

Inspection Report



Name of Service: Inpatient Mental Health Service

Provider: Southern Health & Social Care Trust

Date of Inspection: 20 October 2025 – 27 November 2025

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1.0 Service information

Organisation/Registered Provider: Southern Health and Social Care Trust (SHSCT)	Responsible Person: Mr. Steve Sperry, Chief Executive Officer SHSCT
Person in charge at the time of inspection: Mr. Joe Walker Assistant Director Mental Health and Intellectual Disability Inpatients.	Number of commissioned beds: 64 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 this inspection: 67 beds
Brief description of the accommodation/how the service operates: Inpatient mental health services within the Southern Health and Social Care Trust are provided at the Bluestone Unit, situated on the Craigavon Area Hospital site. Bluestone consists of four wards. The wards are mixed gender and provide assessment and treatment for patients with acute mental health needs for people aged between 18 and 65. Access to Psychiatric Intensive Care Unit (PICU) beds is made available when required and included within the bed numbers. All four wards provide single room occupancy with en-suite facilities. Patients are admitted 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 the SHSCT Inpatient Mental Health service commenced on the 20 October 2025, and concluded with feedback to the Trust on 27 November 2025. The inspection team comprised of three care inspectors, a senior inspector, two pharmacy inspectors, a Consultant Psychiatrist and remote administration support.

Prior to the inspection RQIA received intelligence which raised concern in relation to the management of adult safeguarding incidents, the use of safety interventions, incident management, and communication and engagement with families. Intelligence also indicated the service was experiencing over occupancy and high levels of patient acuity.

RQIA considered available intelligence, including Early Alerts (EA), and recommendations arising from Serious Adverse Incidents (SAI) as an integral part of the inspection methodology. Review of this information provided assurance that recommendations had been embedded into practice, with clear processes in place to support implementation. Robust governance and quality assurance arrangements were in place to monitor progress, audit compliance, and sustain improvements, contributing to positive outcomes 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 a previous inspection of the service during December 2021. The findings of this inspection confirmed that all four AFI's had been fully met. Further detail can be found in section 5.1 of this report.

The inspection methodology was structured around ten thematic areas: 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 the extent to which care and treatment were delivered safely and effectively.

Good practice was identified across a number of areas, in relation to adult safeguarding arrangements and incident management, the provision of therapeutic activities and quality improvement initiatives, including work to reduce restrictive practices. Governance arrangements were robust and evidenced a strong culture of learning, reflection and continuous quality improvement, supporting sustained improvement in patient care.

Robust systems were in place across most aspects of medicines management. However, areas for improvement were identified in relation to care planning for the administration of as and when required medication, mandatory medicines management training and controlled drug audit arrangements; further detail can be found in section 5.2.8 of this report.

Throughout the inspection, staff were observed to be caring and compassionate in their engagement with patients. This was further reflected in positive feedback from patients and relatives regarding their experiences of the service.

As a result of this inspection, nine areas for improvement (AFI's) were identified. These are in relation to the perimeter fence, the provision of privacy, ligature risk assessment, fire risk assessments, staff training, the arrangements for seclusion, restrictive practice care planning and medication management. Details are included within the main body of this report.

3.0 How we inspect

RQIA has a statutory responsibility under the Mental Health (Northern Ireland) Order 1986 to make inquiry into any case of ill-treatment, deficiency in care and treatment, improper detention,

and/or loss or damage to property. Care and Treatment is 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, 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 questionnaires were used to invite staff, patients and relatives to share their views and experiences of the service. A total of 20 questionnaires were received, with all respondents reporting that they were satisfied or very satisfied with all aspects of their care. In addition, inspectors spoke directly with patients, relatives and staff throughout the inspection process. Comments from patients and relatives were positive, acknowledging good care provided and effective communication with staff. These included:

'I am fully involved in my care planning and discharge arrangements'

'My relative receives the best care and treatment'

'The staff are very good; I couldn't fault them'

'Staff provide updates following the Consultants meeting'

Information received indicated that, at times, staffing levels impacted opportunities for patients to go for a walk.

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 MHLA Acute Mental Health Wards in Southern Trust on 8 December 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: 4.2, 4.3 (j) Stated: First time	The Southern Health and Social Care Trust should ensure ward managers are informed and understand the staffing model used to determine normative staffing levels for their respective wards and be involved in this process.	Met
	Action taken as confirmed during the inspection: This AFI has been assessed as met as detailed in section 5.2.3	
Area for improvement 2 Ref: Standard 5.31 (f) 5.32(a) Stated: Second Time	The Southern Health and Social Care Trust must strengthen the governance oversight of incident management to ensure: the grading of incidents reflect the cumulative effect of repeated low risk incidents involving the same patients.	Met
	Action taken as confirmed during the inspection: This AFI has been assessed as met as detailed in section 5.2.2.	
Area for improvement 3 Ref: Standard: 5.2, 5.3.1 (f) 5.3.2 (c) Stated: First time	The Southern Health and Social Care Trust should collate data in relation to adult safeguarding incidents to enable trend analysis at ward and unit level, this will ensure ward managers and members of the MDT have good oversight of themes arising to identify any learning which may help in reducing reoccurrence.	Met
	Action taken as confirmed during the inspection: This AFI has been assessed as met as detailed in section 5.2.2	
Area for improvement 4 Ref: Standard 5.3.1 (c) Stated: First time Carried Forward	The Trust must ensure there is an agreed policy and procedure in place for the management and oversight of the use of CCTV in the hospital. The Trust must implement assurance mechanisms to ensure CCTV is being used in line with the policy (i.e. more than one professional discipline reviewing footage of incidents).	Met

	Action taken as confirmed during the inspection: This AFI has been assessed as met as detailed in section 5.2.2	
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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, Eighth Edition, May 2022 and the Royal College of Psychiatrists Standards for Psychiatric Intensive Care Units Fourth Edition March 2025, to determine if they were conducive to the delivery of safe, effective and compassionate care.

The wards were bright and spacious, offering a variety of communal spaces including dining areas, lounges and family visiting spaces. Sensory areas, tranquillity rooms and dedicated family rooms were available across the wards. Access to outdoor courtyard areas was provided, including one courtyard equipped with gym equipment and a child friendly play area for visiting families. While some areas required redecoration, this had been recognised by the Trust and addressed through a planned rolling programme of redecoration.

The perimeter fence was not effective in preventing unauthorised absence or minimising the introduction of contraband into the Bluestone Unit, presenting an ongoing environmental and security risk. The Trust provided assurance that approval had been granted for the installation of a new perimeter fence, subject to the availability of funding. In the interim, the Trust should ensure that appropriate risk mitigation measures are in place and monitored through established governance and risk management arrangements to reduce the risk of unauthorised absence and the introduction of contraband until the new fence is installed. An AFI has been made in relation to patient safety.

Patient bedrooms were single rooms with en-suite bathrooms. However, a number of saloon style doors had been removed from the bathrooms, which compromised privacy and dignity. While the Trust's rationale for door removal was clear, the arrangements in place did not sufficiently mitigate the impact on privacy. The Trust should ensure that appropriate measures are implemented in all cases, to safeguard patient privacy and dignity when using en-suite facilities. An Area for Improvement (AFI) was identified in this regard.

Due to the sustained demand for mental health in-patient beds, some patients were admitted to contingency spaces. These consisted of chairs that fold down to form beds and were generally situated in re-purposed communal areas such as small lounges off the main ward. Staff reported that patients found using contingency beds uncomfortable and due to their location, patients had limited access to private bathroom and shower facilities.

While acknowledging the occupancy pressures faced by the Trust, the use of contingency bed spaces should be reviewed to ensure that arrangements support patient privacy, dignity and comfort, including timely access to appropriate bathroom facilities. Oversight of these arrangements should be maintained through established governance and risk management processes to ensure that patient experience, safety and therapeutic care are not adversely impacted. Patient experience in relation to this matter is further referenced in section 5.2.6.

Ligature Risk Assessments (LRA) were comprehensive and demonstrated involvement from Health and Safety (H&S) and Estates personnel. However, the LRA within the Psychiatric Intensive Care Unit (PICU) had not been reviewed within the past 12 months, which is not consistent with best practice for such high-risk clinical environment and presents a potential patient safety risk. The Trust should ensure that clear processes are in place to identify when LRA are due for review and that these are reviewed at least annually or more frequently where patient acuity or environmental risk changes. This should be overseen through established patient safety and risk management governance arrangements to provide assurance that ligature risks are proactively identified, managed and mitigated to reduce the risk of harm to patients. An AFI has been made in relation to LRA.

Two of the four wards did not have up to date Fire Risk Assessments (FRA) and there was limited evidence that actions previously identified had been completed or appropriately escalated. One of the wards had experienced a fire setting incident within the previous 12 months. While a fire incident report and a Structured Early Learning Tool (SELT) which is a process used by the Trust to review incidents to improve patient safety, had been completed to capture learning, the associated FRA had not been reviewed. The Trust confirmed that this matter had since been escalated to the Fire Officer. The Trust should ensure that FRAs are reviewed promptly following any fire-related incident, with oversight through established fire safety and risk management governance structures to ensure risks are effectively identified, monitored and mitigated. An AFI has been made in relation to fire safety risk management.

Personal Emergency Evacuation Plans (PEEPS), which identify the level of assistance required to support a patient to safely evacuate in an emergency, were in place in three of the wards. However, there was limited evidence that PEEPS were being completed within the PICU. Post inspection it was confirmed that PEEPS were being completed when required to ensure patient safety. PEEPS should be completed consistently across all inpatient wards for patients who require support in the event that evacuation is necessary.

Evidence of environmental and Infection Prevention and Control (IPC) audits were being completed ensuring the cleanliness of wards and appropriate infection control measures were in place to keep patients safe.

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 set out the requirements for providing a safe environment and the actions and responses required where adults may be at risk of harm or abuse, or are in need of protection.

ASG and incident management arrangements were in line with regional policy. Information on the referral process, including contact details for the Adult Protection Gateway Team, and the Regional Emergency Social Work (out-of-hours) Service (RESWS), was readily available within each of the wards. There was available guidance for staff following the introduction of the Encompass single electronic patient record system, to support the completion of APP1 forms on the new system.

Staff demonstrated good knowledge of ASG processes and adherence to the regional policy in identifying and reporting concerns, with referrals appropriately recorded on the Trust's electronic system for recording incidents (DATIX). Staff demonstrated a clear understanding of the protection measures in place to safeguard patients.

Effective oversight and governance arrangements for the management of adult safeguarding were in place. The lead social worker had collated information on all ASG incidents for review, liaising with Adult Protection Gateway Team (APGT) as appropriate. ASG referrals were also reviewed through multidisciplinary team (MDT) governance meetings. This enabled trends, themes and learnings to be identified, which can help reduce recurrence and improve patient safety. Safeguarding training for staff ranged from 94% to 100% compliance across the four wards.

Prior to the inspection, available intelligence indicated delays in the retrieval of securing Closed Circuit television (CCTV) footage for investigative purposes. The Trust advised that processes had since been reviewed to support the timely retrieval of CCTV footage when required. The Trust policy on the use of CCTV and body worn cameras sets out clear arrangements for the retrieval and review of footage including CCTV reviews which were required to be undertaken by two staff members from different professional backgrounds who had experience of safety intervention training.

Review of incidents recorded on DATIX over the previous three months found that incident grading was broadly consistent with the Regional Risk Matrix. However, some inconsistencies were identified, particularly in relation to patient-on-patient and patient-on-staff incidents. The Trust should strengthen scrutiny at the point of grading to support consistency and ensure that incident severity accurately reflects the potential seriousness of each event.

Some delays were identified in the review and approval of incidents recorded on the DATIX system. The Trust should review and strengthen its arrangements for incident review and approval to ensure the process is timely and supports effective learning and risk management. In addition, the Trust should implement a system to provide assurance that all incidents are reviewed within agreed timescales. Staff had access to post-incident debrief sessions, which provided opportunities for reflection, learning and support.

There was evidence of effective governance and oversight of incident management and SAI recommendations by the Senior Management Team (SMT). The Structured Early Learning Tool (SELT), was applied effectively to identify learning and inform improvements to practice and patient experience.

5.2.3 Staffing

A MDT approach to care and treatment was in operation, including nursing, social work, occupational therapy (OT), psychiatry, medical, physiotherapy, pharmacy and psychology staff.

Nursing staffing levels were determined using the Telford Model, which supports managers to assess appropriate and safe staffing levels based on patient acuity, thereby supporting patient safety. Ward managers confirmed their involvement in this process alongside senior managers, providing oversight of staffing arrangements to maintain safe care delivery. The AFI identified in the previous inspection report was therefore assessed as met.

An escalation policy was in place to support the timely management of staff absence and staffing shortages. Staffing shortfalls and workforce challenges were recorded on), enabling senior management to monitor trends, assess risk and take action where required. The SMT confirmed a reduction in the use of nursing agency staff, which improved continuity of care for patients and supported the development of therapeutic relationships.

Recruitment remained ongoing, with a number of nursing appointments made through internationally and locally based recruitment campaigns, supporting workforce stability. The Trust had an induction programme in place for all new staff, with preceptorship arrangements to provide structured mentorship and support, enabling staff to develop competence and confidence in their roles. Nursing staff reported feeling well supported and spoke positively about working within the service. These arrangements supported continuity of care, reduced reliance on temporary staffing and contributed to the safe and consistent delivery of patient care.

Discussion with staff and observations of practice evidenced a positive organisational culture, with leadership arrangements that promoted the recognition of good practice and valued staff contributions. Greatix, a positive staff feedback system that enables recognition of the work of staff, was embedded across the Bluestone Unit and was reported to support staff morale by helping staff feel valued and appreciated.

Observations of practice demonstrated a skilled and knowledgeable workforce. Arrangements were in place to support continued professional development, appraisal and supervision, contributing to staff competence and safe practice.

Overall compliance with mandatory training was good; however, some gaps were identified including Fire Safety, Promoting Quality Care (PQC), Medicines management, Mental Health Order (MHO) training and Safety Intervention training. The Trust should ensure that an effective and consistent process is in place to monitor mandatory training compliance across all four wards with oversight through governance arrangements to provide assurance that staff are appropriately trained to deliver safe and effective care. An AFI was identified in relation to staff training.

It was positive to note that Patient Experience support staff were well integrated within the ward teams and demonstrated good awareness and understanding of patient risks.

5.2.4 Physical Health

On admission patients received physical health assessments and were monitored using appropriate risk screening tools, including the Malnutrition Universal Screen Tool (MUST) and National Early Warning Score (NEWS). This approach was consistent 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 identified physical healthcare needs had received a comprehensive assessment, with care plans in place. Where required, there was evidence of timely referral to an appropriate healthcare professional, including dietitians and speech and language therapists.

However, it was noted that the NEWS tool was not always completed in line with prescribed requirements, and where this occurred, the rationale for non-compliance had not been recorded. The Trust should ensure that NEWS observations are completed consistently and that any deviation from prescribed monitoring is clearly documented, including the clinical rationale and escalation arrangements, to support timely recognition of deterioration and patient safety.

5.2.5 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 a framework to support best practice in the management of restrictive interventions, including restraint and seclusion.

Restrictive practice is the term used to describe any intervention that restricts a person's freedom of movement. Examples of restrictive practice include locked doors, enhanced levels of observation including prescribed patient observations; physical interventions; the use of 'when required' (PRN) medication; rapid tranquillisation; CCTV and seclusion.

During the inspection, restrictive practices in use within the service included locked exit doors; enhanced levels of observations; the use of physical intervention; PRN medications, the use of low stimulus environments and seclusion.

Staff demonstrated good knowledge of restrictive practices and there was a clear commitment to reducing their use of restrictions through structured quality improvement initiatives. The implementation of the Safewards approach was visibly promoted across inpatient wards. This is an approach to reduce conflict, restraint and seclusion within acute mental health wards by improving staff-patient interactions, relationships and ward culture.

A review of restrictive practice records demonstrated that consideration was given to human rights and that the use of restrictive practices was reviewed routinely through daily safety huddles and weekly MDT meetings.

However, care planning arrangements for restrictive practices differed between the PICU and the acute inpatient wards, resulting in variation in how restrictive practices were documented. Within the PICU a care plan bundle was used to record restrictive practices in operation on the ward. This was made available to patients on admission and signed by both patients and staff, supporting transparency and patient awareness in accordance with the regional policy.

On the acute inpatient wards, patients were provided with an information booklet and admission agreement outlining restrictions relating to entry and exit from the ward due to locked doors. However, there was limited evidence to demonstrate that restrictive practices which may apply during a patient's admission were routinely discussed with patients or clearly documented within individual care plans. This reduced assurance that patients were consistently informed of, involved in and supported to understand restrictive practices, including how these would be applied, reviewed and reduced during their admission.

Across both the acute and PICU wards, gaps were identified in the recording of restrictive practices. Within PICU there was inconsistent evidence that information regarding the use of restrictive practices had been shared with patients, and one patient did not have a restrictive practice care plan bundle in place.

These findings reduced assurance that restrictive practices were being consistently recorded and communicated. An AFI was identified to ensure appropriate documentation, patient involvement and governance oversight in relation to restrictive practices care planning.

Patients admitted to the Seclusion area within the PICU did not have visual access to a clock and the intercom system was not functioning. While this did not adversely affect patients' ability to communicate with staff, the Trust should ensure that appropriate actions are taken to address these environmental issues to support orientation, safety and dignity.

Although the seclusion policy was being implemented, gaps were identified in the completion of required nursing and medical reviews. In addition, documentation lacked clear and concise information, including the consistent recording of patients' food and fluid intake. The Trust should consider alternative or improved methods of recording this information to ensure accuracy, accessibility and effective clinical oversight.

An AFI was identified in relation to the seclusion environment and the quality of seclusion documentation.

5.2.6 Patient Experience

Each ward had a number of noticeboards displaying information for patients, families, and visitors. This included details on mental health support groups, the Trust's complaints procedure, Independent Advocacy services, the Think Family Initiative, which provides wider family support for people with parental mental health challenges, and information on how patients could exercise their rights and access support during their admission. This supported patient awareness, choice and involvement in care.

Staff engaged with patients in a caring, compassionate and person-centred manner, demonstrating respect for individual needs, preferences and autonomy. Interactions observed

supported dignity, choice and involvement, consistent with a recovery-focused and right-based approach to care. Patients were supported, where appropriate, to participate in daily activities and therapeutic programmes that promoted independence and wellbeing. A range of innovative on and off-site therapeutic activities that were highly valued by patients and staff were on offer to patients. These included cycling, kayaking, swimming and bowling. The use of public transport to attend off site activities helped build self-esteem, independence and confidence. This approach demonstrated positive risk taking and supported recovery by promoting social inclusion, skill development, confidence and community integration as part of patients' individual recovery journeys.

Patients and relatives expressed satisfaction with the care and treatment provided describing positive experiences of involvement, support and communication. This was also reflected in the responses received through the questionnaire process, as outlined earlier in this report.

Mealtimes were aligned with the regional 'Mealtimes Matter' framework, with a nominated mealtime co-ordinator overseeing arrangements on the ward. This provided assurance that patients received meals appropriate to their assessed needs, including compliance with the International Dysphagia Diet Standardisation Initiative (IDDSI). To maintain effective oversight, staff should be reminded of the importance of minimising distractions for the nominated mealtime co-ordinator.

Patients were offered a choice of meals, and the food provided appeared appetising. Discussions with Patient Experience Support service staff demonstrated good awareness of patient's individual preferences and dietary requirements, supporting a positive and safe mealtime experience. As part of a Quality Improvement initiative, facilities were introduced to enable patients to access and prepare their own tea, coffee and juices; this was well received by patients, and supported autonomy and choice.

Patients reported dissatisfaction with the contingency arrangements, describing that the environment did not adequately support privacy, comfort or rest during their admission. Staff also acknowledged the limitations of the contingency spaces. While recognising the operational pressures faced, the Trust should review these arrangements to ensure that patient experience, dignity and therapeutic care are consistently supported.

Robust arrangements for the management of complaints were in place, including clear documentation of the nature of complaints, actions taken, and whether matters were resolved locally or escalated to the SMT.

5.2.7 Patient Flow

At the time of inspection, demand for inpatient mental health beds meant that occupancy levels exceeded capacity at 105%. As a result, some patients were accommodated in contingency spaces without access to individual toilet or showering facilities. This impacted on patient dignity and reduced the availability of communal day spaces for other patients.

The level of patient acuity across the wards was high. Staff demonstrated the knowledge and skills required to manage complex patients' needs safely, reflecting positively on workforce capability.

Bed capacity was overseen through established patient flow arrangements. Twice daily reviews between the bed flow coordinator and ward managers supported responsive decision-making, effective use of available beds and the maintenance of safe care delivery.

Records reviewed and discussions with staff evidenced good oversight of discharge planning for patients assessed as fit for discharge but unable to return home. This included proactive engagement with patients, their families and with community teams to secure appropriate placements. There was also evidence that Early Post Discharge Appointments (EPDA) were arranged, supporting continuity of care following discharge.

While it was acknowledged that patients should not be in hospital longer than clinically necessary, a range of factors were impacting the timely discharge of some patients. These included funding constraints, legal processes and the limited availability of suitable community placements. The Trust should ensure that all reasonable steps continue to be taken to support timely and appropriate discharge.

The relocation of Gillis Memory Centre to the Bluestone Unit had resulted in a reduction of four adult acute mental health beds. This was likely contributing to increased occupancy pressures and the use of contingency spaces. The Trust should review the availability of acute mental health beds to identify solutions that may reduce the reliance on contingency arrangements.

5.2.8 Medicines Management

Staff were complimentary of the pharmacy support provided to the wards and the contribution to the safe management of medicines.

The pharmacist support on the three acute assessment and treatment wards included medicines reconciliation for newly admitted patients, ongoing review of kardexes, providing specialist advice on prescribing, managing medicines at discharge and attending the multidisciplinary team (MDT) reviews. The pharmacist aimed to review all kardexes within 24 hours of admission. This did not always happen due to time constraints; priority was therefore given to those patients who were prescribed clozapine or other high-risk and critical medicines. The lead mental health pharmacist attended the MDT reviews in the PICU.

The pharmacy technician co-ordinated the medicine ordering and stock control processes, including reviewing the expiry dates of medicines. On the PICU, nursing staff were responsible for stock management.

There was evidence that nursing staff were knowledgeable regarding the medicines management processes and the medication needs of individual patients, including the need for the timely administration of critical medicines. Nursing staff were familiar with the arrangements for ensuring timely supply of prescribed medicines, including medicines required during out of hours periods.

Arrangements were in place for the safe management of medicines during patient admission and discharge. Details of pre-admission medicines, were routinely obtained as part of the admission process by the admitting doctor. The pharmacist then completed a medicines reconciliation and documented this on Encompass.

Arrangements were in place to manage medicines when patients were discharged from the wards to ensure a continuous supply of their medicines and to ensure they were given any necessary advice and written information. Discharge medicines were dispensed by the pharmacy team on the three assessment and treatment wards; this helped expedite the discharge process. When patients were discharged directly from the PICU the discharge medicines were supplied from the main hospital pharmacy; patients were normally stepped down to one of the acute wards before discharge.

At the weekly MDT reviews, the team considered medication changes, the use of when required (PRN) medicines and additional information, such as blood tests, physical health checks and the use of high dose antipsychotics.

Medicine records were maintained electronically on Encompass. There was evidence that the majority of records were maintained in a satisfactory manner; dosage regimes and the patient's allergy status were appropriately recorded. There was evidence that when PRN medication was prescribed in the context of any regular prescriptions for the same medicine and that patient preferences were taken into account. Some critical medicines including clozapine required clinical screening by a pharmacist before administration each time they were prescribed or the dose was adjusted.

There was evidence that medicine administration records were completed to a satisfactory standard on Encompass. The records indicated that patients were administered their medicines as prescribed. Staff recorded the reason for any omitted doses. The prescriber was informed in instances where patients refused medicines or doses had been omitted. Refusals/omitted doses were reviewed daily in addition to the MDT review.

There were mostly clear parameters specified on Encompass to direct the administration of oral medicines prescribed PRN to manage agitation as part of a de-escalation/behavioural management strategy. This included the indication for each medicine, the minimum frequency intervals and the maximum daily dose. In instances where more than one oral PRN medicine was prescribed, it was clear which medicine was first, second and third line. However, it was not always clear what the minimum interval is before administering second and third line medicines and in addition patient centred care plans did not include these details to direct nurses. An area for improvement was identified.

The reason for and outcome of administration was routinely recorded in the patient case notes. PRN usage was reviewed as part of a PRN audit and at the weekly MDT meetings. There was a focus on reducing PRN use including the installation of a sensory room on one ward and the use of personalised tranquillity cards across all wards.

The Regional Rapid Tranquillisation Policy was in place and nurses were aware of its' content. Nurses advised that staff and patient debriefing took place as soon as was practical after an incident where rapid tranquillisation was needed. A report of the use of rapid tranquillisation was made on a trust incident form DATIX. Nurses advised that the frequency of a patient's use of these medicines was monitored and reviewed at the MDT patient case reviews.

Regional care pathways were in place for both clozapine and lithium. Arrangements were in place for regular review and monitoring of clozapine and lithium treatments, including blood monitoring. Clozapine supply was arranged by the pharmacy team, on a named patient basis.

Controlled drugs were safely and securely stored and the controlled drugs registers had been appropriately maintained. Reconciliation stock checks were completed at shift handovers. The pharmacist carried out a controlled drug audit in preparation for Encompass implementation in May 2025 but no audit has been completed since. Controlled drug audits should be completed in line with the Trust's Standard Operating Procedures. An area for improvement was identified.

Medicines were stored securely on all wards and medicine storage areas were clean, tidy and organised. Some liquids have a limited shelf life once opened. The date of opening had not been recorded on two liquid medicines. These medicines were not in use and were removed for disposal. The need to record the date of opening on liquid medicines to facilitate disposal at expiry was discussed with the lead nurse and lead pharmacist who agreed to share with all nurses and monitor through the audit process.

The management of medicines requiring cold storage was reviewed. On one ward only the current refrigerator temperature was being recorded. The maximum, minimum and current temperatures were noted to be within the recommended range on the day of the inspection. The lead nurse provided assurances that the maximum and minimum temperatures would be recorded daily from the date of the inspection onwards. Although thermometers in two clinical rooms indicated the temperature was below 25°C, medicine storage room temperatures were not monitored or recorded. This was highlighted to the lead pharmacist.

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

Nurses completed mandatory medicines management training and safety intervention training which included the management of PRN medicines. However, records reviewed highlighted that mandatory medicines management training was not up to date for several nurses. An area for improvement was identified in this regard (see section 5.2.3).

There was evidence of a range of quality improvement initiatives and audit. Quality improvement initiatives included: the installation of a sensory room on Bronte and the use of personalised tranquillity cards with a focus on reducing PRN medicine use. Audits included monitoring the appropriateness and effectiveness of PRN medicines to ensure that nonpharmacological de-escalation strategies had been attempted prior to the administration of medicines, a monthly audit of medicine incidents and a nightly audit of the medicine administration process.

The management of medication related incidents was discussed with the lead pharmacist and nursing staff who advised that incidents were investigated, reported and that any learning identified and resultant changes in practice were shared with all staff to prevent a recurrence. In addition, medicine incidents were discussed at the monthly medication management meetings and at quarterly incident review meetings.

5.2.9 Mental Health

There was evidence that patients' mental health needs were assessed on admission and that their care and treatment remained subject to ongoing review and monitoring by the MDT.

Positive therapeutic relationships were evident, with patients having regular one-to-one time with their named nurse. Care plans, Promoting Quality Care (PQC) screening and risk assessments were co-produced with patients and, where appropriate, their families and carers. Care records included next-of-kin details and information relating to consent and any identified limitations to consent.

There were positive links with Community Mental Health Teams (CMHT), supporting continuity of care following discharge. Staff described effective engagement with patients and families as part of discharge planning. The Think Family initiative and health visiting services provided dedicated support for patients with young children, evidencing a holistic and family-focused approach to care. It was positive to note that a dedicated day and outdoor space had been developed on one ward to enable mothers with babies and young children to spend time together away from the main ward environment.

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

For patients receiving electroconvulsive therapy (ECT), a defined care pathway was in place to support the safe and effective management of ECT treatment. Patients were provided with relevant information produced by the Royal College of Psychiatrists, alongside a locally developed practical guide. In accordance with Article 64 of the Mental Health (Northern Ireland) Order 1986, second opinion prescribed forms required for the administration of ECT were completed and available for review, providing assurance that statutory requirements relating to consent and independent medical opinion were met. It was positive to note that a protocol to support patients seeking a second opinion was in development.

However, there was limited evidence of completed audits of care plans across the wards, with the exception of one ward. The Trust should develop a structured process for auditing care plans to provide assurance that they are current, person-centred and consistently implemented across all wards.

It was noted that the Promoting Quality Care (PQC) register, which had been a recommendation following a previous SAI, was not available for review during the inspection. The Trust should review this matter and ensure that a clear process is in place to support the timely completion and oversight of PQC reviews.

5.2.10 Governance

Governance arrangements were reviewed through examination of relevant documentation, including governance meeting minutes and through discussions with members of the MDT. This provided evidence that the SMT, ward managers and lead nurses had systems in place to support oversight, assurance and accountability for the delivery of safe and effective care.

Feedback from some staff indicated that greater clarity regarding the rationale for senior management decision making would be beneficial, highlighting the need to strengthen communication to ensure staff are appropriately informed and understand the basis for decisions taken by the SMT. Matters arising during the inspection were discussed with senior

management, who described the actions taken to address these and provided assurance regarding ongoing oversight at ward level.

Each ward operated structured MDT processes to support the delivery and review of care and treatment. Weekly MDT meetings were held on each ward to review patient care and treatment needs. Review of handover records, daily safety huddles and related documentation evidenced consistent arrangements to support effective information sharing, enabling staff coming on duty to understand patient needs, identify risks and implement appropriate risk management strategies.

Staff meetings provided a mechanism for communication, escalation of concerns and identification of service improvements. However, the content of meeting minutes was limited and would benefit from greater detail to strengthen governance assurance, shared learning and communication for staff unable to attend meetings. Enhancing the quality of recorded minutes would support clearer oversight and assurance at ward level.

Governance meetings were well-organised and review of minutes demonstrated a systematic approach to monitoring performance and risk across key governance domains. These meetings included regular review of incidents, adult safeguarding concerns, complaints and associated learning, providing evidence of organisational oversight and accountability. Actions and learning were monitored to support continuous quality improvement.

It was positive to note that quarterly inter-agency governance meetings with the Northern Ireland Ambulance Service (NIAS), unscheduled care (Emergency Department), the Police Service of Northern Ireland (PSNI), the Approved Social Work (ASW) service and General Practitioner (GPs), to consider shared risks and areas of concern across agencies interfacing with healthcare services. These meetings supported a coordinated approach to risk management and improved communication across frontline services.

Overall, governance arrangements provided evidence of a structured and proactive approach to assurance, risk management and continuous quality improvement, supporting the delivery of safe, effective and well-managed care. Participation in the Quality Network for Working Age Inpatient Mental Health Services (QNWA) provided additional external assurance, through independent peer review and benchmarking against nationally recognised standards for inpatient mental health care, that the quality of care and treatment delivered to patients was safe, effective and person-centred.

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).

	Regulations	Standards
Total number of Areas for Improvement	0	9

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. 5.3.1 Criteria: 5.3.1 (a) Stated: First time To be completed by: 30 March 2026	The SHSCT should ensure that appropriate risk mitigation measures are in place and monitored through established governance and risk management arrangements to reduce the risk of unauthorised absence and the introduction of contraband until the new perimeter fence is installed. Ref 5.2.1
	Response by registered person detailing the actions taken: Estates Services have identified a more secure anti climb fence like what is used across the Region. They have secured funding for this to be installed in the two courtyards across Cloughmore, Bronte and Silverwood, within the financial year. Installation work will commence in 3-4 weeks. This will reduce incidents of absconding via the courtyard fence and reduce opportunity to pass contraband. Risk of Absconding is an amber risk on the Bluestone Risk Register. Risks are reviewed regularly and escalated within 8 weekly Acute Governance meetings. Reducing the risk of AWOL is included in the regional Minimising Restrictive Practice workstream, with meaningful activity and psychological
	interventions planned across the week to engage patients in treatment.
Area for improvement 2 Ref: Standard. 6.3 Criteria: 6.3.2(a)	The SHSCT must ensure that there are suitable arrangements in place to protect and promote patient privacy and dignity where doors to ensuite bathrooms have been removed. Ref: 5.2.1

Stated: First time To be completed by: 30 March 2026	Response by registered person detailing the actions taken: Ensuite doors are in place in all standard bedrooms in Cloughmore, Silverwood, Bronte and Rosebrook apart from rooms which have Disabled access, due to the width. Privacy screens are used and have been added to the ward Ligature Risk Assessment. Bronte have submitted a job request for one ensuite room which has been damaged. Currently Rosebrook ensuite doors are in a locked back position as the patient can lock their bedroom door. An alternative ensuite door has been shared with Estates to see if this would be more suitable. We hope to trial this within Rosebrook. If deemed to be a more suitable door, a business case for funding will be submitted to upgrade all ensuite doors.
Area for improvement 3 Ref: Standard.5.3 Criteria:5.3.1 (a) Stated: First time To be completed by: 30 March 2026	The SHSCT should ensure that clear processes are in place to identify when LRA's are due for review and that these are reviewed in accordance with best practice or more frequently where patient acuity or environmental risk changes. Ref:5.2.1
	Response by registered person detailing the actions taken: There is a structured plan in place to ensure yearly updates take place. Calendar reminders are sent to wards for the yearly review of LRA. Admin staff oversee this process and arrange review dates in advance with each of the wards. Lead Nurse Assurance Reviews are an additional opportunity to ensure the LRA review takes place or to prompt arrangement of an alternative date. LRA has been completed for Rosebrook on 09/03/26, Cloughmore on 25/02/26, Bronte on 05/03/26 and Silverwood on 11/03/26.
Area for improvement 4 Ref: Standard 5.3 Criteria:5.3.1(a)	The SHSCT must ensure All Fire Risk Assessments and associated action plans are kept up to date and completed by appropriately trained personnel Ref: 5.2.1
Stated: First time To be completed by:	

30 March 2026	Response by registered person detailing the actions taken: Ward managers request yearly Fire Risk Assessments be completed however unfortunately due to resource issues outside of Bluestone, there have been delays. Fire risk assessment is on the Lead Nurse Assurance report and spot checks will be carried out to ensure evidence of action/follow up with associated dates/job requests. <table><tr><td></td><td>Cloughmore</td><td>Silverwood</td></tr><tr><td>Fire Risk Assessment</td><td>26-Aug-2025</td><td>05-Feb-2026</td></tr><tr><td>Fire Drill</td><td>13-Jan-2026</td><td>13-Jan-2026</td></tr><tr><td></td><td>Bronte</td><td>Rosebrook</td></tr><tr><td>Fire Risk Assessment</td><td>11-Dec-2025</td><td>31-Mar-2026</td></tr><tr><td>Fire Drill</td><td>13-Jan 2026</td><td>18-Mar-2026</td></tr></table>		Cloughmore	Silverwood	Fire Risk Assessment	26-Aug-2025	05-Feb-2026	Fire Drill	13-Jan-2026	13-Jan-2026		Bronte	Rosebrook	Fire Risk Assessment	11-Dec-2025	31-Mar-2026	Fire Drill	13-Jan 2026	18-Mar-2026
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Fire Drill	13-Jan 2026	18-Mar-2026																	
Area for improvement 5 Ref: Standard 5.3 Criteria: 5.3.3 (c) Stated: First time To be completed by: 30 March 2026	The SHSCT must ensure that there is an effective process for monitoring training compliance which is reviewed and updated on a regular basis. This specifically relates to the following areas: • Fire Safety, • Promoting Quality Care (PQC), • Medicines management, • Mental Health Order (MHO) • Safety Intervention training Ref: 5.2.3 & 5.2.8 Response by registered person detailing the actions taken: Each ward has a Training Matrix in place which includes Mandatory, Best Practice and Professional Scope Training. Training is colour coded to alert the ward manager of Training Status. This has been added to the monthly Ward Assurance report to monitor compliance. The Nurse Development Lead meets with Ward Managers, Ward Support staff and Lead Nurses to review any training issues or concerns including access to Medicines Management																		

	Training, Safety Intervention and Designated Fire Officer training places. These are escalated to Corporate Nursing.
Area for improvement 6 Ref: Standard 5.3 Criteria: 5.3.1 Stated: First time To be completed by: 30 March 2026	The SHSCT must ensure: • Within the seclusion area that; • A clock is visible to patients • There is a fully working intercom system to enable effective communication between patients and staff. Ref: 5.2.5
	Response by registered person detailing the actions taken: A clock has been installed in Rosebrook and Estates have ordered a replacement intercom system which will be installed on arrival.
Area for improvement 7 Ref: Standard 5.3.1 Stated: First time To be completed by: 30 March 2026	The SHSCT must ensure: • There is consistent application of the care planning process when restrictive practices are implemented • All seclusion reviews are completed in accordance with the seclusion policy and Regional Policy on the use of Restrictive Practices (Nov 2023). • All records of food and fluids offered and taken by patients are accurately recorded. Ref: 5.2.5
	Response by registered person detailing the actions taken: All patients requiring seclusion now have a care plan in place, and a standard has been set for care plans to be in place within one hour of commencement of seclusion. The Seclusion Policy is being reviewed to take account of the Regional Policy on the use of Restrictive Practices (Nov 2023). This review involves members of the multi-disciplinary team and when finalised it updated policy will be shared/accessible to all staff. A Deputy Charge Nurse is developing a Standard Operating Procedure for the completion of the seclusion flow sheet on Encompass and this will be shared with relevant staff. This will include prompts for staff to accurately record food and fluid intake.

Area for improvement 8 Ref: Standard 5.3 Criteria: 5.3.1(f) Stated: First time To be completed by: 30 March 2026	The SHSCT must ensure that care plans are person-centred and include details of prescribed medicines and the interval between first- and second-line oral medication is clearly documented. Ref: 5.2.8 Response by registered person detailing the actions taken: All care plans are written to be person-centred and will include details of prescribed medications, frequency and route. Medical induction includes a reminder of the need to provide minimum frequency between doses for agitation/rapid tranquilisation. It also includes advice on how to complete the MAR to ensure 1st line/2nd line etc is correctly documented and max dose in 24 hours. Ward pharmacists to complete a review of all current inpatients prescribed prn medicines and liaise with ward doctor to correct the MAR where details are missing. Currently Rosebrook has clinical pharmacist cover one day per week. From April 2026 Rosebrook will have daily pharmacist provision and all Bluestone wards will have a dedicated clinical pharmacist. This will provide better overview of prescribing in each clinical area. All medication related incidents are discussed on a monthly basis by Medical, Nursing and Pharmacy staff, to identify and address issues.
Area for improvement 9 Ref: Standard 5.3 Criteria: 5.3.1(f) Stated: First time To be completed by: 30 March 2026	The SHSCT must ensure that controlled drug audits should be completed in line with the Trust's Standard Operating Procedures. Ref: 5.2.8 Response by registered person detailing the actions taken: The Lead Inpatient Pharmacist for Bluestone will provide a prompt for staff at the beginning of the month in which CD checks are due and ensure that there is follow up where there is a delay before the deadline for completion.

	Allocation of pharmacists for CD checks is currently overseen by patient services. The Lead Inpatient Pharmacist for Bluestone plans to request reallocation of CD checks to Bluestone clinical pharmacists to ensure CD checks are completed in a timely way. This will allow better oversight by the Lead Inpatient Pharmacist.
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