

# Inspection Report



**Name of Service: Innishfree Assessment and Treatment Unit**

**Provider: Belfast Health and Social Care Trust**

**Date of Inspection: 03 February 2026**

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Assurance, Challenge and Improvement in Health and Social Care

## 1.0 Service information

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| <b>Organisation/Registered Provider:</b><br>Belfast Health & Social Care Trust (the Trust)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>Responsible Individual:</b><br>Ms Jennifer Welsh<br>Chief Executive, BHSC             |
| <b>Person in charge at the time of inspection:</b><br>Chloe Jade McDonald – Assistant Service Manager                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <b>Number of non - registered places:</b><br>Four                                        |
| <b>Categories of care:</b><br>Learning Disability Assessment and Treatment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>Number of patients accommodated in the unit on the day of this inspection:</b><br>Two |
| <b>Brief description of the accommodation/how the service operates:</b><br><br><p>Innishfree Assessment and Treatment Unit (Innishfree) is a 4-bed in-patient unit situated within Knockbracken Healthcare Park.</p> <p>The unit became operational July 2025.</p> <p>Innishfree 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.</p> <p>Patients are admitted on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986.</p> |                                                                                          |

## 2.0 Inspection summary

RQIA completed a scheduled unannounced inspection on 3 February 2026 with feedback to the Ward Manager and Senior Management Staff. The inspection team comprised of two care inspectors, a senior inspector and administrative support was provided remotely.

This was the first RQIA inspection of Innishfree since becoming operational in July 2025. A pre-inspection visit, undertaken on 23 February 2024, did not identify any Areas for Improvement.

RQIA considered a range of intelligence sources as part of its inspection methodology, including concerns raised in relation to patient care and treatment, care planning and use of the Mental Health (Northern Ireland) Order 1986.

The inspection methodology was structured around ten key thematic areas: environment; incidents and adult safeguarding; staffing; physical health; restrictive practice; patient experience; governance; patient flow; medicines management and mental health. Each theme was assessed to determine the safety, quality and effective delivery of care and treatment provided.

Good practice was demonstrated across a number of areas including structured communication process at shift change that promoted continuity of care, shared clinical information, operational

priorities, and patient and staff safety risks, availability and choice of patient activities, medicines management, and specialist training in Trauma Informed Care and Positive Behaviour Support for staff.

Four Areas for Improvement (AFI) were identified during this inspection. These relate to environment, patient experience, and mental health.

### **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. The quality of care and treatment within services is assessed 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 and of high quality.

RQIA's inspections form part of our ongoing assessment of the quality and safety 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.

During this inspection, the team observed patient experience, staff and patient engagement, staffing levels, senior leadership oversight arrangements and the environment. The inspection team also reviewed patient care records; incidents, safeguarding arrangements, discharge planning and governance documentation.

Posters and feedback leaflets were made available on the ward inviting staff, patients, relatives and visitors to either speak with inspectors or provide written feedback on their views and experiences.

### **4.0 What people told us about the service**

Patients who did not wish to, or were less able to provide their views about their experience, were observed to appear comfortable and relaxed within the environment.

Staff were positive about the support provided to them by the ward manager, senior management team and Multi-disciplinary Team (MDT) and good feedback was noted in relation to bespoke training offered. Staff spoke with enthusiasm about the positive impact this training has had on the provision of safe and therapeutic care.

### **5.0 The inspection**

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

This is the first inspection of Innishfree Ward since becoming operational in July 2025.

## **5.2 Inspection findings**

### **5.2.1 Environment**

The ward environment was assessed against the Royal College of Psychiatrists' Standards for Acute Inpatient Learning Disability Services (Fifth edition, April 2025), to determine whether it supported the delivery of safe, therapeutic and compassionate care. These standards were also reflected within the ward's Standard Operating Procedure (SOP) as the benchmark for measuring the quality of care delivery.

The ward environment was observed to be conducive to the therapeutic needs of the patients. It was clean, well lit, and freshly decorated. Patients had access to living, dining and outdoor spaces with the use of pictures to support orientation around the ward and opportunities for personalisation of rooms were provided. Room temperatures were monitored and anti-ligature windows supported safe ventilation.

Close Circuit Television (CCTV) is present in all communal areas and gardens, and is managed and reviewed in accordance with the Standard Operational Procedure in place for Innishfree.

Environmental risk assessments, including ligature and fire risk assessments, were well managed and supported by governance oversight. Personalised Emergency Evacuation Plans (PEEPs) were in place for each patient. A fire safety issue in relation to storage of CO2 cylinder storage and signage was identified as an area for improvement.

A works improvement plan was in place to address essential works that will enhance the ward environment to benefit patients and staff.

It was noted during the pre-inspection of the ward that the kitchen/servery required staff to pass through individual patient living areas, with potential to impact upon privacy and the therapeutic environment. No concerns in this regard were noted during this inspection and assurance was provided that action would be taken in the event of any issues arising.

### **5.2.2 Incident Management and Adult Safeguarding**

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 set 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 to staff on the ward.

Staff demonstrated knowledge of incident reporting and ASG policy and procedures, including escalation pathways. A safeguarding champion was available and staff were familiar with their

role. There was evidence of timely incident reporting via the Trust's incident reporting system (DATIX) and appropriate and timely referral to the Adult Protection Gateway Team (AGPT). Screening by Designated Adult Protection Officers was completed within an appropriate timescale and there was timely implementation of interim protection plans. Relevant information was shared with staff through daily safety briefs and escalated to senior management for discussion at the daily safety huddle.

All nursing staff were required to complete ASG training appropriate to their role. Training records indicated that all staff had achieved Level 2 training; however, some required Level 3 refresher training. Senior management had identified this, with action being taken to address the shortfall.

There were effective governance systems in place for incident management, which supported the identification and dissemination of learning and continuous improvement in patient care. Post incident debrief with staff and weekly incident reviews by MDT evidenced assessment and review of data and behavioural analysis to inform care delivery and support to patients.

Review of governance and reporting systems provided assurance that robust arrangements were in place for the oversight and scrutiny of incidents and ASG. However, documentation could be strengthened to record reviewer name and designation to improve accountability and traceability.

### 5.2.3 Staffing

Innishfree operates an MDT approach to care and treatment. A range of representation from various disciplines including nursing, social work, occupational therapy (OT), psychiatry, medical, physiotherapy, pharmacy and psychology staff to meet the needs of patients.

Nursing staff levels were determined by the use of the Telford Model, a tool that assists in ensuring appropriate staffing based on patient acuity. The daily safety huddle provided a mechanism for oversight of staffing levels, identifying and addressing staffing shortfalls when required. There was a mix of substantive and agency staff working across shifts. To ensure consistency and continuity of care for patients, agency staff were block booked.

All staff had completed role-specific induction training. Whilst training records reflected good engagement with compulsory training, gaps were identified in areas such as Immediate Life Support and Adult Basic Life Support. Safety Intervention Training had been completed within the last year, and ASG training had been completed or was booked for relevant staff. The Trust recognised these as development priorities and provided assurance that actions were being taken.

Agency staff are required to provide evidence of training before any shifts can be booked. This provides assurance that patients' needs are being met by suitably trained staff.

Specialist evidence-based training, including Trauma Informed Care and Positive Behaviour Support, was available to all staff who reported a positive impact on care delivery. However, recording of bespoke training on staff training records was inconsistent. Whilst training provision was effective and relevant, governance processes require strengthening to ensure training is consistently recorded, monitored for renewal, and accessible for new employees.

### 5.2.4 Physical Health

Records reviewed evidenced that patient's physical health care needs were being appropriately assessed, monitored and met. Risk assessments and care plans were in place to support the monitoring of physical health conditions and associated prescribed medications. Patients were supported to access primary healthcare appointments, with consideration being given to the support needs of the patient and reasonable adjustments being made to accommodate those needs.

Documentation demonstrated that patients were offered a comprehensive physical health assessment on admission, identified needs were being addressed. Physical health observations were undertaken in line with the New Early Warning Score (NEWS) and reviewed by the Responsible Medical Officer (RMO), with appropriate monitoring oversight of prescribed medication. There was regular input from a General Practitioner (GP) with specialist interest in Learning Disability (LD) and out-of-hours medical cover.

Patients' physical health needs were individually assessed, with timely referrals made to relevant allied health professionals, there was evidence that individualised physical health care plans were in place and were being followed by staff. There was evidence of regular reviews, with records reflecting if patient's had agreed to or refused to participate in physical health monitoring and escalation of refusal if required.

Systems were also in place to ensure physical health equipment was regularly checked and maintained for safe use.

### 5.2.5 Restrictive Practices

The Regional Policy on the Use of Restrictive Practices in Health and Social Care Settings, Department of Health, November 2023 (the Regional Policy), provides the regional framework for the safe and ethical management of restrictive intervention, restraint, and seclusion. Review of documentation indicated that proactive, preventative and reactive strategies were in place to minimise the use of restrictive practices. There was clear evidence of regular review of observation levels and the use of least restrictive practice approaches.

Restrictive practice is the term used to describe any intervention that restricts or limits a person's freedom of movement. Examples of restrictive practices implemented on the ward include locked doors, enhanced/prescribed patient observations, physical interventions and the use of PRN medication. There was evidence that families/carers and advocates were engaged in discussions regarding the use of restrictions, including the rationale for their implementation both on the ward and during visits to the community.

Patient's level of observation and environmental restrictions were reviewed weekly at ward round with consideration of patient presentation, response to current interventions and level of risk. There was evidence that level of observation for patients had been risk assessed and care planned with consideration to the support required by the patient at that time.

Staff on the ward implement a Positive Behaviour Support (PBS) Framework that aims to reduce the use of restrictive practices by proactively supporting individuals who experience

dysregulated behaviour, through understanding underlying needs and implementing person-centred, preventative strategies.

Each patient had individualised PBS care plans in place to guide staff to understand patient communication needs and behaviours. Whilst plans were comprehensive they were lengthy, which presented difficulty in accessing key behaviour management strategies, and PBS Plans had not been updated since admission to the ward. The Trust should ensure that the PBS care plans are updated to reflect management strategies in line with the changing circumstances/ environment of individual patients.

Trust policies relating to restrictive practices had not been updated to reflect the Regional Policy, and strengthened governance oversight is required to ensure policy alignment.

### 5.2.6 Patient Experience

Patients were observed to have a positive experience at Innishfree with good therapeutic engagement from staff. Overall, patients had access to mobile phones, tablets, and the internet, enabling them to maintain contact with family, carers, and friends, as well as accessing ward based and community activities. Patients had access to outdoor areas and were supported to engage with the community, by utilising MDT agreed hospital leave for walks with staff and with family/carers.

Patients had personalised daily planners based on assessed need, which were an integral aspect of care. A record of patient engagement in activities of daily living were maintained and reviewed to inform care.

Patients were offered daily menu choices, with dietician-approved meal plans in place where required and shared with relevant staff. Information on healthy eating is provided, and staff monitor patients' diet and fluid intake. Patients also had access to an Activities of Daily Living kitchen, enabling participation in meal preparation, drinks, and household tasks, while supporting assessment of independence and future discharge needs.

However, information to support understanding, choice and dignity for patients, was not accessible in a format that met the communication needs of the patients. The Trust should consider the involvement of Speech and Language Therapy in the development of accessible information and to support patient engagement.

Care records reviewed indicated that whilst there was evidence of assessment of patients' needs to understand their choices and preferences, patient engagement in care planning was limited. Records showed inconsistent documentation of patient participation, feedback, and attendance at MDT meetings, and there was little evidence that patients were informed of decisions made about their care. The findings highlight the need to ensure patients receive clear, accessible information and are meaningfully engaged and involved in care and treatment planning wherever reasonably practicable.

The Trust must ensure that care plans and related documentation clearly record best-interest decisions about how information is managed and shared with patients. There should be clear evidence that capacity is considered on an individual basis, with no use of blanket assumptions, and that thoughtful decisions are made about information-sharing. Where information is

withheld in a patient's best interests, this decision and its rationale must be explicitly documented.

The Trust should ensure that patient consent is appropriately considered when external or third-party individuals attend meetings about a patient's care and treatment. Patient preferences around confidentiality should be respected wherever possible. Where a patient is unable to give consent, the Trust must clearly evidence that third-party attendance has been considered and agreed through a best-interests decision-making process.

Two areas for improvement were identified, including the provision of accessible information for patients and to support patient engagement in their care and treatment.

### 5.2.7 Mental Health

Patients in the ward were detained in accordance with the Mental Health Order (Northern Ireland) 1986 (MHO). Records reviewed indicated that the Responsible Medical Officer (RMO) had appropriately completed the required Prescribed Forms with evidence of assessment, and including referral for second opinion approved doctor review. However, there was inconsistency in the storage of the relevant documentation within patient records on Encompass, which is the single electronic patient record. The Trust should ensure that relevant MHO Prescribed Forms are accessible within the patient's record on Encompass.

Patients who had been assessed as lacking capacity to understand the purpose of their detention were supported by the MDT, family or carers, and specialist advocacy services. Patients and their representatives were provided information about their rights, including making an application to the Mental Health Review Tribunal for Northern Ireland, for independent review of a patient's detention and the right to legal representation.

Care records indicated that patients had been made aware of their rights, however there was limited evidence as to how this was being facilitated to meet the communication needs of the patients.

The Trust should consider further improvements in relation to the development and availability of accessible information regarding the MHO and patient rights to ensure patient access and support understanding.

Holistic assessment and treatment plans supported staff to better understand patient needs and ensure the delivery of patient centred care. There was evidence of continuous assessment and review of patient's care and treatment needs, with consideration to their mental health presentation, learning disability and neurological conditions.

Staff demonstrated a clear understanding of patients' needs, and risks, and communicated effectively to provide reassurance and support. However, gaps were identified in the completion, updating, and sharing of risk assessments and this has been identified as an AFI.

### 5.2.8 Patient Flow

At the time of inspection Innishfree was operating at 50% capacity, with no planned admissions and no patients were delayed in their discharge.

Patient flow arrangements, including admissions and discharges, provided assurance that admission criteria was appropriately applied. There was evidence of timely and safe discharge planning, with MDT discussions considering placement options, support needs, risk assessment and future care planning. Family/carers and advocacy services were involved in discharge planning.

The Trust's Community Learning Disability Service and Therapy Support Service continued to be involved in patients' care and treatment during admission. Patient's social worker's and other allied health professionals contributed to weekly MDT meetings, undertaking assessments and informing treatment planning and future placements decisions.

### 5.2.9 Medicines Management

No concerns were identified in relation to the management of medication within Innishfree. Processes for the receipt, storage and administration of medication were adhered to, with appropriate monitoring arrangements in place.

The clinic room was clean, well laid out and had appropriate locked storage units. Cleaning charts, detailing the cleaning and maintenance of physical health observation machines and drug trolleys etc. were complete and the clinic fridge temperature was recorded and monitored.

Medication was correctly stored in locked cabinets and emergency equipment could be accessed easily. However, whilst a room thermometer was in place, the daily check was not added to documentation for recording and monitoring purposes. This issue was raised at the time of inspection and assurance was provided that this would be addressed.

Effective governance arrangements were in place, with regular pharmacy audits and routine checks of emergency resuscitation equipment providing assurance that medicines and equipment were safe, available, and fit for use. Pharmacy were completing quarterly audits of the clinical area, including emergency medication, with no issues identified. Daily and weekly checks of emergency resuscitation equipment were also in place, providing assurance regarding the safety and readiness of equipment.

Although there was no dedicated ward pharmacist, quarterly pharmacy audits provided assurance, with the most recent audit identifying no areas for concern and demonstrating good practice.

### 5.2.10 Governance

The service is not currently commissioned or funded by the Strategic Planning and Performance Group (SPPG). At the time of inspection, Belfast Health and Social Care Trust had submitted a Business Plan and application for funding had to SPPG and were expecting funding agreement from April 1 2026.

Governance arrangements were reviewed through documentation and discussion with the ward manager, Senior Management Team (SMT) and members of the MDT. Effective and structured systems were place to support risk management, communication, and escalation, including handovers, daily safety briefs, and safety huddles.

Leadership was visible and accessible, and staff described supportive supervision, appraisal, and positive engagement with senior managers.

Robust governance processes, including regular incident and audit reporting, demonstrated openness, learning, and a commitment to continuous improvement, with the SMT aware of and actively addressing areas requiring further development.

## 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 |
|----------------------------------------------|-----------|
| <b>Total number of Areas for Improvement</b> | 4*        |

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                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
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| Action required to ensure compliance with The Quality Standards for Health and Social Care (DHSSPSNI March 2006)                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Area for improvement 1</b><br><br><b>Ref:</b> Standard 5.3<br><br><b>Criteria:</b> 5.3.1 & 5.3.2<br><br><b>Stated:</b> First time<br><br><b>To be completed by:</b><br>31 May 2026 | <p>The Belfast Health and Social Care Trust should ensure the secure storage of O2 cylinders in line with the fire risk assessment, to include the appropriate warning signage is in place at all times.</p> <p><b>Ref:</b> 5.2.1</p> <p><b>Response by registered person detailing the actions taken:</b><br/>           Oxygen cylinders have been put onto wall storage within the clinical/treatment room. There is signage on the door to inform that oxygen is being stored in the room. There is a fire extinguisher in the clinical room. This is detailed on the fire risk assessment.</p> |

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| <p><b>Area for improvement 2</b></p> <p><b>Ref: Standard 5.3 &amp; 6.3</b></p> <p><b>Criteria: 5.3.1, 5.3.3 &amp; 6.3.2</b></p> <p><b>Stated: First time</b></p> <p><b>To be completed by: 31 May 2026</b></p> | <p>The Belfast Health and Social Care Trust should ensure the provision of information that appropriately meets the communication needs of patients, and consider the involvement of Speech and Language Therapy in the development of accessible information, to support patient understanding and engagement in all aspects of their care and treatment.</p> <p>Ref: 5.2.6 &amp; 5.2.7</p> <p><b>Response by registered person detailing the actions taken:</b><br/> Innishfree ward have access to community speech and language therapy. This is accessed on a needs basis through referral. Patients can be referred to Speech and language therapy for communication assessments if a communication need is identified. The patients presenting in Innishfree ward have had communication assessments completed by Speech and language therapy and communication with the patient group is based on assessment information and may take the form of verbal communication, written communication, use of communication devices, using signs and symbols or through Makaton/signing. Changes to patient care or appointments are communicated through the use of social stories to aid patient understanding. Both patients have communication plans suitable for their needs, there are meal plans in picture format and talking Mats in place.</p> |
| <p><b>Area for improvement 3</b></p> <p><b>Ref: Standard 5.3 &amp; 6.3</b></p> <p><b>Criteria: 5.3.1, 5.3.3 &amp; 6.3.2</b></p> <p><b>Stated: First time</b></p> <p><b>To be completed by: 31 May 2026</b></p> | <p>The Belfast Health and Social Care Trust should promote patient engagement and involvement in their care and treatment, including evidence of best interest decision making in all aspects of the patients care.</p> <p>Ref: 5.2.6</p> <p><b>Response by registered person detailing the actions taken:</b><br/> MDT proformas have been updated to capture patients views on a weekly basis. These are reviewed as part of the weekly multidisciplinary team meeting. Patients are welcomed to attend this meeting or meet with their responsible clinician following the meeting. The nursing staff work alongside patients using alternative communication skills to ascertain patient views and ensure they are involved in planning their care. The nursing staff support verbal communication with the use of pictures and social stories to consolidate understanding and ensure that information is delivered at the appropriate level to allow the patient to make an informed decision regarding their care. Where it is evidenced that with appropriate, accessible information that the patient is unable to make an</p>                                                                                                                                                                                                                  |

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|                                                                                                                                                                                 | informed decision regarding their care then the best interest decision making process will be considered to inform decision making.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Area for improvement 4</b><br><b>Ref:</b> Standard 5.3 & 6.3<br><b>Criteria:</b> 5.3.1, 5.3.3 & 6.3.2<br><b>Stated:</b> First time<br><b>To be completed by:</b> 31 May 2026 | The Belfast Health and Social Care Trust should ensure the completion, updating, and sharing of risk assessments and care plans.<br><br><b>Ref:</b> 5.2.7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                 | <b>Response by registered person detailing the actions taken:</b><br>Care plans are updated by named nurses and nursing staff on the ward. There is a process for care plan auditing which is ongoing. Any issues identified are communicated back to the named nurse for review/updating. Care plans are reviewed formally six monthly but will be as and when required in line with changes required. Risk assessments are completed for activities and outings. These are reviewed following and updated accordingly with any emerging risks. Family are involved in the completion/review of risk assessments. Risk assessments for the ward/environment are completed as part of the BRAAT which is completed in all areas of the Belfast trust. BRAAT auditing for Innishfree remains ongoing and there is a working group established for this. |

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



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