Issue 8, September 2018.

5.2.2 Adult Safeguarding and Incident Management

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

All the inpatient wards had a Designated Adult Protection Officer (DAPO) aligned to provide support and guidance to staff as required. There was evidence of positive collaborative working between ward staff and the DAPO.

Staff demonstrated knowledge of ASG processes and adherence to the Regional Policy in identifying and reporting ASG concerns. There was also good knowledge of protection measures in place for patients. Staff advised there were open lines of communication and reported that they felt confident in expressing any concerns with their managers.

There was however, a lack of available 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) on the ward for both patients and staff. We recommend the Trust ensure this information is available on all wards.

All ASG referrals were recorded on the Trust's electronic system for recording incidents (DATIX). There was appropriate reporting, categorisation and grading of incidents and escalation to the ASG team where the threshold was met for a referral to the Adult Protection Gateway Team (APGT).

5.2.3 Patient Safety

Staffing

All inpatient wards are required to have a mechanism for responding to low/unsafe staffing levels, when they fall below a minimum agreed level. Staffing levels were determined using the Telford model, a tool to assist staff in defining appropriate staffing levels based on patient need. The Trust aimed to achieve the minimum safe staffing level for every shift and a review of rota's evidenced safe staffing levels to meet the needs of patients across all wards.

The Trust took appropriate action to address staffing related concerns identified in Psychiatric Intensive Care Unit (PICU) operating on the T&F site, as raised in the whistleblowing communication. The skill mix was appropriate for both day and night duty, and staff were equipped with the necessary training to work in this unit. Further assurance was provided by the Trust through weekly audits and spot checks to ensure that the changes implemented as part of the action plan were maintained.

However, Psychiatric Intensive Care operating on the Grangewood site did not operate the same staffing rota. Staffing arrangements required when PIC is operating are provided by ward staff. These arrangements are rotated every one to two hours. This frequent rotation impacts on continuity of care for patients and has the potential to impact on building a therapeutic relationship with the patient. This provision did not align with the recommendations made following the Trust's review of Grangewood's PICU in 2021, when it was recommended provision should be six hourly shifts across day and night. This was raised with SMT during the inspection and discussed during Trust feedback. The Trust should replicate the staffing arrangements in use in the T&F site when Psychiatric Intensive Care is in use in Grangewood to ensure a consistent approach is implemented and to promote continuity of care across both sites. An AFI has been identified in relation to staffing.

Care observed throughout the inspection was found to be safe, compassionate and delivered to a good standard. Patients appeared comfortable in the company of staff, including patients who had enhanced observations prescribed.

Absent without Leave (AWOL) and Leave Policies

The Trust reviews incidents across all wards on a monthly basis through team 'health checks' and other mechanisms as a means of monitoring themes and trends. This includes the number of AWOL incidents. The Trust have implemented an AWOL action plan to ensure that learning from SAI's and findings from a Coroner's Inquest are shared across both sites and embedded in practice. Whilst Staff had knowledge of the AWOL action plan, awareness of relevant SAI's tended to be specific to the site they worked in. It is important to ensure that learning from all SAI's is shared across both sites irrespective of the location where the incident occurred.

All patients assessed as presenting an AWOL risk had an appropriate care plan in place, in line with Trust policy. However, not all detained patients had AWOL care plans despite this being an SAI recommendation. Care plans and risk assessments of patients with a known history of AWOL did not always identify the method of AWOL, which is important for all staff to be aware of to manage and reduce risk. An AFI has been made in relation to the consistency of recordings for patients who are AWOL.

In order to safely support a system of agreed leave from the ward, greater engagement with patients' family/carer/provider has been identified through SAI's to ensure appropriate handover and recording of feedback when patients return from periods of leave. Whilst the Trust have begun to improve these mechanisms through the AWOL action plan, some inconsistencies were found in recording feedback when a patient returned from leave. A more robust approach to obtaining feedback is required by all staff and an AFI has been identified.

The Trust had mechanisms in place to manage leave from the wards which involved discussion and agreement from the MDT. However, differences were noted in the Trust AWOL Policy and Leave Policy as to who could approve detained patients leave. This was discussed during feedback with the SMT and should be addressed to ensure consistency in both policies.

Discussions took place with the Multi-Disciplinary Team (MDT) and SMT around medical cover. Despite deficits in Consultant Psychiatrist cover reported through EA's, there was no indication that this was impacting on patient safety.

5.2.4 Patient's Rights

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; levels of enhanced observations; the use of physical restraint; Pro Re Nata (as and when required) medications and; the additional restrictions inherent to admitting a patient for Psychiatric Intensive Care. All staff undergo training specific to their role working with patients to include Safety Intervention (SI). Staff training records indicated staff were compliant with mandatory training and where required had undertaken SI to the required level to meet the specific needs of individual patients.

Whilst preventative and proactive strategies were in place to minimise the use of restrictive practices, greater oversight is needed to ensure that detained and voluntary patients have had their rights fully explained to them on admission.

The proportion of patients detained under the MHO was higher in the T&F site compared to the Grangewood site. The Trust advised they were aware of this finding and are keeping this under review. Prescribed forms for patients detained under the Mental Health (Northern Ireland) Order 1986 MHO were in place but there was limited evidence that their rights as a detained patient had been explained to them.

For voluntary patients, processes are in place to ensure appropriate risk assessment when patients wish to leave. However, it was not consistently evident within care plan documentation that they had been advised of the locked door policy, or of their rights on leaving and accessing wards. The Trust must ensure that all patients, both voluntary and detained have their rights explained to them with evidence of this included within care plan documentation.

Greater oversight is needed to ensure that restrictive practice documentation is in line with regional and Trust protocols. There had been a small number of instances within the PICU T&F where enhanced observations had not been undertaken in line with the regional policy. Additionally, discontinuation of enhanced observations were not always recorded and signed by the MDT.

The administration and recording of Pro Re Nata (as and when required) medications was good within the T&F site where first, second or third line dosage was consistently recorded in line with Trust protocol with a rationale given for administration. However, this was not the practice within the Grangewood site. Greater oversight is needed to ensure consistency across both sites.

The Trust were in the process of implementing the Safe Wards initiative which will further support the Trust in its efforts to minimise the use of restrictive practices, reduce dysregulated behaviour and increase patient engagement across the inpatient wards.

AFI's have been identified in relation to patients' rights, enhanced observations, review of policies and PRN medication.

5.2.5 Patient Experience

Each ward had ample numbers of noticeboards to display information for patients/family/ visitors which included: staff on shift, Independent Advocacy and availability of services. However, RQIA recommend the Trust consider displaying additional information for patients and visitors relating to: Adult Safeguarding, locked doors, complaints procedures, MHO and Mental Capacity Act (MCA) legislations and information to demonstrate ongoing improvements.

The availability of meaningful activity was limited across the service and staff and patients highlighted a reliance upon OT staff to coordinate and deliver activities. While staff were observed to spend time engaging with patient's in their personal day spaces there was limited activity and therapeutic opportunities on offer. The Grangewood site has a designated day care setting on site providing patients with opportunity to avail of therapeutic activities off the ward through referral by the MDT. Gym equipment was available for patients to use in both the T&F and Grangewood sites, however, the Trust must be assured that staff are appropriately trained to safely support patients using this equipment.

The development of activity schedules with patient involvement could be considered to guide staff in their work with patients, to promote meaningful engagement and enhance patient outcomes. Activity planning should be informed by the patient's assessed need and preferences and all staff should be involved in the implementation.

The Trust has a centralised complaints process for patients and relatives. However, there was a lack of evidence to reflect the management and oversight of informal complaints at ward level. RQIA recommend the Trust devise a process for recording informal complaints, actions taken and if the complainant was satisfied with the outcome and a record of informal complaints kept at ward level.

The processes in place for the management of patient's property/belongings differed across wards. The T&F site secured patient's belongings in lockers whilst Grangewood used open boxes which increases the risk of patients' property being mislaid or placed in the wrong box. The Trust should implement a consistent approach for the safe handling, investigation and recording of outcomes of any misplaced equipment/belongings. An AFI has been identified in relation to the safe handling of patient property.

5.2.6 Other Findings

Inspectors also reviewed the care provided in relation to physical health, medicines management, staffing and patient flow.

Physical Healthcare

Patients were assessed on admission and regularly monitored with appropriate risk screening in place such as Malnutrition Universal Screen Tool (MUST) and National Early Warning Score (NEWS) which is in line with 'A picture of Health?' - A review of the quality of physical healthcare provided to adult patients admitted to a mental health inpatient setting.

Most patients with physical healthcare needs had received an assessment of their needs and a care plan was in place. It was positive to note collaborative working with other Trust professionals to meet specialised physical health needs. However, a small number of patients did not have a care plan to address such needs which was raised with ward management and actions were taken to address this.

A number of patients were on a modified diet; this was noted in patient care plans. Information was available in the ward kitchen and patient clinical notes regarding the Speech and Language Therapy (SLT) advice for eating, drinking and swallowing needs. Mealtimes were aligned with the regional framework 'Mealtimes Matter' where a co-ordinator had oversight of mealtime on the ward. This offered assurance that patients were receiving the appropriate level within the International Dysphagia Diet Standardisation Initiative (IDDSI). The food appeared appetising and choice was available to patients as well as alternative options.

Mental health care plans were generic rather than person centred. The Trust advised that a Quality Improvement (QI) project was in progress to enable the Trust to evidence a more streamlined approach while improving the delivery of person centred care and treatment.

The implementation of Encompass will also ensure that each patient has an individual assessment and care plan in place going forward.

There was evidence of regular prescribing reviews of medications. Clozapine and lithium pathways were followed consistently across all the inpatient wards.

Staffing

Each ward operated a MDT approach to care and treatment including; nursing, social work, occupational therapy (OT), psychiatry, medical and psychology staff. MDT meetings took place each morning Monday to Friday during which tasks were agreed, prioritised and actioned to ensure patients were receiving appropriate care and treatment. Examination of handover documentation proved to be comprehensive, providing staff coming on shift with the appropriate information to address the needs of the patient group in each ward. It was positive to note that the Trust had arranged psychology input and reflective practice groups for staff. However, staff told us that these were often cancelled/delayed due to different pressures across sites. We recommend that these are prioritised to support staff.

Review of staff meeting minutes evidenced that learning from SAI's and Inquests were part of the meeting agenda for staff. Staff told us that SMT, Middle Management Team (MMT) shared learning from SAI's, Inquests Whistleblowing and Early Alerts with them as and when they are received by the Trust.

Patient Flow

During the inspection we reviewed bed flow reports and attended bed flow meetings with bed flow co-ordinators within the Trust. These meetings take place twice a day and we evidenced bed occupancy numbers including leave bed numbers being submitted to the regional bed flow management team for all inpatient wards via Information Technology (IT) systems. This was in keeping with the Regional Bed Management Protocol for Acute Psychiatric Beds, January 2022. The Trust Bed Management Protocol also included local escalation plans and patients on leave. This matter is further referenced in section 5.2.7.

There was evidence on PARIS (patient electronic care record) system that discharge letters were completed within seven days of the patients discharge. This was in accordance with the Trust discharge policy.

5.2.7 Rathview

Rathview is a six bedded ward operating as an assessment unit for patients experiencing a mental health episode, who are unable to receive treatment in their own home but do not require admission to an acute hospital bed. All patients admitted to Rathview are voluntary and had risk assessments and care plans initiated and completed by nursing staff on admission. The unit aims to reduce mental health admissions to Emergency Departments and acute care wards.

The ward manager confirmed that staff are rostered for Rathview and are not redeployed to other wards. Should additional support be required, staff from the T&F site are allocated as alarm responders to Rathview whilst staff in Rathview are no longer required to respond to alarms activated in the T&F site.

There has been previous engagement between RQIA and the Trust regarding the operational functioning of Rathview following the last inspection in November 2023. This is due to concerns that Rathview's current model of care is not accurately reflected within the operational policy which states that Rathview is registered as a Nursing Home and an application for Nursing Home status was submitted to RQIA in August 2023. This creates concerns should a voluntary patient wish to leave while presenting a risk to themselves or others as the policy does not include provision for the Trust to utilise powers under the MHO to hold a patient safely under these circumstances.

Admissions to the ward are organised by either the Mental Health Liaison Service (MHLS) or the Crisis Resolution and Home Treatment Team (CRHTT). Despite the absence of a formal pathway for transfer from an acute ward, there had been a small number of instances where patients had been stepped down from an acute ward to Rathview. An AFI from the previous inspection was assessed as partially met and has been stated a second time.

Rathview patient flow information is recorded and maintained at Trust bed flow meetings but bed numbers are not shared with the regional bed management forum.

Following formal feedback to the Trust, a meeting was held on 23 May 2025 to discuss these concerns and agree next steps. The Trust has since confirmed that Rathview does not meet the definition of a Nursing Home as defined by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and has agreed to withdraw the application and pursue plans to establish this service as an Acute Mental Health Inpatient Assessment Unit. This will ensure that all patient admissions to the service will comply with the necessary legal frameworks. RQIA will then be assured that the safeguards afforded to patients admitted under the Mental Health (Northern Ireland) Order 1986 will be in place.

RQIA has requested that the Trust inform the Strategic Planning and Performance Group (SPPG) that they intend to operate as an Acute Mental Health Inpatient Assessment Unit. The Trust has also been asked to ensure the operational policy is updated to reflect the model of care operating within Rathview, provide clarity about what the service offers and ensure the policy reflects clear criteria on the pathways to admission and the specific and/or exceptional circumstances where a patient may be transferred from an acute ward.

Visiting arrangements were observed during the inspection and were noted to take place at the entrance of the ward. This is not conducive for visits and does not offer the patient/family/visitor any privacy. We recommend the Trust consider other options to facilitate visiting provision.

Two AFI's from the previous inspection to Rathview are assessed as not met and have been stated a second time. An additional AFI has been identified in relation to the updating the Operational Policy to include provision under the MHO.

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 three hat have been stated for a second time.

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

Quality Improvement Plan	
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).	
Area for improvement 1 **Ref:** Standard 5.1 Criteria: 5.3.1 (f) **Stated:** Second time **To be completed by:** 30 November 2025	The WHSCT must: • Ensure Ligature Risk Assessments in all wards including Rathview reflect all identified risks and include the necessary mitigations to address them. • Ensure the installation of door sensors on all patient bedrooms including dormitory doors in the T&F site. • Ensure effective monitoring of the functionality of the sensors. Ref: 5.2.1

	Response by registered person detailing the actions taken: Ligature Risk Assessments across all sites will be completed with support of the Estates Department and these will reflect any mitigations to manage the identified risks. A Business Case has been completed to install sensors in all dormatory doors across the T&F site. Task and Finish money has been approved from the Department to enable these works to be completed. To ensure effective monitoring of the functionality of the seonsors weekly monitoring checks will be undertaken and recorded across both the sites.
Area for improvement 2 **Ref:** Standard 6.1 Criteria: 6.3.1(a) **Stated:** Second time **To be completed by:** 30 November 2025	The WHSCT must review the Operational Policy for Rathview to ensure all pathways for admission are reflected including clear criteria to be used should step down from the acute inpatient units be required. Ref: 5.2.7
	Response by registered person detailing the actions taken: The Operational Policy for Rathview House will be shared with RQIA before the 31st August
Area for improvement 3 **Ref:** Standard 6.1 Criteria: 6.3.1 (a) **Stated:** Second time **To be completed by:** 29 March 2024	The WHSCT must ensure Rathview patient flow information is recorded and included in the regional bed management forum. Ref: 5.2.7
	Response by registered person detailing the actions taken: A meeting with SPPG on the 22nd August 2025 to discuss the 6 beds operating in Rathview House are included in the regional Mental Health inpatient numbers.
Area for improvement 4 **Ref:** Standard 6.1 Criteria: 6.3.1 (a) **Stated:** First time	The WHSCT must update their Operational Policy for Rathview to include provision for the Trust to utilise powers under the MHO should a voluntary patient require assessment under the MHO while an inpatient in Rathview. Ref: 5.2.7

To be completed by: 30 November 2025	**Response by registered person detailing the actions taken:** The operational policy for Rathview House will be shared with RQIA before the 31st August. This will include provision for the Trust to utilise powers under the Mental Health Order should a voluntary patient require assessment under the Mental Health Order while an inpatient in Rathview.

Area for improvement 5 **Ref:** Standard 5.1 Criteria: 5.3.1 (f) **Stated:** First time **To be completed by:** 30 November 2025	The WHSCT should ensure: • All Fire Risk Assessments are up to date and completed by appropriately trained personnel. • All fire checks are completed and recorded in fire files. Ref: 5.2.1
	Response by registered person detailing the actions taken: Fire Risk assessments for all wards will be reviewed by SMT to ensure they are up to date and completed appropriatley An audit process will be developed to monitor compliance with the completion and recording of fire checks in all wards
Area for improvement 6 **Ref:** Standard 4.1 Criteria: 4.3 (n) **Stated:** First time **To be completed by:** 30 November 2025	The WHSCT should review the staffing arrangements in Grangewood PICU and introduce a similar rota already in use in the T&F site for continuity across the Trust. Ref: 5.2.3
	Response by registered person detailing the actions taken: The management of staffing in Grangewood PICU's had been changed to six hour shifts day and night following the previous inspection. This had been maintained for a sustained period however, had reverted back in the months preceeding this inspection to ensure a substantive staff presence in the PICU throughout each shift following a particularly difficult period of time where the service had been heavily reliant on agency staff. Measures have now been taken to stabilise the nursing workforce across the inpatient wards including the commitment to employ an additional sixteen registered nurses on each hospital site. This will enable Grangewood PICU to implement a rota similar to the T&F site.
Area for improvement 7 **Ref:** Standard 4.1 Criteria: 4.3 (n) **Stated:** First time **To be completed by:** 30 November 2025	The WHSCT must ensure a review of their AWOL processes by: • Ensuring all detained patients have an AWOL care plan and mitigations in place. • When a patient is at risk of AWOL the method of AWOL should be clearly recorded in patient's risk assessment and care plan. • Review of AWOL and Leave Policies to ensure that they are consistent in outlining which grade of medical staff who can approve leave for detained patients. Ref: 5.2.3

	Response by registered person detailing the actions taken: AWOL and Leave policies will be reviewed to reflect that all detained patients will have an AWOL care plan and mitigations in place. This will also include a clear risk assessment. The policy will also be reviewed to ensure there is a consitent appraoch to identify the correct grade of medical staff who can approve leave for detained patients.
Area for improvement 8 **Ref:** Standard 5.3 Criteria: 5,3,3 (a) **Stated:** First time **To be completed by:** 30 November 2025	The WHSCT must ensure that there are robust mechanisms in place to collect feedback and enhance carer/family/stakeholder involvement when patients return from periods of leave. Ref: 5.2.3
	Response by registered person detailing the actions taken: The Leave policy will be reviewed to ensure that there is documented notes recorded within Encompass which will evidence care family stakeholder invovlement when patients return from leave.
Area for improvement 9 **Ref:** Standard 5.1 Criteria: 5.3.1 (f) **Stated:** First time **To be completed by:** 30 November 2025	The WHSCT should undertake regular audits of kardexes across all wards to ensure PRN medication is administered as prescribed and recorded as directed. Ref: 5.2.4
	Response by registered person detailing the actions taken: The Trust has commited to a Band 7 Pharmacist within T&F who will undertake audits of kardex. Funding is being sought for a Band 7 within the Grangewood site moving forward.
Area for improvement 10 **Ref:** Standard 5.1 Criteria: 5.3.1 (f) **Stated:** First time **To be completed by:** 30 November 2025	The WHSCT must implement a method of disposal for sanitary wear in accordance with the IPC Policy and team and which maintains patient safety, privacy and dignity. Ref 5.2.1
	Response by registered person detailing the actions taken: The service will engage with the IPC Team to explore options with regard to sanitary disposal to ensure a process is established that will maintain patient safety, privacy and dignity

Area for improvement 11 **Ref:** Standard 7.1 Criteria: 7.3 (c) **Stated:** First time **To be completed by:** 30 November 2025	The WHSCT must establish an assurance mechanism to ensure that all detained patients in acute wards have had their rights under the MHO 1986 explained to them with a record of this held in their file. All voluntary patients in acute wards are made aware of the locked door policy, have had their rights about restricted access explained to them with a record of this held in their file. Ref: 5.2.4
	Response by registered person detailing the actions taken: The Trust will develop a robust audit process to ensure that all detained patients have had their rights explained to them. Throught the Care Plan Quality Improvement initiative, there will be clear documentation that pateints have been made aware of the lock door policy and have had their rights about restrictive practice explained.

Area for improvement 12 **Ref:** Standard 5.3 Criteria: 5.3.3 (d) **Stated:** First time **To be completed by:** 30 November 2025	The WHSCT must ensure: • Any changes to enhanced observations are agreed by the MDT and reflected in the patient's prescription. • Where enhanced observations are discontinued, the appropriate prescriptions should be updated to reflect this. Ref: 5.2.4
	Response by registered person detailing the actions taken: The Observation Policy will be circulated to all members of the Multi Disiplinary Team and an audit of enhanced observations prescription and discontinuation of presecriptions will be undertaken by our Governance leads across both sites.
Area for improvement 13 **Ref:** Standard 5.1 Criteria: 5.3.1 (f) **Stated:** First time **To be completed by:** 30 November 2025	The WHSCT should ensure a consistent approach to the storage and security of patient property in all wards and that staff are made aware of the protocols for investigation and recording of outcomes following investigation. Ref: 5.2.5
	Response by registered person detailing the actions taken: The patient property protcol will be reviewed and a Task and Finish Group established to ensure implimentation of the protcol and consistency across both sites. The Task and Finish Group will also establish a process for communication around invesitgations and outcomes of investigation.

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

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