

Inspection Report



Name of Service: Willow and Gillis Memory Centre

Provider: Southern Health and Social Care Trust

Date of inspection: 09 – 10 February 2026

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1.0 Service information

Organisation/Registered Provider: Southern Health and Social Care Trust (SHSCT)	Registered Provider: Mr Steve Spoerry Interim Chief Executive Southern Health and Social Care Trust (SHSCT)
Person in charge at the time of inspection: Mr. Joe Walker Assistant Director Mental Health and Intellectual Disability Inpatients.	Number of commissioned beds: Willow – 10 Gillis Ward – 10
Categories of care: Dementia Care Mental Health Acute Admission for persons over 65 years	Number of patients accommodated in the ward on the day of this inspection: Willow – 7 Gillis - 13
Brief description of the accommodation/how the service operates: Willow ward provides inpatient care to men and women aged 65 years and over who require assessment and treatment in an acute psychiatric care setting. Gillis Memory Centre Ward provides assessment, care and treatment to male and female patients with dementia. The wards are situated within the Bluestone Unit, which is located on the grounds of Craigavon Area Hospital. Both wards provide single occupancy bedrooms with ensuite facilities. Patients are admitted either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).	

2.0 Inspection summary

An unannounced inspection took place on 09 February 2026 and concluded with summary feedback to the SHSCT senior management team (SMT) on the 10 February 2026. The inspection team consisted of two care inspectors and a senior inspector.

The inspection sought to assess SHSCT's progress against the areas for improvement (AFI) identified in the Quality Improvement Plan (QIP) following a previous inspection of the service in January 2024. The findings of this inspection confirmed that all five AFIs 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; physical health; restrictive practices; patient experience; patient flow; medicines management; mental health; and governance. Each theme was assessed to determine the extent to which care and treatment were delivered safely and effectively.

This inspection reviewed the arrangements in place to accommodate both groups of patients who share the same environment. Since the last inspection in January 2024, the wards had undergone some refurbishment to create additional space. The inspection provided an opportunity to review the alterations to the environment and determine whether patient outcomes and lived experience had improved, in addition to assessing the impact for patients in continuing to share the same communal spaces. See section 5.2.1 and 5.2.6.

Good practice was identified across a number of areas, in relation to adult safeguarding arrangements, the provision of therapeutic activities, staff/patient interactions, physical care, mental health and communication with families. Governance arrangements were robust and evidenced a strong culture of learning and continuous quality improvement, supporting improvement in patient care.

Throughout the inspection, staff at all levels were observed to be kind, 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 and is discussed further in 5.2.6.

As a result of this inspection, six areas for improvement (AFI's) were identified. These are in relation to the development of a dedicated dementia ward, the use of plastic bags, storage of equipment, covert administration of medicines, recording of medicines that are prescribed for administration "when required" and monitoring the temperature of the medicines storage room.

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 SHSCT 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

We spoke with a number of patients, relatives and staff and we received seven completed questionnaires.

Overall comments from relatives were positive about all aspects of their family member's care and treatment. Staff were described as being 'very compassionate' with a high level of 'thoughtfulness'. There were opportunities to attend family meetings, staff were very open and there was time to ask questions.

Patients spoke highly of the staff acknowledging the care and support provided in a caring compassionate manner. Feedback from staff was also very positive. Staff spoke of good support from colleagues and management with good induction processes and opportunities for on-going training and development. Staff also acknowledged the positive impact the ward renovations have had on patient experience and care.

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 Willow and Gillis wards on 16-17 January 2024		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).		Validation of compliance
Area for improvement 1 Ref: Standard 5.3.1	The Southern Health and Social Care Trust must ensure that the ligature risks and fire safety risks are regularly reviewed to provide assurance that identified and emerging risks in all areas are being managed safely. This	Met
Stated: Second time	includes ensuring that a system is developed to ensure fire doors are not propped open. Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.1.	
Area for improvement 2 Ref: Standard 5.3.1 Stated: First time	The Southern Health and Social Care Trust must ensure that where protection plans are subject to change these are discussed and agreed with all relevant parties and ensure that there is effective communication with managers responsible for the oversight of the protection plans.	Met
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.2	
Area for improvement 3 Ref: Standard 5.3.1 Stated: Second time	The Southern Health and Social Care Trust must ensure that all incidents recorded take account of the HSC Regional Risk Matrix and the actual and potential impact of incidents along with the risk likelihood are considered and recorded.	Met

	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.2	
Area for improvement 4 Ref: Standard 8.3 Stated: Second time	The Southern Health and Social Care Trust must ensure that whilst communal spaces continue to be shared between patient groups, regular meetings between staff teams are facilitated to enhance relationships, team building and sharing of information.	Met
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.10	
Area for improvement 5 Ref: Standard 5.3.1 Stated: Second time	The Southern Health and Social Care Trust must ensure that all staff receive appropriate up to date mandatory training.	Met
	Action taken as confirmed during the inspection: This AFI has been assessed as met. See section 5.2.10	

5.2 Inspection findings

5.2.1 Environment

The inspection sought to assess the ward environments against the Royal College of Psychiatrists Standards for Older Adult Mental Health Services 6th Edition, January 2025 to determine if they were conducive to the delivery of safe, therapeutic and compassionate care.

Willow and Gillis Memory Centre wards continue to operate in a shared environment, however since the previous inspection there has been substantial estates works to improve the environment for both patient groups. This includes the creation of additional lounge space, extension to the dining area and a room which serves as a meeting room for the Multi – Disciplinary Team (MDT), an activity room and visitors area.

These environmental changes have improved patient experience but there remains insufficient circulation space in communal corridors for Gillis patients. Whilst the inspection team observed good staff support to enable the patients to navigate these spaces safely, the situation is far from ideal which was acknowledged by the SHSCT.

Bluestone remains the only mental health service in Northern Ireland that does not have a dedicated dementia assessment and treatment unit. SHSCT fully acknowledges the impact this shared space has on both groups of patients and has submitted a business case to the Strategic Planning and Performance Group (SPPG) for the development of a separate dementia assessment unit to be built on the Bluestone site.

SHSCT should continue to liaise with SPPG to ensure there is an equitable provision of dementia services for patients in the SHSCT based on assessed needs. An AFI has been identified in this regard.

The wards were bright with lots of natural light. Overall cleanliness on both wards were of an acceptable standard with evidence of environmental audits being completed. It was positive to see that the ward was being redecorated during the inspection to maintain the standard of the environment.

There was appropriate signage to aid orientation on patient's bedroom doors, for Gillis patients, this was a picture or photo that was personal to them. Due to a shortage of beds, a small number of Gillis patients were accommodated in Willow ward and this practice would also support orientation in these circumstances. Signage in some rooms, where there had been a change of use following estates works, such as an activity room which has now been made into an office for staff, require to be replaced to reflect their current use.

One assisted bathroom was being used to store equipment and unable to be used by patients, which has the potential to impact patient choice and comfort. The SHSCT should review storage arrangements for equipment to ensure the bathroom is freely available for patients' use. An AFI was identified in this regard.

The Fire Risk Assessment (FRA) and action plan had not been reviewed within the past year or updated following the recent estates works. This had the potential of new risks not being identified and was escalated to SMT. Assurances were provided by the Inpatient Dementia Coordinator that the fire officer had been notified and a review of the risk assessment had been requested. Confirmation was received the following day that the Fire Officer had conducted a site visit and completed a fire safety inspection.

Greater oversight is needed through established fire safety and risk management governance structures to ensure the FRA is reviewed annually and when there are any structural changes to the ward environment. This is important so that risks are effectively identified, monitored and mitigated.

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.

A Ligature Risk Assessment (LRA) was reviewed which was comprehensive and demonstrated involvement from Health and Safety (H&S) and Estates personnel.

The use of plastic bags in areas accessible to patients was evident which presents a potential risk to patients. This was brought to the attention of the ward manager and removal was recommended. SHSCT must ensure compliance with regional guidance on the use of plastic bags in Mental Health (MH) inpatient wards as noted in LL-SAI-2018-033(MH) and Learning Matters Quality 2020 Issue 8, September 2018 and SHSCTs own policy on restricted items. An AFI was identified in relation to the use of plastic bags in patient areas.

Due to the demand for mental health beds a room normally used as a quiet lounge area for Willow patients had been repurposed as a bedroom with no access to an ensuite toilet. This has the potential to compromise the patient's privacy and dignity. 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.

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 processes 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.

Information on the referral process, including contact details for the Adult Protection Gateway Team (AGPT), and the Regional Emergency Social Work (out-of-hours) Service (RESWS), was readily available within each of the wards. There was also guidance available for staff, to support the completion of referral (APP1) forms on the new Encompass single electronic patient

record system. Whilst staff demonstrated good knowledge of ASG processes and adherence to the regional policy in identifying concerns, there were some challenges in the recording of information. On a number of occasions referrals had not been accepted by the AGPT as the APP1 form had not been fully completed on the electronic recording system. This has potential to delay an ASG referral with an associated risk to patients.

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.

However it was observed that not all APP1 referrals had been recorded on SHSCT's electronic system for recording incidents (DATIX). This has the potential for inaccurate analysis and under reporting of ASG incidents. SHSCT should ensure that when an ASG referral is made this is also completed on DATIX to allow effective monitoring by SMT.

SHSCT should ensure that all staff are fully trained in the use of the electronic reporting of ASG referrals and completion of DATIX to reduce any delay in reporting, subsequent implementation of protection plans and effective monitoring arrangements.

Staff demonstrated a clear understanding of the protection measures in place to safeguard patients, with no evidence that staff were working out with a protection plan. The previous AFI has been assessed as met.

Review of incidents recorded on DATIX over the previous three months found that the recording of incidents was consistent with the Regional Risk Matrix. The actual and potential impact of incidents was reflected in the records reviewed and the previous AFI has been assessed as met.

Staff had access to post-incident debrief sessions, which provided opportunities for reflection, learning and support.

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 speech and language therapy (SLT) 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. A protocol for safe staffing and guidance on service continuity was in place to support the timely management of staff absence and staffing shortages.

Ward managers 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. SHSCT 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. The majority of staff reported feeling well supported and staff spoke positively about working within the service and the support they received from their ward managers and members of the SMT.

Greatix, a staff feedback system that enables recognition of the work of staff, was embedded in Willow and Gillis Memory Centre. This supports staff morale by helping staff feel valued and appreciated. The feedback received was displayed on notice boards within the ward.

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), Braden score, a clinical assessment used to predict a patient's risk of developing pressure sores, and a falls screening tool. There was evidence these were reviewed on a regular basis or when the patient's physical health changed. 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*. Monitoring arrangements in the form of safety cross and safety 'walking stick' were used to record the occurrence of pressure sores and falls. This assists with the analysis for learning and to reduce recurrence.

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 SLT, and where any treatment was required in other healthcare settings this was arranged.

Mealtimes were aligned with the regional 'Mealtimes Matter' framework, with a nominated mealtime co-ordinator overseeing arrangements on the ward. The SLT assesses patients with swallowing difficulties. This provided assurance that patients received meals appropriate to their assessed needs and reduced the risk of choking; including compliance with the International Dysphagia Diet Standardisation Initiative (IDDSI). The recommendations from these assessments was readily available for staff. It was positive to note that a copy was in each patient's bedroom.

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. Restrictive practices in use included locked doors, enhanced observations, the use of bed rails, sensor mats, the use of covert medication and physical safety interventions. It was positive to note the use of assistive technology, such as sensor mats, was in place to reduce the use of more restrictive options.

Staff demonstrated a good knowledge of restrictive practices. Care plans were in place for locked doors for voluntary patients who may request to leave and who were deemed safe to do so. There was weekly MDT reviews of restrictions and evidence of Human Rights considerations within patient care plans.

A number of patients were administered their medicines covertly. This means that medicine is given without the patient's knowledge, generally concealed in food or drink, in cases where they are incapable of giving informed consent to treatment.

The care plans for covert medication gave broad indications for its use and that it should be a last resort. However, the care plans lacked detail on what strategies should be attempted prior to administering medicines covertly, or how the medicines should be administered in its concealed form, and any risks associated with this. It was also not clear if the pharmacist had been involved in the decision to administer medicines covertly and providing advice on the safety of adding medicines to food and drinks.

SHSCT should ensure that there are suitable arrangements in place to review the process and documentation for administration of covert medication. This should include a risk assessment and evidence of a best interests meeting and that all members of the MDT have been involved in the decision making process. An AFI was identified in relation to covert medication.

Care plans were in place for patients who were subject to safety interventions to maintain the safety of patients and staff, however these lacked detail on how staff should apply these. This may increase the risk of inappropriate methods being used by staff with subsequent risk to patients. The SHSCT should ensure that care plans are developed to clearly detail the type of interventions to be used by staff and subject to ongoing audit and review through the governance process.

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, SHSCT's complaints procedure, Dementia support groups and Independent Advocacy services.

Patients and relatives expressed satisfaction with the care and treatment provided describing positive experiences of involvement, support and communication. They spoke very highly of the staff and this was further evidenced through the relative questionnaires returned.

As part of this inspection the Short Observational Framework for Inspection (SOFI) was used. SOFI is an approved, internationally recognised and evidence based tool for regulators. The tool was developed to capture the experiences of people who use services and who may not be able to express their opinions and preferences. It was originally designed for inspectors to use while inspecting services for people with dementia or severe learning disabilities; however, it has since been developed and extended in its use to include anyone who has difficulties communicating their experience of care.

Observation of the mealtime experience using SOFI demonstrated that this was well managed and patients who required assistance with eating and drinking were supported in a caring compassionate manner by staff. Staff showed genuine warmth and respect, promoting and encouraging patient's independence.

Where medicines were administered covertly, the process involved a delay in patients receiving their meal. This has the potential for the temperature of the food to be affected and impact on the overall quality of the meals provided. SHSCT must review the process for covert medication administration to ensure that the quality of the food is unaffected.

There was a weekly activity planner for patients arranged by the OT. A number of these activities were off the ward to support patients retain social skills. There was a Tovertafel table, which is an interactive projector that helps promote activity, stimulation and reduce agitation in people with dementia, as well as a range of tactile objects available to provide comfort.

5.2.7 Patient Flow

At the time of inspection Gillis ward was operating at 130% bed occupancy. This resulted in Willow's operational capacity being reduced by three beds, which impacts on the capacity of Willow to admit patients over 65 years of age. There was also no capacity for Gillis Memory Centre to admit patients with dementia in need of acute assessment and treatment. As noted in 5.2.1 of this report SHSCT must continue to liaise with SPPG in relation to current and future commissioning arrangements for dementia assessment and treatment beds particularly in light of the increase in future projections for dementia care requirements.

We evidenced records of discharge planning meetings which were held weekly to review and plan for discharge. There was evidence that patients' next of kin had been invited to these meetings or updates provided if they could not attend.

At the time of inspection there were a number of patients who were delayed in their discharge. This was due to a lack of community provision in either care homes or packages of care in the community to facilitate patients' return home.

5.2.8 Medicines Management

Medicines were stored securely on the wards and medicine storage areas were clean, tidy and organised. The temperature of the medicine storage room was not being monitored or recorded. The temperature in one of the rooms was in excess of 25°C, which is the maximum recommended temperature for medicine storage. This was reported to the ward manager who provided assurances that the arrangements for monitoring temperatures would be reviewed. An AFI has been identified in relation to medicine storage.

There was evidence that nursing staff were knowledgeable regarding the medicines management processes and the needs of individual patients, including the need for the timely administration of critical medicines.

In instances where more than one medicine was prescribed on a “when required” basis, there was an inconsistent approach to the recording and it was not always clear which medicine was to be administered first, and second line. In addition, patient centred care plans did not include these details to direct nurses on which medicine to administer and when. An area for improvement was identified in this regard.

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.

Controlled drugs were safely and securely stored, with stock checks completed twice daily at handovers. We evidenced medication audits were being completed on a regular basis.

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

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.

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.

'This is me' a support tool, developed by the Alzheimer's Society, to support people living with dementia, helps with communication and minimises distress by including details on each patient's preferences and choices was being completed.

For patients who had distressed behaviours, care plans were in place although these lacked specific details of what may trigger distressed behaviours or clear de-escalation strategies to support the patient. The SHSCT should ensure that care plans are reviewed to ensure actual and potential trigger events and situations are included in care plans to minimise any distress for patients.

There was limited evidence that instances of distressed behaviours recorded on DATIX were subject to analysis to identify causes of these. This has the potential for staff to miss opportunities to prevent or minimise distress or agitation which may impact on the well-being of the patient or others. The SHSCT should ensure that there is evidence of systematic analysis of distressed behaviour incidents to determine root causes.

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.

Both wards 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. This is particularly important when two different groups of patients share the environment and effective communication between the two staff groups is required.

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.

There was evidence of effective communication between the two staff teams, both formal and informal, to improve patient care and ensure that any risks are effectively managed to ensure patient safety.

Staff training records demonstrated most staff were up to date with their mandatory training or had been arranged to take place. Dementia training records highlighted that a number of staff had still to receive this training. It is recommended that this training is prioritised for staff.

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	6

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. 6.1 Criteria. 6.3.1 Stated: First time	The SHSCT should ensure there is ongoing liaison with SPPG in relation to the future planning of dementia services to ensure there is an equitable provision of dementia services based on assessed needs within the SHSCT area. Ref: 5.2.1
To be completed by: 30 June 2026	Response by registered person detailing the actions taken: Liaison with the SPPG is ongoing. Architect plans are in place, awaiting final decision in respect of commissioning as per public consultation outcome
Area for improvement 2 Ref: Standard Criteria Stated: First time	The SHSCT should review storage arrangements for equipment that is currently stored in a bathroom to ensure the bathroom is available for patients' use. Ref: 5.2.1
To be completed by: 30 June 2026	Response by registered person detailing the actions taken: A meeting was held with estates services on 11th May to discuss possible storage arrangements. Estates are currently costing the option of an external covered disposal hold for bins which will allow the current disposal room to be repurposed as additional storage.

Area for improvement 3 Ref: Standard 5.3.1 Criteria. 5.3.1 (a) (f) Stated: First time To be completed by: 30 June 2026	The SHSCT must ensure compliance with regional guidance on the use of plastic bags in Mental Health (MH) inpatient wards as noted in LL-SAI-2018-033(MH) and Learning Matters Quality 2020 Issue 8, September 2018 and the SHSCT own policy on restricted items in adult mental health wards. Ref: 5.2.1 Response by registered person detailing the actions taken: All plastic bags have been removed from patient areas within Willows and Gillis. This is on the ward health and safety checklist, monitored by a daily, with oversight by the Ward and Deputy Managers.
Area for improvement 4 Ref: Standard. 5.3 Criteria.5.3.1 Stated: First time To be completed by: 30 June 2026	The SHSCT should ensure that there are robust arrangements in place administration of covert medicines. Ref: 5.2.5 Response by registered person detailing the actions taken: The Bluestone Lead Pharmacist is reviewing the Covert Medication policy, alongside Multi-disciplinary team members. When this is completed, and operational, care plans will be updated to reflect the guidance.
Area for improvement 5 Ref: Standard. 5.3 Criteria 5.3.1 (f) Stated: First time To be completed by: 30 June 2026	The SHSCT should ensure that medicines are stored at the correct temperature and there are arrangements to monitor the temperature of the medicine storage room. Ref: 5.2.8 Response by registered person detailing the actions taken: Estates Services completed a walk around and have installed a portable air cooler in the willows clinical room. They have turned off the heating and have reset the temperature gauge. This is monitored every day on a daily check and is maintaining recommended room temperature.

Area for improvement 6 Ref: Standard 5.3 Stated: First time Criteria. 5.3.1 (f) To be completed by: 30 June 2026	The SHSCT must ensure that there is sufficient detail recorded to direct nurses on the safe and timely administration of medicines prescribed on a “when required” basis. Ref. 5.2.8 Response by registered person detailing the actions taken: Doctor’s induction has been updated to over the need to specify 1st 2nd and 3rd line medications, when prescribing on oral de-escalation or rapid tranquilisation on the MAR. Nursing staff and the ward pharmacist will monitor this and raise concern if detail is not sufficient. MAR can be reviewed at MDT or more often if required. Staff nurses will ensure care plans are up to date and reflective.
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