Unannounced Follow Up Inspection Report
4 and 5 September 2017

Erne Ward 2

Resettlement Ward
Muckamore Abbey Hospital
1 Abbey Road
Antrim
BT41 4SH

Tel No: 028 95042087

Inspector
Wendy McGregor

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Erne Ward 2 is a six bedded resettlement unit for male and female patients who have a learning disability. On the days of inspection there were six patients on the ward.
All patients on the ward were assessed as ready for resettlement. There were no patients on the ward detained in accordance with the Mental Health (Northern Ireland) Order 1986.
Care was provided by a multi-disciplinary team that included nursing, medical, psychiatry, speech and language and occupational therapy. Patients had access to advocacy services.

3.0 Service details

Responsible person: **Martin Dillon**	**Ward Manager:** **Frances Maguire**
Category of care: Resettlement	**Number of beds: 6**
Person in charge at the time of inspection: Frances Maguire	

4.0 Inspection summary

An unannounced follow-up inspection took place over two days on 4 and 5 September 2017.

The inspection sought to assess progress with findings for improvement raised from the unannounced inspection on 19 – 21 July 2016.

It was good to note that all of the areas for improvement identified on the last inspection in July 2016 had been met. Trust staff are to be commended for the significant improvements observed in relation to the ward environment, health and safety issues and for improving patient comfort. The environment was observed as person centred and welcoming. There was evidence that staff had made significant efforts to improve the care documentation and there was evidence that staff were working on making further improvements. Staff and relatives who were interviewed all confirmed that that the care on the ward and the ward environment had improved. Staff stated they felt supported. A “buddy” system was in place for new staff to pair up with a staff member who is familiar with the needs of each patient, the ward environment and to provide support. This provides staff with a point of contact to share information, and highlight any concerns.
Staff interviewed during the inspection had a good understanding of the needs of each patient. Relatives said that communication between relatives and staff had improved. Relatives also said that they were happy with the care their family member received on the ward and commented that care was compassionate and person centred.

It was good to note that four patients had been discharged and resettled into the community since the last inspection in July 2016. There were resettlement plans in place for the six remaining patients. Community placements had been identified for three patients and work was ongoing to source appropriate placements for the three remaining patients.

The findings of this report will provide the Trust with the necessary information to assist them to fulfil their responsibilities, enhance practice and service user experience.

4.1 Inspection outcome

Total number of areas for improvement	0

There were no areas identified for improvement.

5.0 How we inspect

The inspection was underpinned by:

- The Mental Health (Northern Ireland) Order 1986.
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.
- The Human Rights Act 1998.
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

The following areas were examined during the inspection:

- Fire safety assessments.
- Patient forum meetings.
- Staff duty rota.
- Duty allocation sheets.
- Care documentation in relation to three patients.
- Ward environment.
- Advocacy service.
- Activity schedule.
- Staff meetings.
- Environmental assessments.
- Emergency equipment checks.
- Safety briefing records.
- Patient finance records.
- The management and storage of confidential records.
- Ward performance records and audits.
- Feedback from five relatives.
- Feedback from six staff.
- Observations of staff practice and engagement with patients

6.1 Review of areas for improvement from the last unannounced inspection 19 – 21 July 2016

The most recent inspection of Erne Ward 2 was an unannounced inspection. The completed Provider Compliance Plan (PCP) was returned and approved by the responsible inspector. This PCP was validated by inspectors during this inspection.

Areas for Improvement		Validation of Compliance
Number/Area 1 **Ref**: Standard 5.3.1 (e) **Stated:** First Time	**The responsible person must ensure that:** All urgent actions identified in the fire risk assessment are addressed. Patient's personal emergency evacuation plans are updated and regularly reviewed. Staff are aware of and can respond appropriately to each patient's individual needs in the event of a fire. Staff that come to assist in the event of a fire are given clear guidance and direction. Emergency exits are free from obstruction.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed all documentation in relation to fire safety and noted the following. The urgent actions identified in the fire risk assessment during the last inspection in July 2017 had been addressed. Evacuation procedures had been reviewed and had been changed from horizontal evacuation to full evacuation. Patients' personal emergency evacuation plans had been reviewed and were up to date. Measures had been put in place to ensure that staff can respond to each patient's individual needs in the event of a fire. Fire safety and evacuation was discussed at the monthly staff meeting. Following the staff meeting staff went on a walk around the ward and were	

	reminded of the evacuation routes. Emergency exits were observed to be free from obstruction on the days of the inspection. Staff were allocated on a daily basis to check the environment for any fire safety issues. Escape routes, fire detectors, emergency exits and emergency fastening devices were routinely checked every week. Fire extinguishers, fire doors and closing devices were routinely checked every month. All staff had received up to date fire training. The fire evacuation records since July 2016 evidenced that there were three full evacuations and three and walk / talk through evacuations. The trust fire officer visited the ward in August 2017 and complimented the staff on their knowledge of the environment and the action required in the event of a fire. The evacuation policy had been read and signed by all staff working on the ward and included housekeeping staff.	
Number/Area 2 **Ref**: Standard 5.3.1 (f) **Stated:** First Time	**The responsible person must ensure that**: The resuscitation trolley and other emergency equipment is checked in accordance with the Trust's policy. **Action taken as confirmed during the inspection**: The inspector reviewed the check lists in relation to the resuscitation equipment. There was evidence that the equipment had been checked in accordance with trust policy.	**Met**
Number/Area 3 **Ref**: Standard 5.3.1 (f) **Stated:** First Time	**The responsible person must ensure that:** The hygiene, maintenance and tidiness of the ward are improved and maintained to a satisfactory level. Patient's privacy, dignity and comfort are upheld and enhanced by the provision of appropriate clothing, soft furnishings, window coverings, mattresses and garden shelter.	**Met**

	Action taken as confirmed during the inspection: The inspector observed the ward environment and noted it had significantly improved. The ward had been painted and maintained. The ward was clean, tidy and clutter free. New soft furnishings were in place. Window coverings were in place and all beds had a properly fitted mattress with appropriate and comfortable bedding. Patients were noted to be suitably dressed to suit the weather conditions and the temperature of the ward. The garden area had been cleaned and maintained.	
Number/Area 4 **Ref**: Standard 5.3.3 (d) **Stated:** First Time	**The responsible person must ensure that:** Staffing levels in Erne Ward reflect the needs of the patients, to include safe supervision, address the environmental design and ensure patients have access to planned activities.	**Met**
	Action taken as confirmed during the inspection: On the days of the inspection there were six patients on the ward. Each patient required assistance with their daily living needs and required different levels of supervision. Levels of supervision on the ward ranged from general observations to within eye sight at all times. The inspector reviewed the duty rota over a three month period and noted that staffing levels fluctuated between 5 and 6 staff. The ward manager stated that there had been occasions when the staffing levels had reduced to four. This was because staff were required to meet the shortfall in staffing levels on other wards on the Muckamore site. An incident form was completed on DATIX on these occasions. This was monitored and reviewed by trust senior management. There was no evidence that hospital appointments were cancelled due to staff shortages. There was a minor impact on planned community activities, as the inspector noted that these were rarely cancelled. Ward based activities continued and patients continued to attend day care every day. To ensure patient safety the ward manager	

	ensured that all areas used by patients on the ward were adequately supervised and individual supervision needs were met. The ward manager stated that they ensured that the ward had sufficient staff to support and maintain the safety of patients particularly during meal times. This meant that staff were requested to return to the ward from the other wards during those times. Duties were allocated on a daily basis to ensure that the needs of the patients were met and patients were supervised. A safety briefing was also completed every day and there was evidence that housekeeping were informed of any risks on the ward.	
Number/Area 5 **Ref**: Standard 5.3.1 (a) **Stated:** First Time	**The responsible person must ensure that:** Assessments, care plans and risk assessments are thorough, up-to-date, reflect changing needs and specialist assessments; Care plans are evaluated, reviewed and recorded in a timely manner in accordance to trust, regional policies and professional guidance; Progress notes are accurate, complete and are easily accessible to all staff delivering care.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed care documentation in relation to three patients. Assessments, care plans and risk assessments were recorded on the patient electronic recording system (PARIS). Assessments had been reviewed and were noted to be up to date. Care plans were reviewed, up to date and reflected the assessed needs of the patients. Each patient had a completed risk screening tool in place. These were noted to be completed in accordance with Promoting Quality Care – Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. Any risks identified were recorded and managed through the patient's care plan. Specialist assessments were in place for patients who required additional support with needs such as eating and drinking, skin care and mobility. Care	

	plans were also in place to address any specialist needs identified. The deputy ward manager had completed a monthly care documentation audit and there was evidence that any deficiencies identified were addressed with the patients' named nurse. It was good to note that staff were working towards ensuring that care plans were evidenced based. Case notes reviewed, were detailed and included an update on patients' care plans. Case notes were noted to be person centred.	
Number/Area 6 **Ref**: Standard 5.3.1 (c) **Stated:** First Time	**The responsible person must ensure that**: Patient financial transactions are in accordance with trust policies and procedures.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed financial transactions in relation to two patients. There was evidence that financial transactions and the storage of patients money was completed in accordance with trust policy and procedure. Patients' monies that were held on the ward were checked by two staff every morning and evening. Financial records were audited by the ward manager every week and by the senior nurse manager every three months.	
Number/Area 7 **Ref**: Standard 6.3.2 (a) **Stated:** First Time	**The responsible person must ensure that:** Patients have; • Access to advocacy on the ward. Advocates should take into consideration the communication support needs of the patients • Patient representative forum meetings which are recorded and ensure all actions identified are followed up	**Met**
	Action taken as confirmed during the inspection: Information in relation to advocacy was displayed on the ward. Each patient had access to an	

	advocate. The advocate attended each patient's resettlement meeting. Patients' forum meetings were held every month. Outcomes from the patient forum meeting were displayed on the ward, in a format that considered the communication needs of the patients. There was evidence that actions identified were followed up by staff.	
Number/Area 8 **Ref**: Standard 6.3.2 (a,b & c) **Stated:** First Time	**The responsible person must ensure that:** Patients have information in a format that meets the communication needs of patients to; • assist in orientation around the ward • know who is on duty and; • what activities are on offer	**Met**
	Action taken as confirmed during the inspection: The inspector observed that signage around the ward had improved and assisted with orientation. Details of the multi-disciplinary team and who was on duty was displayed. This was in the form of photographs of staff. Activities on offer were also displayed as pictures. This was noted to be creative and colourful and staff informed the inspector that patients had shown an interest in the display. Staff were commended on the improvement in this area.	
Number/Area 9 **Ref**: Standard 5.3.1 (f) **Stated:** First Time	**The responsible person must ensure that:** Patient records and files are managed and stored in accordance with trust and data protection policies and procedures and Nursing Midwifery Council guidance on record keeping.	**Met**
	Action taken as confirmed during the inspection: The inspector noted that all patients' records and files were securely locked in the nursing office and were stored in accordance with trust and data protection policies and procedures and Nursing Midwifery Council (NMC) guidance on record	

	keeping.	
Number/Area 10 **Ref**: Standard 5.3.1 (f) **Stated:** First Time	**The responsible person must ensure that**: The ward's performance is audited and outcomes are displayed for patients' carers, relatives and staff.	**Met**
	Action taken as confirmed during the inspection: The inspector observed that that information in relation to the ward's performance was displayed for patients, carers, relatives and staff. This included complaints, compliments, falls, vulnerable adults, patient forum meetings and the outcome from patient satisfaction surveys. Patient satisfaction scores were displayed in relation to patient centred care, safe and effective care, privacy, dignity, capacity and consent.	
Number/Area 11 **Ref**: Standard 6.3.2 (b) **Stated:** First Time	**The responsible person must ensure that** : Relatives are informed in advance of the purpose of meetings.	**Met**
	Action taken as confirmed during the inspection: The inspector spoke with four relatives. Relatives stated that communication had improved and that they were now informed in advance of the purpose of meetings. Relatives were complimentary about staff and the sharing of information. Relatives said they were involved in decisions in relation to the care of their family member. Relatives said that staff were always available and were approachable.	
Number/Area 12 **Ref**: Standard 5.3.1 (e) **Stated:** Second	**The responsible person must ensure that** : There is a ward specific environmental assessment completed and an action plan is completed which should include a timeframe / responsible person for action.	**Met**

Time	**Action taken as confirmed during the inspection**: The inspector noted that an environmental assessment was completed and was up to date. All actions had been addressed. An environmental check was completed every day by allocated staff. Any areas identified were recorded and addressed promptly. There was evidence that senior management attended the ward every week to review the environment.	

7.0 Actions to be taken by the service

The responsible person should review the report for factual accuracy and contact the mental health team if required otherwise return the report signed by the ward manager and the responsible person to Team.MentalHealth@rqia.org.uk by 16 October 2017.

Name of Ward manager	Frances Maguire		
Signature of Ward manager	Frances Maguire	**Date completed**	16th October 2017
Name of responsible person approving the report	Mairead Mitchell		
Signature of responsible person approving the report	Mairead Mitchell	**Date approved**	16th October 2017
Name of RQIA inspector	Wendy McGregor		
Signature of RQIA inspector	Wendy McGregor	**Date approved**	16 October 2017

Please ensure this document is completed in full and returned to MHLD.DutyRota@RQIA.org.uk from the authorised email address

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Assurance, Challenge and Improvement in Health and Social Care

Mental Health and Learning Disability Inpatient Inspection Report
2 – 4 October 2017

Killead Ward

Female Admissions
Muckamore Abbey Hospital
1 Abbey Road
Muckamore
Antrim, BT41 4SH

Tel No: 02895 042079

Inspectors: Wendy McGregor, Audrey McLellan, Dr B Fleming, Anne Simpson

www.rqia.org.uk
Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of Service

Killead ward is a 20 bedded female admission ward on the Muckamore Abbey Hospital site. The purpose of the ward is to provide assessment and treatment to patients with a learning disability who need to be supported in an acute care setting. At the time of the inspection the ward was providing care and treatment to patients from three health and social care trusts. The ward had relocated from Cranfield Female Ward on 4 July 2016.

Patients within Killead have access to a multi-disciplinary team (MDT) which incorporates psychiatry, nursing, clinical psychology, occupational therapy, behavioural support, speech and language therapy, and social work professionals. Patient and relative/carer advocacy services were also available.

On the days of the inspection there were 17 patients on the ward. Nine patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986. There were also two patients who were on leave. Inspectors were informed that the discharge of 11 patients had been delayed due to a lack of appropriate community resources.

3.0 Service Details

Responsible person: Martin Dillon
Ward manager: Mary Bogues
Person in charge at the time of inspection: Grace Carey

4.0 Inspection Summary

An unannounced inspection took place over a period of three days on 2 – 4 October 2017.

This inspection focused on the theme of Person Centred Care. This means that patients are treated as individuals, and the care and treatment provided to them is based around their specific needs and choices.

We assessed if Killead Ward was delivering, safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to the use of restrictive practices. Patients confirmed that an explanation was given why they required a physical intervention and indicated they had been well supported and reassured following the intervention. Patients also informed inspectors that when personal items were removed from them they were given an explanation as to why the item was removed. Good practice was also found in relation to the support provided to staff. There were monthly reflective practice sessions for staff. Staff said they found these beneficial for learning and support with managing difficult situations. Medication prescriptions were completed to a good standard and medication was prescribed in accordance with British National Formulary guidelines.

Areas requiring improvement were identified during the inspection. These were in relation to the out of date ligature risk assessment, fire drills not completed in accordance with the Trust fire manual and the management of locally resolved complaints. Other areas requiring improvement were identified in relation to care documentation and the lack of clinical pharmacy support. Inspectors noted that there has been reduced staffing levels on the ward. RQIA is aware that this is an issue for the hospital site. There was evidence of ongoing active recruitment in Muckamore.

Inspectors were concerned about the management of a patient who had specific speech and language guidelines in place in relation to their eating and drinking. Ward staff addressed this issue during the inspection and also submitted their action plan to the inspector on 6 October 2017.

Inspectors met with eight patients during the inspection. Patients spoke positively about their care and treatment and were positive with their comments about the multi-disciplinary team. Patients indicated that staff treated them with dignity and respect and their privacy was maintained. Patients said they enjoyed the activities on the ward and attending day-care. However, seven out of eight patients said they sometimes do not feel safe, but also said that staff were there to support and offer them reassurance. All eight patients interviewed said the ward was noisy. Patients also said that they were frustrated about having to wait to be discharged from the ward.

The findings of this report will provide the service with the necessary information to enhance practice and service user experience.

4.1 Inspection Outcome

Total number of areas for improvement	7

Findings of the inspection were discussed with senior trust managers, the multi-disciplinary team and ward staff as part of the inspection process. Findings from the report can be found in the main body of the report.

5.0 How we Inspect

The inspection was underpinned by:

- The Mental Health (Northern Ireland) Order 1986.
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.
- The Human Rights Act 1998.
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

Prior to inspection we review a range of information relevant to the service. This included the following records:

- The operational policy or statement of purpose for the ward.
- Incidents and accidents.
- Safeguarding vulnerable adults.
- Complaints.

- Health and safety assessments and associated action plans.
- Information in relation to governance, meetings, organisational management, structure and lines of accountability.
- Details of supervision and appraisal records.
- Policies and procedures.

During the inspection inspectors met with eight patients, seven members of the multi-disciplinary team and two advocates. There were no relatives available to meet with inspectors during the inspection.

A lay assessor was present during the inspection and their comments are included within this report.

The following areas were examined during the inspection:

- Care documentation in relation to five patients.
- Care documentation audits.
- Staff rota.
- Training records.
- Staff meetings.
- Patient forum meetings.
- Patient experience audits.
- Medication prescription records.
- Patient finances.
- Ward welcome pack.
- Staff induction records.
- Informal complaints.
- Fire safety records.
- The ward physical environment.

During the inspection inspectors observed staff working practices and interactions with patients using a Quality of Interaction Schedule Tool (QUIS).

We reviewed the area for improvement made at the last inspection in relation to noise levels on the ward. An assessment of compliance was recorded not met.

6.0 The Inspection

6.1 Review of Areas for Improvement / Recommendations from the Most Recent Inspection dated 14 - 15 February 2017

The most recent inspection of Killead Ward was an unannounced inspection. The completed provider compliance plan was returned and approved by the

responsible inspector. This provider compliance plan was validated by the responsible inspector during this inspection.

6.2 Review of Areas for Improvement / Recommendations from Last Inspection dated 14 to 15 February 2017

Areas for Improvement		Validation of Compliance
Area for Improvement No. 1 **Ref**: Quality Standard 6.3.1 (c) **Stated:** First Time	When a number of patients are in the main communal area/dining room the noise levels appear to echo and reverberate which can be distracting and unpleasant for patients in this room.	**Not Met**
	Action taken as confirmed during the inspection: Inspectors observed high levels of noise during the three days of the inspection. This was also further impacted by the complex behavioural and mental health needs of patients on the ward. Some patients were presenting as very vocal. There were also patients who were at different stages of admission including 11 patients whose discharge was delayed. The NICE Guidelines *Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges May 2015* states that environments with too much sensory stimulation can increase the risk of challenging behaviours. Inspectors noted that there were a high number of recorded incidents caused by challenging behaviours on the ward. Inspectors were informed that one patient was transferred to the hospital's Psychiatric Intensive Care Unit (PICU) because of the high volume of noise and the impact that this was having on patient behaviours. All of the eight patients interviewed said the ward was noisy and some said that is was noisy at night. Inspectors were informed that the trust have been in contact with a company	

	called Ecophon. Two staff from Ecophon have attended the ward and assessed the acoustics and measurements and cost etc. The trust is waiting on formalised quotation from company. This area for improvement will be restated a second time.	

7.0 Review of Findings

.1 Is Care Safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Areas of Good Practice

Patients were involved in their risk assessments and risk management plans.

Risk assessments and management plans informed patients' care plans.

Safeguarding vulnerable adult referrals and follow up action plans had been completed in accordance with Regional Safeguarding Policy. There were appropriate safety plans in place where required.

With the exception of the ligature risk assessment, all other environmental risk assessments were up to date.

Each patient who required a profiling bed had a care plan in place.

The ward environment was clean and tidy.

There were daily safety briefings which included all staff working on the ward.

Staff raised any concerns they had in relation to patient and/or environmental safety with their line manager.

Staff followed trust policy and procedure in relation to the management of incidents and the use of restrictive practices.

Staff stated they did not work beyond their role and experience.

Staff were observed to manage the patient dynamic very well given the complex range of needs of the patients. Staff were observed responding

quickly and effectively to incidents. Staff were observed to be present in the communal areas at all times during the inspection.

Patients who were detained in accordance with the Mental Health (Northern Ireland) Order 1986 had been appropriately referred to the Mental Health Review Tribunal.

Capacity for consent for different care interventions was recorded and staff were knowledgeable on each patient's capacity to consent, how consent was obtained and how a patient indicates their capacity to consent. Patients also indicated that staff sought consent.

Areas for Improvement

Inspectors were concerned about the management of patients who have specific speech and language guidelines in place in relation to their eating and drinking.

The ligature risk assessment was out of date and did not include the four profiling beds and the ligature risk identified in the TV room.

There was evidence of one walk/talk through fire drill involving eight staff and 12 patients on 5 March 2017. This was not in accordance with the Trust fire manual which states "There should be an annual program of fire drills designed so that every member of staff has the opportunity to participate in at least one."

A record of locally resolved complaints was maintained on the ward. This record did not include the outcome of complaints.

Number of areas for improvement	4

.2 Is Care Effective?

The right care, at the right time in the right place with the best outcome

Areas of Good Practice

All assessments, care plans and progress notes were consistently recorded on the patient electronic recording system (PARIS).

Each patient had a comprehensive, person centred assessment in place.

Multi-disciplinary team case notes were detailed and person centred.

Patients who were assessed as requiring care and treatment were reviewed every week by the multi-disciplinary team (MDT) and patients whose

discharge was delayed were reviewed every two weeks by the MDT. The minutes of the review evidenced a holistic patient centred approach. Patients were offered the opportunity to attend their meetings.

There was a comprehensive record of the 1:1 meetings between each patient and their named/associate nurse.

Patients could access a range of care and treatment options.

The use of restrictive practices was clearly documented and reviewed frequently. There was evidence of review of practices such as enhanced observations and reduction following review.

Areas for Improvement

There were duplications of care plans. This was confusing and unnecessary. For example one patient had five copies of a care plan and another patient had seven care plans, in place in relation to similar behaviours, with the same interventions recorded. The date the care plans were written or the author was not recorded. There was an inconsistent approach to reviewing care plans.

Patient care documentation was audited however the name of the auditor and date was not always recorded. It was also unclear if the deficiencies identified in the care documentation had been addressed.

Number of areas for improvement	2

7.3 Is Care Compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Areas of Good Practice

Patients stated they were treated with dignity and their privacy is respected.

Staff were observed throughout the period of the inspection to respond compassionately to patients who were physically and / or emotionally distressed.

Inspectors and the lay assessor observed staff treating patients with dignity and respect and were compassionate toward patients. Staff were also observed making every effort to maintain a calm environment.

Patients confirmed they were offered the opportunity to attend meetings about their care, treatment and discharge plans.

There was a range of easy to read information available to assist patient to make informed choices.

The use of restrictive practices was explained to patients.

Advocacy services were available to patients and relatives. Advocates confirmed they attended meetings in relation to resettlement.

Areas for Improvement

No areas for improvement in relation to compassionate care were identified during the inspection.

Number of areas for improvement	0

4 Is the Service Well Led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

Areas of Good Practice

Staff from the multi-disciplinary team said they were well supported and that there was a good working relationship between the team.

There were systems in place to analyse risks, accidents, incidents, complaints, safeguarding referrals, and the effectiveness of protection plans, staff disciplinary matters, whistleblowing and mortality rates. There was a focus on learning when things go wrong. Learning was shared with all relevant staff.

Patient forum meetings were held every month. Areas for action were identified and addressed. There was a person centred approach to patients' views of their care and treatment.

A patient satisfaction survey was completed in September 2017. Findings from the survey were positive and were displayed on the ward.

Good attendance was noted at the monthly staff meetings. Relevant information was discussed at the meetings such as any new processes. It was noted that staff were commended for their work at staff meetings.

There was good attendance noted at the monthly reflective practice sessions. A good range of issues were discussed such as managing Absence Without Leave (AWOL), managing allegations against staff, managing aggression,

working with patients who have safety plans, staff morale and the impact of RQIA and educational audits and delayed discharges.

Overall feedback from the multi-disciplinary team was positive about their role on the ward.

Areas for Improvement

There was no regular clinical pharmacy support to the ward.

Number of areas for improvement	1

8.0 Provider Compliance Plan

Areas for improvement identified during this inspection are detailed in the provider compliance plan. Details of the provider compliance plan were discussed at feedback, as part of the inspection process. The timescales commence from the date of inspection.

The responsible person should note that failure to comply with the findings of this inspection may lead to further /escalation action being taken. It is the responsibility of the responsible person to ensure that all areas identified for improvement within the provider compliance plan are addressed within the specified timescales.

8.1 Actions to be taken by the Service

The provider compliance plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed provider compliance plan by 24 November 2017.

Provider Compliance Plan Killead Ward	
Priority 1	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** Quality Standard 5.3.1 (a) **Stated:** First time **To be completed by:** 6 October 2017	Inspectors were concerned about the management of patients who have specific speech and language guidelines in place in relation to their eating and drinking.
	Response by responsible person detailing the actions taken: In response to this area of improvement, ward staff addressed the particular issue (in relation to one patient), highlighted during the inspection and submitted an action plan to RQIA on 6th October. Other patients on the ward who have specific speech and language guidelines in place in relation to their eating and drinking have had a referral to Speech & Language Therapy and a personal place mat developed. This is reflected in their nursing assessment and plan of care.
Area for Improvement No. 2 **Ref: Quality Standard 5.3.1 (f)** **Stated:** First time **To be completed by:** 6 November 2017	The ligature risk assessment was out of date.
	Response by responsible person detailing the actions taken: In response to this area of improvement, the up to date ligature Risk Assessment is available in the Ward, this was been updated in August 2017 for the incoming year and includes the four profiling beds and the ligature risk identified in the TV room.
Area for Improvement No. 3 **Ref: Quality Standard 8.3 (k)** **Stated:** First time	The record of locally managed complaints did not include an outcome of the complaints.
	Response by responsible person detailing the actions taken: In response to this area of improvement, locally managed complaints now include an outcome of the complaint; this is

To be completed by: 6 November 2017	recorded on the Trust complaint record form.
Priority 2	
Area for Improvement No. 4 **Ref:** Quality Standard 5.3.1(e) **Stated:** First time **To be completed by:** 12 January 2018	Fire drills were not completed in accordance with the Trust's fire manual.
	Response by responsible person detailing the actions taken: In response to this area of improvement, a walk/talk fire drill and an evacuation were completed on 8th and 22nd November. The ward management team have devised a template to facilitate fire drills to ensure every member of staff has the opportunity to participate in at least one
Priority 3	
Area for Improvement No. 5 **Ref:** Quality Standard 6.3.1 (c) **Stated:** Second time **To be completed by:** 4 April 2018	When a number of patients are in the main communal area/dining room the noise levels appear to echo and reverberate which can be distracting and unpleasant for patients in this room.
	Response by responsible person detailing the actions taken: In response to this area of improvement, costs have been confirmed from the supplier and a bid has been submitted to the capital evaluation team as a prioritised bid.
Area for Improvement No. 6 **Ref:** Quality Standard 5.3.1 (a) **Stated:** First time **To be completed by:** 4 February 2018	There were duplications of care plans. The date that the care plans were written and the author was not recorded. There was an inconsistent approach to reviewing care plans.
	Response by responsible person detailing the actions taken: In response to this area of improvement, training is ongoing with registrants in relation to care planning. Duplicate plans of care are closed. All assessments and plans of care are signed, date and time stamped on completion.

Area for Improvement No. 7 **Ref:** Quality Standard 5.3.1 (a) **Stated:** First time **To be completed by:** 4 April 2018	There was no regular clinical pharmacy support to the ward.
	Response by responsible person detailing the actions taken: The hospital has pharmacy support from the Trust pharmacy department. There is no dedicated pharmacy for Muckamore and currently no funding for this. The trust will discuss clinical pharmacy support with HSCB to highlight this area of improvement.

Name of person(s) completing the provider compliance plan	Oonagh McMackin		
Signature of person(s) completing the provider compliance plan	Oonagh McMackin	**Date completed**	November 17
Name of responsible person approving the provider compliance plan	Mairead Mitchell		
Signature of responsible person approving the provider compliance plan	Mairead Mitchell	**Date approved**	November 17
Name of RQIA inspector assessing response	Wendy McGregor		
Signature of RQIA inspector assessing response	Wendy McGregor	**Date approved**	27 November 2017

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Assurance, Challenge and Improvement in Health and Social Care

Unannounced Follow Up Inspection Report
24 October 2017

Erne Ward 1

Resettlement Ward
Muckamore Abbey Hospital
1 Abbey Road
Antrim
BT41 4SH

Tel No: 028 95042087

Inspector: Cairn Magill

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Erne Ward 1 is a seven bedded resettlement unit for male patients who have a learning disability. On the days of inspection there were five patients on the ward.

There were no patients on the ward detained in accordance with the Mental Health (Northern Ireland) Order 1986.

Care was provided by a multi-disciplinary team that included nursing, medical, psychiatry, and occupational therapy. An activity coordinator also provided a service to patients. Patients' had access to behavioural support and psychology services via referral. Independent advocacy services also visited the ward.

3.0 Service details

Responsible person: **Martin Dillon**	**Ward Manager:** **Rhona Brennan**
Category of care: Resettlement	**Number of beds: Seven**
Person in charge at the time of inspection: Rhona Brennan	

4.0 Inspection summary

An unannounced follow-up inspection took place on 24 October 2017.

The inspection sought to assess progress with findings for improvement raised from the most recent previous unannounced inspection 19-21 July 2016.

It was good to note that progress was made with all 12 areas of improvement from the inspection in July 2016. The ward had a relaxed, calming and welcoming atmosphere. The ward environment had undergone significant improvement in its presentation, hygiene and cleanliness. The ward was decluttered and flooring had been replaced in some areas and new furniture had been purchased. Patients' bedrooms were personalised and each patient had a personalised activity plan in place. Information and signage were presented in a format compatible with patients communication needs. New white boards had been ordered and placed throughout the ward to share information with patients and carers. There was evidence that significant improvements were made with care documentation and new structures were implemented to assist in sharing of information with staff. There was also evidence that relationships between the members of the multi-disciplinary, cleaning services and estate services had improved and developed. Cleaning staff reported that there was a team approach to maintaining hygiene standards on the ward.

Staff reported that they felt supported and were part of a “great team and that the manager, deputy manager and operations manager were supportive approachable and helpful”. Staff also reported that they believed patients now experienced a better quality of life.

Two patients were able to inform the inspector what activities they were about to complete. Patients appeared relaxed and at ease and were dressed appropriate for the weather. There was evidence that staff had detailed knowledge of patient’s needs.

Patients said,

The inspector met with three patients. All three patients reported they were happy with the care and treatment they received on the ward. One patient said he was delighted to have a key to his own bedroom.

"I like my room but I want to get my own home."

"I like it here"

"I go horse riding and like to go out for a drink."

"It's alright" (Patient response to the question; How they like being on the ward?)

"I am going shopping today and getting my hair cut.”

“I am going to the day centre.”

Relatives said,

There were no relatives on the ward during the inspection.

Staff said,

The inspector met with five members of the nursing staff team, one member of cleaning staff, and one visiting professional during the inspection. All comments received were positive in relation to the changes on the ward. Staff reported there was a more cohesive team on the ward and all members of staff felt valued. S taff reported there was good leadership on the ward.

“We are all working as a team.”

“Patients have a better quality of life now.”

“It’s a great team and there is great support.”

“The debriefing in the morning is really good. We can discuss any issues that have happened and everyone is involved in the safety debrief.”

“It’s the simple things we had to get right. Once we keep up with the schedules it’s easy to keep on top of things.”

“The reason it works is because everyone does their share of cleaning.”

“Management is very approachable and very helpful. I have found them helpful in terms of my personal and professional development”

Staff were commended on the significant progress made in all twelve areas of improvement. The inspector noted and acknowledged with staff their effort, commitment, cooperation and the cohesiveness in bringing about such positive changes.

The findings of this report will provide the Trust with the necessary information to assist them to fulfil their responsibilities, enhance practice and service user experience.

4.1 Inspection outcome

Total number of areas for improvement	0

There were no areas identified for improvements during this inspection.

5.0 How we inspect

The inspection was underpinned by:

- The Mental Health (Northern Ireland) Order 1986.
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.
- The Human Rights Act 1998.
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

The following areas were examined during the inspection:

- Fire safety assessments.
- Patient forum meetings.
- Staff duty rota.
- Daily allocation sheets.
- Care documentation in relation to three patients.
- Ward environment.
- Advocacy service.
- Activity schedule.
- Minutes of staff meetings.
- Environmental assessments.
- Emergency equipment checks.
- Safety briefing records.
- Patient finance records.
- The management and storage of confidential records.
- Ward performance records and audits.

- Feedback from six staff.
- Observations of staff practice and engagement with patients.

We reviewed the areas for improvements made at the previous inspections and an assessment of compliance was recorded as met.

6.0 Review of areas for improvement from the last unannounced inspection 19-21 July 2016

The most recent inspection of Erne Ward 1 was an unannounced inspection. The completed Quality Improvement Plan (QIP) was returned and approved by the responsible inspector. This QIP was validated by inspectors during this inspection.

Areas for Improvement from last inspection		Validation of Compliance
Area for improvement 1 **Ref**: Standard 5.3.1 (e) **Stated: First Time**	**The responsible person must ensure that:** All urgent actions identified in the fire risk assessment are addressed. Patient's personal emergency evacuation plans are updated and regularly reviewed. Staff are aware of and can respond appropriately to each patient's individual needs in the event of a fire. Staff that come to assist in the event of a fire are given clear guidance and direction. Emergency exits are free from obstruction.	
	Action taken as confirmed during the inspection: The inspector examined the fire risk assessment and associated action plan, fire training and fire drill records. There was evidence in the records that the majority of action points highlighted on the fire risk action plan had been addressed. There were a number of action points which were placed on the	**Met**

	corporate risk register as they required capital funding to action. This issue was discussed in detail with the business manager. The Belfast Trust has a process of risk assessing where capital funds money will be spent. Testing of emergency lighting was issued to a third party for inspection and the five year checks were scheduled for inspection during this year. Evacuation procedures had been reviewed and had been changed from horizontal evacuation to full evacuation. All staff had up-to-date fire training and there were seven members of the Erne staff team who received additional training as fire wardens. All staff were familiar with fire evacuation procedures. Patient emergency evacuation plans were updated and reviewed outlining the support needs of patients in the event of a fire. There were two evacuation fire drills completed on 27 January 2017 and 6 July 2017. Four patients refused to leave the ward on 27 January 2017 and two patients refused to leave the ward on 6 July 2017. The Belfast Trust has a process in place in accordance with their fire training policy to manage situations where patients refuse to leave the building. The fire officer visited the ward on 12 September 2017 and completed a walk/talk fire drill with staff. Emergency exits were observed to be free from obstruction on the days of the inspection. Staff were allocated the responsibility on a daily basis to check the environment for any fire safety issues. Escape routes, fire detectors, emergency exits and emergency fastening devices were routinely checked every week. Fire extinguishers, fire doors and closing devices were routinely checked every month.	
Area for	**The responsible person must ensure that:** The resuscitation trolley and other emergency	**Met**

improvement 2 **Ref**: Standard 5.3.1 (f) **Stated: First Time**	equipment is checked in accordance with the Trust's policy.	
	Action taken as confirmed during the inspection: The inspector reviewed the check lists in relation to the resuscitation equipment. There was evidence that the equipment had been checked in accordance with trust policy.	
Area for improvement 3 **Ref**: Standard 5.3.1 (f) **Stated: First Time**	**The responsible person must ensure that:** The hygiene, maintenance and tidiness of the ward are improved and maintained to a satisfactory level. Patient's privacy, dignity and comfort are upheld and enhanced by the provision of appropriate clothing, soft furnishings, window coverings, mattresses and garden shelter.	**Met**
	Action taken as confirmed during the inspection: The inspector observed the ward environment and noted it had significantly improved. Nursing and patient experience staff had a shared understanding and commitment to cleaning schedules. The ward was clean, tidy and clutter free. New flooring had been purchased for the dining room and new furniture was evidenced throughout the ward. Window coverings were in place and all beds had a properly fitted mattress with appropriate and comfortable bedding. Patient rooms were personalised. Patients were noted to be suitably dressed to suit the weather conditions and the temperature of the ward. The garden area had been cleaned and maintained. There was appropriate shelter outside for patients.	
Area for improvement 4	**The responsible person must ensure that:** Staffing levels in Erne Ward reflect the needs of the patients, to include safe supervision, address the environmental design and ensure patients have	

Ref: Standard 5.3.3 (d) **Stated: First Time**	access to planned activities. **Action taken as confirmed during the inspection**: On the days of the inspection there were five patients on the ward. Each patient required assistance with their daily living needs and required different levels of supervision. Levels of supervision on the ward ranged from general observations to two to one observation. Erne Ward 1 has four separate communal areas. Three patients each have separate living areas with a bedroom, bathroom and living/ dining area to accommodate their specific care needs. The ward manager stated that the ward required a minimum of nine staff per shift due to supervision levels and environmental design with a minimum of three qualified staff. There are occasions when staffing numbers were reduced to seven staff per shift however this is generally planned in accordance with patient routine and home visits. On occasions due to casual sickness, the shortfall is reported immediately to the Nursing Office as per protocol. This was monitored and reviewed by trust senior managers. There was no evidence that hospital appointments were cancelled due to staff shortages. Ward based activities continued and patients continued to attend day care every day. Duties were allocated on a daily basis to ensure that the needs of the patients were met and patients were supervised. A safety briefing was also completed every day and there was evidence that housekeeping were informed of any risks on the ward.	**Met**
Area for improvement 5 **Ref**: Standard 5.3.1 (a) **Stated: First Time**	**The responsible person must ensure that:** Assessments, care plans and risk assessments are thorough, up-to-date, reflect changing needs and specialist assessments. Care plans are evaluated, reviewed and recorded in a timely manner in accordance to trust, regional policies and professional guidance.	**Met**

	Progress notes are accurate, complete and are easily accessible to all staff delivering care.	
	Action taken as confirmed during the inspection: The inspector reviewed care documentation in relation to three patients. Assessments, care plans and risk assessments were recorded on the patient electronic recording system (PARIS). Assessments had been reviewed and were noted to be up to date. Care plans were person centred and underwent regular review and reflected the assessed needs of the patients. Each patient had a completed risk screening tool in place. These were noted to be completed in accordance with Promoting Quality Care – Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. Any risks identified were recorded and managed through the patient's care plan. Elements of restrictive practices were recorded in assessments and care plans. These were reviewed and terminated when they were no longer required demonstrating adherence to best practice. Case notes and daily progress notes were detailed, and person centred. There was evidence in case notes that family members were kept informed and up-to-date on each patient's progress. The consultant psychiatrists and medical staff were recording their involvement in patients' care and treatment on the PARIS system.	
Area for improvement 6 **Ref**: Standard 5.3.1	**The responsible person must ensure that:** Patient financial transactions are in accordance with trust policies and procedures.	**Met**

(c) **Stated: First Time**	**Action taken as confirmed during the inspection**: The inspector reviewed the financial records pertaining to all patients on the ward. Robust checking mechanisms were in place and it was noted that there was good adherence to the Trusts financial policies and procedures. Patients' monies that were held on the ward were checked by two staff every morning and evening. Financial records were audited by the ward manager every week and by the senior nurse manager every three months.	
Area for improvement 7 **Ref**: Standard 6.3.2 (a) **Stated: First Time**	**The responsible person must ensure that:** Patients have; • Access to advocacy on the ward. Advocates should take into consideration the communication support needs of the patients. • Patient representative forum meetings which are recorded and ensure all actions identified are followed up.	**Met**
	Action taken as confirmed during the inspection: It was pleasing to note that access to advocacy services had improved for patients on Erne Ward 1. Photograph of advocates are displayed. The ward notice board identifies the advocate for each individual patient. Advocates visit the ward on a weekly basis. Dates of patient forum meetings are displayed on the ward notice board and minutes are available for review and actions followed up. A new easy read template was designed to capture patient related issues. This template is completed with patients prior to the monthly patient forum.	
Area for improvement 8 **Ref: Standard6.3.2 (a, b & c)**	**The responsible person must ensure that:** Patients have information in a format that meets the communication needs of patients to; • assist in orientation around the ward, • know who is on duty and,	**Met**

Stated: First Time	• what activities are on offer. **Action taken as confirmed during the inspection**: There was appropriate signage displayed throughout the ward to help orientate patients. This was in a format appropriate to patient's communication needs. There were photographs displayed of multidisciplinary staff on duty each shift. Each patient had an individual activity schedule which was depicted in symbols/ photographs. The inspector spoke to two patients who were aware of their activity schedule and who were able to inform the inspector of their respective activity for that afternoon.	
Area for improvement 9 **Ref**: Standard 5.3.1 (f) **Stated: First Time**	**The responsible person must ensure that:** Patient records and files are managed and stored in accordance with trust and data protection policies and procedures and Nursing Midwifery Council guidance on record keeping. **Action taken as confirmed during the inspection**: All members of the multidisciplinary staff record on the PARIS system which is a secure electronic record of patient notes. In addition each patient had a hard copy medical file which contained hardcopy information that could not be recorded in a digital format such as lab results etc. These files were kept in accordance with trust and data protection policies and procedures and Nursing Midwifery Council guidance on record keeping. Hardcopy files were stored in a secure filing cabinet in the main office.	**Met**
Area for improvement 10 **Ref: Standard 5.3.1 (f)** **Stated: First Time**	**The responsible person must ensure that:** The ward's performance is audited and outcomes are displayed for patients' carers, relatives and staff. **Action taken as confirmed during the inspection**:	**Met**

	The inspector noted the wards performance was displayed on the main notice board for patients, relatives and carers. Information displayed related to the number of incidents, safeguarding referrals, complaints and compliments and minutes of patient forum outcomes.	
Area for improvement 11 **Ref**: Standard 6.3.2 (b) **Stated: First Time**	**The responsible person must ensure that:** Relatives are informed in advance of the purpose of meetings. **Action taken as confirmed during the inspection**: There were no relatives available on the day of inspection however the ward manager advised that medical records department are now charged with the responsibility of writing out to relatives in advance of a meeting inviting them to attend and outlining the purpose of the meeting. The inspector also noted reference to letters for carers in patient files.	**Met**
Area for improvement 12 **Ref: Standard 5.3.1 (e)** **Stated: Second Time**	**The responsible person must ensure that:** There is a ward specific environmental assessment completed and an action plan is completed which should include a timeframe / responsible person for action. **Action taken as confirmed during the inspection**: An environmental check was completed every day by allocated staff. Any areas requiring attention were identified, recorded and addressed promptly. The inspector reviewed the jobs request book which evidenced appropriate action taken. There was evidence that senior management attended the ward every week to review the environment.	**Met**

7.0 Actions to be taken by the service

There were no areas for improvement identified during this inspection, and a provider compliance plan is not required or included, as part of this inspection report.

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Assurance, Challenge and Improvement in Health and Social Care

Whistleblowing Inspection Report
20 December 2017

Cranfield Ward 2
Muckamore Abbey Hospital
1 Abbey Road,
Muckamore,
BT41 4SH
Tel No: 02895 042063

Inspectors: Wendy McGregor and Audrey McLellan

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Cranfield Ward 2 is a 15 bedded ward with an additional apartment (on another ward) that provides care and treatment to male patients with a learning disability who have an enduring mental illness, and complex behaviours that challenge.
On the days of the inspection there were 15 patients on the ward and one patient in the apartment. Three patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986.

3.0 Service details

Responsible person: **Martin Dillon**	**Ward Manager:** **Linda McCartney**

4.0 Inspection summary

A Whistleblowing inspection took place on 20 December 2017.

The inspection was undertaken in response to the following concerns raised from an anonymous telephone call to the RQIA office.

1. Unsafe staffing levels.
2. Staffing levels were not in place to address the number of patients in receipt of enhanced observations / supervision.
3. The effect of low staffing levels on the number and nature of incidents.
4. Adherence to the Belfast Health and Social Trust Policy Levels of Supervision/observation within Learning Disability Inpatient Services (November 2013).

RQIA contacted the Acting Head of Learning Disability Services and informed them of the concerns raised by the anonymous caller. RQIA requested that the Trust forward the minimum staffing levels per shift, the staffing levels obtained and information in relation to the number of patients who required enhanced observations.

On receipt and analysis of this documentation RQIA requested additional information and a decision was made to visit the hospital to complete an announced Whistleblowing inspection.

Specific methods/processes used in this inspection included the following:

- Review and analysis of incidents and accidents, duty rotas, complaints and staff absence levels.
- Review of the Belfast Health and Social Trust Policy on Levels of Supervision/observation within Learning Disability Inpatient Services (November 2013).
- Discussions with Trust senior management and the ward manager.
- Examination of care records in relation to seven patients who were in receipt of enhanced observations or supervision.
- The day care schedule.
- Review of the risk register.

Any other information received by RQIA about this service and the service delivery was also considered by inspectors in preparing for this inspection. Findings in relation to the allegation are discussed below.

4.1 Inspection outcome

Inspectors examined the ward's situation in relation to the allegations made by the anonymous caller. The nature of the allegations and the inspectors findings are detailed below.

1. Unsafe staffing levels.

Inspectors reviewed ward occupancy levels and staffing levels from 9 October 2017 to 5 November 2017. Inspectors also reviewed staff absence.
In respect of ward occupancy levels the ward has been 100% occupied in this period.

The number of staff required for safe staffing levels on the ward is as follows:

- 0730 – 1315hrs = 10 staff
- 1300 -2030hrs = 10 staff
- 2000 – 2300hrs = 8 staff
- Night duty = 5 staff

Inspectors noted that 51% of shifts had not achieved the required staffing levels. In RQIA's view this percentage is high and there would be concerns in relation to safe and effective care if this was happening on a regular basis.

Inspectors noted that staffing levels have improved since 20 November 2017. Since this date three staff nurses who were working as health care assistants had received their Nursing and Midwifery Council (NMC) PIN numbers and commenced their staff nurse post and three staff have been redeployed to Cranfield Ward 2 from another ward that had recently closed. The ward manager and two deputy ward managers had returned after a period of absence and overall staff absence had reduced.

Inspectors reviewed the ward duty rota ward from 6 December 2017 to 20 December 2017 and noted an improvement in staffing levels. It was also noted that the number of shifts that did not achieve the required staffing levels had reduced to 29% of shifts.

There was evidence of robust governance mechanisms in place to monitor staffing levels. The inability to meet minimum staffing levels was assessed as a high risk on the Trust's directorate risk register. Ward staff reported staffing shortages to the senior nurse manager, the duty officer and recorded it as an incident on the incident recording system (DATIX). All attempts were made to address staff shortages through the use of bank staff and agency staff.

This allegation was substantiated. Staffing levels remain a concern for the Muckamore site as there are some shifts that do not achieve the required staffing levels. However, there was evidence that staffing levels had improved due to a reduction in staff absence and redeployment of staff from a recently closed ward. There was evidence of ongoing recruitment of staff for Muckamore.

2. Staffing levels were not in place to address the number of patients in receipt of enhanced observations / supervision.

On the day of the inspection, inspectors confirmed that seven out of 16 patients required different levels of enhanced observations or supervision which were recorded as follows:

- Patient A - 24 hour one to one support in an acute general hospital.
- Patient B – 24 hour level 3 within eyesight due to aggression towards self and others.
- Patient C – Level 3 within eyesight when in communal areas. Level 2 observations (15min checks) when in their bedroom. Due to disinhibited behaviours and aggression toward others. Inspectors noted that the length of time varied for level 3 support. However it was recorded that the patient prefers to spend much of their day in their bedroom and generally goes to bed around 8.30pm.
- Patents D – Level 3 within eyesight when in communal areas. (Level 1 general observations when in bedroom). Due to disinhibited behaviours and aggression toward others.
- Patient E – 24 hour level 3 within eyesight due to aggression towards others.
- Patient F and Patient G – One to one support during meal times due to risk of choking.

The remaining nine patients were on level 1 general observations.

Inspectors reviewed the care documentation in relation to the seven patients. There was recorded evidence that decisions in relation to enhanced observations or supervision were agreed and reviewed every week by the multidisciplinary team. From the information reviewed it was noted that the rationale for the enhanced observation or supervision was recorded and was proportionate to the assessed risk.

Inspectors noted that on average four patients in the morning and six patients in the afternoon leave the ward to attend day care. Level 3 enhanced observations for patients C and D reduced to level 2 and level 1 observations during the day, when they went to their bedroom. This reduced the pressure on staffing levels.

Inspectors reviewed the duty rota from 6 December to 20 December and noted that staffing levels were in place to meet the needs of patients who require enhanced observation / supervision. **This allegation was unsubstantiated.**

3. The effect of low staffing levels on the number and nature of incidents.

Inspectors reviewed a record of incidents and cross referenced these with the number of staff on duty. There were 78 incidents recorded and reported onto the DATIX system from 9 October 2017 to 26 November 2017. 74% of the incidents were in relation to abuse against staff by patients and 19% of incidents were in relation to patient on patient abuse. A safeguarding vulnerable adult referral was made following each incident of patient on patient abuse.

This allegation was unsubstantiated. There was no correlation between the number and nature of incidents with the number of staff on duty. For example on a day when number of staff working on the ward was below the required number there were no incidents.

4. Adherence to the Belfast Health and Social Care Trust Policy Levels of Supervision and observation within Learning Disability Inpatient Services (November 2013).

Inspectors reviewed staff rotas, the number of patients receiving enhanced observations and the daily allocation sheets from 9 October 2017 to 5 November 2017. During this period of time there was evidence that the policy was not always adhered to as there were not enough staff to rotate during the enhanced observations of patients. However this has improved with the increase in staffing levels. The daily allocation sheets reviewed by the inspectors evidenced that from 6 December 2017 staff providing enhanced observations have been rotated in accordance with the Trust policy and procedure.

This allegation was substantiated for the period of time from 9 October 2017 – 5 November 2017. However this has improved with the increase in staffing levels. The daily allocation sheets reviewed by the inspectors evidenced that from 6 December 2017 staff providing enhanced observations have been rotated in accordance with Trust policy and procedure.

Additional information

It was good to note that there have been no complaints received during the period of 10 September 2017 to 26 November 2017 and staff shortages have not impacted on patients attending day care or attendance any medical appointments.

7.0 Conclusion

Two out the four allegations were substantiated. These are in relation to the provision of safe staffing levels and adherence to the Belfast Health and Social Care Trust Policy on Levels of Supervision and Observation within Learning Disability Inpatient Services (November 2013). Inspectors did not make any areas for improvement as there has been an increase in the number of staff working on the ward due to a decrease in staff absence and redeployment of staff with the closure of Erne Ward 2. The Trust continues to use bank and agency staff and is proactively attempting to recruit staff.

The remaining two allegations were unsubstantiated. Staffing levels were in place to address the number of patients in receipt of enhanced observations / supervision and there was no recorded evidence to confirm that reduced staffing levels had any effect on the number and nature of incidents on the ward.

7.1 Actions to be taken by the service

The responsible person should review the report for factual accuracy and contact the mental health team if required otherwise return the report signed by the ward manager and the responsible person via the web portal by **13 February 2018.**

Name of Ward manager	Linda Macartney		
Signature of Ward manager	Linda Macartney	**Date completed**	18th January 2018
Name of responsible person approving the report	Martin Dillon		
Signature of responsible person approving the report	Martin Dillon	**Date approved**	18th January 2018
Name of RQIA inspector	Wendy McGregor		
Signature of RQIA inspector	Wendy McGregor	**Date approved**	23 January 2018

Please ensure this document is completed in full and returned to MHLD.DutyRota@RQIA.org.uk from the authorised email address

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Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority

Unannounced Follow Up Inspection Report
5 - 6 February 2018

Cranfield ICU
Muckamore Abbey Hospital
1 Abbey Road
Muckamore
Co. Antrim

Tel No: 02895042066

Inspector: Wendy McGregor

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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1.0 What we look for

2.0 Profile of service

Cranfield ICU is a six bedded mixed gender ward. The purpose of the ward is to provide assessment and treatment to patients with a learning disability who need support in an intensive psychiatric care (PICU) environment. On the days of the inspection six patients on the ward were detained in accordance with the Mental Health (Northern Ireland) Order 1986. There were four patients whose discharge from hospital was delayed.

Patients receive input from a multidisciplinary team (MDT) which includes a consultant psychiatrist, medical staff, nursing staff, a behaviour nurse therapist and a social worker. Patients can access occupational therapy (OT), speech and language therapy and a clinical psychologist through a referral system. Patients and carers have access to an advocacy service.

3.0 Service details

Responsible person: Martin Dillon	**Ward Manager:** Sean Murray
Category of care: Psychiatric Intensive Care (PICU)	**Number of beds:** 6
Person in charge at the time of inspection: Sean Murray	

4.0 Inspection summary

An unannounced follow-up inspection took place over two days on 5 – 6 February 2018.

The inspection sought to assess progress with findings for improvement raised from the last unannounced inspection 6 – 8 December 2016.

The inspector noted that the ward had made improvements since the last inspection. Five out of the seven areas for improvement were assessed as met.

- Each patient reviewed had up to date care plans completed that addressed their assessed needs.
- Malnutrition Universal Screening Tool (MUST) assessments were reviewed in accordance with Trust policy. (MUST is a screening tool used to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese).
- The date when a patient was admitted to Cranfield ICU was recorded on their assessment. Staff can also obtain a report from the patient electronic recording system (PARIS) of each patient's admission and discharge date from PICU.

- The minutes of the ward manager's meetings evidenced that all issues pertaining to the ward had been discussed and reviewed. The minutes were noted to be comprehensive.
- Minutes from patient forum meetings evidenced individual comments and suggestions from each patient.
- Patients had access to a clinical psychologist by referral. A behaviour nurse therapist was allocated to Cranfield ICU and attended the ward every day from Monday to Friday. The behaviour nurse therapist was involved with every patient on the ward.

Staff duty rotas reviews evidenced that the required staffing levels were achieved on most days.

Two areas for improvement were assessed as partially met.

- 1:1 therapeutic interventions were not recorded every week in the correct section on the PARIS system.
- Patient forum meetings were not held regularly and the date of the next forum meeting was not displayed.

Two new areas for improvement were identified. Not every patient on the ward had a primary nurse and ward managers meetings were not held regularly.

The inspector spoke to one patient, one relative and observed care and practice on the ward. The patient was positive about their care and treatment and did not raise any concerns. They said the staff were good to them and they liked being on the ward. The relative said they were currently happy with the care and treatment their family member was receiving. The inspector observed that there were times during the inspection that patients were unsettled and presenting with behaviours that were distressing. Staff were observed to remain calm and support patients during these times of distress. Staff engaged with patients using good therapeutic communication skills and were warm and friendly in their approach toward patients. The inspector observed staff and patients taking part in activities together. During the inspection there was enough staff on the ward to meet the needs of the patients.

The inspector spoke to four staff members of the multidisciplinary team. Staff said care was safe, effective and compassionate. Staff said they were well supported by the ward manager and senior management. Staff knew triggers for patient's distress and how to best support the patient. Staff were also very knowledgeable on the needs of the patients and spoke about each patient in a positive and compassionate way.

The findings of this report will provide the Trust with the necessary information to assist them to fulfil their responsibilities, enhance practice and service user experience.

4.1 Inspection outcome

Total number of areas for improvement	3

The total number of areas for improvement comprises:

- 2 restated for a second time
- 1 new area for improvement

These are detailed in the Quality Improvement Plan (QIP).

5.0 How we inspect

The inspection was underpinned by:

- The Mental Health (Northern Ireland) Order 1986.
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.
- The Human Rights Act 1998.
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

The following areas were examined during the inspection:

- Psychology and behaviour support service.
- Care Documentation in relation to three patients.
- Ward environment.
- Minutes from staff meetings.
- Minutes from patient forum meetings.
- Staff duty rotas.

We reviewed the areas for improvements made at the previous inspections and an assessment of compliance was recorded as met/partially met and not met.

6.0 The inspection

6.1 Review of areas for improvement from the last unannounced inspection 6 – 8 December 2016

The most recent inspection of Cranfield ICU was an unannounced inspection. The completed QIP was returned and approved by the responsible inspector. This QIP was validated by inspectors during this inspection.

<table>
<tr><th colspan="2">Areas for Improvement</th><th>Validation of Compliance</th></tr>
<tr><td rowspan="2">Number/Area 1

Ref: Standard 5.3.1 (a)

Stated: First Time</td><td>In two sets of care records there were a number of care plans that had not been completed when there had been an identified need.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

The inspector reviewed three sets of care records stored on the patient electronic recording system</td></tr>
</table>

	(PARIS). The inspector reviewed both the assessment and care plans for each patient. A care plan was in place for every identified need. Assessments and care plan were reviewed regularly and were up to date.	
Number/Area 2 **Ref**: **Standard 5.3.1 (a)** **Stated:** First time	Malnutrition Universal Screening Tool (MUST) assessments were completed for patients and when they were assessed as low risk it stated in the care records that they should be reviewed monthly as per trust policy but these were not reviewed on a monthly basis.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed the (MUST) assessments for three patients. Each patient was assessed as a low risk. Each MUST assessment was reviewed every month in accordance with trust policy.	
Number/Area 3 **Ref**: **Standard 5.3.1 (f)** **Stated:** First Time	There was a section on the PARIS system to record weekly 1:1 therapeutic intervention by nursing staff. However, a number of staff had recorded this intervention in the progress records. Therefore it was difficult to track the patients' progress.	**Partially Met**
	Action taken as confirmed during the inspection: The inspector reviewed the section on the PARIS system to record the weekly 1:1 therapeutic intervention by nursing staff. The following was noted: Patient A – 1:1 therapeutic interventions were recorded up until 15 November 2017 Patient B – 1:1 therapeutic interventions were recorded up until 11 November 2017 Patient C – 1:1 therapeutic intervention were recorded up until 11 January 2018 This area for improvement has been assessed as partially met and restated a second time.	
Number/Area 4 **Ref**: **Standard 5.3.1**	It was difficult to ascertain on the PARIS system the date when patients were admitted onto Cranfield ICU the ward.	**Met**

(f) **Stated:** First Time	**Action taken as confirmed during the inspection**: In the three records reviewed the date of admission to PICU was recorded in the each patient's assessment. Staff can also obtain a report from the PARIS system of the patient's admission and discharge dates from PICU.	
Number/Area 5 **Ref: Standard 4.3 (a)** **Stated:** First Time	The minutes of the ward manager's meetings did not evidence that all issues pertaining to the ward had been discussed and reviewed as the minutes were very limited in content. **Action taken as confirmed during the inspection**: The inspector reviewed the minutes of four ward managers meetings. The minutes were noted to be comprehensive. Issues pertaining to the ward such as the use of CCTV, Trust policy's, supervision of patients and day to day running of the ward were discussed. The minutes were available for staff. The inspector noted the meetings were not held regularly. Dates of meetings were as follows: 27 February 2017 19 May 2017 10 August 2017 15 November 2017 A new area for improvement has been made in relation to this.	**Met**
Number/Area 6 **Ref**: **Standard 8.3 (a)** **Stated:** First Time	Patient forum meetings were not held on a regular basis on the ward, the minutes of these meetings were not recorded in an easy to ready format and information was not displayed regarding the next patient forum meeting. **Action taken as confirmed during the inspection**: The inspector reviewed the minutes from the patient forum meetings. The minutes reviewed evidenced that the meetings were person centred and each patients view / suggestions were recorded. Minutes were recorded in an easy to read format.	**Partially Met**

	However the meetings were not held regularly. There were only three meetings held in 2017. The last meeting to be held was in August 2017. The date of the next meeting was not displayed on the ward. This area for improvement has been assessed as partially met and will be restated a second time.	
Number/Area 7 **Ref**: **Standard 4.3 (j)** **Stated:** First Time	There was no clinical psychologist attached to the ward to form part of the MDT. **Action taken as confirmed during the inspection**: The inspector was informed by the ward manager that patients can access a clinical psychologist via referral. The behaviour support service is managed by the clinical psychologist and comes under the remit of the psychology service. The behaviour support service is allocated to the ward and attends the ward Monday – Friday. The inspector observed the behaviour support service attend the ward during the two days of the inspection. There was evidence that the behaviour support service was involved with every patient admitted to Cranfield ICU.	**Met**

7.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with senior trust representatives, members of the multi-disciplinary team, ward manager, and ward staff as part of the inspection process. The timescales commence from the date of inspection.

The responsible person must ensure that all areas for improvement identified within the QIP are addressed within the specified timescales. The responsible person should note that failure to comply with the findings of this inspection may lead to escalation action being taken.

7.1 Actions to be taken by the service

The quality improvement plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed quality improvement plan via the web portal by 21 March 2018.

Quality Improvement Plan

The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** Quality Standard 5.3.1 (f) **Stated:** Second time **To be completed by:** 6 March 2018	There was a section on the PARIS system to record weekly 1:1 therapeutic intervention by nursing staff. However, a number of staff had recorded this intervention in the progress records. Therefore it was difficult to track the patients' progress
	Response by responsible individual detailing the actions taken: In response to this area of improvement, this area of improvement was actioned immediately; all staff are recording a weekly 1:1 with each patient in the appropriate section of PARIS.
Area for Improvement No. 2 **Ref:** Quality Standard 8.3 (a) **Stated:** Second time **To be completed by**: 6 March 2018	Patient forum meetings were not held on a regular basis on the ward, the minutes of these meetings were not recorded in an easy to ready format and information was not displayed regarding the next patient forum meeting.
	Response by responsible individual detailing the actions taken: In response to this area of improvement, dates have been set for patient forum meetings on a monthly basis, the date of the next meeting is displayed on the notice board and minutes are recorded in an easy read format.
Area for Improvement No. 4 **Ref:** Quality Standard 4.3 (a) **Stated:** First time **To be completed by:** 6 March 2018	Ward managers meetings were not held regularly
	Response by responsible individual detailing the actions taken: In response to this area of improvement, ward manager meetings have been scheduled to take place on the 1st of each month.

Name of person (s) completing the QIP	Sean Murray		
Signature of person (s) completing the QIP	Sean Murray	**Date completed**	05/03/2018
Name of responsible person approving the QIP	Martin Dillon		
Signature of responsible person approving the QIP	Martin Dillon	**Date approved**	08/03/2018
Name of RQIA inspector assessing response	Wendy McGregor		
Signature of RQIA inspector assessing response	Wendy McGregor	**Date approved**	21 March 2018

Please ensure this document is completed in full and returned to MHLD.DutyRota@RQIA.org.uk from the authorised email address

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Assurance, Challenge and Improvement in Health and Social Care

Unannounced Follow Up Inspection Report
20 -21 February 2018

Six Mile Ward
Muckamore Abbey Hospital
1 Abbey Road
Muckamore
Co. Antrim
BT41 4SH

Tel No: 028 95042146

Inspector: Cairn Magill

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Six Mile ward is the regional low secure unit providing care and treatment to male patients with a learning disability who have mental health difficulties and have had previous contact with forensic services. At the time of the inspection the ward was providing care and treatment to 17 patients. Fourteen of the patients had been admitted to the ward in accordance to the Mental Health (Northern Ireland) Order 1986.

The ward is separated into two units. Six patients were receiving treatment and care in the ward's assessment unit and 11 patients were being cared for in the wards treatment unit. Patients on the ward are supported by a multi-disciplinary team (MDT) including; nursing staff, a consultant psychiatrist, a forensic psychologist, a social worker, day services staff, a specialist forensic nurse practitioner and a behavioural therapist. Access to occupational therapy services is via a referral.

3.0 Service details

Responsible person: Martin Dillon; Chief Executive	**Ward Manager:** Dessie McAuley
Category of care: Low secure assessment and treatment learning disability.	**Number of beds:** 19
Person in charge at the time of inspection: Dessie McAuley	

4.0 Inspection summary

An unannounced follow-up inspection took place over two days on 20 - 21 February 2018.

The inspection sought to assess progress with findings for improvement identified from the most recent unannounced inspection 31 January – 2 February 2017.

There were two areas of improvement identified at the previous inspection. One area for improvement was assessed as being met and one was not. The area for improvement not met related to medical staff completing a case summary for each patient. This area for improvement will be restated for the second time. The area for improvement assessed as being met related to the dates action items were completed on the ward's ligature risk assessment. There were no new areas for improvement identified during this inspection.

Other Findings

The inspector was advised that there was one patient who did not require a forensic bed. This patient (patient B) was admitted to Six Mile ward from another ward in Muckamore Abbey hospital to accommodate a new admission (patient A). Patient B was transferred to Six Mile to create a bed for patient A, who was admitted to an acute ward. On the second day of inspection patient B was transferred to another ward before being discharged home. The

inspector had no concerns regarding this arrangement as it was in accordance with the regional bed management protocol.

The inspector was also informed that one patient who presented with complex needs and behaviours that were challenging to manage requested to be secluded from other patients in the ward. The facilitation of self-requested seclusion was documented on every occasion. The inspector reviewed the patient's care documentation. The inspector was satisfied that the MDT was mindful of and considered the patient's human rights and the implications in relation the deprivation of the patient's liberty. On each occasion the patient was supervised on a 1:1 basis by a member of staff in accordance with good practice guidelines.

Staffing Levels

The inspector discussed staffing levels with the ward manager and senior trust staff. The inspector also reviewed the nursing staff duty rota from the end of November 2017 to the end of February 2018.

The inspector reviewed the daily staffing levels for the ward. The inspector was informed that the optimum staff levels for a morning shift were nine and the safe levels to support patients on the ward are eight in the morning. Night shift optimum staffing levels are five with safe levels being four. Within these numbers staff provide, additional supervision levels to two patients who require additional support such as 1:1 observations as well as escort patient's to appointments and /or on ground leave. The ward use bank staff to ensure cover is provided. Bank staff are ward staff that are willing to cover extra shifts or retired staff that have opted to cover some shifts. The inspector was informed that a large portion of the ward manager and deputy manager's time is taken up to ensure cover is provided on the ward. Nurses and health care assistants were reported to be extremely flexible and accommodating whenever possible to cover shifts. It was acknowledged that without this commitment from staff the ward would struggle even more to ensure safe staffing levels. The inspector is satisfied that safe staffing levels have been maintained on the ward.

Over the course of four months there were 21 times when the specialist forensic practitioner was required to work on the ward to maintain safe levels (outside of their specialist role to work as a mental health nurse), the ward manager was required on the floor seven times to maintain safe levels. There were 21 occasions when the ward required relief staff (brought in from other wards) to maintain safe numbers during the day and 16 occasions when relief staff were required to maintain safe numbers during the night. There is a protocol in place to alert the duty manager of staffing shortages so that they can arrange for relief cover from other wards as and when is necessary.

RQIA have been aware of the staffing shortage within Muckamore Abbey Hospital site and of the Trust's efforts to recruit new staff. The Belfast Trust has a rolling advertisement for nurses and has recently completed a local recruitment drive in an effort to address the staffing shortage. RQIA are satisfied that the Trust is doing all it can to address the staffing shortages. In addition, senior Trust staff reported that they are reviewing the optimum and safe level allocations for Six Mile to reflect the changing need of the patient population and the number of patients requiring escort and additional supervision levels.

Patients said:

The inspector met with eight patients. Four were from the assessment side of the ward and four were from the treatment side. Patients referenced how low staffing numbers had an impact on whether or not they had opportunities to go on escorted ground leave or attend community outings.

Patients were asked to rate their response to a range of questions designed to capture patient experience. Patients were asked if they believe the care they receive is safe, effective, and compassionate and if the ward is well- led. Patients rated their experience from 1 (very unsatisfied) to 5 (very satisfied).

The responses to the questions were as follows;

Questions asked of patients	**No. of patients who responded on the scale from 1 (very unsatisfied) to 5 (very satisfied)**					
	1	**2**	**3**	**4**	**5**	**Total Number of patients**
Is care safe?	2	3	0	1	2	8
Is care compassionate?	0	0	4	1	3	8
Is care effective?	1	2	0	3	2	8
Is care well-led?	1	1	1	2	3	8

Patients who rated feeling safe on the ward as 1 or 2 explained that they sometimes did not feel safe due to the behaviour of other patients or as a result of their own mental health. They also stated that they were concerned about the safety of staff particularly female staff when other patients were presenting with behaviours that challenge.

Patients made the following statements;

“There is not enough staff sometimes.”

“I wish there was more staff all the time. When we have nine staff they take staff off us and then we can’t go on outings.” (This is to ensure safe levels of staff on other wards)

“If you’re looking to go to the shop I have to go with staff and if there is not enough they say come back in half an hour.”

Most patients reported being happy with the compassionate care they received.

“Staff go out of their way to help patients.”

“If I am annoyed, they’ll (staff) calm me down a bit.”

“XX is the best one. He really cares 100%.”

Three patients reported to be unsatisfied with the effectiveness of their treatment. One patient did not believe he was making progress (the patient's relative reported that the patient has improved since he was admitted but was experiencing a relapse at the time of the inspection). One patient was just admitted a week before the inspection and was still in the process of assessment and one patient did not elaborate why he thought his treatment was not effective.

Five patients were satisfied that their care and treatment was effective;

"I am happy enough. I am getting better."

"Any care I get is brilliant"

"You are always informed. They'd even sit down with you and have 1:1. They would tell me if there is a change in tablets. They are very good at that."

Patients who were unsatisfied about the ward being well-led referred to a lack of staff which impacted on activities/outings being cancelled or postponed.

"Sometimes there is not enough staff this side (assessment side). This does my head in. I can't go up and play pool."

"Sometimes there is not enough staff. Sometimes supper is late.

Relatives said:

The inspector met with one relative during the inspection. The relative stated they were happy with the care their family member received on Six Mile ward. They stated that they felt the care provided in the ward was safe, compassionate, effective and well-led.

Staff said:

The inspector spoke with twelve members of ward staff including the ward manager, deputy ward managers, nursing staff and nursing assistants and the forensic specialist nurse practitioner. The inspector also spoke with the locum consultant psychiatrist and staff grade psychiatrist, social worker, and day care worker who were all part of the multi-disciplinary team. Seven members of staff completed the staff questionnaire.

Questions asked of staff	**No. of staff who responded on the scale from 1 (very unsatisfied) to 5 (very satisfied)**					
	1	**2**	**3**	**4**	**5**	**Total Number of staff**
Is care safe?	0	0	0	2	5	7
Is care compassionate?	0	0	0	0	7	7
Is care effective?	0		0	2	5	7
Is care well-led?	0	0	0	0	7	7

The locum consultant psychiatrist commenced their post a week prior to the commencement of the inspection. The locum assured the inspector that they had received a thorough comprehensive two day hand-over from the previous consultant psychiatrist. They stated that they have had supervision scheduled once a week with the medical director who was reported as being very supportive and approachable and available as required. The locum had completed all mandatory training.

All staff who completed the questionnaire reported that they were very satisfied the care on the ward was safe, compassionate, effective and well-led. Comments made by staff in relation to safe care related to their concern that the ward was operating with low nursing staffing numbers at times. This was investigated and the inspector was satisfied with the interim management plan to ensure adequate staffing levels while at the same time the Trust was in the process of recruiting more staff.

Comments made in relation to effective care referred to the fact that some patients who did not have a forensic history were accommodated in a forensic ward at times due to bed management issues. Staff stated that they believed a forensic ward was not the most appropriate ward for patients who do not have a need to be in a forensic ward. This concern was acknowledged by the inspector who was assured by the Trust that patients who do not require a forensic bed are only accommodated in a forensic ward as a last resort for the least possible time in line with the regional bed management protocol.

Staff stated:

“Staffing numbers are consistently too low on the unit and at times are unsafe both for patients and staff.”

The inspector had investigated the staffing issues and was satisfied that appropriate measures were in place.

“I feel part of the team even though I am bank staff. Management are very approachable and will listen. I still enjoy coming in and I don’t have to be here. I still enjoy listening to patients talk.”

“I…really enjoy working in Six Mile. I started banking here in July 2016…. I find the ward staff and managers caring professionals who provide an excellent service. By coming back to bank in Six Mile I have been reminded as to why I got into nursing all those years ago.”

The findings of this report will provide the Trust with the necessary information to assist them to fulfil their responsibilities, enhance practice and service user experience.

4.1 Inspection outcome

Total number of areas for improvement	One

One area for improvement in relation to medical staff needing to complete a case summary has been restated for a second time. There were no new areas for improvement identified during this inspection.

5.0 How we inspect

The inspection was underpinned by:

- The Mental Health (Northern Ireland) Order 1986.
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.
- The Human Rights Act 1998.
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

The following areas were examined during the inspection:

- Care Documentation in relation to all patients.
- Staff duty rota.
- Ward environmental ligature risk assessment.
- Datix /Incident records.

The inspector reviewed the areas for improvements made at the previous inspections and an assessment of compliance was recorded as met/partially met and not met.

6.0 The inspection

6.1 Review of areas for improvement from the last unannounced inspection 31 January – 02 February 2017

The most recent inspection of Six Mile Ward was an unannounced inspection. The completed QIP was returned and approved by the responsible inspector. This QIP was validated by the inspector during this inspection.

Areas for Improvement from last inspection		Validation of Compliance
Number/Area 1 **Ref: Standard** 5.3.3(a) **Stated:** First time **To be completed by:** 3 March 2018	Medical staff should complete case summaries for each patient to ensure staff can access information succinctly and quickly.	**Not met**
	Action taken as confirmed during the inspection: The inspector reviewed the hardcopy medical notes and the PARIS records of four patients. There were no case summaries completed by medical staff. The inspector noted Nursing Pen Pictures which were completed for each individual patient. The pen picture contained the following information;	

	The patient's name – usually accompanied by a photograph, their date of birth, date of admission, their status their clinical type, reason for admission, level of supervision required, synopsis of physical, mental health and behaviours, family contact and any other relevant information. Given that medical case summaries were not available this area for improvement will be restated for a second time in the QIP accompanying this report.	
Number/Area 2 **Ref**: **Standard 5.3.1 (f)** **Stated:** First time **To be completed by:** 1 May 2018	The ward's ligature risk assessment should include a timeframe within which alterations to ligature points would be completed. **Action taken as confirmed during the inspection**: The inspector reviewed the ward ligature risk assessment completed in August 2016. All recorded actions to be taken had been addressed with the exception of the removal of support bars in the disabled bathrooms. It was agreed at feedback that removing these bars would be inappropriate for patients presenting with limited or poor mobility. The ward ligature risk assessment was reviewed with the Trust's Health and Safety Manager on 22 February 2018 and forwarded to RQIA on this date. The disabled bedroom/bathroom door is locked when not in use. If a patient is using these rooms the risks are locally managed under supervision from staff. This area for improvement has therefore been assessed as met.	**Met**

7.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with senior trust representatives, members of the multi-disciplinary team, ward manager, and ward staff as part of the inspection process. The timescales commence from the date of inspection.

The responsible person must ensure that all areas for improvement identified within the QIP are addressed within the specified timescales. The responsible person should note that failure to comply with the findings of this inspection may lead to escalation action being taken.

7.1 Actions to be taken by the service

The quality improvement plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed quality improvement plan via the portal for assessment by the inspector by 13 April 2018.

Quality Improvement Plan	
The responsible person must ensure the following findings are addressed:	
Number/Area 1 **Ref: Standard** 5.3.3(a) **Stated:** Second time **To be completed by:** 21 March 2018	Medical staff should complete case summaries for each patient to ensure staff can access information succinctly and quickly.
	Response by responsible individual detailing the actions taken: In response to this area of improvement and following further consultation with RQIA, it has been agreed that the current 'patient pen picture' available in the ward will be developed and provide a multidisciplinary summary allowing information to be accessed succinctly and quickly.

Name of person (s) completing the QIP	Dessie McAuley		
Signature of person (s) completing the QIP	Dessie McAuley	**Date completed**	April 18
Name of responsible person approving the QIP	Martin Dillon		
Signature of responsible person approving the QIP	Martin Dillon	**Date approved**	April 18
Name of RQIA inspector assessing response	Cairn Magill		
Signature of RQIA inspector assessing response	Cairn Magill	**Date approved**	13/04/2018

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

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Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority

Unannounced Follow - Up Inspection Report
7 - 8 March 2018

Cranfield Ward 2
Mental Health Acute Inpatient Ward
Muckamore Abbey Hospital
1 Abbey Road
Muckamore
BT41 4SH

Tel No: 02895042063

Inspectors: Cairn Magill and Wendy McGregor
Lay Assessor: Alex Parkinson

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Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Cranfield Ward 2 is a 15 bedded ward with an additional apartment that provides care and treatment to male patients with a learning disability who have an enduring mental illness and complex behaviours that challenge. On the days of the inspection there were 15 patients on the ward and one patient in the apartment. Two patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986. Fourteen patients were delayed in their discharge.

3.0 Service details

Responsible person: Michael McBride	**Ward Manager: Linda Macartney**
Category of care: Acute Mental Health	**Number of beds: 16**
Person in charge at the time of inspection: Linda Macartney	

4.0 Inspection summary

An unannounced follow-up inspection took place over two days on 7-8 March 2018.

The inspection sought to assess progress with the findings for improvement raised from the most recent previous unannounced inspection 28 – 30 November 2016.

Of the five areas of improvement that were noted at the previous unannounced inspection, four were met and one was partially met. Improvement was noted with regard to completion of;

- promoting quality care (PQC)
- risk assessments,
- financial risk assessments,
- review of dysphasia assessments and
- the involvement of consultant psychiatrists and medical staff in discharge planning meetings.

Some progress was noted in the writing of care plans to ensure they could be measured. Whilst this was good to note inspectors found that this approach was inconsistent. This area for improvement has been assessed as partially met.

Inspectors observed patient and staff interaction during the inspection. On the first day of inspection the ward was busy with members of the multi-disciplinary team such as physiotherapists visiting patients on the ward. Inspectors observed patients were offered a

choice for their breakfasts and the inspector observed a friendly relaxed interaction between patients and staff. It was good to note patients had access to day care on a daily basis.

A lay assessor accompanied the inspectors on inspection. The lay assessor met with three patients. Patients stated that they felt safe on the ward and that staff were sometimes busy, there were new named nurses allocated which patients were getting to know and sometimes the days were very long as there wasn't much to do on the ward during the day, evenings or weekends. Patients stated they could attend their meetings and ask any questions about their care.

Patients said,

"Yes (being in here) has helped me."

"Day care is not for me. It is very stressful being in the ward. They are very long days."

"I am looking out to the community to get my own place and get my life back to normal."

"I got a new named nurse and I am getting to know her."

"Staffing is a big issue."

"I feel upset sometimes because the whole process (discharge) takes too long."

Relatives said;

There were no relatives available during the inspection.

Staff said;

Inspectors met with five staff.

All staff who met with inspectors reported that they were satisfied that care on the ward was compassionate, effective and well-led.

Staff said that there were times were staffing levels were reduced. RQIA recognise that this is an ongoing issue on the Muckamore site and are aware that the Trust continues to actively recruit staff. A member of staff informed inspectors they were involved in an incident of verbal abuse with regard to their culture. The incident was recorded in accordance with Zero Tolerance from Abuse policy and procedures. However the nurse reported they did not receive individual support post incident. This scenario was discussed at feedback with senior members of the Trust. Senior managers of the Trust agreed to review their policy of offering individualised support to staff post incident and in particular with regard to culturally motivated verbal abuse.

All staff interviewed were knowledgeable on raising concerns in relation to patient safety, incidents and safeguarding vulnerable adults.

Staff comments include;

"With our safe numbers things are just manageable."

“This is a great staff team.”

“We know the patients very well.”

“We have supervision. It is good to have the ward manager back.”

“Non-mandatory training has been cancelled due to staffing levels.”

“I wouldn’t be here if I didn’t want to be here.”

“I am here because I am needed.”

“There is really constant communication.”

“Patients have their own forum.”

“We had our staff meeting last Wednesday.”

“I could approach X if I needed to.”

The findings of this report will provide the Trust with the necessary information to assist them to fulfil their responsibilities, enhance practice and service user experience.

4.1 Inspection outcome

Total number of areas for improvement	One

One area for improvement has been restated for a second time.

This is detailed in the Quality Improvement Plan (QIP).

Areas for improvement and details of the QIP were discussed with senior Trust representatives, members of the multi-disciplinary team, the ward manager and ward staff as part of the inspection process. The timescales for completion commenced from the date of inspection.

5.0 How we inspect

The inspection was underpinned by:

- The Mental Health (Northern Ireland) Order 1986.
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.
- The Human Rights Act 1998.
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

The following areas were examined during the inspection:

- Care documentation in relation to four patients.
- Risk assessments in relation to three patients.
- Financial capacity assessments in relation to four patients.
- Ward environment.
- Minutes of Community and Hospital discharge planning meetings.

During the inspection the inspectors observed staff working practices and interactions with patients using a Quality of Interactions Schedule Tool (QUIS).

We reviewed the areas for improvements made at the previous inspections and an assessment of compliance was recorded as met/partially met.

6.0 The inspection

6.1 Review of areas for improvement from the last unannounced inspection 28 – 30 November 2016

The most recent inspection of Cranfield Ward 2 was an unannounced inspection. The completed QIP was returned and approved by the responsible inspector. This QIP was validated by inspectors during this inspection.

Areas for Improvement from last inspection		Validation of Compliance
Area for improvement 1 **Ref**: 5.3.1(a) **Stated: First Time**	One patient who had a history of choking had a nursing care plan in place which included guidance from speech and language therapy (SALT). However the patient had not been reviewed by SALT since August 2015. This was addressed with the deputy ward manager during the inspection and an appointment was arranged for SALT to review the patient on Friday 2 December 2016.	**Met**
	Action taken as confirmed during the inspection: The ward manager identified the patient who had a history of choking. The inspectors reviewed the patient's care documentation. Care documentation evidenced that the patient had received a review of their (dysphagia) swallow assessment in December 2016. A further review was completed in August 2017 following an incident when the patient	

	choked. It was noted that the care plan in relation to the patient's dysphagia assessment was reviewed and updated following this incident. The patient had a further review two weeks following the incident. The inspectors assessed this area of improvement as being met in accordance with the Dysphagia management guidance.	
Area for improvement 2 **Ref**: 5.3.1(a) **Stated: First Time**	Each comprehensive risk assessment and management plan was reviewed in accordance with PQC guidance. The information recorded in the review documentation was comprehensive and relevant however the review did not always reflect if the risk had reduced; remained the same or increased. **Action taken as confirmed during the inspection**: Inspectors reviewed comprehensive risk assessments, risk management plans and reviews in relation to three patients. Inspectors noted that reviews reflected if the risk had reduced; remained the same or increased.	**Met**
Area for improvement 3 **Ref**: 5.3.1(a) **Stated: First Time**	One patient did not have their financial capacity assessment completed in full. Although it was recorded that the patient was assessed as incapable with managing their finances, the scores were not completed to confirm the rationale for this decision. **Action taken as confirmed during the inspection**: The inspectors reviewed four sets of patient's financial capacity assessments. All four financial capacity assessments were completed in full. The scores were completed to confirm the rationale for the decision.	**Met**
Area for improvement 4 **Ref**: 6.3.1 **Stated: First Time**	14 out of 16 patients on the ward were assessed as ready for discharge. A number of patients on the ward were admitted due to a breakdown in their community placements. Patients expressed their frustration as their lives were more restricted than necessary. Of note patients who required admission for care and treatment had to wait for a bed to become available. Inspectors were informed that there was a lack of involvement of	**Met**

	consultant psychiatrists and ward nursing staff in the commissioning, planning and delivery of community placements. This applies to the hospital site. There were a lack of meetings between consultants and senior managers.	
	Action taken as confirmed during the inspection: Since the previous inspection the service manager coordinated monthly meetings for hospital and community staff to come together to discuss and plan complex discharges. Since then there were nine meetings. Medical representation was noted at all nine meetings with consultant psychiatrists at seven meetings. The minutes note those present which included, nursing staff, care managers, service and operation managers both from the community and the hospital staff. Issues discussed include; • Availability of placements. • The management structure of the facilities. • Staffing compliment and skill mix in the facilities. Identifying the challenges such as facility staff not reading care plans. • Policy development such as a policy to support outreach and in reach processes. • Reviewing resettlement progress Do any patients require restrictions and how these might be managed	
Area for improvement 5 **Ref**: 5.3.1(a) **Stated: First Time**	Goals were not consistently recorded in patient's care plans. It was noted that goals were documented as interventions and were not specific to the assessed need. For example it was documented that one patient's mode fluctuates and the goal was to promote positive mental health. This would have made the effectiveness of this care plan difficult to measure.	**Partially met**
	Action taken as confirmed during the inspection: Inspectors reviewed care plans for five patients. There was evidence that some progress has been made to address this area for improvement. However there was evidence of an inconsistent approach to recording goals that were specific and measurable. This area for improvement has been assessed as partially and will be restated for a second time.	

7.0 Provider Compliance Plan

Areas for improvement identified during this inspection are detailed in the Quality Improvement Plan (QIP). Details of the QIP were discussed with senior Trust representatives, members of the multi-disciplinary team, ward manager, and ward staff as part of the inspection process. The timescales commence from the date of inspection.

The responsible person must ensure that all areas for improvement identified within the QIP are addressed within the specified timescales. The responsible person should note that failure to comply with the findings of this inspection may lead to escalation action being taken.

7.1 Actions to be taken by the service

The quality improvement plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed quality improvement plan via the web portal for assessment by the inspector by 3 May 2018.

Quality Improvement Plan	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** 5.3.1(a) **Stated:** Second Time **To be completed by 7 June 2018**	Goals were not consistently recorded in patient's care plans. It was noted that goals were documented as interventions and were not specific to the assessed need. For example it was documented that one patient's mood fluctuates and the goal was to promote positive mental health. This would have made the effectiveness of this care plan difficult to measure. **Response by responsible individual detailing the actions taken:** In response to this area of improvement, the ward manager will ensure all registrants attend training in relation to care planning, a section of this training focuses on goal setting.

Name of person (s) completing the QIP	Linda Macartney		
Signature of person (s) completing the QIP	Linda Macartney	**Date completed**	April 2018
Name of responsible person approving the QIP	Martin Dillon		
Signature of responsible person approving the QIP	Martin Dillon	**Date approved**	April 18
Name of RQIA inspector assessing response	Cairn Magill		
Signature of RQIA inspector assessing response		**Date approved**	3/05/2018

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

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Assurance, Challenge and Improvement in Health and Social Care

Unannounced Inspection Report
9 and 10 July 2018

Cranfield Ward 1, Ward 2 and the Psychiatric Intensive Care Unit
Muckamore Abbey Hospital
1 Abbey Road
Muckamore
Co. Antrim
BT41 4SH

Tel No: 02895 042058

Inspectors: Wendy McGregor, Kieran Murray and Dr John Simpson

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

1.1 Terminology explained

Sleeping out
Sleeping out occurs when there are not enough beds for patients in a particular ward. Sleeping out generally occurs when a new patient requires admission to a ward. A patient who has been in the ward and who appears to be settled may be asked to sleep out in another ward until such time as a bed in this ward becomes available.

Trial resettlement
Trial resettlement occurs when a long-term placement has been identified for and with a patient and their family/carers. Patients are afforded the safety of having their place in the hospital protected for a period of time to facilitate a settling in period in their new placement. The resettlement period is concluded when the patient's consultant psychiatrist in consultation with the multidisciplinary community team decides that the patient is sufficiently settled in their new community home.

Trial leave
Trial leave occurs when members of the multi-disciplinary team along with the patient and their family members/ carers agree a discharge plan on a step-down basis. The patient is temporarily discharged from the ward but has access to the ward and members of the hospital multi-disciplinary team. The trial leave period is concluded when the patient's consultant psychiatrist in consultation with the multidisciplinary community team decides that the patient is sufficiently settled in the community.

2.0 Profile of Service

Cranfield Unit is an assessment, care and treatment unit for male patients with a learning disability aged 18 and above, situated on the grounds of Muckamore Abbey Hospital. There are three wards in the Cranfield Unit and each ward has its own specific function. Across the three wards there are 36 beds. Nineteen patients admitted to Cranfield Unit, were detained in accordance with the Mental Health (Northern Ireland) Order 1986.

Cranfield Ward 1
Cranfield Ward 1 is an admission and assessment ward. The purpose of the ward is to provide assessment and treatment to male patients with a learning disability who need to be supported in an acute psychiatric care environment. On the days of the inspection there were eight patients in Cranfield Ward 1 and one patient who was sleeping out on another ward. There was also one patient in Antrim Area Hospital, one patient on trial resettlement and two patients on trial leave.

Cranfield Ward 2
Cranfield Ward 2 provides care and treatment to male patients with a learning disability who have an enduring mental illness, and complex behaviours that challenge. On the days of inspection there were 15 patients in Cranfield Ward 2.

Psychiatric Intensive Care Unit
The Psychiatric Intensive Care Unit (PICU) is a six bedded unit. The purpose of the ward is to provide assessment and treatment to patients with a learning disability who need to be supported in an intensive care environment. During this inspection the ward was at full occupancy with six patients.

Patients in the Cranfield Unit have access to a multi-disciplinary team consisting of nursing, psychiatry, medical, occupational therapy, psychology, behaviour support and social work. Speech and language therapy and physiotherapy are also available on the Muckamore Abbey site on a referral basis.

A patient and carer advocacy service is also available.

3.0 Service Details

Responsible person: Martin Dillon, Chief Executive Officer, Belfast Health and Social Care Trust	**Ward manager:** Cranfield Ward 1 - Oisin McAuley Cranfield Ward 2 - Linda McCartney Cranfield PICU - Sean Murray
Category of care: Learning disability Assessment and Treatment and Psychiatric Intensive Care Unit (PICU)	**Number of beds:** Cranfield Ward 1 - 14 Cranfield Ward 2 - 16 Cranfield PICU - 6
Person in charge at the time of inspection: Cranfield Ward 1 Oisin McAuley Cranfield Ward 2 Audrey Lewis Cranfield PICU Manus Murphy	

4.0 How we inspect

The Regulation and Quality Improvement Authority (RQIA) inspects quality of care under four domains.

- Is care well-led? Under this domain we look for evidence that the ward is managed and organised in such a way that patients and staff feel safe, secure and supported;
- Is care safe? Under this domain we look for evidence that patients are protected from harm associated with the treatment, care and support that is intended to help them;
- Is care effective? Under this domain we look for evidence that the ward or unit or service is providing the right care, by the right person, at the right time, in the right place for the best outcome; and
- Is care compassionate? Under this domain we look for evidence that patients, family members and carers are treated with dignity and respect and are fully involved in decisions affecting their treatment, care and support.

Under each of these domains and depending on the findings of our inspection we may recommend a number of actions for improvement that will form the basis of a Quality Improvement Plan (known as a QIP). Through their QIP the hospital and Trust will put in place measures to enhance the quality of care delivered to patients and to effectively deal with issues we have identified during inspection.

The inspection was underpinned by:

- The Mental Health (Northern Ireland) Order 1986.
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.
- The Human Rights Act 1998.
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

During inspections, the views of and feedback received from patients and service users is central to helping our inspection team build a picture of the care and experienced in the areas inspected. We use questionnaires to facilitate patients and relatives to share their views and experience with us.
Our inspection team also observes communication between staff and patients, staff and relatives/family members and staff and visitors. These observations are carried out by members of our inspection team using the Quality of Interaction Schedule observation tool. This tool allows for the systematic recording of interactions to measure the quality of interactions.

We also facilitate meetings and focus groups with staff at all levels and all disciplines in the areas or services we inspect. We use this information to inform the overall outcome of the inspection and the report produced after the visit.

The following areas were examined during the inspection:

- Care documentation in relation to nine patients focusing on:
  - Podiatry
  - Dietetics
  - Skin care
  - Health screening
  - Elimination
  - Weight
  - Food and Fluid intake records
  - Dentistry
  - Assessments and care plans
- Ward environment.
- Medical cover and GP arrangements
- Treatment kardex's in relation to 30 patients
- Staff knowledge of patients' health care needs
- Temperature of wards
- Minutes of patient forum meetings (ICU)
- Minutes of ward meetings (ICU)

We reviewed the areas for improvements made at the previous inspections and an assessment of compliance was recorded as met and partially met.

5.0 Inspection Summary

An unannounced inspection took place over two days commencing on 9 and concluding on 10 July 2018.

The inspection sought to assess progress with findings for improvement identified during the unannounced inspections of Cranfield Ward 1 on 16 – 18 May 2017, Cranfield Ward 2 on 7 – 8 March 2018 and Cranfield PICU on 5 – 6 February 2018.

The inspectors also reviewed concerns raised by relatives in relation to the management of some aspects of the physical health care needs of patients in the Cranfield Unit. RQIA are aware that some concerns are being managed through the Belfast Health and Social Care Trust's (the Trust) formal complaints procedure.

It was good to note that the three wards had met five out of the six areas for improvement identified at the previous inspections.

- A pharmacist has been recruited for 21 hours per week and is due to commence in September 2018.
- The occupational therapy (OT) service has increased and there are now three full time equivalent OT's on the Muckamore Abbey Site.
- There was evidence that patients received one to one therapeutic interventions every week and this was now recorded in the one to one section on the patient electronic recording system (PARIS) system in Cranfield PICU.
- Patient forum meetings were held on a regular basis and minutes were available in an easy to read format in Cranfield PICU.
- Ward meetings now occurred every month in Cranfield PICU.

One area for improvement in relation to ensuring that goals were consistently recorded in care plans was reviewed. Since the previous inspection a number of staff had received training in this area and there was evidence that staff who had been trained had implemented the training into practice. A new area of improvement has been made to ensure all staff receive this training.

Progress has been made toward the resettlement of patients from hospital to the community since the last inspection. During the inspection, five patients were on trial resettlement or trial leave.

Patient care records reviewed, confirmed that appropriate referrals had been made to hospital medical staff and/or the GP when required. Access to podiatry, dentistry, the tissue viability nurse, physiotherapy and dietetics was good. However, there was no consistent approach to the management and recording of patient's weights and elimination needs.

Nursing staff informed inspectors that the GP evening and weekend service was very beneficial however they stated that access to this service was not always available.

Patients who had been in the Cranfield wards for over a year had not received their GP annual health check. A pilot scheme ran for three months with the aim of developing a physical health care pathway for patients and this had commenced on another ward on the Muckamore Abbey Hospital site, but was not extended to all wards.

Patient and staff interactions were observed as positive. Staff were respectful toward patients and maintained their privacy. Staff attended to patients who required assistance promptly. Staff confirmed that the care on the wards was safe, effective and compassionate. However they highlighted concerns in relation to reduced staffing levels and the increased use of agency staff. RQIA are aware that there are ongoing difficulties with the recruitment of staff. The Trust have informed RQIA of their efforts to address this challenge.

The environment in the three wards was clean and tidy and the temperature of each ward was comfortable.

The findings of this report will provide the Trust with the necessary information to assist them to fulfil their responsibilities, enhance practice and service user experience.

5.1 Inspection Outcome

Total number of areas for improvement	Four

These are detailed in the Quality Improvement Plan (QIP).

The inspection focused on reviewing areas for improvement from previous inspections and on concerns received from relatives in relation to the management of some aspects of the physical health care needs of patients.

6.0 The inspection

Areas of good practice

Staffs' knowledge of patients' physical health needs
Staff demonstrated they had a good knowledge of patient's health care needs. Patients' physical health care needs were assessed on admission and reviewed at their weekly multidisciplinary meetings. Inspectors noted that patients had an up to date care plan in place to address a physical health care need where identified. Care plans reviewed were up to date. Patients' health care needs were reviewed on a daily basis and this was recorded in the patients' daily progress notes.

There was evidence that when patients were assessed as requiring their food and fluid intake to be monitored, a record was maintained. Fluids were being offered and readily available during the days of the inspection.

Care documents reviewed, evidenced that patients who presented with concerns in relation to their physical health were appropriately referred to the medical team and were seen promptly. There was evidence that care plans were developed from the outcome of these appointments and updated regularly.

The inspector observed a handover meeting from night staff to day staff. The handover detailed any concerns in relation to patients' health from the day before and during the night. The office telephone rang during handover and it was good to note that patients' confidentiality was maintained during the handover as the night nurse suspended the handover until the phone call ended.

Inspectors noted that all patients had routine blood screening completed. Patients who require specific blood screening for medication monitoring and physical health conditions had this completed. Blood results were all recorded and available on the PARIS system and could be easily reviewed.

Access to primary health care
Access to podiatry and dentistry was satisfactory and available on site once a week. There was evidence that patients requiring treatment were referred and seen promptly. Patients also have access to a dental hygienist who visits the ward. The inspector noted that podiatry records were maintained on the patient electronic recording system (PARIS).

Access to physiotherapy and dietetics was by referral and there was evidence that patients who were referred were seen promptly. Access to Speech and Language Therapy (SALT) was good. When concerns were identified in relation to patients' swallow, a prompt assessment or review was completed by SALT and care plans were updated accordingly. Patients also had an assessment completed in relation to their communication needs. There was evidence that patients were seen by the physiotherapist when assessed as requiring this support.

Medication
Inspectors observed staff administering medication and reviewed patients' treatment kardex's. Medication administration observed, was completed in accordance with Nursing and Midwifery standards for the administration of medication. The dispensing of medicine administered by percutaneous endoscopic gastrostomy (PEG) tube was completed in accordance with procedural guidelines. Patient's treatment kardex's were completed to a good standard and medication was prescribed in accordance with the British National Formulary. There was evidence that patients who were prescribed antipsychotic medication were monitored, although no monitoring tool was used, it was recorded in the patients' care plans and progress notes. Echo Cardiograms (ECG) were two weeks behind but a mechanism is now in place to address this.

Staff and patient interactions.
During the inspection the inspectors observed staff working practices and interactions with patients using a Quality of Interactions Schedule Tool (QUIS).

Interactions between multidisciplinary staff and patients were positive. Staff were courteous and responded promptly to patients requiring support or assistance. Staff were offering patients a choice of drinks and food and were empathetic and compassionate towards patients and interested in finding out about the patients' day. Staff gave good explanations to patients and sought consent when supporting patients with their physical health care needs. Members of the multidisciplinary team including physiotherapy and behaviour support services, visited the wards frequently during the day to see patients in accordance with their care plans.

Ward environment
There had been ongoing complaints in relation to the temperature of the ward being too hot. Staff said that the ward can be too hot when the temperature outside rises. The Trust has reviewed this and are piloting a heat deflector film on sky light windows in Cranfield Ward 1. This will be reviewed in one month. The temperature on the ward during the inspection was comfortable. Although of note, the temperature outside was normal.

Staff views
Staff said that staffing levels continue to be reduced although they were satisfied that care on the wards was safe, effective and compassionate. Some staff raised concerns in relation to the use of agency staff and said they hadn't been trained in the Management of Actual or Potential Aggression (MAPA). This was raised with senior management at the conclusion of

the inspection. Senior management confirmed that training had been organised for the week beginning 23 July 2018 for all agency staff. This training will be provided and funded by the Trust. Following the inspection we received confirmation that agency staff have now completed their training.

Areas for Improvement

Bowel care
There was no evidence of a consistent approach to the monitoring, review and recording of patients who have a history of constipation or who required support with bowel care. There was no system in place to ensure laxatives are administered as prescribed. Treatment kardex's should clearly identify when the medication should be administered. This should be agreed by the multidisciplinary team.

Weight management
There was no consistent approach to the management of patient's weights. There was no agreement regarding the frequency of weighing patients.

Dental care records
Dental records were not recorded on the patient electronic recording system (PARIS)

Access to GP service at evenings and weekends
Staff reported that onsite access to the GP was not always available in the evenings and weekends. Senior trust representatives advised that the GP service was available every day however there was no mechanism in place to track how frequently this service was required in the evening and weekends against the frequency of it being available.

Physical healthcare pathways
Patients who have been in hospital for more than a year had not received a GP annual health check or appropriate health screening in accordance with Department of Health screening directives.

Inspectors were informed by staff that a pilot (with the aim of developing a physical health care pathway) had commenced but finished after three months as the staff member leading the pilot had left their post. This was a good initiative which had commenced on another ward in the hospital but had not been completed on the remainder of the wards. Trust senior management stated that an advertisement has been sent to the Antrim GP federation requiring a GP for two sessions a week. It is expected that the GP appointed would continue with the development of the physical health care pilot and progress with the GP annual health check thereby ensuring patients who have been in Muckamore Abbey Hospital for over a year have equal access to services.

6.1 Review of areas for improvement from the last inspection

Prior to this inspection, Cranfield Unit was inspected on an individual ward basis. These inspections were unannounced inspections. The completed Quality Improvement Plans (QIP's) were returned and approved by the responsible inspector. These QIP's were validated by inspectors during this inspection.

Follow-up on recommendations made following the unannounced inspection in Cranfield Male Ward 1 on 16 to 18 May 2017

Areas for Improvement		Validation of Compliance
Number 1 **Ref**: Quality Standard 5.3.1 (e) **Stated:** First Time	The Trust should ensure that patients and staff can access pharmacy services based within the hospital site.	**Met**
	Action taken as confirmed during the inspection: Senior management informed inspectors that a pharmacist has now been recruited to work 21 hours per week in the hospital and will commence employment in September 2018. This area has been assessed as met. Pharmacy services will be reviewed on the next inspection of Muckamore Abbey Hospital.	
Number 2 **Ref**: Quality Standard 5.3.1 (e) **Stated:** First time	The Trust should ensure that patients in Cranfield Male Ward 1 can access a ward based occupational therapist at least two and a half days per week.	**Met**
	Action taken as confirmed during the inspection: The OT service has increased on the Muckamore Abbey site to three whole time equivalents. OT services are available on every ward. There was evidence that patients were appropriately referred to OT services and promptly received this service. This area for improvement has been assessed as met. RQIA will continue to monitor the OT service during the next inspection of Muckamore Abbey hospital.	

Follow-up on recommendations made following the unannounced inspection Cranfield Male Ward 2 on 7 to 8 March 2018

Areas for Improvement		Validation of Compliance
Number 1 **Ref**: Quality Standard 5.3.1 (a) **Stated:** Second Time	Goals were not consistently recorded in patient's care plans. It was noted that goals were documented as interventions and were not specific to the assessed need. For example it was documented that one patient's mood fluctuates and the goal was to promote positive mental health. This would have made the effectiveness of this care plan difficult to measure.	**Met**
	Action taken as confirmed during the inspection: Inspectors were informed that all staff were undergoing training in relation to ensuring care plans are goal based and could be measured for effectiveness. On Ward 2, three out of seven trained staff have received this training and four staff were attending this training during the inspection. Inspectors reviewed four care plans. Appropriate goals were recorded in only one out of the four care plans reviewed. This care plan had been completed by a staff nurse who had attended the training which evidenced that the training was effective. There was no change in relation to the setting of appropriate goals in the other three care plans reviewed. RQIA agreed to assess this area as met. Whilst, not all staff had been trained in care planning, there was evidence that staff who had been trained had implemented the training by writing care plan goals which could be measured. Although this area has been assessed as met a new area for improvement has been made to ensure all staff receive this training.	

Follow-up on recommendations made following the unannounced inspection of Cranfield Psychiatric Intensive Care Unit (PICU) on 5 to 6 February 2018

Areas for Improvement		Validation of Compliance
Number 1 **Ref**: Quality Standard 5.3.1 (f) **Stated:** Second Time	There was a section on the patient electronic recording system (PARIS) system to record weekly 1:1 therapeutic intervention by nursing staff. However, a number of staff had recorded this intervention in the progress records. Therefore it was difficult to track the patients' progress	**Met**
	Action taken as confirmed during the inspection: Inspectors reviewed the patient electronic recording system in relation to all six patients in PICU. There was evidence that patients received 1 to 1 therapeutic intervention every week and this was recorded in the 1 to 1 therapeutic intervention/weekly interviews section on the PARIS system. This area for improvement has been assessed as met.	
Number 2 **Ref**: Quality Standard 8.3 (a) **Stated:** Second time	Patient forum meetings were not held on a regular basis on the ward, the minutes of these meetings were not recorded in an easy to ready format and information was not displayed regarding the next patient forum meeting.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed the records retained for patient forum meetings. Patient forum meetings were held on a regular basis and minutes were available in an easy to read format. This area has been assessed as met.	
Number 3 **Ref**: Quality Standard 4.3 (a) **Stated:** First Time	Ward managers meetings were not held regularly.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed the records maintained for the ward meetings and noted that they now occur every month. This area has been assessed as met.	

7.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with senior trust representatives, members of the multi-disciplinary team, ward manager, and ward staff as part of the inspection process. The timescales commence from the date of inspection.

The responsible person must ensure that all areas for improvement identified within the QIP are addressed within the specified timescales. The responsible person should note that failure to comply with the findings of this inspection may lead to escalation action being taken.

7.1 Actions to be taken by the Service

The quality improvement plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed quality improvement plan to RQIA via the web portal for assessment by the inspector by 15 March 2019.

Quality Improvement Plan

The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** Quality Standard 5.3.1 (a) **Stated:** First time **To be completed by:** 10 January 2019	It is recommended that all nurses receive training in the writing of care plans to ensure goals are written in such a manner that patient's progress can be measured.
	Response by responsible individual detailing the actions taken: In response to this recommendation, training for nurses in the writing of care plans to ensure goals are written in such a manner that patient's progress can be measured is ongoing. Guidance on writing goals has been shared with all registrants.
Area for Improvement No. 2 **Ref:** Quality Standard 5.3.1 **Stated:** First time **To be completed by:** 10 September 2018	It is recommended that patients have access to a GP service to ensure their health care needs are being met in a timely manner.
	Response by responsible individual detailing the actions taken: In response to this area of improvement, Muckamore Abbey Hospital currently provides evening and weekend GP services for patients; however, the hospital is working towards having a dedicated daytime GP GMS Like Service to be run as a typical community GP Clinic where patients would book in for all their physical health care needs. The hospital has provided two expressions of interest with both the Belfast and Northern Trust GP Federation services without success, currently the hospital is working with the contracts department to explore what other options are available to allow engagement with a GP/GP's on a regular weekly basis.
Area for Improvement No. 3 **Ref:** Quality Standard 5.3.1 (a) **Stated:** First time **To be completed by:** 10 January 2019	It is recommended that patient's physical health care needs are routinely assessed by relevant health care staff and the necessary actions are taken to address any identified deficits. All relevant interventions must be appropriately documented in the patient's health care records.
	Response by responsible individual detailing the actions taken: In response to this area of improvement, the wards are developing a physical health pathway to supplement the nursing assessment, based on NICE guidelines. The named nurse will routinely assess on admission and on specified times based on individual need and any necessary actions taken to address any identified deficits. All relevant interventions are appropriately documented and reviewed in the patient's plan of care. Medical entries on Paris are now recorded in Casenote (medical) and are easily assessable.

Area for Improvement No. 4 **Ref:** Quality Standard 6.3.1 (a) **Stated:** First time **To be completed by:** 10 December 2018	It is recommended that the Trust develops and implement a robust governance system to ensure all patient's physical health care needs are met.
	Response by responsible individual detailing the actions taken: In response to this area of improvement, Muckamore Abbey Hospital currently provides evening and weekend GP services for patients; however, the hospital is working towards having a dedicated daytime GP GMS Like Service to be run as a typical community GP Clinic where patients would book in for all their physical health care needs. The hospital has provided two expressions of interest with both the Belfast and Northern Trust GP Federation services without success, currently the hospital is working with the contracts department to explore what other options are available to allow engagement with a GP/GP's on a regular weekly basis. The wards are also developing a physical health pathway to supplement the nursing assessment, based on NICE guidelines. The named nurse will routinely assess on admission and on specified times based on individual need and any necessary actions are taken to address any identified deficits.

Name of person (s) completing the QIP	Oisin McAuley Judith Glenholmes Linda MacCartney Jenni Armstrong		
Signature of person (s) completing the QIP	Oisin McAuley Judith Glenholmes Linda MacCartney Jenni Armstrong	**Date completed**	18 March 19
Name of responsible person approving the QIP	Martin Dillon		
Signature of responsible person approving the QIP	Martin Dillon	**Date approved**	18 March 19
Name of RQIA inspector assessing response	Wendy McGregor		
Signature of RQIA inspector assessing response	Wendy McGregor	**Date approved**	18 March 2018

Please ensure this document is completed in full and returned to RQIA via the web portal

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Assurance, Challenge and Improvement in Health and Social Care

Unannounced Inspection Report
22 November 2018

Cranfield Ward 1
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Tel No: 02895 042058

Inspectors: Wendy McGregor and Alan Guthrie

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Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of Service

Cranfield ward 1 is a twelve bedded ward on the Muckamore Abbey Hospital site. The purpose of the ward is to provide assessment and treatment to male patients with a learning disability who need to be supported in an acute psychiatric care environment. On the day of the inspection there were 12 patients admitted to the ward. Five patients were detained under the Mental Health (Northern Ireland) Order 1986. There were six patients on the ward whose discharge from hospital was delayed.

Patients within the ward receive support from a multidisciplinary team (MDT) which includes: psychiatry; nursing; clinical psychology, behavioural support and social work professionals. A patient advocacy service is also available.

3.0 Service details

Responsible person: Martin Dillon, Chief Executive Officer, Belfast Health and Social Care Trust	**Ward Manager:** Oisin McAuley (Acting ward manager)
Category of care: Learning Disability	**Number of beds:** 12
Person in charge at the time of inspection: Morning – Staff Nurse Bronagh Agnew Afternoon – Acting ward manager Oisin McAuley	

4.0 How We Inspect

To prioritise the areas we visit, we consider a range of factors including risk, quality and the context of the services.

These may include, for example, a ward:

- where previous inspections or our intelligence monitoring has flagged a concern or risk
- about which we have received a complaint, there has been a safeguarding alert or we have heard a disclosure from a whistle blower
- we have not inspected for a long period
- we have been made aware of areas of good practice
- a request has been made by the Department of Health, Health and Social Care Board or Public Health Agency
- which have been subject to serious adverse incident(s) and or media attention

We review a range of intelligence relevant to the service including: ward performance reports, use of Mental Health (NI) Order (1986) (MHO) legislation, quality indicators, quality improvement plans and ward and trust wide governance documents.

Each ward is assessed using an inspection framework. The inspection methods used include; discussion with patients and relatives, observation of practice; focus groups with staff and review of documentation. Records examined during the inspection include: nursing records, medical records, senior management and governance reports and minutes of meetings, staffing levels and rotas, performance reports and training records.

4.1 Inspection summary

An unannounced inspection took place on 22 November 2018.

The purpose of the inspection was to assess if the Trust's safeguarding procedures had been followed to support and help ensure the safety of a patient. The inspection was assessed as necessary following receipt of information, of a safeguarding nature, in respect of a specific patient being brought to our attention.

Inspectors visited the ward and reviewed the care and treatment and safeguarding processes in place for the patient. Inspectors evidenced the following outcomes:

Good practice

- There were comprehensive multi-disciplinary assessments in place for the patient. The assessments identified the patient's complex, physical and behavioural needs;
- Safeguarding processes were adhered to in every event that a concern was raised regarding the patient;
- A safeguarding vulnerable adult protection plan was in place;
- Communication between the ward staff and the patient's family was good.

Inspectors were concerned that

- The patient's discharge was delayed and they no longer required to remain in hospital;
- Coordination and oversight of the patient's care and treatment plans required improvement;
- Staff were not consistently recording aspects of the patient's physical health care such as their weight, elimination records and food and fluid records. We previously made an area for improvement regarding the management of patients' physical health care needs. The quality improvement plan (QIP) from the previous inspection was not reviewed as part of this inspection. However, inspectors were concerned that the management of patient's physical health care needs continued to be a concern. Subsequently, this area for improvement will be stated for a second time.

4.2 Inspection outcome

Following our inspection we provided feedback on our findings to the ward manager. This feedback, delivered by the lead inspector highlighted the areas of good practice and identified areas for improvement. The inspection considered the following areas specific to the patient's care and treatment.

Safeguarding arrangements for the Patient

Inspectors reviewed the safeguarding arrangements for the patient. Five safeguarding referrals had been made and these were at different stages of the safeguarding process. Inspectors reviewed safeguarding referrals that had been made recently and referrals that had progressed to investigation by a designated adult protection officer (DAPO). Inspectors noted no concerns in relation to the management and investigation of safeguarding referrals for this patient.

Allegations against staff were being investigated external to the Trust and in accordance with the regional adult safeguarding policy and procedure. The safeguarding lead for the Belfast Trust was co-ordinating and facilitating the investigations and reviews.

Protection plans for the patient were being implemented and recorded in the patient's care records. The protection plans detailed the following actions to help ensure the patient's safety and wellbeing:

- The patient was prescribed level 3 enhanced observations supported by two staff at all times. This was to ensure that should the patient make an allegation this is witnessed by two staff. The patient's continued need for enhanced observations was reviewed weekly by the ward's MDT. However, inspectors were concerned that the presence of two staff at all times was not clinically required. An area for improvement to review the level of observations required has been made.
- A staff member whom the patient had identified as someone they did not wish to work with them had been reassigned and did not provide any direct care to the patient.
- Visits continued to be supervised.
- The patients care records indicated that they had a long history of unexplained scratches and marks. As a result body charts were being completed by two staff each morning and evening. Over the period 15 to 22 November 2018 there was limited variation of

presenting marks. Inspectors were concerned that this level of body mapping was overly intrusive. An area for improvement has been made to review the level of body mapping for this patient. Inspectors also suggested that the use of the body charts should be reviewed by the safeguarding team to ensure that the patient's capacity and right to privacy is considered alongside the necessity of completing the body charts. The patient was residing in a separate living space within Cranfield Ward 1. Close circuit television (CCTV) was not available in the patient's living room and dining room areas. The ward social worker and ward manager confirmed that there are plans to install CCTV in the two areas.

It was the view of inspectors that Trust staff had adhered to the regional adult safeguarding policy and procedures. Areas for improvement in relation to the level of enhanced observations and the frequency of completing body maps have been made.

The allegation that ward staff and the Trust were not following proper procedures in relation to safeguarding the patient was not substantiated.

The Patient's care and treatment

The patient's living space was located in a private area within the ward. The area had a bedroom with en-suite facilities, an activity room/ living room and dining room. The area had its own entry from outside and could also be accessed through the ward.

A range of MDT assessments were in place. These included assessments and care plans for communication, behaviour and needs, physical health, psychology, nutritional needs, activities of daily living and day time activities. Each assessment was comprehensive and based on the patient's presenting needs.

Ward staff complete daily reviews of the patient's progress and circumstances. Reviews included; a fluid and food intake record, elimination records, antecedent behaviour and consequence (ABC) charts and an exit strategy to ensure consistency by staff when they need to leave the room as a result of the patient becoming unsettled.

Inspectors noted that there was MDT involvement in the patient's care and treatment. However, no one individual staff member had complete oversight of the patient's circumstances and progress. It is recommended that the MDT identify a named worker who will review all of the patient's assessments, reviews, daily monitoring records and daily evaluation. The named worker will help ensure consistency of approach in providing the patient's care and treatment and in reporting to the MDT.

The patient had a number of physical health concerns. Care records detailed that appropriate medical assessments and required treatments had been completed. The patient's records detailed a history of the patient presenting with marks and scratches. The history dated back to 2012 when concerns regarding marking were reviewed by paediatric services. The records indicated that there were multiple cuts on the patient's arms and legs currently as a result of them picking their skin.

The patient continued to be reviewed by the dietician and was prescribed dietary supplements in an attempt to support weight gain. A care plan detailed that the patient's weight should be monitored weekly and bowel movements and fluid / food intake should be monitored daily.

Inspectors were concerned to note that the patient's weight, food/fluid intake and bowel movements had not been monitored consistently. It was not clear if the patient's weight, food/fluid intake and bowel movements had been reviewed by the MDT. An area for improvement with respect to the monitoring of patients physical health care needs and action taken as necessary has been stated for a second time.

It is has also been recommended that the MDT identify a staff member who will have full oversight of the patient's assessments including: mental health, physical health monitoring, behaviour support and discharge planning. This will support an overall view of the patient's presentation and allow greater opportunity to assess potential casual factors between the patient's behaviour and their physical health.

Despite the patient being ready to be discharged from the ward a suitable community placement was not available. Ward staff maintained ongoing contact with their colleagues in the community teams and potential placement providers continued to be assessed. The Trust ensured that the Health and Social Care Board remained informed regarding the patient's circumstances.

The findings of this report will provide the Trust with the necessary information to assist them to fulfil their responsibilities, enhance practice and service user experience.

Total number of actions for improvement	Four

The four areas for improvement comprise of two new areas for improvement and two areas for improvement which will be stated for a second time. These are detailed in the Quality Improvement Plan (QIP).

Areas for improvement and details of the QIP were discussed with the ward manager and ward staff as part of the inspection process. The timescales for completion commenced from the date of inspection.

Escalation action did not result from the findings of this inspection. The escalation policies and procedures are available on the RQIA website.
https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

5.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with the ward manager, and ward staff as part of the inspection process. The timescales commence from the date of inspection.

The responsible person must ensure that all areas for improvement identified within the QIP are addressed within the specified timescales. The responsible person should note that failure to comply with the findings of this inspection may lead to escalation action being taken.

5.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

5.2 Actions to be taken by the service

The quality improvement plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed quality improvement plan to RQIA via the web portal for assessment by the inspector by **15 March 2018.**

Quality Improvement Plan

The responsible person must ensure the following findings are addressed:

Area for Improvement No. 1 **Ref:** Quality Standard 5.3.1 (c) **Stated:** First time **To be completed by**: Immediate and ongoing	The ward's MDT must ensure that enhanced observations prescribed to patients are proportionate, appropriate and based on the patient's assessed needs. **Response by responsible individual detailing the actions taken:** In response to this area of improvement, enhanced observations prescribed to patients are discussed at the MDT meeting each week to ensure they are proportionate, appropriate and based on the patient's assessed needs. This is recorded on the MDT case conference record.
Area for Improvement No. 2 **Ref:** Criteria 5.3.3 (b) **Stated:** First time **To be completed by:** Immediate and ongoing	The ward's MDT should identify one member of staff to review all of the patient's assessments, care plans, behaviour plans, daily monitoring records (including body maps) and daily evaluations. This will help ensure consistency in the provision of care and during reviews of the patient's progress. **Response by responsible individual detailing the actions taken:** In response to this area of improvement, all patients have a named nurse and an associate nurse responsible for reviewing the patient's assessments, care plans, behaviour plans, daily monitoring records (including body maps) and daily evaluations.
Area for Improvement No. 3 **Ref:** Quality Standard 5.3.1 (a) **Stated:** Second time **To be completed by:** Immediate and ongoing	It is recommended that patient's physical health care needs are routinely assessed by relevant health care staff and the necessary actions are taken to address any identified deficits. All relevant interventions must be appropriately documented in the patient's health care records. **Response by responsible individual detailing the actions taken:** In response to this area of improvement, the ward is developing a physical health pathway to supplement the nursing assessment, based on NICE guidelines. The named nurse will routinely assess on admission and on specified times based on individual need and any necessary actions are taken to address any identified deficits. All relevant interventions are appropriately documented and reviewed in the patient's plan of care. Medical entries on Paris are now recorded in Casenote (medical) and are easily assessable.
Area for Improvement	It is recommended that a system should be put in place by the MDT to

No. 4 **Ref:** 5.3.1 (a) **Stated:** Second time **To be completed by**: Immediate and ongoing	ensure that bowel and weight management care practices and recordings are consistent and adhered to.
	Response by responsible individual detailing the actions taken: In response to this area of improvement, if a patient has an identified need relevant to elimination, a paper record of bowel movement is completed for the duration an intervention is required. If a patient is independent re elimination, this will recorded in their notes and staff ask re bowel movements, easy read documentation is available if required. Weight management is recorded at a minimum of monthly in the assessment details of the patients LD nursing assessment.

Please ensure this document is completed in full and returned to RQIA via the web portal

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Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority

Unannounced Inspection Report
26, 27 & 28 February 2019

Belfast Health and Social Care Trust

Muckamore Abbey Hospital

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Assurance, Challenge and Improvement in Health and Social Care

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Paulina Spychalska	Inspection Coordinator Regulation and Quality Improvement Authority
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Abbreviations

AHP	**Allied Health Professionals**
BHSCT	Belfast Health and Social Care Trust
DoH	Department of Health
MAH	Muckamore Abbey Hospital
MDT	Multi-disciplinary Team
MHO	Mental Health(Northern Ireland) Order 1986
NHSCT	Northern Health and Social Care Trust
OCP	Office of Care and Protection
PICU	Psychiatric Intensive Care Unit
QIP	Quality Improvement Plan
RQIA	Regulation and Quality Improvement Authority
SEHSCT	South Eastern Health and Social Care Trust

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of the service

Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability Hospital managed by Belfast Health and Social Care Trust (BHSCT). The hospital provides inpatient care to adults 18 years and over who have a learning disability and require care and treatment in an acute psychiatric care setting. Patients are admitted either on a voluntary basis or in accordance with the Mental Health (Northern Ireland) Order 1986.

MAH provides a service to people with a Learning Disability from BHSCT, Northern Health and Social Care Trust (NHSCT) and South Eastern Health and Social Care Trust (SEHSCT). There were 83 beds in the hospital at the time of the inspection. The Psychiatric Intensive Care Unit (PICU) had temporarily closed on 21 December 2018 and has remained closed since.

At the time of the inspection there were five wards on the MAH site:

- Cranfield One (Male assessment)
- Cranfield Two (Male treatment)
- Ardmore (Female assessment and treatment)
- Six Mile (Forensic Male assessment and treatment)
- Erne (Long stay/re-settlement).

A hospital day care service was also available for patients.

On the days of the inspection there were 67 patients receiving care and treatment in MAH.

3.0 Service details

Responsible person: Mr Martin Dillon Belfast Health and Social Care Trust (BHSCT)	**Position:** Chief Executive Officer
Category of care: Acute Mental Health & Learning Disability	**Number of beds:** 83
Person in charge at the time of inspection: Mairead Mitchell, Interim Co- Director, Learning Disability Services, Adult Social and Primary Care Directorate, BHSCT.	

4.0 Inspection summary

We undertook an unannounced inspection to MAH over three days commencing on 26 February 2019 and concluding on 28 February 2019. All five wards were visited over the course of the inspection.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).
We employed a multidisciplinary inspection methodology during this inspection. The multidisciplinary inspection team examined a number of aspects of the hospital, from front line care and practices, to management and oversight of governance across the organisation. We met with individual staff members and various staff groups, patients and a small number of relatives, observed care practice and reviewed relevant records and documentation to support the governance and assurance systems.

Key Findings

We noted some measures which had recently been introduced to improve staff well-being, additional pharmacist input to wards had been secured and day care staff were in reaching into the wards. We were unable to determine that these measures were having the desired impact on patient care and treatment.

We identified both a structural and a psychological disconnect in relation to communication between clinical/ward based staff and hospital management. We noted the significant impact the recent abuse allegations, the ongoing police investigation and staff suspensions were having on staff, leading to poor morale amongst the staff groups in each of the wards we visited.

Overall we observed a reactive and crisis approach to management. We did not find effective arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to patients and proactive identification of issues in relation to the safety and quality of some aspects of care.

Governance arrangements were found to be insufficiently developed to be capable of providing assurance to BHSCT that services in MAH are safe and well led. We suggested that additional resources and external support was required. This is necessary to provide robust assurance of the quality and safety of care provided in the hospital, to ensure appropriate planning for transition of identified patients from the hospital to suitable community placements and to define the hospital's overall purpose within the wider HSC system (current and future).

During this inspection we identified six areas of significant concern in relation to the following overarching themes emergent:

- Staffing;
- Patients' physical health care needs;
- Financial governance;
- Safeguarding;
- Restrictive practices (seclusion); and
- Hospital governance.

We provided feedback to BHSCT senior management team on 1 March 2019. At this meeting we informed BHSCT that RQIA had serious concerns in relation to the care, treatment and services as provided for patients in MAH in respect of the emergent themes.

In response to our ongoing concerns we invited the Chief Executive and up to four BHSCT colleagues to attend a meeting at RQIA on 7 March 2019 as it was our intention to serve six Improvement Notices to BHSCT in respect of MAH.

We also wrote to the Department of Health (DoH) in accordance with the provision of Articles 4 and 35 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. We advised the DoH of our serious concerns in relation to care, treatment and services provided for patients at MAH and recommended that the DoH agrees and implements a special measure for BHSCT in relation to MAH. The recommendation was made with a view to supporting BHSCT (and the other two HSC Trusts served by MAH), to improve care and treatment of patients currently in MAH, to ensure appropriate governance systems/arrangements are in place, and to ensure appropriate planning for patients who have completed their active assessment/treatment and who will relocate out of MAH to accommodation in the community over the coming months.

At our Intention to serve six Improvement Notices meeting on 7 March 2019, representatives from three of the HSC Trusts who have patients receiving care and treatment at MAH were provided with an opportunity to outline and discuss evidence/information relating to each of the six areas of concern identified. After thorough consideration of BHSCT representation at our meeting on 7 March 2019 and of the additional information provided by BHSCT to RQIA on 8 March 2019, we determined not to serve Improvement Notices to BHSCT at this point in time. We advised BHSCT that we will continue to closely monitor each of the six areas of concern and the quality of care and treatment delivered to patients in MAH. We advised that we will seek evidence of improvement resulting from the actions/measures BHSCT is now progressing as the main provider of care in MAH and/or in conjunction with other providers, in particular with NHSCT and SEHSCT.

Following our determination not to serve Improvement Notices to BHSCT we also wrote to the Department of Health (DoH) on 14 March 2019 in accordance with the provision of Articles 4 and 35 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to update them about our determination. At this time we advised that our recommendation that the DoH agrees and implements a special measure for BHSCT in relation to MAH remained valid.

4.1 Inspection outcome

Total number of areas for improvement	11

We identified 11 areas for improvement in relation to the six emergent themes arising from this inspection. These relate to:

- Staffing
- Safeguarding
- Close Circuit Television (CCTV)
- Restrictive practices (seclusion)
- Patient observations
- Management of medicines

- Patients' physical health care needs
- Discharge planning
- Strategic planning & communication
- Hospital governance
- Financial governance

Detailed findings of this unannounced inspection were shared with the BHSCT senior management team during a feedback session held on 1 March 2019. At this meeting we advised that RQIA had serious concerns in relation to care, treatment and services as provided for patients in MAH in respect of the emergent themes.

In response to our ongoing concerns we invited the Chief Executive and up to four BHSCT colleagues to attend an Intention to serve six Improvement Notices meeting at RQIA on 7 March 2019. We also wrote to DoH recommending the implementation of a special measure for BHSCT in respect of MAH.

After thorough consideration of BHSCT representation at our meeting on 7 March 2019 and of the additional information provided by the BHSCT to RQIA (8 March 2019), we determined not to serve Improvement Notices to BHSCT at this point in time. We advised BHSCT that we will continue to closely monitor each of the six areas of concern and the quality of care and treatment delivered to patients in MAH. We also wrote to the DoH to update them about our determination. At this time we advised that our recommendation that the DoH agrees and implements a special measure for BHSCT in relation to MAH remained valid.

The Quality Improvement Plan (QIP) should be completed and detail the actions taken to address the areas for improvement identified. The timescales for implementation of these improvements commence from the date of this inspection.

4.2 Action/enforcement taken following our most recent inspections

The most recent inspections of the wards were as detailed:

Erne Ward: No further actions were required following the most recent unannounced inspection on 24 October 2017.
Donegore: No further actions were required following the most recent unannounced inspection on 17 and 18 May 2017.
Killead: No further actions were required following the most recent unannounced inspection from 2 October to 4 October 2017.
Cranfield PICU: Cranfield PICU was closed temporarily on 21 December 2018 and has remained closed since.
Cranfield One: No further actions were required following the most recent inspection on 22 November 2018.
Cranfield Two: No further actions were required following the most recent inspection on 9 and 10 July 2018.

N.B. RQIA were notified on 7 December 2018 that the BHSCT had restructured Killead and Donegore wards and amalgamated the staff team into one ward. The new ward was renamed Ardmore.

Other than those actions detailed in the QIP's no further actions were required to be taken.

5.0 How we inspect

Prior to this inspection a range of information relevant to MAH was reviewed, including the following records:

- Previous inspection reports
- Serious Adverse Incident notifications
- Information on Concerns
- Information on Complaints
- Other relevant intelligence received by RQIA

Each ward is assessed using an inspection framework. The methodology underpinning our inspections includes; discussion with patients and relatives, observation of practice, focus groups with staff involved in all functions from across the hospital and review of documentation. Records examined during the inspection include; nursing records, medical records, senior management and governance reports, minutes of meetings, duty rotas and training records.

Questionnaires were provided to patients during the inspection by the lay assessor on behalf of RQIA. Returned completed patient questionnaires were analysed following the inspection.

We invited staff to complete an electronic questionnaire during this inspection. We did not receive any returned completed staff questionnaires following this inspection.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspections

Erne Ward: The most recent inspection was an unannounced inspection on 24 October 2017. There were no areas for improvement identified as a result of that inspection.

Donegore and Killead amalgamated on 7 December 2018 to become Ardmore ward. Prior to amalgamation they were inspected individually.

Donegore: The most recent inspection was an unannounced inspection on 17 and 18 May 2017. There were no areas for improvement identified as a result of that inspection.

Killead: The most recent inspection was an unannounced inspection from 2 October 2017 to 4 October 2017. Seven areas for improvement were identified as a result of that inspection. These areas related to speech & language therapy recommendations, ligature risk assessment, complaints management, fire safety, environment, care plan management and lack of clinical pharmacy support. These areas of improvement were reviewed as part of this inspection.

PICU: Was closed temporarily on 21 December 2018 and has remained closed since.

Cranfield One: The most recent inspection was an unannounced inspection on 22 November 2018. Four areas for improvement were identified as a result of that inspection. These areas related to the management of patient observations and the management of patients physical health care. These areas were reviewed as part of this inspection.

Cranfield Two: The most recent inspection was an unannounced inspection from 9 to 10 July 2018. Four areas for improvement were identified as a result of that inspection. These areas related to the management of patients physical health care and were reviewed as part of this inspection.

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

6.3.1 Staffing

We observed that nursing staff throughout the wards were responsive to patient requests and managed them in a caring manner. Staff described the multidisciplinary team (MDT) within each of the wards as being patient centred and safety focused.

We reviewed patient care records and evidenced that patient progress and safety was being monitored and regularly reviewed by nursing staff. It was noted that each patient's care pathway/plan was reviewed on a weekly basis.

Discussions with staff and a review of duty rotas evidenced that the nursing staff complement for MAH for the week commencing 26 February 2019 was subject to significant deficits. This was as a result of a combination of long-term sickness absence, precautionary suspensions, maternity leaves and unfilled vacant posts.

There was evidence of insufficient staffing at ward level to meet patients' prescribed level of observation, to implement and execute appropriate therapeutic care plans for patients, or to appropriately manage patients' physical health care needs. We evidenced insufficient staffing at ward level on each day of the three day inspection visit. Staff of all grades throughout the hospital site informed us there was insufficient staffing at ward level. Due to staff shortages at ward level, staff are at times unable to appropriately fulfil their responsibilities and this is impacting on the quality and assurance of care delivered and is in itself a source of anxiety for staff.

We noted good evidence of psychology assessments and positive behaviour support (PBS) plans for patients who presented with challenging behaviour. These plans were being regularly reviewed and adapted to meet patients' needs. However, there was limited evidence that PBS plans were being incorporated into care plans and interventions undertaken by nursing staff. Inspectors noted that specialist behavioural nurses were rostered to general duties on wards. This was having a significant impact upon the availability of support to implement patients' PBS plans. We noted that this was having a detrimental effect for patients and staff.

Staff informed us that they were unable to attend training due to low numbers of staff available at ward level.

We determined that staff morale was low and has been particularly impacted by events at MAH over the last 18 months. We highlighted that the impact of psychological trauma experienced by staff was significant.

We highlighted that the insufficient staffing at ward level had the potential to impact on patient safety and the safety of staff that are at risk from the challenging behaviour of patients who present as unwell. We noted from the minutes of a recent MAH live governance meeting that high levels of adverse incidents involving staff injuries in Ardmore and Cranfield One had been discussed.

We noted that almost all wards were in a cycle of continuous crisis management which was impacting on the quality, safety and effectiveness of care delivered.

We highlighted our concerns regarding the large number of vacancies that exist and which greatly exceed the number of additional staff recently recruited or in the process of being recruited. BHSCT Senior Management informed us of an on-going recruitment campaign for nurse staffing.

A day care coordinator had recently been appointed to support all wards and day care staff are now in-reaching to wards. Ward managers confirmed that this has been introduced as a measure to reduce the risk associated with staff having to leave a ward to support a patient attending MAH's day care facility.

We highlighted that staff currently in the hospital (both front-line and managerial) have displayed enormous resilience, they are to be commended for their dedicated service to the patients in MAH, however they now require additional support and resources in order to continue to provide safe care.

An area for improvement in relation to staffing has been made.

6.3.2 Management of Incidents

Policies and procedures in relation to incident/risk management were reviewed and found to be up to date and incidents were being recorded, reviewed and approved on the Datix incident system.

We determined that incident reports were being completed in accordance to the required policies and staff were able to effectively describe the processes to report incidents. We could not evidence how the learning from incidents was shared or how it resulted in changes to practice. There was no evidence of analysis of incidents to determine patterns or trend data and information coming from incidents was not being shared with frontline ward staff.

Members of the senior management team informed us that incidents and risk management issues are being reviewed on a weekly basis at the recently established site situation report (SITREP) and MAH live governance meetings. Having reviewed the information feeding into the SITREP and MAH live governance meetings we were unable to determine that incident/risk management processes were sufficiently integrated within the overall MAH governance system or intelligent enough to consistently feed risk information to BHSCT management/Board. We highlighted that this was necessary in order to assure the safety and effectiveness of care.

We were concerned to find that a number of adverse incidents involving glass in Ardmore had been reported but that this issue or an action plan to address it was not detailed on the risk register.

An area for improvement in relation to strengthening of the governance arrangements, (into which management of incidents will feed), in MAH has been detailed under the "Is the service well led?" domain.

6.3.3 Safeguarding Practices

MAH adult safeguarding guidance was reviewed and found to be up to date and in accordance with the regional safeguarding policy.

We noted a high number of frequently reported safeguarding referrals for individual patients as a result of the same issue (physical abuse, assault or violence). We were unable to evidence any change in outcome or learning from these incidents and there was no evidence of how these incidents resulted in changes to practice.

Staff advised us that there was a process to review and screen incidents out of the safeguarding process at ward level. We were unable to evidence that incidents screened out at ward level were being audited to confirm and assure this screening process.

There was evidence that some information in relation to safeguarding referrals was being reported into governing arrangements for MAH but there was no evidence that learning was identified and shared back out to front line ward staff.

We highlighted the need for learning to be shared in a meaningful way with frontline ward staff. We acknowledged that this was also made difficult due to the challenges with staffing levels on wards.

We recommended that safeguarding incidents or allegations are assessed by a multidisciplinary team to determine the best action and outcome for the patient(s) and staff member(s). We advised that this approach would assist with addressing potential root causes giving rise to and/or influencing repeated referrals.

From an analysis of information provided our inspection team did not find evidence of effective deployment of safeguarding referrals, of implementation of learning arising through safeguarding investigations or that the outcomes from safeguarding investigations were positively impacting patient well-being. A structural disconnect between various groups of professional staff was evident within the current safeguarding arrangements.

<u>Close Circuit Television (CCTV)</u>

The inspection team was clear that staff across the site were fearful. The inspection team found a number of examples where staff had allowed themselves to be struck by patients because they feared the consequences of using legitimate intervention techniques in which they had been trained, to support patient's behaviour. The use of CCTV on site has contributed to this fear, with many staff unable to articulate to the inspection team their understanding of how and why CCTV was used. We determined that there was some confusion with respect to how CCTV is being used and the associated operational parameters of its use.

The Senior Management Team must develop policies and associated operational procedures to clearly define how CCTV is being used at the MAH site.

Once defined staff must be supported to develop their understanding of CCTV use and the MDT team must be utilised as a safe environment for staff to learn how CCTV use can assist them in their practice.

An area for improvement in relation to safeguarding has been made. An area for improvement regarding the management and monitoring of CCTV has also been made.

6.3.4 Restrictive Practices (Seclusion)

The only purpose built seclusion room, which meets with relevant best practice guidance in terms of a seclusion environment, on the MAH site, is located in the PICU. In December 2018, BHSCT made a decision to temporarily close PICU and relocate the six patients to other wards across the hospital site. Two patients had been relocated to Ardmore, one patient to Cranfield One, two patients to Cranfield Two and one patient to Six Mile. We reviewed the care and treatment of these patients as part of our inspection focus.

The use of seclusion across the MAH site was also reviewed. We found that seclusion of patients as an appropriate and managed therapeutic intervention was taking place across the hospital site. In the main staff were found to be managing the practice well with evidence of de-escalation measures in use and required documentation in place.

The MAH seclusion policy and procedure provided to the inspection team was dated November 2016 and did not reflect the changes which had been introduced following the temporary closure of the PICU in December 2018.

Cranfield Two which had previously been an open ward was found to be locked. We were unable to locate evidence of the decision making process with regards to this change. Staff told us that patients who had been risk assessed as being safe to leave the ward knew how to do so. We observed this to be the case but found no evidence that care plans of individual patients had been updated to reflect these risk assessments.

We highlighted concerns that following the closure of PICU, the physical environments utilised for seclusion across a number of wards in MAH do not meet best practice guidelines. We observed that ward MDTs were implementing local arrangements to facilitate seclusion for patients in the absence of a clearly defined policy and following the closure of PICU. These arrangements were being provided in rooms that did not meet best practice guidelines for seclusion. In addition, various practices such as; seclusion; self-seclusion; de-escalation or practice agreed as part of a patient's management/care plan were being described across the wards. In the absence of a clearly defined policy it was difficult to determine what information was being reported into the SITREP or MAH's weekly live governance meetings.

The inspection team highlighted the need for the use of restrictive practices (seclusion) to be closely monitored. We could not find evidence of seclusion practices being audited and trends monitored over time. There was no evidence of robust assurance arrangements with respect to restrictive practices (seclusion).

We recognised that this issue is complex and will be challenging to address and suggested the BHSCT obtain ongoing expert support to ensure clear definitions and practices in relation to use of seclusion, self-seclusion, de-escalation and patient care planning.

BHSCT senior managers advised that they have recently sought support from the East London and Mersey Care NHS Foundation Trusts to assist with a review of restrictive practices in general and seclusion specifically.

An area for improvement has been made to ensure that the use of restrictive practices (seclusion) is reviewed across the MAH site in line with the following best practice guidance:

- Challenging Behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges; NICE guideline NG11 (2015);
- Nice Clinical Guidance NG-54 Mental Health Problems in people with learning difficulties: prevention, assessment and management DoH (NI) (2016) and
- Guidance: Isolation in detention; National Preventive Mechanism (2017)

The review should include daily discussion and MDT review at ward level and as a core component of MAH's weekly live governance meeting.

The BHSCT seclusion policy should also be reviewed and updated in line with these best practice guidelines and should include involvement of patients' families, staff and advocacy organisations.

6.3.5 Patient Observations

We reviewed the arrangements in place for the management of prescribed patient observations. We reviewed patient numbers, supervision ratios and the number of patients receiving enhanced one to one care.

Samples of patient observation records were reviewed and we noted that patients' observations were prescribed as required but were not always completed. Staff informed us that due to current nurse staffing they were unable to meet patients prescribed observations levels.

We observed that nurse staffing shortages were having a detrimental impact on patient behaviour and ward routine.

There was no evidence of audits of observations being carried out at ward level. We recommended that there should be engagement with ward managers and frontline nursing staff to implement a regular programme of audits of patient observations across the wards in MAH. An area for improvement in relation to this has been made.

6.3.6 Management of Medicines

We reviewed the arrangements in place for the management of medicines within MAH to ensure that medicines are safely, securely and effectively managed in compliance with legislative requirements, professional standards and guidelines. We evidenced that an up to date Medicines Code was in place.

There was evidence of satisfactory systems in place for medicines management. Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were observed to be clean, tidy and organised.

Pharmacist input is provided across the hospital site for 18.75 hours each week. The pharmacist input includes provision of medicines reconciliation at admission and discharge, review of prescribing and monitoring of stock levels.

We found a number of examples of medicines which had been prescribed for on-going treatment for several long-stay patients as having been ordered "urgently" on supplementary

requisition sheets. This evidenced that stock management and effective anticipatory ordering was not consistent.

There was no Pharmacy Technician support. We highlighted that this would be beneficial in supporting/reducing pressure on nursing staff, releasing the pharmacist time to concentrate upon patient facing activities and to support stock management and address deficiencies (stock levels/ordering/expiry date checking).

We reviewed patient kardexes and found that they were well maintained overall. We noted the good practice of highlighting dates for medicines prescribed at intervals.

A review of administration records highlighted a number of unexplained missing nursing staff signatures and we identified four examples of medicines being unavailable for administration. We did not see evidence of these areas being audited at ward level, except in Erne where some evidence of medication audit was found.

In relation to anxiolytic and antipsychotic medicines prescribed on a 'when required' basis e.g. to manage agitation, there were clear parameters to direct administration of these medicines on the patient's kardex. This included the indication for the medicine, the minimum frequency intervals and the maximum daily dose. Details of first line and second line (and occasionally third line) treatment were clearly recorded.

Samples of case notes (on the PARIS system) were reviewed and the rationale for any administration within a strategy for de-escalation was detailed; however, the assessment of effectiveness of the administration of these medicines was not consistently recorded. Staff advised us that the incidence of use was monitored and reviewed as part of patient reviews/ward rounds.

A range of audits should be completed to include: omitted doses, completion of administration records and effectiveness and appropriateness of 'when required' medicines be undertaken to improve medicines assurance.

Staff advised us of a regular review of stock to ensure that the medicine trolley only contained medicines for patients currently in the ward. However, we found some expired medicines including an anaphylaxis kit in Ardmore. We highlighted these to staff for removal (none of these medicines were in use) and advised that they ensure the immediate replacement of the anaphylaxis kit.

In relation to medicines requiring refrigeration we found a number of medicines which had expired or which did not require refrigeration. These were subsequently removed. We noted that refrigerator temperature was not being consistently recorded in Ardmore. The minimum and maximum medicine refrigerator temperatures should be recorded in all wards.

It was not always clear that therapeutic blood monitoring/other monitoring of physical health parameters associated with antipsychotic prescribing was being systematically undertaken or followed up to ensure that it was completed at required intervals (in accordance with the hospital's antipsychotic monitoring protocol). To remind staff when these are due for completion staff advised us that the required intervals would be recorded in the nurse's diary.

An area for improvement has been made regarding medication management.

6.3.7 Environment

Ardmore and Erne were the specific focus of the environmental inspection parameters; however, all five wards were visited over the course of the three day inspection.

Ardmore

The environment was observed to be clean and appropriately maintained.

We observed that when patients are in the dining room/communal area the noise echoes throughout both sides of the ward and creates a noise reverberation which can be very distracting and unpleasant.

Ward staff informed us that they have tried to encourage patients to access other parts of the ward. We found that there are a number of rooms in the ward which patients can avail of which are very pleasant.

We noted that patients tended to congregate in the large open dining room/communal area as the nurses' station is located there and it appears to be the hub of the ward.

Patients with hearing impairments, sensory problems and autism may find this area very distressing due to the high ceiling creating vibrating sounds. We suggested consideration of a possible review of furnishings/layout to try and absorb noise and reduce the echo effect.

Erne

The environment was observed to be clean, clutter free and well maintained.
There was good ventilation, large lounge areas and neutral odours.

We observed that the ward was undergoing renovation work. We noted that this was being well managed.

Ward furnishings were observed to be well maintained and comfortable.

The ward is of an older design and has a number of areas, annexes and rooms with some limitation to sight lines.

Cranfield One and Two

The Cranfield wards were observed to be similar in design to Ardmore.

Number of areas for improvement	**6**

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome

6.4.1 Care Pathways & Plans

There were 67 patients receiving care and treatment in MAH at the time of the inspection.

We reviewed a sample of patient care plans. There was evidence of an up to date mental health needs review of each patient, as well as records of decision making by the MDT involved in delivery of the patient's care.

We noted that MAH operates a dual records system. Patient care documentation was available on the PARIS electronic patient information system and in hard copy. Core care records were centrally located on the PARIS system and we observed that staff are familiar with the system. We found that continuing care records were difficult to track and locate.

Staff demonstrated good understanding of individual patient needs. We noted that nursing staff also demonstrated a high level of skill when supporting patients who presented with challenging behaviour. Effective use of de-escalation techniques with patients was observed throughout the duration of the inspection.

We found that there were good psychological formulations recommended for individual patients but they were not being fully implemented. Staff informed us that this was because they were complex in nature and staff did not have the time required to implement them. Staff reported that the deficit of positive intervention was impacting patient behaviour adversely.

BHSCT senior managers informed us that they were trying to resolve this issue by each ward having dedicated support from psychology staff to assist ward staff with the implementation of patients' positive behaviour support plans.

We found that the management and recovery of patients was being adversely affected by the mix of patients present in wards and delays in the discharge of patients who no longer required treatment. Acutely unwell patients were being admitted whilst patients' whose assessment and treatment had been completed were experiencing delays in their discharge. We were told that this combination was contributing to deterioration in patient behaviour.

We highlighted that other key expected activities including the audit of prescribed observations and the provision of nurse led ward based activities for patients were not being undertaken as nursing staff had prioritised the primary care needs of patients.

An area for improvement in relation to audit of patient observations has been detailed under the "Is care safe?" domain.

6.4.2 Physical Health Care Needs

We reviewed patient care records and ward procedures and processes for the management of patients' physical health care needs.

We found evidence of reactive measures for patients in respect of their physical health. No evidence of annual physical health checks or monitoring of co-existing physical health conditions was found.

Ward staff were observed to respond quickly to patients if they became ill or suffered injury as a result of a fall or from the effects of a seizure. We were told that patients could access out of hours general practitioner services as required.

Senior managers informed us that they had recently advertised for a general practitioner to facilitate in hours clinical sessions on the hospital site. They told us about the development of a physical health checklist which was to be piloted. Whilst we welcomed this development we highlighted that this approach may assist with addressing local ward arrangements but will not introduce a sustainable system level solution.

Reviews of patient care records evidenced that patients did not have their physical health appropriately monitored. We found they did not access health or population screening appropriate to their gender and/or age, and did not have appropriate access to primary care services. We noted that this placed them at a disadvantage when compared to their peers living in the community.

We found that there were no regular audits of patients' physical health care records being undertaken at ward level. We also found that some patients who were prescribed antipsychotic medications did not experience appropriate monitoring of related parameters of physical health as required in accordance to MAH's antipsychotic monitoring protocol.

Dental screening was in place but we found that this was not consistent across the hospital.

MAH must develop an appropriate system to ensure that the range of patients' physical health care needs are robustly addressed and monitored. An area for improvement has been made.

6.4.3 Discharge Planning

We did not find robust systems in place to ensure that agreed discharge arrangements are recorded and co-ordinated with all services that are involved in the patient's on-going care.

We were informed by BHSCT senior managers that they are continuing to progress a collaborative regional approach to ensure the hospital functions as an assessment and treatment hospital. They highlighted multi-agency involvement with all stakeholders including other Trusts, the Health and Social Care Board (HSCB), the Public Health Agency (PHA) and the Department of Health (DoH).

Discharge planning arrangements were reviewed. We found that 32 patients no longer required treatment and were experiencing a delay in their discharge from hospital.

During discussions with ward staff we were told that they often did not have up to date information about the plans for patients who have completed their active assessment and treatment and are awaiting discharge. Staff told us about the challenges that this presents as patients, family members/carers seek their advice in relation to possible discharge options. We

did not find evidence of clear communication with families taking place. We could not find detailed or up to date information in relation to proactive discharge planning for patients who are delayed in leaving the hospital.

An area for improvement has been made to ensure that ward staff have access to the most up to date information regarding patients who are awaiting discharge from MAH.

We acknowledged that wider systemic issues were negatively impacting on the hospital's ability to discharge patients. We noted a lack of appropriate community infrastructure had resulted in the delayed discharge of a number of patients.

Senior managers advised they recognise that urgent action is needed to facilitate reintegration back into the community of those patients who no longer require hospital treatment. They told us that they had set a priority for all patients to have a discharge address and plan and for this to be developed using a co-production model.

6.4.4 Strategic Planning and Communication

Following discussions with senior managers and reviewing minutes of meetings we found that BHSCT had a number of priorities in relation to re-modelling services in MAH. These priorities include review of admission criteria so that admission to MAH will only be for mental ill health or severe behavioural concerns that require hospital intervention, development of a clinical assessment unit and a target that use of seclusion would be reduced to zero.

Discussions with a wide range of staff across the whole MAH site identified that a large number were not aware of the plans for the hospital. We highlighted an issue relating to how the hospital's management team communicated plans to staff.

Staff told us that they were unclear as to the role and function of the hospital's PICU. During discussions some staff advised us that they were in temporary positions whilst PICU was closed for a short time; whilst others who had been relocated from PICU believed that they had been moved permanently to other wards.

We advised that stated aims and objectives for the hospital's PICU should be developed and disseminated to frontline staff so that there is clarity regarding both the unit and staff aligned to this service.

We noted that the poor understanding of the of hospital plans was symptomatic of this disconnect between what the management team were trying to achieve and what staff actually understood.
We found that this disconnect was common across several areas

An area for improvement has been made regarding the provision of a forward plan for MAH to include stated aims and objectives for the PICU.

Number of areas for improvement	**3**

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

6.5.1 Person centred care

Compassionate and positive interactions between staff and patients were observed throughout the inspection.

We observed staff treating patients with dignity and respect and responding compassionately to patients presenting with physical and/or emotional distress.

We found that nursing staff had good knowledge and understanding of the specific needs of individual patients they were caring for.

All staff described the MDT teams within each ward as patient centred, inclusive and supportive. We noted that MDTs included the range of professionals necessary to provide the required care and treatment to patients.

6.5.2 Patient Engagement

We reviewed how MAH engages with patients and/or their representatives.

We found that when appropriate and in accordance with each individual's presenting needs and health, patients were given the opportunity to be involved in any meetings where decisions about their care and treatment were being made.

We evidenced that care and treatment options were discussed with patients and their relatives.

During the inspection the Lay Assessor met with five patients from three wards, namely, Ardmore, Erne and Cranfield One. Patient staff interactions observed by the Lay Assessor were positive. Patients remained relaxed and at ease throughout the inspection. The Lay Assessor noted that when a patient became unsettled or agitated staff intervened quickly in a sensitive, supportive and caring manner.

One patient reported that their relationship with staff was good and they knew who to talk to if they were unhappy or had a concern. The Lay Assessor observed that ward staff were familiar with this particular patient's care needs and that the patient and staff had a close informal relationship. Two patients described the ward they were on as being clean and tidy. Both patients stated that there were not always enough activities to keep them busy at nights and at weekends. Both patients stated that when they had a concern or difficulty regarding their care they could discuss this with their named nurse. Patients told inspectors that they knew who was involved in their care and who to talk to if they were not happy or they were upset.

The Lay Assessor was also provided with feedback in relation to the impact of delays in obtaining a suitable community placement. One patient stated that they had been on the ward for three years and there was no suitable community placement available for them. Another patient informed the Lay Assessor that they had no concerns regarding the care provided however, the patient expressed frustration at having to remain in hospital as they wanted to be

in their own home. The Lay Assessor was informed that there was no community placement currently available for this patient.

A third patient discussed their concerns and frustrations in relation to their discharge from the ward being delayed. The patient explained that they understood why their discharge had been delayed and the reasons for this.

BHSCT senior management informed us that it plans to appoint a Carers' Consultant to enhance family/carer experience and to influence and shape services from a holistic perspective.

Number of areas for improvement	0

6.6 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

6.6.1 Planning and oversight of staffing levels

We reviewed the staffing arrangements in MAH. The multidisciplinary team (MDT) for each ward included nursing, occupational therapy, psychiatry, clinical psychology, behavioural support and social work professionals. In addition there is forensic psychology and specialist nurse practitioner support available. Independent advocacy services also visit the wards in MAH.

Senior managers told us that they had implemented nurse staffing planning measures and escalation arrangements to support ward managers. We were advised that bank and agency staff had been employed and that staffing levels on each ward were being monitored daily.

Wards were staffed using a mix of BHSCT, bank and agency staff. Staff told us that this mix did not always contain the required knowledge and skills to meet the complex needs of the patients currently receiving care and treatment in MAH. Staff told us that the BHSCT policy of agency staff not being permitted to take charge of the wards was creating difficulty in getting BHSCT only staff in charge to cover the wards.

Staff reported their experiences which indicated that morale was poor. Staff told us they had been significantly affected by the recent abuse allegations, the ongoing police investigation and staff suspensions. Staff told us that they could not complete the required level of observations, that they frequently had to cancel therapeutic and leisure activities and that they continually had to spend time inducting new members of agency staff. They informed us that this inability to fulfil their responsibilities is a further source of anxiety. We noted that it is impacting on the quality of care that staff are providing.

We were told that frequent changes of staff and increased use of agency staff was negatively impacting patients and their behaviour due to unfamiliarity. We highlighted the importance of continuity of staffing for patients with learning disabilities. Ward managers told us that they did not feel supported to address the daily workforce shortfall.

The monitoring and escalation arrangements in relation to staff shortages were reviewed. We found they did not accurately identify the impact the nurse staffing shortages were having on the care and treatment experienced by patients on some wards.

We found no evidence of an overarching forward plan for staffing in MAH which details how the BHSCT is going to find, retain and support staff.

The importance of the BHSCT engaging with colleagues from NHSCT and SEHSCT to seek necessary staff resources to facilitate adequate nurse staffing cover in MAH was discussed. It was noted that the BHSCT is experiencing difficulty in recruiting sufficient numbers of learning disability trained nurses because of the low numbers of nurses available within Northern Ireland.

An area for improvement in relation to planning arrangements for nurse staffing at MAH has previously been made in the “Is care safe?” domain.

This area of improvement has been made to ensure:

- A model to determine safe levels of ward staffing (including registrant and non-registrant staff) is defined. The model should be based on the assessed needs of the current patient population and incorporate flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements; and
- An effective process for oversight and escalation of challenges relating to staffing across the hospital site is implemented.

Senior managers informed us that they had recently introduced a number of arrangements to improve staff support. These included facilitating staff information/update sessions, access to one to one meetings with occupational health staff, information and support regarding the management of personal and professional issues, a keeping in touch system for absent staff and a Health and Wellbeing strategy.

Staff told us that they do not feel empowered, that they are fearful and that they are not engaged with the support measures.

We advised of the need for monitoring of the effectiveness of these arrangements after adequate time has been allowed for staff engagement and reflection. This is included in the area for improvement.

6.6.2 Hospital Governance

We reviewed the arrangements in place to support hospital governance.

MAH governance arrangements and documentation was discussed with senior managers, senior nursing managers, ward managers and members of the MDT.

We found that a BHSCT Assurance Committee covering the Learning Disability Division and chaired by the Chair of Division and Clinical Director has recently been established.

Hospital Services meetings were operating on a monthly basis. We found that they are chaired by the hospital services manager and are attended by ward managers and MDT staff. A review of sampled minutes illustrated that items discussed included staffing, patient discharges, site updates and Datix incidents.

MDT staff told us that weekly consultant led MDT meetings were taking place. We were told that Leadership Walk Arounds with a safety and quality focus are undertaken on a monthly basis by senior managers from both within and outside the division.

Staff informed us that they were unclear about the functions and operational purpose of the committees, meetings and walk arounds. Staff could not describe how these arrangements were supporting them to discharge their responsibilities. We highlighted that in view of psychological trauma experienced by staff it is important that there is clear communication about any new arrangements introduced. We also advised that the BHSCT should avoid implementing too many new arrangements at once so that staff do not feel overwhelmed.

We noted and welcomed that the BHSCT had introduced new approaches to review and strengthen governance arrangements including; introduction of a SITREP tool, weekly safety pause meeting and a weekly MAH live risk management/governance meeting. We observed both types of meetings during the inspection and found them to have been effectively chaired. There was limited evidence that the SITREP tool was used to escalate issues of concern to the service managers or BHSCT more widely. We highlighted that the tool may require some revision in order to be sensitive to pertinent issues, such as finance and pharmacy, and to be utilised to its' full potential.

The benefit of the weekly safety pause meeting becoming embedded within the overall governance system was discussed.

Ward managers advised us that they meet on a weekly basis and that a ward based morning safety briefing (huddle) is being piloted in two wards (Cranfield One and Two). We observed briefings and noted that they were attended by the MDT. We found them to be open, inclusive and effective particularly with regard to the sharing of patient information and providing updates on patient progress. We noted that the outputs from these meetings would also help to improve decision making with respect to appropriate escalation of issues.

The benefit of the daily safety huddle becoming embedded across all the wards in MAH was discussed.

Erne was observed as being well led. Local governance arrangements and effective auditing were noted as having been implemented by the ward manager. Supervision and appraisals were evidenced as being up to date. We noted that a programme of audit of case records, safeguarding referrals and incident reports was being undertaken. Nursing staff were visible and approachable and there was evidence of effective leadership. Patients and relatives who met with inspectors reflected positive experiences and reported a good standard of care and treatment being provided by the ward's MDT.

We acknowledged that the new governance system arrangements were at an early stage and would take time to become fully embedded throughout the hospital. Current arrangements were not sensitive enough to identify risks so as to consistently feed them to management. We highlighted that this development will be necessary in order to provide assurance to BHSCT that all operational aspects of MAH are robust.

We advised that the governance system requires further strengthening to ensure it is robust and supports collection and analysis of governance data at both ward and management level.

An area for improvement has been made relating to comprehensive implementation of robust governance arrangements at ward and hospital level.

6.6.3 Financial Governance

We assessed how the BHSCT discharged its' responsibilities in accordance with Articles 116 and 107 of the Mental Health (Northern Ireland) Order 1986 (MHO). This legislation sets outs the requirements for the Trust in managing monies and valuables on behalf of patients and the conditions for referring a patient to The Office of Care of Protection (OCP) to enable appropriate financial decisions to be made.

We noted a number of cases where monies was held in excess of 20K and where neither consent has been obtained by RQIA or referral had been made to The Office of Care and Protection to enable a controller to be appointed. We advised that the necessary steps should be taken to ensure that the Trust is compliant with its responsibilities.

We were informed that the MAH site manager acts as appointee for 13 patients but found related documentation for only six of these patients. We noted that none of the 13 patients' files were fully complete, entirely clear or contained evidence of an overarching financial plan. We were not assured that the designated appointee had sufficient knowledge and understanding of the individual patients for whom they had been appointed to enable fully informed best interest decisions to be made.

We noted that ward level ledgers, used for recording routine transitions were in place. However, we found these were sometimes inaccurately completed and that weekly checks by ward managers or monthly checks by senior managers were not being undertaken consistently.

We reviewed a sample of three sets of patient finance records. We found no evidence of discussions with patients regarding their choices or evidence of support being provided for decisions relating to spending. We found records of expenditure which were not supported by accompanying receipts. We identified a case where a safeguarding referral had not been made when there was some indication of potential financial abuse. Ward staff reviewed the patient's circumstances and a safeguarding referral was completed and forwarded to the responsible Adult Safeguarding Team.

We reviewed a sample of patients' property records and identified that three patients did not have an accurate record of their personal property and that one patient's record was last completed in June 2016.

The ward procedure for maintaining property records was discussed with two members of staff. We were informed by one member of staff that property records are not routinely maintained following a patient's admission to the ward and that items deposited for safekeeping were not recorded. We were advised by the second member of staff that property is recorded on admission and discharge only. We were told that items acquired and disposed of during the patient's stay are not recorded.

We determined these findings reflected a lack of understanding by ward managers and other ward staff, of their responsibilities for patient finances and we recommended this be urgently addressed. We also highlighted the need for improvement in the consistency and accuracy of completion of weekly and monthly ledger checks.

The BHSCT Patient Finances policy was reviewed and we noted it was only in draft form. We did not find evidence of regular financial audits being completed in MAH. An audit had been last completed in 2015. We recommended that the Patient Finances policy be updated and then an audit of its' operational use be undertaken to assure it full implementation.

We advised that there is a need for BHSCT to implement a programme of regular audits of compliance with its financial procedures across all wards in MAH to ensure a robust system approach to oversight and governance.

An area for improvement with respect to financial governance has been made and incorporates all of the concerns outlined.

6.6.4 Quality Assurance

We found evidence of active quality improvement initiatives with respect to violence reduction (Ardmore) and improving physical health (Cranfield Two).

Weekly incident audits and audits of the use and cost of bank and agency staff were evidenced as being undertaken and subsequently reviewed at the weekly SITREP meeting.

We were informed by BHSCT Senior Management Team that feedback and learning from a workshop undertaken on 30 January 2019 in relation to the purpose of MAH as an Assessment and Treatment unit, the patient pathway and desired outcomes would be utilised for future quality improvement initiatives. We were told that the learning would also be used for improving communication with frontline staff and remodelling of service provision.

BHSCT Senior Management Team informed us that they will be participating in NHS Benchmarking for Learning Disability Services. We recognised this was an opportunity for appropriate service data to be collected and analysed and also for local peer comparator review.

We welcomed these elements as signs of early development of an improvement culture in MAH and encouraged their progression moving forward.

Number of areas for improvement	2

6.7 Staff views

No staff questionnaires were received by RQIA.

Inspectors met formally and informally with staff from various professions during the inspection.

Structured staff interviews were undertaken with two members of junior medical staff, one member of agency nursing staff, one hospital social worker and a ward deputy manager. Focus groups with senior management staff, allied health professionals (social work, occupational therapy and psychology) and support staff were also held.

All staff interviewed highlighted issues with nurse staffing. The nursing staff who spoke with the inspection team told us about the impact of the increased use of agency staff and the challenge of seeking additional staff on a daily basis. They highlighted the impact of this upon the safety of staff and patients. Staff discussed the challenges of ensuring that there was an appropriate number of trained nursing staff available to cover each shift. This was noted as being particularly challenging during nightshifts.

All staff interviewed indicated that they felt patient care was compassionate. They highlighted an approach of continuous assessment and of patient focused MDT working.

We were told by staff that the effectiveness of care would be improved by appropriate placements being available in the community.

Staff experience of management support was mixed. One staff member described their manager as someone who was approachable and always listened. The staff member reflected that they felt valued. Another staff member told inspectors that staff job plans changed continually and there was uncertainty regarding the future and purpose of some wards.

A number of staff commented on the hospitals inconsistent approach and the completion of patient medical reviews. Staff stated that medical reviews were completed as required and that there was no system to ensure continuous routine patient medical reviews.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the Deputy Chief Executive & Medical Director, BHSCT Senior and Executive Management Team and ward staff as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

BHSCT should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further action. It is the responsibility of BHSCT to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas for improvement

Areas for improvement have been identified in which action is required to ensure compliance with The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to meet the areas for improvement identified. The BHSCT should confirm that these actions have been completed and return the completed QIP to bsu.admin@rqia.org.uk for assessment by the inspector by 5 March 2020.

Quality Improvement Plan

The Trust must ensure the following findings are addressed:

Staffing

Area for improvement No. 1 **Ref**: Standards 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1, 5.3.3) **Stated:** Second time **To be completed by:** Before 14 May 2019	The Belfast Health and Social Care Trust must: 1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at MAH, which; a) is based on the assessed needs of the current patient population *and* b) Incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements. 2. Implement an effective process for oversight and escalation to senior management and the executive team when challenges in nurse staffing arise. 3. Implement an effective assurance mechanism to provide oversight of the implementation of the model and escalation measures. 4. Engage the support of the other key stakeholders, including the commissioner in defining the model to determine safe levels of nurse staffing.
	Response by the Trust detailing the actions taken: 1. a. Work progressed to determine safe staffing levels through an assessment of the current patient population's acuity and dependency. Acuity and dependency was determined using the current level of observation employed by the staff to safely care for patients, and using Telford to determine the registrant levels. This triangulated approach has resulted in a nursing model, which is in use to describe safe staffing levels. b. The model is in use by the ward managers and reviewed regularly to respond to temporary or unplanned variations in patient assessed needs and/or service requirements. 2. Ward staffing levels are reviewed on a daily basis Monday to Friday and at the weekly Ward Managers meeting (Friday) for the weekend. ASMs are on site Monday to Friday and review the requirements daily. An OoH co-ordinator also reviews staffing levels on site in the OoH period. Any issues of concern are raised by the wards to the ASM/OoH Co-Ordinator to Service manager and then to Collective leadership team. In the OoH there is a senior manager on call rota in place to provide additional support to staff OoH. 3. The Model was developed with engagement from the ward managers and ASMs in the first instance to ensure buy in. the Divisional Nurse worked closely with the ward Managers and ASMS to determine the current patients' needs on site in order to inform the model. Also a Telford exercise was undertaken with each of the ward managers.

	Once the model was developed the DN met with each of the Ward managers and ASMS to implement. Assurances are sought at the weekly ward managers meeting that the model is in use. When there are any issues Ward managers and ASMS are able to contact and talk it through with the DN if that support is required. The pathway used to escalate issues is Ward Manager to ASM to SM and then to the Collective Leadership team. 4. The nursing model has been developed by the senior team in MAH (in conjunction with the ward managers and ASMs) and approved by the Executive Director of Nursing and the Expert Nurse Advisor, DoH, and it has been presented to and supported by RQIA.
Safeguarding	
Area for improvement No. 2 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for adult safeguarding at MAH and ensure: a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations; b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively; c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care; d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding are improved. 2. Implement an effective process for oversight and escalation of matters relating to adult safeguarding across the hospital site; this should include ward sisters, hospital managers, BHSCT senior managers and / or the Executive team as appropriate. 3. Implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital.
	Response by the Trust detailing the actions taken: A detailed action plan was developed by the ASG and management team at MAH. There are 37 actions in place to ensure that the key 3 areas outlined in the QIP are achieved. At present 34 of these actions have been completed, the remaining 3 actions are currently on hold following advice from the PSNI not to proceed whilst the investigation is ongoing.

	There are plans in place to meet with the PSNI to discuss further. There are currently monthly ASG audits taking place on site to provide assurance that the changes implemented through the action planned are still in place and compliant.
CCTV	
Area for improvement No. 3 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for the management and monitoring of CCTV within MAH and ensure: a) that all staff understand the procedures to be followed with respect to CCTV; b) that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively; 2. Ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH.
	Response by the Trust detailing the actions taken: The CCTV policy has been reviewed, included update to forms included within the policy, the policy is currently with the Trust's Standard and Guidelines Committee for tabling. All staff have access to the initial policy approved in MAH. Further policy review and update is planned to improve the use of CCTV for safety monitoring. This is being progressed with the CCTV working Group and will be shared with staff when fully approved. There are agreed procedures within the hospital for monitoring and managing CCTV images, the template for requesting a download of footage has been updated. Work is required to improve the robustness, monitoring and functionality of the CCTV system on site. The Co-Director is awaiting quotes from Estate Services/ RadioContact and a business case will be developed. A CCTV working group has been set up (this includes a representation from ward staff, safeguarding staff, management, litigation and unions) to review the current use of use and the development of use within the hospital. Feedback surveys and processes have been developed to gather feedback on the current use and developed use of CCTV for safety monitoring within the hospital. Feedback is being sought from staff, families, carers, advocates and patients.

Restrictive Practices (Seclusion)	
Area for improvement No. 4 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1, 5.3.3) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must: 1. Undertake an urgent review of the current and ongoing use of restrictive practices including seclusion at MAH whilst taking account of required standards and best practice guidance. 2. Develop and implement a restrictive practices strategy across MAH that meets the required best practice guidance. 3. Ensure that the use of restrictive practices is routinely audited and reported through the BHSCT assurance framework. 4. Review and update BHSCT restrictive practices policy and ensure the policy is in keeping with best practice guidelines.
	Response by the Trust detailing the actions taken: MAH have implemented a suite of reports including a weekly patient safety report and a monthly governance report to ensure a clear statistical position for the use of restrictive practice is available for each setting. Reports are shared at both Executive Team and Trust Board. To date the use of seclusion and physical intervention have greatly decreased in the hospital. Audits have been implemented for the use of seclusion and patient observations, they are carried out on a monthly basis. The finding and actions from the audits are discussed at Pipa meetings and at the monthly Governance Committee. Restrictive Practices usage is discussed at a range of meetings, a Live Governance Call takes place each week when ward staff discuss the use of seclusion, Physical Intervention and use of PRN medication at patient level. The use of restrictive practice is included in the weekly Patient Safety Report and reviewed at the monthly Governance Committee. A Restrictive Practice Working group has been set up to provide a strategic overview of the use of and future use of Restrictive Practices within the hospital. The group has presentation of medical staff, ward staff, management, Safeguarding Staff, Governance, PBS and pharmacy. The suite of Restrictive Practice policies have been reviewed by an MDT within the hospital, an overarching Restrictive Practice Policy has been developed in line with best practice across the UK. MAH have formed a ‘critical friend’ relationship East London NHS Foundation Trust to act as critical friend to provide support and challenge in respect of all restrictive practices

Patient Observations	
Area for improvement No. 5 **Ref:** Standard 5.1 Criteria 5.3 (5.3.3) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must address the following matters in relation to patient observations: 1. Engage with ward managers and frontline nursing staff to ensure that a regular programme of audits of patient observations is completed at ward level. 2. Ensure that there is an effective system in place for assessing and managing patient observation practices, which is multi-disciplinary in nature and which enables staff to deliver effective care and learn collaboratively.
	Response by the Trust detailing the actions taken: A monthly audit process has been embedded across the hospital. The audit looks at the use of observations and reports compliance or non-compliance with the policy. The outcome of each audit is circulated to the management team, discussed at PiPa and reviewed at the Governance Committee meeting. Assessing and management of patient observation practices are reviewed through PiPa meeting with a MDT approach.
Management of Medicines	
Area for improvement No. 6 **Ref**: Standard 5.1 Criteria 5.3.1(f) **Stated:** First time **To be completed by:** 28 August 2019	The Belfast Health and Social Care Trust must strengthen arrangements for the management of medicines in the following areas: 1. Recruit a Pharmacy Technician to support stock management and address deficiencies (stock levels/ordering/expiry date checking) in wards in MAH to assist with release of nursing staff and pharmacist time. 2. Undertake a range of audits of (i) omitted doses of medicines (ii) standards of completion of administration records and (iii) effectiveness & appropriateness of administration of “when required” medicines utilised to manage agitation as part of de-escalation strategy. 3. Implement consistent refrigerator temperature monitoring recording (Actual/Minimum & Maximum) across all wards in MAH.
	Response by the Trust detailing the actions taken: 1. The existing registered pharmacist has agreed to increase hours from 0.5wte to 0.8 wte from the beginning of April 2020. The pharmacy technician post is in the early stages of recruitment. 2. The pharmacist reviews the kardexes for omitted does and completion of administration records at the PIPA meetings and any omissions or areas of concern raised at that time. With the increase in the Pharmacy hours, a more formalised approach can now be developed.

	A POMH audit on antipsychotic prescribing in ID patients, led by the Trust Pharmacy team will commence by the end of March 2020. 3. Each ward sister is responsible to ensuring that refrigerator temperature monitoring recording (Actual/Minimum & Maximum) is in place on their ward. This will be placed on the safety brief for daily checking. In addition the Pharmacist will audit the temperature monitoring when the Controlled drug audits are being undertaken.
Physical Health Care Needs	
Area for improvement No. 7 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must develop and implement a systematic approach to the identification and delivery of physical health care needs to: 1. Ensure that there is an appropriate number of suitability qualified staff to ensure that the entire range of patients physical health care needs are met to include gender and age specific physical health screening programmes. 2. Ensure that patients in receipt of antipsychotic medication receive the required monitoring in accordance with the hospital's antipsychotic monitoring policy. 3. Ensure that specialist learning disability trained nursing staff understand and oversee management of the physical health care needs of patients in MAH. 4. A system of assurance in respect of delivery of physical healthcare.
	Response by the Trust detailing the actions taken: A GP role has been recruited to the hospital to focus on physical health checks for all patients. There are 3 SHO positions within the hospital which are made up of one GP trainee and 2 psychiatry trainees. There is an out of hours GP available on site from 7pm-11pm each day with all other hours are covered by the onsite GP, the 3 SHOs and the psychiatry team for physical health care and queries. A lookback exercise has taken place to gather all physical health information for each patient including family history were available. This information is now stored on one template which is available on the PARIS system and in a physical health folder kept on each ward. Patients who meet the guidelines set out by Northern Ireland screening programmes have had their screening completed and added to the registers to ensure they are called appropriately with the general population. (Cervical cancer, Bowel screening, mammograms, AAA and diabetic eye. Each relevant patient now has an annual Chronic Health Condition review (Eye exams, asthma review, epilepsy review, hypertension review, testicular exams, breast exams and cervical screening.

	A review of all patients' health checks in regards to antipsychotic medication has been carried out. Each patient has an anti-psychotic monitoring chart which is reviewed by both a medical professional and a pharmacist. Six monthly (March & September) checks in line with Maudsley Guidelines is carried out, this includes bloods, ECG and all other relevant physical checks. All patient physical check information is stored on one template providing assurance that historical check information, family history and planned checks are available to all relevant staff. This provides assurance that all relevant checks have taken place or planned within the required timeframe. 1. All patients receive a physical examination within 24 hours of admission (ward trainee/on call trainee and nursing staff observations). We have ECG machines, physical observation equipment and venepuncture facilities available on site. 2. Past medical history and medicines reconciliation are confirmed within the first week (ward trainee/pharmacist) 3. Any initial concerns about physical health are followed up accordingly (ward trainee) 4. Longer term conditions and screening are managed by or GP locum doctor who also offers advice to trainees where required 5. For non-urgent physical concerns on the ward, the ward trainee is called 6. For urgent physical concerns, we have a duty bleep system for our site doctors and staff are aware to also contact NIAS in emergencies (as we have limited resuscitation facilities on site). Mandatory training for staff includes Life Support Training (at various levels depending on the grade/role of staff) accessed via the Trust HRPTS system 7. PIpA Visual Control Boards on each ward include prompts regarding physical healthcare, screening and antipsychotic monitoring. 8. We operate daily ward rounds (PIpA model) with focus days, one of which per week is about health promotion 9. All material pertaining to physical healthcare concerns are kept in manual files on the wards for easy access at PIpA and for out of hours doctors 10. Antipsychotic monitoring is performed as required and routinely every six months (March and September) now by our GP locum doctor and ward nursing staff. An audit of this across the site was carried out in December

	11. Current completion of the POMH audit: Antipsychotic prescribing in people with a learning disability under the care of mental health services (4/2-27/3/20 period, all inpatients and a sample of community patients). To compare with previous audit findings 12. We have the facility to refer to podiatry, dietetics, SALT, physio, OT on site and to our visiting dentist. 13. We have close links with and advice from the lead AMH pharmacist. We also have a part time pharmacist on site. 14. Future plans to develop the role of our locum GP colleague in the 'ID Physician' model to bridge the knowledge gap between primary and secondary care and improve the quality of physical healthcare assessment for our patients with complex co morbidities
Discharge Planning	
Area for improvement No. 8 **Ref**: Standard 5.1 Criteria 5.3 (5.3.3(b)) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must ensure that ward staff have access to detailed and current information regarding patients who have completed their active assessment and treatment and are awaiting discharge from MAH. **Response by the Trust detailing the actions taken:** Patient level assessment and discharge information and plans are discussed at weekly PiPa meetings at ward level. Information from these meetings is shared appropriately at ward level by the ward representatives at Pipa. Patient transition plans are shared at ward level and there is an MDT approach for transition planning. The Transition team attend the ward managers meetings and the ASM meetings when there are updates to patient resettlement plans. A Quality Improvement project has been initiated involving staff from across the hospital to focus on standardising and improving the transition processes for patients resettling from hospital.
Strategic Planning & Communication	
Area for improvement No. 9 **Ref**: Standards 4.1 & 8.1 Criteria 4.3 (b, d and e), 8.3 (b) **Stated:** Second time	The Belfast Health and Social Care Trust must address the following matters to strengthen hospital planning: 1. Ensure that a comprehensive forward plan for MAH is developed, communicated, disseminated and fully understood by staff. 2. Ensure that stated aims and objectives for the hospital's PICU are developed and disseminated to frontline nursing staff so that there is clarity regarding both the unit and staff positions.

To be completed by: 14 May 2019	**Response by the Trust detailing the actions taken:** A workshop (invite open to all MAH staff) is planned for the 26 Mar 2020 to discuss plans and development for the future of the hospital site. Monthly staff briefing meetings have been embedded within the hospital, these meetings aim to share information with staff across the site and respond to any questions. A weekly newsletter is distributed to all staff across the hospital, providing information updates and sharing news. The PICU is no longer in use and will not be restored to its previous function, this information has been communicated to staff. The workshop planned for March and future planning meetings will include discussion around the future use of the PICU space.
Hospital Governance	
Area for improvement No. 10 **Ref**: Standards 4.1 and 5.1 Criteria 4.3 (a) and 5.3.1.(f) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must review the governing arrangements in MAH and consider the following matters in order to strengthen the governance arrangements: 1. Enhance communication, staff knowledge and understanding of relevant committees and meetings to support local leadership and governance on the MAH site. 2. Embed the recently introduced Daily Safety Huddle (at ward level) and the Weekly Safety Pause (hospital level) meetings. 3. Implement an effective assurance framework.
	Response by the Trust detailing the actions taken: A governance framework has been developed within the hospital, this consists of a hierarchy of meetings which provide the space for discussion, challenge, review and assurance. There have been a suite of reports developed to provide statistics, analysis and oversight of key governance areas within the hospital. The governance meeting and reports framework has been illustrated in a flow chart and provided to staff to assist with understanding of the reports and meetings within / about the hospital. The daily safety huddle now takes place on a daily basis within each ward. A weekly live governance call has been embedded within the hospital, this meeting has multi-disciplinary representation and is led by ward level information. The assurance framework has been embedded, this has been built from ward level reports and meetings building into Hospital management meetings which feed into Executive and Trust Board level meetings.
Financial Governance	
Area for improvement No. 11	The Belfast Health and Social Care Trust must ensure: 1. That the BHSCT is appropriately discharging its full responsibilities, in accordance with Articles 107 and 116

Ref: Standard 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	of The Mental Health (Northern Ireland) Order 1986. 2. In respect of those patients in receipt of benefits for whom BHSCT is acting as appointee, that appropriate documentation is in place and that individual patients are in receipt of their correct benefits. 3. Implementation of a robust system to evidence and assure that all arrangements relating to patients' monies and valuables are operating in accordance with The Mental Health (Northern Ireland) Order 1986 and BHSCT policy and procedures; this includes: a) that appropriate records of patients' property are maintained; b) that staff with responsibility for patients' income and expenditure have been appropriately trained for this role; c) that audits by senior managers of records retained at ward level are completed in accordance with BHSCT policy; d) that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in MAH.
	Response by the Trust detailing the actions taken: A comprehensive action plan has been developed by the finance team and management team at MAH. The plan consists of 18 actions (8 completed, 9 in progress and 1 no longer applicable). The appointment of a Finance Liaison Officer has been very successful and enabled individual financial plans to be produced. The Trust has recently received a response from RQIA to our request to hold balances over £20k for 4 patients and we are currently addressing the questions raised and remain confident that the Trust is best placed to manage these monies on patient's behalf. The Trust has sought and received appropriate documentation including benefit entitlement for all patients we are appointee for with the exception of one patient that transferred to MAH from a Trust supported living accommodation – the documentation for this one patient is currently being followed up. The Trust Policy has been extensively reviewed and updated a number of times since the inspection and training has been delivered to all relevant staff. Although the current version of the Policy has been issued to staff it continues to be reviewed and updated in light of in-house monitoring findings. The BSO Internal Audit has now taken place and the Trust is due to meet with auditors on 25th March to discuss findings.

Name of person (s) completing the QIP	Gillian Traub		
Signature of person (s) completing the QIP	Gillian Traub	**Date completed**	12 March 2020
Name of Responsible Person approving the QIP	Gillian Traub		
Signature of Responsible Person approving the QIP	Gillian Traub	**Date approved**	18 September 2020
Name of RQIA Inspector assessing response	Wendy McGregor		
Signature of RQIA Inspector assessing response	Wendy McGregor	**Date approved**	18 September 2020

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Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority

Unannounced Inspection Report
15 & 16 April 2019

Belfast Health and Social Care Trust

Muckamore Abbey Hospital

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Assurance, Challenge and Improvement in Health and Social Care

Membership of the Inspection Team

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Lynn Long	Assistant Director Regulation and Quality Improvement Authority
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Alan Guthrie	Inspector, Mental Health and Learning Disability Team Regulation and Quality Improvement Authority
Cairn Magill	Inspector, Mental Health and Learning Disability Team Regulation and Quality Improvement Authority
Wendy McGregor	Inspector, Mental Health and Learning Disability Team Regulation and Quality Improvement Authority
Carmel Tracey	Inspector, Mental Health and Learning Disability Team Regulation and Quality Improvement Authority
Briege Ferris	Inspector, Finance Regulation and Quality Improvement Authority
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Claire McNicholl	Inspection Coordinator Regulation and Quality Improvement Authority
Pauline Morris	Inspection Coordinator Regulation and Quality Improvement Authority

Abbreviations

AHP	Allied Health Professionals
BHSCT	Belfast Health and Social Care Trust
DoH	Department of Health
MAH	Muckamore Abbey Hospital
MDT	Multi-disciplinary Team
MHO	Mental Health(Northern Ireland) Order 1986
NHSCT	Northern Health and Social Care Trust
OCP	Office of Care and Protection
PICU	Psychiatric Intensive Care Unit
QIP	Quality Improvement Plan
RQIA	Regulation and Quality Improvement Authority
SEHSCT	South Eastern Health and Social Care Trust

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation,

1.0 What we look for

2.0 Profile of the service

Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability Hospital managed by Belfast Health and Social Care Trust (BHSCT). The hospital provides inpatient care to adults 18 years and over who have a learning disability and require care and treatment in an acute psychiatric care setting. Patients are admitted either on a voluntary basis or in accordance with the Mental Health (Northern Ireland) Order 1986.

MAH provides a service to people with a Learning Disability from BHSCT, Northern Health and Social Care Trust (NHSCT) and South Eastern Health and Social Care Trust (SEHSCT). There were 83 beds in the hospital at the time of the inspection. The Psychiatric Intensive Care Unit (PICU) had temporarily closed on 21 December 2018 and has remained closed since.

At the time of the inspection there were five wards on the MAH site:

- Cranfield One (Male assessment)
- Cranfield Two (Male treatment)
- Ardmore (Female assessment and treatment)
- Six Mile (Forensic Male assessment and treatment)
- Erne (Long stay/re-settlement).

A hospital day care service was also available for patients.

On the days of the inspection there were 63 patients receiving care and treatment in MAH.

3.0 Service details

Responsible person: Mr Martin Dillon Belfast Health and Social Care Trust (BHSCT)	**Position:** Chief Executive Officer
Category of care: Acute Mental Health & Learning Disability	**Number of beds:** 83
Person in charge at the time of inspection: Mairead Mitchell, Interim Co- Director, Learning Disability Services, Adult Social and Primary Care Directorate, BHSCT.	

4.0 Inspection summary

We undertook an unannounced inspection to MAH over two days commencing on 15 April 2019 and concluding on 16 April 2019. All five wards were visited over the course of the inspection.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

The focus of this unannounced inspection was to assess the progress made by BHSCT to address the areas of significant concern in relation to six overarching themes emergent during our inspection to MAH from 26 to 28 February 2019:

- Staffing;
- Patients' physical health care needs;
- Financial governance;
- Safeguarding;
- Restrictive practices (seclusion); and
- Hospital governance.

We employed a multidisciplinary inspection methodology during this inspection. The multidisciplinary inspection team examined a number of aspects of the hospital, from front line care and practices, to management and oversight of governance across the organisation. We met with individual staff members and various staff groups, patients and a small number of relatives, observed care practice and reviewed relevant records and documentation to support the governance and assurance systems.

Key Findings

Overall we evidenced limited progress in relation to the 10 areas for improvement and the six areas of significant concern previously identified.

We identified that staffing levels had not improved and there continued to be a lack of support for ward managers when they experienced challenges in relation to staffing. We did not find effective escalation arrangements in relation to staffing and we remain concerned that there is a lack of evidence that staffing at ward level and across the site is managed and assured on the basis of assessed patient need.

We did not find evidence of any mechanisms/tools in use by the BHSCT to determine the staffing model required. We were not able to demonstrate that current planning arrangements were achieving consistency across the site and assurance in respect of the delivery of safe and effective care.

Staff morale was observed to still be significantly impacted. The staff well-being measures recently introduced were not found to have led to the desired improvements in staff health and well-being.

We again identified a structural disconnect between professional staff in relation to the current safeguarding arrangements for the hospital. We noted that the approach to safeguarding practices was process driven. There was no improvement in integration of social care staff and frontline nursing/ward staff. It was concerning to note that safeguarding incidents were being reviewed in isolation and ward(s) MDT's were not being appropriately utilised to improve debriefing and learning between staff groups.

We noted that the BHSCT CCTV policy was a generic BHSCT wide policy. The CCTV policy had not been updated to support the use of CCTV within the MAH site.

Improvements in appropriate recording and monitoring of restrictive practices (seclusion) were noted. We found that the overall use of seclusion had reduced since the February 2019 inspection but we remain concerned regarding the environments currently used for seclusion across the hospital site.

We found that patient observations were being carried out as required, however we found no evidence of a regular programme of audits of patient observations being completed at ward level.

We noted some improvements in relation to patients' physical health care needs including the completion of annual checks for most patients in the hospital. Appropriate monitoring of physical health parameters of patients receiving antipsychotic medications in accordance with the hospital protocol was evidenced. We did not, however, find effective arrangements in place to support robust assessment and/or planning to ensure patients are included in appropriate population screening programmes.

We found limited progress had been made to ensure that agreed discharge arrangements were recorded and co-ordinated with all services involved with patients' on-going care.

The inspection team determined that the governance systems were not working effectively to assure the Senior Management and Executive Teams that the care provided at MAH is safe, effective and compassionate. We did not find that arrangements to improve hospital governance were having the required impact on patient safety or improving integration and communication with staff groups.

Limited progress was evidenced in relation to financial governance. We did not find robust arrangements in place to monitor, audit and review the effectiveness of financial oversight or that the BHSCT was discharging its' responsibilities in accordance with Articles 116 and 107 of the MHO.

We provided feedback to BHSCT Senior and Executive Management Teams on 17 April 2019. At this meeting we informed BHSCT that RQIA continued to have significant concerns in relation to the care, treatment and services as provided for patients in MAH in respect of the emergent themes.

Following the inspection RQIA wrote to the Chief Medical Officer on 30 April 2019 in accordance with the provision of Articles 4 and 35 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inform him of RQIA's continuing serious concerns in relation to care, treatment and services as currently provided for patients in Muckamore Abbey Hospital. In this letter we recommended the establishment of two taskforces:

(i) a taskforce to stabilise the hospital site, in support of patients currently receiving care and of staff delivering that care and
(ii) a taskforce to manage, deliver and govern a programme to relocate patients who are delayed in their discharge from MAH to the community.

We also wrote to the Department of Health (DoH) in accordance with the provision of Articles 4 and 35 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. We advised the DoH of RQIA's continuing serious concerns in relation to care, treatment and services as currently provided for patients in MAH. We recommended that the DoH agrees and implements a special measure for BHSCT in relation to MAH. The recommendation was made with a view to supporting BHSCT (and the other two HSC Trusts served by MAH), to improve care and treatment of patients currently in MAH, to ensure appropriate governance systems/arrangements are in place, and to ensure appropriate planning for patients who have completed their active assessment/treatment and who will relocate out of MAH to accommodation in the community over the coming months.

4.1 Inspection outcome

Total number of areas for improvement	11

As outlined previously the focus of this inspection was the six emergent themes and 11 areas for improvement arising from our inspection to MAH (26 to 28 February 2019). The area for improvement in relation to medications management identified during the last inspection was not reviewed during this inspection. This area will be carried forward for review at the next inspection

We identified ten areas for improvement from this inspection. These relate to:

- Staffing
- Safeguarding
- Close Circuit Television (CCTV)
- Restrictive practices (seclusion)
- Patient observations
- Patients' physical health care needs
- Discharge planning
- Strategic planning & communication
- Hospital governance
- Financial governance

Detailed findings of this unannounced inspection were shared with Dr Cathy Jack, Deputy Chief Executive & Medical Director, BHSCT Senior and Executive Management Teams and ward staff during the feedback session on 17 April 2019 held at the conclusion of the inspection.

4.2 Action/enforcement taken following our most recent inspections

The most recent inspection of MAH was an unannounced inspection commencing on 26 February 2019 and concluding on 28 February 2019. Following this inspection we continue to engage with BHSCT and the DoH to secure improvements across the hospital site.

Ongoing enforcement action resulted from the findings of this inspection.

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.or.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Enforcement notices for registered establishments and agencies are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

In response to our ongoing concerns we invited the Chief Executive and BHSCT colleagues to attend an Intention to Serve six Improvement Notices meeting at RQIA on 7 March 2019. We also wrote to DoH recommending the implementation of a special measure for BHSCT in respect of MAH.

After consideration of BHSCT representation at our meeting on 7 March 2019 and of the additional information provided by the BHSCT to RQIA (8 March 2019), we determined not to serve Improvement Notices to BHSCT at that point in time. We advised BHSCT that we will continue to closely monitor each of the six areas of concern and the quality of care and treatment delivered to patients in MAH. We also wrote to the DoH to update them about our determination.

5.0 How we inspect

Prior to this inspection a range of information relevant to MAH was reviewed, including the following records:

- Previous inspection reports
- Serious Adverse Incident notifications
- Information on Concerns
- Information on Complaints
- Other relevant intelligence received by RQIA
- BHSCT action plan for MAH received by RQIA on 8 March 2019

Each ward is assessed using an inspection framework. The methodology underpinning our inspections includes; discussion with patients and relatives, observation of practice, focus groups with staff involved in all functions from across the hospital and review of documentation. Records examined during the inspection include; nursing records, medical records, senior management and governance reports, minutes of meetings, duty rotas and training records.

We invited staff to complete an electronic questionnaire during this inspection.
We did not receive any returned completed staff questionnaires following this inspection.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection on 26, 27 & 28 February 2019

Areas for improvement		Validation of compliance
Staffing		
Area for improvement No.1 **Ref**: Standards 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1, 5.3.3) **Stated:** First time	The Belfast Health and Social Care Trust must: 1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at MAH, which; a) is based on the assessed needs of the current patient population; and a) incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements. 2. Implement an effective process for oversight and escalation to senior management and the executive team when challenges in nurse staffing arise. 3. Implement an effective assurance mechanism to provide oversight of the implementation of the model and escalation measures. 4. Engage the support of the other key stakeholders, including the commissioner in defining the model to determine safe levels of nurse staffing.	**Not met**
	Action taken as confirmed during the inspection: Inspectors evidenced significant staffing deficits in each of the wards. Evidence of robust plans and allocation of nurse staffing, including registrant and non-registrant staff, on the basis of assessed patient need was not demonstrated. We could not accurately confirm nursing staff requirements as compared to nursing staff provision across the hospital. We were unable to evidence any mechanisms/tools in use by the BHSCT to determine the staffing	

	model required. Site managers described escalation arrangements in the context of staffing challenges. We found these arrangements were unclear and we were not assured that they were working effectively. Frontline staff told us they were not receiving adequate support from senior managers when they escalated staff shortages. We found that to date additional nursing staff had not been secured through collaborative working arrangements with the NHSCT and SEHSCT.	

Safeguarding		
Area for improvement No. 2 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** First time	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for adult safeguarding at MAH and ensure: a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations; b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively; c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care; d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding are improved. 2. Implement an effective process for oversight and escalation of matters relating to adult safeguarding across the hospital site; this should include ward managers, hospital managers, BHSCT senior managers and / or the Executive team as appropriate. 3. Implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital.	**Not met**
	Action taken as confirmed during the inspection: As in our previous inspection, we did not find evidence of implementation of learning from safeguarding investigations or that he outcomes from safeguarding investigations were positively impacting patient well-being. Due to the complexity and mix of patients in some wards and staffing levels, we noted that	

	meaningful implementation of protection plans was a significant challenge. A structural disconnect between professional staff was again evident within the current safeguarding arrangements for the hospital.	
CCTV		
Area for improvement No. 3 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** First time	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for the management and monitoring of CCTV within MAH and ensure: a) that all staff understand the procedures to be followed with respect to CCTV; b) that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively; 2. Ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH.	**Not met**
	Action taken as confirmed during the inspection: We noted that the BHSCT CCTV policy was a generic BHSCT wide policy. The CCTV policy had not been updated to support the use of CCTV within the MAH site. Staff told us that they were not clear as to how and when CCTV was used. A MAH CCTV policy had not been implemented and that they had not received any further update since the February 2019 inspection. We found no evidence of a CCTV images monitoring system to support staff to deliver care and learn collaboratively.	

Restrictive Practices		
Area for improvement No. 4 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1, 5.3.3) **Stated:** First time	The Belfast Health and Social Care Trust must: 1. Undertake an urgent review of the current and ongoing use of restrictive practices including seclusion at MAH whilst taking account of required standards and best practice guidance. 2. Develop and implement a restrictive practices strategy across MAH that meets the required best practice guidance. 3. Ensure that the use of restrictive practices is routinely audited and reported through the BHSCT assurance framework. Review and update BHSCT restrictive practices policy and ensure the policy is in keeping with best practice guidelines.	**Not met**
	Action taken as confirmed during the inspection: The overall use of seclusion had reduced. However we remained concerned about the environments being used for seclusion across the hospital site as they did not meet the required standards. We remained concerned that MAH site managers did not appear to appreciate the considerable distance between arrangements and practices as outlined in the Trust's updated seclusion policy and practices as currently implemented in the hospital. Our inspection team noted that staff involved in managing patients with challenging behaviours did not appear to be supported through structured debriefing and there were limited opportunities to identify and share learning in a meaningful way.	

Patient Observations		
Area for improvement No. 5 **Ref**: Standard 5.1 Criteria 5.3 (5.3.3) **Stated:** First time	The Belfast Health and Social Care Trust must address the following matters in relation to patient observations: 1. Engage with ward managers and frontline nursing staff to ensure that a regular programme of audits of patient observations is completed at ward level. 2. Ensure that there is an effective system in place for assessing and managing patient observation practices, which is multi-disciplinary in nature and which enables staff to deliver effective care and learn collaboratively.	**Partially met**
	Action taken as confirmed during the inspection: We found that patient observations were being carried out as required. We found no evidence of a regular programme of audits of patient observations being completed at ward level. We found no evidence that an effective system was in place for assessing and managing patient observation practices, which is multi-disciplinary in nature.	

Management of Medicines		
Area for improvement No. 6 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1(f)) **Stated:** First time	The Belfast Health and Social Care Trust must strengthen arrangements for the management of medicines in the following areas: 1. Recruit a Pharmacy Technician to support stock management and address deficiencies (stock levels/ordering/expiry date checking) in wards in MAH to assist with release of nursing staff and pharmacist time. 2. Undertake a range of audits of (i) omitted doses of medicines (ii) standards of completion of administration records and (iii) effectiveness & appropriateness of administration of "when required" medicines utilised to manage agitation as part of de-escalation strategy. 3. Implement consistent refrigerator temperature monitoring recording (Actual/Minimum & Maximum) across all wards in MAH.	**Not Reviewed**
	Action taken as confirmed during the inspection: This area for improvement was not reviewed during this inspection and will be carried forward for review during the next inspection.	

Physical Health Care Needs		
Area for improvement No. 7 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** First time	The Belfast Health and Social Care Trust must develop and implement a systematic approach to the identification and delivery of physical health care needs to: 1. Ensure that here is an appropriate number of suitability qualified staff to oversee that the entire range of patients physical health care needs are met to include gender and age specific physical health screening programmes. 2. Ensure that patients in receipt of antipsychotic medication receive the required monitoring in accordance with the hospital's antipsychotic monitoring policy. 3. Ensure that specialist learning disability trained nursing staff understand and oversee management of the physical health care needs of patients in MAH. A system of assurance in respect of delivery of physical healthcare.	
	Action taken as confirmed during the inspection: We noted improvements since our previous inspection in regards to annual physical health checks for patients and monitoring of physical health parameters of patients receiving antipsychotic medication. However we did not find evidence of robust assessment and/or planning to ensure patients were included in appropriate population screening programmes.	**Not met**

Discharge Planning		
Area for improvement No. 8 **Ref**: Standard 5.1 Criteria 5.3 (5.3.3(b)) **Stated:** First time	The Belfast Health and Social Care Trust must ensure that ward staff have access to detailed and current information regarding patients who have completed their active assessment and treatment and are awaiting discharge from MAH.	**Not met**
	Action taken as confirmed during the inspection: Ward staff told us that they did not have up to date information for all patients who had completed their active assessment and treatment and were awaiting discharge. We found limited progress had been made to ensure that agreed discharge arrangements were recorded and co-ordinated with all services involved in patients' on-going care.	
Strategic Planning & Communication		
Area for improvement No. 9 **Ref**: Standards 4.1 & 8.1 Criteria 4.3 (b, d and e), 8.3 (b) **Stated:** First time	The Belfast Health and Social Care Trust must address the following matters to strengthen hospital planning: 1. Ensure that a comprehensive forward plan for MAH is developed, communicated, disseminated and fully understood by staff. 2. Ensure that stated aims and objectives for the hospital's PICU are developed and disseminated to frontline nursing staff so that there is clarity regarding both the unit and staff positions.	**Not met**
	Action taken as confirmed during the inspection A forward plan for MAH had not been developed. We were unable evidence a clear strategic direction and robust planning regarding staffing, safeguarding, management of patients' physical health care, discharge planning and financial governance Staff were not clear about the plans for the future of the hospital. This was due to a combination of factors relating to a cessation of patient admissions, delayed discharges, the inability to safely staff the hospital, and uncertainty about the hospital's PICU.	

Hospital Governance		
Area for improvement No. 10 **Ref**: Standards 4.1 & 5.1 Criteria 4.3 (a) and 5.3.1.(f) **Stated:** First time	The Belfast Health and Social Care Trust must review the governing arrangements in MAH and consider the following matters in order to strengthen the governance arrangements: 1. Enhance communication, staff knowledge and understanding of relevant committees and meetings to support local leadership and governance on the MAH site. 2. Embed the recently introduced Daily Safety Huddle (at ward level) and the Weekly Safety Pause (hospital level) meetings. 3. Implement an effective assurance framework.	
	Action taken as confirmed during the inspection: Frontline staff informed us that they were unclear about the role and functions of the various meetings and arrangements. Our inspection team could not clearly determine the linkages between the constituent parts of the governance system. We noted discrepancies in information reported through various parts of the hospital's operating and governing systems. We could not evidence that the hospitals governance arrangements were having the required impact on safety and effectiveness of care for patients or on the health and well-being of staff.	**Not met**
Financial Governance		
Area for improvement No. 11 **Ref**: Standard 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1) **Stated:** First time	The Belfast Health and Social Care Trust must ensure: 1. That the BHSCT is appropriately discharging its full responsibilities, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986. 2. In respect of those patients in receipt of benefits for whom BHSCT is acting as appointee, that appropriate documentation is in place and that individual patients are in receipt of their correct benefits. 3. Implementation of a robust system to	

	evidence and assure that all arrangements relating to patients' monies and valuables are operating in accordance with The Mental Health (Northern Ireland) Order 1986 and BHSCT policy and procedures; this includes: a) that appropriate records of patients' property are maintained; b) that staff with responsibility for patients' income and expenditure have been appropriately trained for this role; c) that audits by senior managers of records retained at ward level are completed in accordance with BHSCT policy; d) that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in MAH.	**Not met**
	Action taken as confirmed during the inspection: We could not evidence appropriate documentation relating to appointee-ship arrangements for six of 13 patients, we could not identify improvements in completion of patient property records or in completion of ledgers at ward level. Monthly monitoring of ward finances by senior site managers was inconsistently completed, and when completed lacked evidence of appropriate assurance. The inspection team could not evidence work relating to the Trust's planned audit of financial procedures across the site, to be undertaken during April 2019 as advised in the Trust's action plan.	

6.2 Inspection Findings

Staffing

We reviewed the staffing arrangements in MAH against the BHSCT action plan and new information/assurances provided to us on 7 March 2019. We found limited progress in relation to staffing. Significant deficits in staffing levels on all of the wards had continued since the previous inspection.

As part of the assurance provided to RQIA on the 7 March 2019 in respect of the safety of the site, the Trust Chief Executive had advised that seven additional nurse registrants had been recruited, inducted and would begin work on the site in the week commencing 11 March. The inspection team noted on this inspection that the seven additional nursing registrants had not in fact been in post since 11 March. Over the two days of the inspection, conflicting information in respect of the actual numbers of new staff recruited and in post was given to inspectors. However RQIA was eventually able to ascertain that four additional nursing registrants were in post and that these are all agency staff.

We were informed that five experienced Band 7 nurses and two other senior staff would move from their roles/posts in MAH in the near future.

We reviewed the data provided by the MAH senior nursing office and detailed in the minutes of hospital situation report (SITREP) meetings for numbers of staff in post, vacancies, sick or maternity leaves, precautionary suspensions and also the numbers of agency staff for each ward. We examined staff rotas and spoke to ward managers when reviewing staffing levels and applicable ward data.

There was evidence of insufficient staffing at ward level to meet patients' prescribed level of observation, to implement and execute appropriate therapeutic care plans for patients, or to appropriately manage patients' physical health care needs. We evidenced insufficient staffing at ward level on each day of the two day inspection visit. Staff of all grades throughout the hospital site informed us there was insufficient staffing at ward level. Due to staff shortages at ward level, staff are at times unable to appropriately fulfil their responsibilities and this is impacting on the quality and assurance of care delivered and is in itself a source of anxiety for staff. Frontline ward staff told us that activities are frequently cancelled or re-scheduled causing frustration for patients.

Considerable difficulty was experienced with regards to accurately confirming nursing staff requirements as compared to nursing staff provision across the hospital. We were unable to accurately confirm the BHSCT determination of this.

We found that checks of the numbers of nursing staff in the wards were being undertaken. We highlighted that the issue was not in relation to numbers of staff but rather the requirements to achieve consistency across the site. Evidence of robust planning and allocation of nurse staffing, including registrant and non-registrant staff, on the basis of assessed patient need was not demonstrated. We were unable to evidence any mechanisms/tools in use by the BHSCT to determine the staffing model required.

Site managers described escalation arrangements in the context of staffing challenges. We found these arrangements were unclear and we were not assured that they were working effectively so as to appropriately support frontline ward staff when they experience challenges in relation to staffing. Frontline staff told us they were receiving poor support from senior managers and that they could not escalate staff shortages as in practice the responsibility to address the staffing deficits is retained with them.

We noted a mismatch between information supplied by site managers and that supplied by ward staff/managers with regards to nursing staff provision across the site.

We found that to date additional nursing staff had not been secured through collaborative working arrangements with the NHSCT and SEHSCT. We could not evidence a plan for permanent recruitment.

Concerns regarding the skill mix and appropriate deployment of staff were shared with the inspection team.

Specialist behavioural nurses continued to be rostered to cover general duties on wards. We were unable to evidence the commencement of improvement work to develop the roles of AHPs in MAH.

We acknowledged that front line staff continue to display enormous resilience and they are to be commended for their dedicated service to the patients in MAH and their families.

Safeguarding Practices

We reviewed the safeguarding arrangements in MAH against the BHSCT action plan and new information/assurances provided to us on 7 March 2019.

From an analysis of information provided our inspection team did not find evidence of effective deployment of safeguarding referrals, of implementation of learning arising through safeguarding investigations or that the outcomes from safeguarding investigations were positively impacting patient well-being. A continued structural disconnect between various groups of professional staff was evident within the current safeguarding arrangements

We noted that the approach to safeguarding practices was process driven. There was no improvement in integration of social care staff and frontline nursing/ward staff. We again evidenced that safeguarding incidents were being reviewed in isolation. We observed that MDTs were not being optimally utilised to improve debriefing, learning and connection between staff groups. We did not find evidence of any implementation of learning arising from safeguarding investigations. There was no evidence that outcomes from safeguarding investigations were positively impacting patients' care.

Figures for current adult safeguarding incidents and referrals, including the time period for referrals received by the designated adult protection officer (DAPO), were found to be collated by ward and type and reported at the weekly SITREP meetings.

Due to the complexity and mix of patients in some wards and with current staffing levels, it was again noted that meaningful implementation of protection plans was a significant challenge. We recommended that safeguarding incidents or allegations are assessed by a multidisciplinary team to determine the best action and outcome for the patient(s) and staff member(s). We advised that this approach would assist with addressing potential root causes giving rise to and/or influencing repeated referrals.

BHSCT senior managers informed us that the discharge of patients from MAH is a factor strongly influencing the implementation of effective safeguarding arrangements. We noted that the number of patients being looked after in MAH since the February 2019 inspection has largely remained static.

It was positive to note that following commencement of a recent Quality Improvement project there had been a 10% reduction in violence and that there were plans to introduce activity boxes to each ward.

Overall we found that arrangements for reviewing, risk assessing and recommending safeguarding measures were not robust.

CCTV

The inspection team was clear that staff across the site remained fearful of the use and implications of CCTV. The inspection team found a number of examples where staff had allowed themselves to be struck by patients because they feared the consequences of using legitimate intervention techniques in which they had been trained, to support patient's behaviour. The use of CCTV on site has contributed to this fear, with many staff unable to articulate to the inspection team their understanding of how and why CCTV was used. We determined that there was continued confusion with respect to how CCTV is being used and the associated operational parameters of its use.

Policies and associated operational procedures to clearly define how CCTV is being used at the MAH site were not in place. Staff told us that MAH did not have a CCTV policy and that they had not received any further update since the February 2019 inspection with regards to purpose and operational parameters of use.

Once defined staff must be supported to develop their understanding of CCTV use and the MDT team must be utilised as a safe environment for staff to learn how CCTV use can assist them in their practice. We again highlighted the impact upon staff and the importance of clear communication with them regarding this issue.

Restrictive Practices (Seclusion)

It was positive to note that overall use of seclusion had reduced since the February 2019 inspection. We evidenced that care staff were appropriately recording and monitoring when seclusion was used. We found that staff were trying to reduce the number of areas that patients were secluded to. Seclusion was evidenced as being discussed at patients' MDT meetings and during weekly MAH live governance meetings. We found that a report of contemporaneous CCTV viewing is also being produced and reported at governance meetings

We observed that staff involved in managing patients with challenging behaviour (in particular patients for whom restraint and/or seclusion may be required) did not appear to be supported through structured debriefing. Additionally, there appeared to be limited opportunities to identify and share learning in a meaningful way.

There was no change in respect of the environments used for seclusion since the February 2019 inspection. We again highlighted our concerns regarding patient safety and comfort.

We noted that the PICU remains closed with the consequence that the environments currently used for seclusion did not meet required standards.

We found that Site Managers did not appear to appreciate the considerable distance between arrangements and practices as outlined in the BHSCT updated Seclusion Policy and the actual operational practices implemented in the hospital.

We noted that the BHSCT had recently updated its' Seclusion Policy and that it was out for review/comment. However, we were unable to evidence any plan which the BHSCT had for implementation of its' refreshed Seclusion Policy. There were also no details regarding how the BHSCT intends to move from the current operational practices in relation to seclusion of patients in MAH to the position stated in the Policy.

Whilst we welcomed the stated commitment of the BHSCT to seek expert input/support from both East London and Mersey Care NHS Foundation Trusts, we were unable to evidence the level of engagement or the impact to date.

Patient Observations

We reviewed the arrangements in place for the management of prescribed patient observations in each ward. We noted patient numbers, supervision ratios and the number of patients receiving enhanced one to one care. Four of the five wards we visited continued to experience staffing shortages. Despite this inspectors found that patient observations were being carried out as required and that day care and in reach services were ongoing on the site. Staff were challenged in taking breaks and leaving on time after their shifts. It was noted that the Behaviour Nurses were not always operating in this capacity and that this was not helpful in respect of the therapeutic interventions that would improve patient outcomes.

Patient observation records reviewed by inspectors evidenced that patients' observations were prescribed as required. We observed that nurse staffing shortages in each ward, with the exception of Erne, continued to have a detrimental impact on patient behaviour and ward routine.

We found no evidence of audits of observations being carried out at ward level.

Physical Health Care Needs

The inspection team found evidence of appropriate monitoring of physical health parameters of patients receiving antipsychotic medications in accordance with MAH's protocol. Inspectors noted that an audit of antipsychotic monitoring had been completed since the previous inspection in February 2019.

We also evidenced that annual checks of physical health had been completed for most patients in the hospital (52 patients checks completed). We noted that eleven patients had not received a physical health check (3 patients on leave and 8 patients declined). Whilst we welcomed that this work had been undertaken we noted that the medical staff deployment was on a short-term basis. We did not find evidence of a plan to ensure the completion of checks for patients on leave or a rolling programme for managing patients' physical health checks going forward.

The hospital situation report (SITREP) dated 04 April, 2019 was reviewed and found to state that physical health checks for all patients were complete. We found that this was not an accurate reflection of our findings.

Arrangements to support robust assessment and/or planning to ensure patients are included in appropriate population screening programmes (breast, cervical, abdominal aortic aneurysm (AAA) and/or diabetic retinopathy screening) were not found to be in operation.

We found evidence of some consideration of how many patients might need a particular screening test ((eg) mammography) but we could not evidence a hospital-wide system to identify, arrange and assure appropriate participation of patients in population screening programmes relevant to their age and gender.

In hours general practitioner (GP) clinical sessions are not provided on the MAH site. We found that there was no local partnership/service level agreement arrangement in place with any of the local GP practices to address this requirement. We noted that this disadvantages patients in MAH when compared to their peers living in the community.

Discharge Planning

We found limited progress for those patients experiencing a delay in the discharge. Ward staff told us that they did not have up to date information for all patients who had completed their active assessment and treatment and were awaiting discharge. Inspectors met with several patients who were experiencing a delay in their discharge from MAH. Patients and staff discussed the challenges that this presents as patients, family members/carers continued to seek advice and support in relation to possible discharge options.

Staff of all grades and professions highlighted the ongoing difficult in securing appropriate community based resources to support patients upon their discharge from hospital. BHSCT continued to progress a collaborative regional approach to ensure the hospital functions as an assessment and treatment hospital. The MAH management team advised us that a Supported Living Service was being developed close to the hospital site. The service will provide accommodation for up to twelve individuals and was in the process of registering with RQIA.

It was positive to note continued multi-agency involvement with all stakeholders including other Trusts, the Health and Social Care Board (HSCB), the Public Health Agency (PHA) and the Department of Health (DoH). However, we found limited progress had been made to ensure that agreed discharge arrangements were recorded and co-ordinated with all services involved in patients' on-going care.

Discharge planning arrangements were reviewed. We found that a high percentage of patients no longer required treatment and were experiencing a delay in their discharge from hospital.

Strategic Planning and Communication

Following the most recent inspection of MAH BHSCT had introduced a number of priorities to support the re-modelling of services within MAH. At the time of the inspection the hospital was not accepting new admissions and patients requiring acute care were being redirected to facilities in other Trusts.

MAH admission criteria had been reviewed to ensure that only those patients presenting with mental ill health or severe behavioural concerns would be admitted to the hospital going forward.

Despite the introduction of new arrangements we remained concerned about the hospital's strategic planning. We did not evidence a clear strategic direction and robust planning regarding staffing, safeguarding, management of patients' physical health care, discharge planning and financial governance.

Discussions with a wide range of staff across the whole MAH site identified that a large number were not aware of the future plans for the hospital.

Staff told us that they were unclear as to the role and function of the hospital's PICU. During discussions some staff advised us that they were in temporary positions whilst PICU was closed for a short time; whilst others who had been relocated from PICU believed that they had been moved permanently to other wards.

Ward MDT's continued to implement local arrangements to facilitate seclusion for patients as they were unable to access the purpose built seclusion room located within the PICU. These arrangements were being provided in rooms that did not meet the required standards and best practice guidelines for seclusion.

Hospital Governance

MAH governance arrangements and documentation was discussed with BHSCT senior managers, senior nursing managers, ward managers and members of the MDT.

We welcomed that a BHSCT Assurance Committee has been established and that daily, weekly and monthly governance meetings were also occurring at ward/hospital level. We found that the Deputy Chief Executive/Medical Director chairs a weekly assurance meeting. We noted that SITREP meetings included a weekly governance review section during which staffing, service continuity, incidents, seclusion, complaints, risk register issues and updates regarding on-going CCTV monitoring are reported. Whilst these metrics are useful we highlighted that the tool may require some revision in order to be fully sensitive to all pertinent issues and to be utilised to its' full potential. We did not find that exploration of alternative safety measurement and monitoring frameworks had been undertaken.

Governance arrangements were found to be insufficiently developed to be capable of providing assurance to BHSCT that services in MAH are safe and well led. We suggested that additional resources and external support was required. This is necessary to provide robust assurance of the quality and safety of care provided in the hospital, to ensure appropriate planning for transition of identified patients from the hospital to suitable community placements and to define the hospital's overall purpose within the wider HSC system (current and future).

Frontline staff again informed us that they were unclear about the role and functions of the various meetings and arrangements. We were unable to clearly determine the linkages between the constituent parts of the governance system.

We noted discrepancies in information reported through various parts of the hospital's operating and governing systems.

We were concerned to find that incidents meeting the threshold for Serious Adverse Incident (SAI) review were not being robustly reviewed, assessed and progressed through the system. An incident in which a patient had threatened to self-harm using glass and then subsequently threatened staff was noted. We were concerned that it appeared that the categorisation of the incident had been on the basis of outcome (no significant injury occurred) rather than the potential for a catastrophic injury.

A review of the minutes of SITREP of 04 March 2019 indicated that a member of the medical staff team was "conducting serious event audit review". We found frontline staff were unclear whether this was focusing solely upon the incident in Ardmore or involved a review of a different incident/number of serious adverse incidents.

BHSCT senior managers informed us that on-site presence and leadership had been refreshed.

We spoke to a wide range of staff from across the hospital a large number of who told us that they did not feel appropriately supported. We were informed that there was only two middle management staff on site when the complement should be four. Staff told us that this was causing them significant pressure and contributing to them being unsupported. Staff experiences shared with us evidenced that morale continued to be poor. It remained a significant cause for concern. Staff told us that they were often subject to a lot of assaults by patients. They reported that there was no formal debrief following an incident but they instead accessed support from within the immediate team or their peers.

We were told that debriefs post incident usually only occur when staff who have been off sick return to work or when there is a serious incident. We observed that nursing staff continue to experience enormous challenges and may not be able to avail of comfort breaks or finish their working hours on time due to the demands of providing care in these complex and challenging circumstances. Staff also told us that they have had to carry over a lot of annual leave and feel at risk of burnout.

The inspection team noted that a BHSCT survey of MAH staff in relation to the question "How safe did you feel in work today?" was reported at the weekly SITREP meeting on 18 March 2019. The results indicated that 60% of (150 staff) reported that they felt very unsafe.

We again could not evidence that the local governance arrangements or the support measures were having the required impact on safety and effectiveness of care for patients or on the health and well-being of staff.

Financial Governance

We confirmed that the outstanding safeguarding referral in relation to one patient identified during the previous inspection had been completed. We were unable to evidence progress in relation to the other aspects of financial oversight and governance.

We reviewed a sample of patient property records and ward ledgers and were unable to identify improvements in the standard of their completion. The documentation and knowledge deficiencies with respect to the appointee-ship arrangements for 13 patients identified during the previous inspection in February 2019 were not found to have been comprehensively addressed.

We found that monthly monitoring of ward finances by senior site managers was inconsistently completed. The records we reviewed highlighted a lack of evidence of appropriate assurance.

The report of a previous financial audit undertaken in 2015 by the internal audit team was reviewed. We noted that many of the priority one and two recommendations in this report were similar to those identified during this inspection and also the previous inspection in February 2019. We highlighted the timeline of this audit report (>3 years old) in the context of a need for more recent audit and assurance. We were unable to evidence that BHSCT had undertaken an audit of its' financial procedures across all wards in the MAH site during April 2019.

Overall we were not assured that implementation of and compliance with financial procedures was consistent across all wards in order to provide assurance of robust financial governance.

7.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the Deputy Chief Executive & Medical Director, BHSCT Senior and Executive Management Team and ward staff as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

BHSCT should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further action. It is the responsibility of BHSCT to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas for improvement

Areas for improvement have been identified in which action is required to ensure compliance with the Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to meet the areas for improvement identified. The BHSCT should confirm that these actions have been completed and return the completed QIP to bsu.admin@rqia.org.uk for assessment by the inspector by 5 March 2020.

Quality Improvement Plan	
The Trust must ensure the following findings are addressed:	
Staffing	
Area for improvement No. 1 **Ref**: Standards 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1, 5.3.3) **Stated:** Second time **To be completed by:** Before 14 May 2019	The Belfast Health and Social Care Trust must: 1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at MAH, which; a) is based on the assessed needs of the current patient population *and* b) Incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements. 2. Implement an effective process for oversight and escalation to senior management and the executive team when challenges in nurse staffing arise. 3. Implement an effective assurance mechanism to provide oversight of the implementation of the model and escalation measures. 4. Engage the support of the other key stakeholders, including the commissioner in defining the model to determine safe levels of nurse staffing.
	Response by the Trust detailing the actions taken: 1. a. Work progressed to determine safe staffing levels through an assessment of the current patient population's acuity and dependency. Acuity and dependency was determined using the current level of observation employed by the staff to safely care for patients, and using Telford to determine the registrant levels. This triangulated approach has resulted in a nursing model, which is in use to describe safe staffing levels. b. The model is in use by the ward managers and reviewed regularly to respond to temporary or unplanned variations in patient assessed needs and/or service requirements. 2. Ward staffing levels are reviewed on a daily basis Monday to Friday and at the weekly Ward Managers meeting (Friday) for the weekend. ASMs are on site Monday to Friday and review the requirements daily. An OoH co-ordinator also reviews staffing levels on site in the OoH period. Any issues of concern are raised by the wards to the ASM/OoH Co-Ordinator to Service manager and then to Collective leadership team. In the OoH there is a senior manager on call rota in place to provide additional support to staff OoH. 3. The Model was developed with engagement from the ward managers and ASMs in the first instance to ensure buy in. the Divisional Nurse worked closely with the ward Managers and ASMS to determine the current patients' needs on site in order to inform the model. Also a Telford

	exercise was undertaken with each of the ward managers. Once the model was developed the DN met with each of the Ward managers and ASMS to implement. Assurances are sought at the weekly ward managers meeting that the model is in use. When there are any issues Ward managers and ASMS are able to contact and talk it through with the DN if that support is required. The pathway used to escalate issues is Ward Manager to ASM to SM and then to the Collective Leadership team. 4. The nursing model has been developed by the senior team in MAH (in conjunction with the ward managers and ASMs) and approved by the Executive Director of Nursing and the Expert Nurse Advisor, DoH, and it has been presented to and supported by RQIA.
Safeguarding	
Area for improvement No. 2 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for adult safeguarding at MAH and ensure: a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations; b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively; c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care; d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding are improved. 2. Implement an effective process for oversight and escalation of matters relating to adult safeguarding across the hospital site; this should include ward sisters, hospital managers, BHSCT senior managers and / or the Executive team as appropriate. 3. Implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital.
	Response by the Trust detailing the actions taken: A detailed action plan was developed by the ASG and management team at MAH. There are 37 actions in place to ensure that the key 3 areas outlined in the QIP are

	achieved. At present 34 of these actions have been completed, the remaining 3 actions are currently on hold following advice from the PSNI not to proceed whilst the investigation is ongoing. There are plans in place to meet with the PSNI to discuss further. There are currently monthly ASG audits taking place on site to provide assurance that the changes implemented through the action planned are still in place and compliant.
CCTV	
Area for improvement No. 3 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for the management and monitoring of CCTV within MAH and ensure: a) that all staff understand the procedures to be followed with respect to CCTV; b) that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively; 2. Ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH.
	Response by the Trust detailing the actions taken: The CCTV policy has been reviewed, included update to forms included within the policy, the policy is currently with the Trust's Standard and Guidelines Committee for tabling. All staff have access to the initial policy approved in MAH. Further policy review and update is planned to improve the use of CCTV for safety monitoring. This is being progressed with the CCTV working Group and will be shared with staff when fully approved. There are agreed procedures within the hospital for monitoring and managing CCTV images, the template for requesting a download of footage has been updated. Work is required to improve the robustness, monitoring and functionality of the CCTV system on site. The Co-Director is awaiting quotes from Estate Services/ RadioContact and a business case will be developed. A CCTV working group has been set up (this includes a representation from ward staff, safeguarding staff, management, litigation and unions) to review the current use of use and the development of use within the hospital. Feedback surveys and processes have been developed to gather feedback on the current use and developed use of CCTV for safety monitoring within the hospital.

	Feedback is being sought from staff, families, carers, advocates and patients.
Restrictive Practices (Seclusion)	
Area for improvement No. 4 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1, 5.3.3) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must: 1. Undertake an urgent review of the current and ongoing use of restrictive practices including seclusion at MAH whilst taking account of required standards and best practice guidance. 2. Develop and implement a restrictive practices strategy across MAH that meets the required best practice guidance. 3. Ensure that the use of restrictive practices is routinely audited and reported through the BHSCT assurance framework. 4. Review and update BHSCT restrictive practices policy and ensure the policy is in keeping with best practice guidelines.
	Response by the Trust detailing the actions taken: MAH have implemented a suite of reports including a weekly patient safety report and a monthly governance report to ensure a clear statistical position for the use of restrictive practice is available for each setting. Reports are shared at both Executive Team and Trust Board. To date the use of seclusion and physical intervention have greatly decreased in the hospital. Audits have been implemented for the use of seclusion and patient observations, they are carried out on a monthly basis. The finding and actions from the audits are discussed at Pipa meetings and at the monthly Governance Committee. Restrictive Practices usage is discussed at a range of meetings, a Live Governance Call takes place each week when ward staff discuss the use of seclusion, Physical Intervention and use of PRN medication at patient level. The use of restrictive practice is included in the weekly Patient Safety Report and reviewed at the monthly Governance Committee. A Restrictive Practice Working group has been set up to provide a strategic overview of the use of and future use of Restrictive Practices within the hospital. The group has presentation of medical staff, ward staff, management, Safeguarding Staff, Governance, PBS and pharmacy. The suite of Restrictive Practice policies have been reviewed by an MDT within the hospital, an overarching Restrictive Practice Policy has been developed in line with best practice across the UK.

	MAH have formed a 'critical friend' relationship East London NHS Foundation Trust to act as critical friend to provide support and challenge in respect of all restrictive practices
Patient Observations	
Area for improvement No. 5 **Ref:** Standard 5.1 Criteria 5.3 (5.3.3) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must address the following matters in relation to patient observations: 1. Engage with ward managers and frontline nursing staff to ensure that a regular programme of audits of patient observations is completed at ward level. 2. Ensure that there is an effective system in place for assessing and managing patient observation practices, which is multi-disciplinary in nature and which enables staff to deliver effective care and learn collaboratively.
	Response by the Trust detailing the actions taken: A monthly audit process has been embedded across the hospital. The audit looks at the use of observations and reports compliance or non-compliance with the policy. The outcome of each audit is circulated to the management team, discussed at PiPa and reviewed at the Governance Committee meeting. Assessing and management of patient observation practices are reviewed through PiPa meeting with a MDT approach.
Management of Medicines	
Area for improvement No. 6 **Ref**: Standard 5.1 Criteria 5.3.1(f) **Stated:** First time **To be completed by:** 28 August 2019	The Belfast Health and Social Care Trust must strengthen arrangements for the management of medicines in the following areas: 1. Recruit a Pharmacy Technician to support stock management and address deficiencies (stock levels/ordering/expiry date checking) in wards in MAH to assist with release of nursing staff and pharmacist time. 2. Undertake a range of audits of (i) omitted doses of medicines (ii) standards of completion of administration records and (iii) effectiveness & appropriateness of administration of "when required" medicines utilised to manage agitation as part of de-escalation strategy. 3. Implement consistent refrigerator temperature monitoring recording (Actual/Minimum & Maximum) across all wards in MAH.
	Response by the Trust detailing the actions taken: 1. The existing registered pharmacist has agreed to increase hours from 0.5wte to 0.8 wte from the beginning of April 2020. The pharmacy technician post is in the early stages of recruitment. 2. The pharmacist reviews the kardexes for omitted does and completion of administration records at the

	PIPA meetings and any omissions or areas of concern raised at that time. With the increase in the Pharmacy hours, a more formalised approach can now be developed. A POMH audit on antipsychotic prescribing in ID patients, led by the Trust Pharmacy team will commence by the end of March 2020. 3. Each ward sister is responsible to ensuring that refrigerator temperature monitoring recording (Actual/Minimum & Maximum) is in place on their ward. This will be placed on the safety brief for daily checking. In addition the Pharmacist will audit the temperature monitoring when the Controlled drug audits are being undertaken.
Physical Health Care Needs	
Area for improvement No. 7 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must develop and implement a systematic approach to the identification and delivery of physical health care needs to: 1. Ensure that there is an appropriate number of suitability qualified staff to ensure that the entire range of patients physical health care needs are met to include gender and age specific physical health screening programmes. 2. Ensure that patients in receipt of antipsychotic medication receive the required monitoring in accordance with the hospital's antipsychotic monitoring policy. 3. Ensure that specialist learning disability trained nursing staff understand and oversee management of the physical health care needs of patients in MAH. 4. A system of assurance in respect of delivery of physical healthcare.
	Response by the Trust detailing the actions taken: A GP role has been recruited to the hospital to focus on physical health checks for all patients. There are 3 SHO positions within the hospital which are made up of one GP trainee and 2 psychiatry trainees. There is an out of hours GP available on site from 7pm-11pm each day with all other hours are covered by the onsite GP, the 3 SHOs and the psychiatry team for physical health care and queries. A lookback exercise has taken place to gather all physical health information for each patient including family history were available. This information is now stored on one template which is available on the PARIS system and in a physical health folder kept on each ward. Patients who meet the guidelines set out by Northern Ireland screening programmes have had their screening completed and added to the registers to ensure they are called appropriately with the general population. (Cervical cancer,

	Bowel screening, mammograms, AAA and diabetic eye. Each relevant patient now has an annual Chronic Health Condition review (Eye exams, asthma review, epilepsy review, hypertension review, testicular exams, breast exams and cervical screening. A review of all patients' health checks in regards to antipsychotic medication has been carried out. Each patient has an anti-psychotic monitoring chart which is reviewed by both a medical professional and a pharmacist. Six monthly (March & September) checks in line with Maudsley Guidelines is carried out, this includes bloods, ECG and all other relevant physical checks. All patient physical check information is stored on one template providing assurance that historical check information, family history and planned checks are available to all relevant staff. This provides assurance that all relevant checks have taken place or planned within the required timeframe. 1. All patients receive a physical examination within 24 hours of admission (ward trainee/on call trainee and nursing staff observations). We have ECG machines, physical observation equipment and venepuncture facilities available on site. 2. Past medical history and medicines reconciliation are confirmed within the first week (ward trainee/pharmacist) 3. Any initial concerns about physical health are followed up accordingly (ward trainee) 4. Longer term conditions and screening are managed by or GP locum doctor who also offers advice to trainees where required 5. For non-urgent physical concerns on the ward, the ward trainee is called 6. For urgent physical concerns, we have a duty bleep system for our site doctors and staff are aware to also contact NIAS in emergencies (as we have limited resuscitation facilities on site). Mandatory training for staff includes Life Support Training (at various levels depending on the grade/role of staff) accessed via the Trust HRPTS system 7. PIpA Visual Control Boards on each ward include prompts regarding physical healthcare, screening and antipsychotic monitoring. 8. We operate daily ward rounds (PIpA model) with focus days, one of which per week is about health promotion 9. All material pertaining to physical healthcare concerns are kept in manual files on the wards for

	easy access at PIpA and for out of hours doctors 10. Antipsychotic monitoring is performed as required and routinely every six months (March and September) now by our GP locum doctor and ward nursing staff. An audit of this across the site was carried out in December 11. Current completion of the POMH audit: Antipsychotic prescribing in people with a learning disability under the care of mental health services (4/2-27/3/20 period, all inpatients and a sample of community patients). To compare with previous audit findings 12. We have the facility to refer to podiatry, dietetics, SALT, physio, OT on site and to our visiting dentist. 13. We have close links with and advice from the lead AMH pharmacist. We also have a part time pharmacist on site. 14. Future plans to develop the role of our locum GP colleague in the 'ID Physician' model to bridge the knowledge gap between primary and secondary care and improve the quality of physical healthcare assessment for our patients with complex co morbidities
Discharge Planning	
Area for improvement No. 8 **Ref**: Standard 5.1 Criteria 5.3 (5.3.3(b)) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must ensure that ward staff have access to detailed and current information regarding patients who have completed their active assessment and treatment and are awaiting discharge from MAH.
	Response by the Trust detailing the actions taken: Patient level assessment and discharge information and plans are discussed at weekly PiPa meetings at ward level. Information from these meetings is shared appropriately at ward level by the ward representatives at Pipa. Patient transition plans are shared at ward level and there is an MDT approach for transition planning. The Transition team attend the ward managers meetings and the ASM meetings when there are updates to patient resettlement plans. A Quality Improvement project has been initiated involving staff from across the hospital to focus on standardising and improving the transition processes for patients resettling from hospital.

Strategic Planning & Communication	
Area for improvement No. 9 **Ref**: Standards 4.1 & 8.1 Criteria 4.3 (b, d and e), 8.3 (b) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must address the following matters to strengthen hospital planning: 1. Ensure that a comprehensive forward plan for MAH is developed, communicated, disseminated and fully understood by staff. 2. Ensure that stated aims and objectives for the hospital's PICU are developed and disseminated to frontline nursing staff so that there is clarity regarding both the unit and staff positions.
	Response by the Trust detailing the actions taken: A workshop (invite open to all MAH staff) is planned for the 26 Mar 2020 to discuss plans and development for the future of the hospital site. Monthly staff briefing meetings have been embedded within the hospital, these meetings aim to share information with staff across the site and respond to any questions. A weekly newsletter is distributed to all staff across the hospital, providing information updates and sharing news. The PICU is no longer in use and will not be restored to its previous function, this information has been communicated to staff. The workshop planned for March and future planning meetings will include discussion around the future use of the PICU space.
Hospital Governance	
Area for improvement No. 10 **Ref**: Standards 4.1 and 5.1 Criteria 4.3 (a) and 5.3.1.(f) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must review the governing arrangements in MAH and consider the following matters in order to strengthen the governance arrangements: 1. Enhance communication, staff knowledge and understanding of relevant committees and meetings to support local leadership and governance on the MAH site. 2. Embed the recently introduced Daily Safety Huddle (at ward level) and the Weekly Safety Pause (hospital level) meetings. 3. Implement an effective assurance framework.
	Response by the Trust detailing the actions taken: A governance framework has been developed within the hospital, this consists of a hierarchy of meetings which provide the space for discussion, challenge, review and assurance. There have been a suite of reports developed to provide statistics, analysis and oversight of key governance areas within the hospital. The governance meeting and reports framework has been illustrated in a flow chart and provided to staff to assist with understanding of the reports and meetings within / about the hospital.

	The daily safety huddle now takes place on a daily basis within each ward. A weekly live governance call has been embedded within the hospital, this meeting has multi-disciplinary representation and is led by ward level information. The assurance framework has been embedded, this has been built from ward level reports and meetings building into Hospital management meetings which feed into Executive and Trust Board level meetings.
Financial Governance	
Area for improvement No. 11 **Ref**: Standard 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must ensure: 1. That the BHSCT is appropriately discharging its full responsibilities, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986. 2. In respect of those patients in receipt of benefits for whom BHSCT is acting as appointee, that appropriate documentation is in place and that individual patients are in receipt of their correct benefits. 3. Implementation of a robust system to evidence and assure that all arrangements relating to patients' monies and valuables are operating in accordance with The Mental Health (Northern Ireland) Order 1986 and BHSCT policy and procedures; this includes: a) that appropriate records of patients' property are maintained; b) that staff with responsibility for patients' income and expenditure have been appropriately trained for this role; c) that audits by senior managers of records retained at ward level are completed in accordance with BHSCT policy; d) that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in MAH.
	Response by the Trust detailing the actions taken: A comprehensive action plan has been developed by the finance team and management team at MAH. The plan consists of 18 actions (8 completed, 9 in progress and 1 no longer applicable). The appointment of a Finance Liaison Officer has been very successful and enabled individual financial plans to be produced. The Trust has recently received a response from RQIA to our request to hold balances over £20k for 4 patients and we are currently addressing the questions raised and remain confident that the Trust is best placed to manage these monies on patient's behalf. The Trust has sought and received appropriate documentation including benefit entitlement for all patients

	we are appointee for with the exception of one patient that transferred to MAH from a Trust supported living accommodation – the documentation for this one patient is currently being followed up. The Trust Policy has been extensively reviewed and updated a number of times since the inspection and training has been delivered to all relevant staff. Although the current version of the Policy has been issued to staff it continues to be reviewed and updated in light of in-house monitoring findings. The BSO Internal Audit has now taken place and the Trust is due to meet with auditors on 25th March to discuss findings.

Name of person (s) completing the QIP	Gillian Traub		
Signature of person (s) completing the QIP	Gillian Traub	**Date completed**	12 March 2020
Name of Responsible Person approving the QIP	Gillian Traub		
Signature of Responsible Person approving the QIP	Gillian Traub	**Date approved**	18 September 2020
Name of RQIA Inspector assessing response	Wendy McGregor		
Signature of RQIA Inspector assessing response	Wendy McGregor	**Date approved**	18 September 2020

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Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority

Announced Finance Inspection Report
1 July 2019

Belfast Health and Social Care Trust

Muckamore Abbey Hospital

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Assurance, Challenge and Improvement in Health and Social Care

Membership of the Inspection Team

Emer Hopkins	Deputy Director Regulation and Quality Improvement Authority
Caroline Hannon	Solicitor Consultant, Regulation and Quality Improvement Authority
Wendy McGregor	Inspector, Mental Health and Learning Disability Team, Regulation and Quality Improvement Authority
Briege Ferris	Finance Inspector Regulation and Quality Improvement Authority

Abbreviations

AHP	Allied Health Professionals
BHSCT	Belfast Health and Social Care Trust
DoH	Department of Health
MAH	Muckamore Abbey Hospital
MDT	Multi-disciplinary Team
MHO	Mental Health (Northern Ireland) Order 1986
NHSCT	Northern Health and Social Care Trust
OCP	Office of Care and Protection
PICU	Psychiatric Intensive Care Unit
QIP	Quality Improvement Plan
RQIA	Regulation and Quality Improvement Authority
SEHSCT	South Eastern Health and Social Care Trust

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability Hospital managed by Belfast Health and Social Care Trust (BHSCT). The hospital provides inpatient care to adults 18 years and over who have a learning disability and require care and treatment in an acute psychiatric care setting. Patients are admitted either on a voluntary basis or in accordance with the Mental Health (Northern Ireland) Order 1986.

MAH provides a service to people with a Learning Disability from BHSCT, Northern Health and Social Care Trust (NHSCT) and South Eastern Health and Social Care Trust (SEHSCT).

At the time of the inspection there were five wards on the MAH site:

- Cranfield One (Male assessment)
- Cranfield Two (Male treatment)
- Ardmore (Female assessment and treatment)
- Six Mile (Forensic Male assessment and treatment)
- Erne (Long stay/re-settlement).

The PICU was closed for refurbishment. A hospital day care service was also available for patients.

3.0 Service details

Responsible person: Mr Martin Dillon Belfast Health and Social Care Trust (BHSCT)	**Position:** Chief Executive Officer
Category of care: Acute Mental Health & Learning Disability	**Number of beds:** 83
Person in charge at the time of inspection: Marie Heaney, Director of Community Learning Disability and Community Older People	

4.0 Inspection summary

Prior to this inspection RQIA undertook an unannounced inspection of MAH on 26, 27 & 28 February 2019. A total of 11 areas for improvement against the standards were identified during this inspection. Serious concerns were identified in relation to the following six areas:

1. Staffing levels;
2. Patients' physical health care needs;
3. Financial governance;
4. Safeguarding vulnerable adult practices;
5. Restrictive practices (seclusion);
6. Hospital governance.

Following the initial inspection during February 2019 we wrote to the Chief Executive of BHSCT on 05 March 2019. We informed him of the six areas of serious concern and our intention to serve six improvement notices in respect of failures to comply with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (DoH, 2006). We subsequently held an intention to serve improvement notices meeting with BHSCT on 07 March 2019. During this meeting we received the Trust's formal action plan. After considering the detail of the Trusts the action plan we determined this to be a constructive response with good potential to improve BHSCT's position in relation to each of the areas of serious concern identified. A decision was made not to serve Improvement Notices at this time.

A further unannounced inspection of MAH took place over two days on 15 and 16 April 2019. The purpose of this inspection was to assess progress regarding the implementation of the action plan and to test the assurances provided by the BHSCT. We evidenced limited progress in relation to 10 areas for improvement (medicines management was not assessed) and the six areas of significant concern previously identified.

The specific focus of this announced inspection on 1July 2019, was to assess the financial governance arrangements within the hospital. This inspection also examined how the Trust was executing its responsibilities in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986. The inspection was also underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

An area for improvement against the standards was identified during this inspection in relation to the hospital's financial governance arrangements as identified during previous inspections.

Key Findings

The inspection team could not evidence appropriate documentation relating to appointee-ship arrangements for five patients, an issue which had been highlighted at the previous inspection. In relation to a number of patients for whom the BHSCT held in excess of £20,000, we noted that no referrals to the Office and Care of Protection had been made and neither was there evidence of plans to seek consent from RQIA to hold patient balances in excess of £20,000.

There was no system in place for reviewing patient's benefits entitlement or a system to identify a patient's changing financial circumstances.

We evidenced inconsistencies in financial records and gaps in the weekly and monthly ledger checks completed at ward level by senior managers. This had not improved since identified at the previous inspection. We could not evidence discussion or best interest decision making in respect of decisions to spend patient's monies.

Overall we were not assured of the implementation of and compliance with agreed financial procedures across the hospital and we were neither assured of the Trusts capacity to provide robust financial governance in relation to this patient group

4.1 Inspection outcome

Total number of areas for improvement	8

Following this inspection we remained concerned about the arrangements in respect to oversight, management and governance of patients' finances in MAH and the approach of the BHSCT to holding and management of patient funds.

Detailed findings of this unannounced inspection were shared with Ms Breige Connery Senior Nurse Manager at the end of the inspection. This report is not intended to repeat this detailed feedback

As outlined previously the focus of this inspection was the assessment of MAH financial governance arrangements. The remaining10 areas for improvement identified following our inspection to MAH (15 & 16 April 2019) were not reviewed during this inspection. Eight of these areas for improvement have been carried forward to be assessed during the next inspection.

Further intelligence received since the Inspection of April

Following a review of the findings from our three inspections (February 2019, April 2019 and July 2019) and assessment of the additional intelligences received regarding MAH, we informed BHSCT of our intention to serve four Improvement Notices in respect to failures to comply with the following Quality Standards.

The quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).

Standard 4.1:

The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.

Standard 5.1:

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

These failures related to staffing, financial governance, restrictive practices (seclusion) and safeguarding.

We met with BHSCT's Chief Executive and the MAH senior management team at RQIA on 14 August 2019. We sought further assurances on BHSCT on how BHSCT intended to address each of the issues.

Following this meeting, and in accordance with Article 39 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, we determined that the most appropriate course of action was to serve three Improvement Notices in respect of financial governance, staffing and safeguarding. A notice was not served in relation to restrictive practices following the consideration of assurance received at this meeting. These notices were served as a result of BHSCT failure to comply with the following standards:

4.2 Action/enforcement taken following our most recent inspections

Following a review of findings from this inspection and the inspections we completed on 26, 27 & 28 February 2019 and 16 & 17 April 2019 and having assessed additional intelligence we received regarding MAH, we determined that the most appropriate course of action was to issue three Improvement notices to BHSCT. Consideration was given to issuing a fourth notice in the area of restricted practices. However after lengthy consideration of the Trust plans/actions to deliver improvements in this area we were satisfied with the progress made and proposed actions to ensure further improvement.

Three notices were served to BHSCT on the 16 August 2019 and related to:

- Staffing: Improvement notice number IN000003
- Financial governance: Improvement notice number IN000004
- Safeguarding: Improvement notice number IN000005

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.or.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Enforcement notices for registered establishments and agencies are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

5.0 How we inspect

This focussed finance inspection specifically examined the assurance and governance arrangements for the management of patients' finances in line with the trust responsibilities under Article 116 and 107 of the MHO.

Following this inspection we continued to review all information received in relation to MAH. This included further intelligence, incident reports and updates in relation to the six areas of serious concern identified during previous inspections completed in February and April 2019.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection dated 15 -17 April 2019

Areas for improvement		Validation of compliance
Staffing		
Area for improvement No.1 **Ref**: Standards 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1, 5.3.3) **Stated:** First time	The Belfast Health and Social Care Trust must: 1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at MAH, which; a) is based on the assessed needs of the current patient population; and a) incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements. 2. Implement an effective process for oversight and escalation to senior management and the executive team when challenges in nurse staffing arise. 3. Implement an effective assurance mechanism to provide oversight of the implementation of the model and escalation measures. 4. Engage the support of the other key stakeholders, including the commissioner in defining the model to determine safe levels of nurse staffing.	

	Action taken as confirmed during the inspection/review: During our inspection in February 2019 we found evidence of insufficient staffing at ward level to meet patients' prescribed level of observation, to appropriately manage patients' physical health care needs and to implement and execute appropriate therapeutic care plans for patients. During our second unannounced inspection in April 2019, we evidenced limited progress in relation to staffing. Additional nursing resources did not commence work in early March as advised during our 'Intention to Serve' meeting (7 March 2019). We also became aware that five experienced Band 7 nurses would move from their roles/posts in MAH and two other senior staff were also moving from their roles/posts. We were unable to accurately confirm BHSCT determination of the nursing staff requirement at MAH. Additional information in respect of nurse staffing has been provided to us in correspondence from BHSCT on 20 June 2019 and 22 July 2019. Having reviewed all information held we were not satisfied that there were effective staffing model and assurance mechanism in place to ensure safe levels of staffing based on assessed patient need. Following an intention to serve meeting with BHSCT on 7 August 2019 we issued an Improvement Notice in relation to staffing.	**Not met improvement notice IN000003 served**
Safeguarding		
Area for improvement No. 2 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** First time	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for adult safeguarding at MAH and ensure: a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or	

	notifications to other relevant stakeholders and organisations; b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively; c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care; d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding are improved. 2. Implement an effective process for oversight and escalation of matters relating to adult safeguarding across the hospital site; this should include ward managers, hospital managers, BHSCT senior managers and / or the Executive team as appropriate. 3. Implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital.	
	Action taken as confirmed during the inspection/review: During our inspection in February 2019 we did not find evidence of effective deployment of safeguarding referrals, we did not find evidence of the implementation of learning arising through safeguarding investigations or that the outcomes from safeguarding investigations were positively impacting patient well-being. A structural disconnect between professional staff was evident in the safeguarding arrangements in place.	**Not met improvement notice IN000005 served**

	During our second unannounced inspection in April 2019, we evidenced limited progress in relation to safeguarding practices. As in our previous inspection, we did not find evidence of implementation of learning arising from safeguarding investigations or that the outcomes from safeguarding investigations were positively impacting patient well-being. Following this inspection we continued to receive intelligence and assess the Trust's response in relation to its management of safeguarding incidents on the site. We were not assured that the current systems were working effectively and were not always able to receive accurate and timely information in relation to individual incidents. Following an intention to serve meeting with BHSCT on 7 August 2019 we issued an Improvement Notice in relation to safeguarding.	
CCTV		
Area for improvement No. 3 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** First time	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for the management and monitoring of CCTV within MAH and ensure: a) that all staff understand the procedures to be followed with respect to CCTV; b) that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively; 2. Ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH.	
	Action taken as confirmed during the inspection/review: This area for improvement will be assessed during the next inspection.	**Not reviewed**

<table>
<tr><th colspan="3">Restrictive Practices</th></tr>
<tr><td rowspan="2">Area for improvement No. 4

Ref: Standard 5.1 Criteria 5.3 (5.3.1, 5.3.3)

Stated: First time</td><td>The Belfast Health and Social Care Trust must:
1. Undertake an urgent review of the current and ongoing use of restrictive practices including seclusion at MAH whilst taking account of required standards and best practice guidance.
2. Develop and implement a restrictive practices strategy across MAH that meets the required best practice guidance.
3. Ensure that the use of restrictive practices is routinely audited and reported through the BHSCT assurance framework.

Review and update BHSCT restrictive practices policy and ensure the policy is in keeping with best practice guidelines.</td><td rowspan="2">Improvement Notice Meeting - Decision Improvement Notice not served.</td></tr>
<tr><td>Action taken as confirmed during the inspection/review:

Following consideration of information from two previous inspections and additional information received in intelligences and review of the Trusts action plans in relation to our concerns this issue. This was discussed at an intention to serve meeting on the 7 August 2019.

After reviewing progress and planned improvements in relation to this area and considering an overall reduction in the use of seclusion we determined not to issue an improvement Notice in relation to this Area. Progress will be assessed during future inspections.</td></tr>
</table>

Patient Observations		
Area for improvement No. 5 **Ref**: Standard 5.1 Criteria 5.3 (5.3.3) **Stated:** First time	The Belfast Health and Social Care Trust must address the following matters in relation to patient observations: 1. Engage with ward managers and frontline nursing staff to ensure that a regular programme of audits of patient observations is completed at ward level. 2. Ensure that there is an effective system in place for assessing and managing patient observation practices, which is multi-disciplinary in nature and which enables staff to deliver effective care and learn collaboratively.	
	Action taken as confirmed during the inspection/review: This area for improvement will be assessed during the next inspection.	**Not reviewed**
Management of Medicines		
Area for improvement No. 6 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1(f)) **Stated:** First time	The Belfast Health and Social Care Trust must strengthen arrangements for the management of medicines in the following areas: 1. Recruit a Pharmacy Technician to support stock management and address deficiencies (stock levels/ordering/expiry date checking) in wards in MAH to assist with release of nursing staff and pharmacist time. 2. Undertake a range of audits of (i) omitted doses of medicines (ii) standards of completion of administration records and (iii) effectiveness & appropriateness of administration of "when required" medicines utilised to manage agitation as part of de-escalation strategy. 3. Implement consistent refrigerator temperature monitoring recording (Actual/Minimum & Maximum) across all wards in MAH.	
	Action taken as confirmed during the inspection/review: **This area for improvement will be assessed during the next inspection.**	**Not reviewed**

Physical Health Care Needs		
Area for improvement No. 7 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** First time	The Belfast Health and Social Care Trust must develop and implement a systematic approach to the identification and delivery of physical health care needs to: 1. Ensure that here is an appropriate number of suitability qualified staff to oversee that the entire range of patients physical health care needs are met to include gender and age specific physical health screening programmes. 2. Ensure that patients in receipt of antipsychotic medication receive the required monitoring in accordance with the hospital's antipsychotic monitoring policy. 3. Ensure that specialist learning disability trained nursing staff understand and oversee management of the physical health care needs of patients in MAH. A system of assurance in respect of delivery of physical healthcare.	
	Action taken as confirmed during the inspection/review: This area for improvement will be assessed during the next inspection.	**Not reviewed**
Discharge Planning		
Area for improvement No. 8 **Ref**: Standard 5.1 Criteria 5.3 (5.3.3(b)) **Stated:** First time	The Belfast Health and Social Care Trust must ensure that ward staff have access to detailed and current information regarding patients who have completed their active assessment and treatment and are awaiting discharge from MAH.	
	Action taken as confirmed during the inspection/review: This area for improvement will be assessed during the next inspection.	**Not reviewed**
Strategic Planning & Communication		
Area for improvement No. 9 **Ref**: Standards 4.1 & 8.1 Criteria 4.3 (b,	The Belfast Health and Social Care Trust must address the following matters to strengthen hospital planning: 1. Ensure that a comprehensive forward plan for MAH is developed, communicated, disseminated and fully understood by staff.	

d and e), 8.3 (b) **Stated:** First time	2. Ensure that stated aims and objectives for the hospital's PICU are developed and disseminated to frontline nursing staff so that there is clarity regarding both the unit and staff positions.	
	Action taken as confirmed during the inspection/review: This area for improvement will be assessed during the next inspection.	**Not reviewed**
Hospital Governance		
Area for improvement No. 10 **Ref**: Standards 4.1 & 5.1 Criteria 4.3 (a) and 5.3.1.(f) **Stated:** First time	The Belfast Health and Social Care Trust must review the governing arrangements in MAH and consider the following matters in order to strengthen the governance arrangements: 1. Enhance communication, staff knowledge and understanding of relevant committees and meetings to support local leadership and governance on the MAH site. 2. Embed the recently introduced Daily Safety Huddle (at ward level) and the Weekly Safety Pause (hospital level) meetings. 3. Implement an effective assurance framework.	
	Action taken as confirmed during the inspection/review: This area for improvement will be assessed during the next inspection.	**Not reviewed**

Financial Governance		
Area for improvement No. 11 **Ref**: Standard 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1) **Stated:** First time	The Belfast Health and Social Care Trust must ensure: 1. That the BHSCT is appropriately discharging its full responsibilities, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986. 2. In respect of those patients in receipt of benefits for whom BHSCT is acting as appointee, that appropriate documentation is in place and that individual patients are in receipt of their correct benefits. 3. Implementation of a robust system to evidence and assure that all arrangements relating to patients' monies and valuables are operating in accordance with The Mental Health (Northern Ireland) Order 1986 and BHSCT policy and procedures; this includes: a) that appropriate records of patients' property are maintained; b) that staff with responsibility for patients' income and expenditure have been appropriately trained for this role; c) that audits by senior managers of records retained at ward level are completed in accordance with BHSCT policy; d) that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in MAH.	**Not met improvement notice IN000004 served**

	Action taken as confirmed during the inspection: We could not locate appropriate/complete documentation relating to appointee-ship arrangements to all patients for whom the Trust was acting as appointee. We could not identify improvements in completion of patient property records or in completion of ledgers at ward level. Monthly monitoring of ward finances by senior site managers was inconsistently completed. The Trust's planned audit of financial procedures across the site, to be undertaken during April 2019 as advised in the Trust's action plan had not commenced. Following an intention to serve meeting with BHSCT on 7 August 2019 we issued an Improvement Notice in relation to Financial governance.	

6.2 Inspection findings

BHSCT's action plan submitted on the 7 March 2020 detailed plans to update the hospital's policy in respect of the management of patients' moneys and valuables and ensure staff received appropriate training and guidance in relation to the implementation of the new policy. Following the previous inspection we received the revised draft policy for management of patients' monies and valuables. The draft policy was discussed with the senior manager and we identified several weaknesses within the policy and determined it was insufficient to ensure the Trust met with all its responsibilities under the Mental Health (Northern Ireland) Order 1986. Trust representatives agreed that further work would be undertaken to update the policy in line with the comments received. Discussions with ward managers had commenced for the purpose of familiarising staff with proposed revisions to the policy but the inspection team determined that these did not represent training of staff as detailed within the Trusts action plan.

During the inspection we sampled the records of four patients for whom the Trust was holding money. We ensured some of the patients sampled were holding sums in excess of £20,000 and some less. We sought evidence that the appropriate assessment of the patient's capacity to manage their finances had been documented. On reviewing the patient records we found that patient's capacity assessments had been completed and it was documented, where appropriate, that there was no need for ongoing capacity review.

Briege Connery Senior Nurse Manager reported that at the time of the inspection BHSCT held money for 51 patients receiving care and treatment in MAH. We reviewed the banking records retained by BHSCT for each patient and noted that four accounts had accumulated negative balances (overdrawn) in June 2019. This was contrary to BHSCT policy which detailed that accounts should not be allowed to become overdrawn. Although the sums were small we were concerned this may indicate limited monitoring of the balances within individual accounts.

In accordance to the MHO (Article 116) BHSCT where it appears the patient is incapable, by reason of mental disorder, of managing and administering their property and affairs, BHSCT may receive and hold money and valuables on behalf of that patient (MHO,1986).

Information provided during the inspection confirmed that fifteen current patients had an appointee to manage their finances. An appointee is an individual who is given responsibility for managing a person's benefits from the Department of Communities (DoC), and also for paying bills and managing a small and limited amount of savings in case of unforeseen circumstances (OCP, 2020).

The BHSCT was appointee for thirteen patients and the appointee for the remaining two patients was a relative. Inspectors were concerned to note that BHSCT had not evidenced that from the DoC of the appointee arrangements for five patients. As such there was no evidence they had been formally appointed to act for the patient.

Under Article 116(4) of the MHO, BHSCT is not permitted to receive or hold balances in excess of an agreed sum without the consent of RQIA. Seven of the patients for whom BHSCT was appointee had balance in their accounts in excess in of £20,000[1]. Inspectors noted that BHSCT had not implemented a system to identify those patients whose balances

[1] This sum was set by the DoH at no more than £20,000 for any individual patient in September 2012.

were likely to exceed this amount in the near future or put in place a system to provide assurance that the necessary RQIA consent to hold these balances was in place or that if required referrals to the office of care and protection had been made.

Senior managers and finance officers who met with inspectors could not describe a clear system for reviewing the benefit entitlement of patients. Benefit entitlements may be reduced when a patient has savings in access of £16,000. However, there was not an effective system in place to complete ongoing review of patients' balances and to notify the DoC of any savings accrued by patients..

We reviewed a sample of patients' income and expenditure records and identified that these records were up to date and receipts were available to account for all patient expenditure. We found one occasion of the use of a staff store loyalty card on purchases made using a patients' money which is contrary to the Trusts policy as staff should not be seen to benefit from loyalty points on purchases made on behalf of a patient.

We reviewed ward based ledgers for accuracy. We noted at times errors made on financial ledgers which had been overwritten and where the persons making the change to the records had not signed or initialled the record to identify who had made the amendment. Some entries which had been over-written were illegible

Inspectors identified that the weekly checks of ward based ledgers were not regularly completed. Several records identified that only two checks of patients' ward balances in hand to the records had been performed over a period of several weeks. In another case, a patient's ledger identified that between 3 April 2019 and 26 June 2019 only two weekly checks had been documented.

The MHO (1986) requires that decisions are made with due regard for what decision a patient would make in regards to their moneys and valuables if it were not for their impaired capacity. We reviewed the care plans for four patients and we did not see evidence of best interests decision making in relation to previous purchases or and evidence of forward financial planning, which is particularly relevant for those patient with significant accruals of money.

Patients' records were reviewed to identify whether each patient's personal property record had been appropriately maintained. Four sets of patient's records were sampled and we identified that three of the patients did not have a personal property record maintained. One patient had a record which was dated June 2016. Inspectors discussed this finding with ward staff. One staff member reported that property records were not updated following a patient's admission to the ward. This staff member also confirmed that items deposited for safekeeping were not recorded. A second staff member confirmed that property is recorded only on admission and discharge; acknowledging patients often acquire and dispose of items during their hospital stay.

The report of a previous financial audit undertaken in 2015 by BHSCT internal audit team was reviewed. We noted that many of the priority one and two recommendations made in this report related to issues similar to those identified during both this inspection and also the previous inspections in February and April 2019. We highlighted that this audit report was more than three years old and there is a need for more frequent audit and assurance. BHSCT had not undertaken an audit of its' financial procedures across all wards in the MAH site since the last RQIA inspection in April 2019 as detailed in its action plan. We were advised that the reason for this was that the policy in respect of the management of patients moneys and valuables was being updated and had not yet been approved or implemented

and that it was planned that there would be a future detailed audit of compliance with the new policy in the near future.

Overall we were not assured that implementation of and compliance with financial procedures was inadequate across and that the Trust did not have effective systems in place to ensure financial governance and provide assurance that it was meeting it responsibilities under Article 116 and 107 of the MHO.

7.0 Quality improvement plan

One Area for Improvement identified during this inspection is detailed in the QIP. Details of the QIP were discussed with Ms Briege Connery of BHSCT on 1 July 2019. The timescales for implementation of these improvements commence from the date of this inspection.

It is the responsibility of BHSCT to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas for improvement

An Area for Improvement in relation to Financial Governance identified during the previous inspection was assessed as not met.

On 16 August 2019 an Improvement Notice was issued in relation to Financial Governance.

Further action is required to ensure the BHSCT is compliant with the Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

7.2 Actions to be taken by the service

The QIP should be completed and detail of the actions taken to meet the areas for improvement identified. The BHSCT should confirm that these actions have been completed and return the completed QIP to bsu.admin@rqia.org.uk for assessment by RQIA 20 March 2020.

Quality Improvement Plan

The Trust must ensure the following findings are addressed:

Staffing

Area for improvement No. 1 **Ref**: Standards 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1, 5.3.3) **Stated:** Second time **To be completed by:** Before 14 May 2019	The Belfast Health and Social Care Trust must: 1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at MAH, which; a) is based on the assessed needs of the current patient population *and* b) Incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements. 2. Implement an effective process for oversight and escalation to senior management and the executive team when challenges in nurse staffing arise. 3. Implement an effective assurance mechanism to provide oversight of the implementation of the model and escalation measures. 4. Engage the support of the other key stakeholders, including the commissioner in defining the model to determine safe levels of nurse staffing.
	Response by the Trust detailing the actions taken: 1. a. Work progressed to determine safe staffing levels through an assessment of the current patient population's acuity and dependency. Acuity and dependency was determined using the current level of observation employed by the staff to safely care for patients, and using Telford to determine the registrant levels. This triangulated approach has resulted in a nursing model, which is in use to describe safe staffing levels. b. The model is in use by the ward managers and reviewed regularly to respond to temporary or unplanned variations in patient assessed needs and/or service requirements. 2. Ward staffing levels are reviewed on a daily basis Monday to Friday and at the weekly Ward Managers meeting (Friday) for the weekend. ASMs are on site Monday to Friday and review the requirements daily. An OoH co-ordinator also reviews staffing levels on site in the OoH period. Any issues of concern are raised by the wards to the ASM/OoH Co-Ordinator to Service manager and then to Collective leadership team. In the OoH there is a senior manager on call rota in place to provide additional support to staff OoH. 3. The Model was developed with engagement from the ward managers and ASMs in the first instance to ensure buy in. the Divisional Nurse worked closely with the ward Managers and ASMS to determine the current patients' needs on site in order to inform the model. Also a Telford exercise was undertaken with each of the ward managers.

	Once the model was developed the DN met with each of the Ward managers and ASMS to implement. Assurances are sought at the weekly ward managers meeting that the model is in use. When there are any issues Ward managers and ASMS are able to contact and talk it through with the DN if that support is required. The pathway used to escalate issues is Ward Manager to ASM to SM and then to the Collective Leadership team. 4. The nursing model has been developed by the senior team in MAH (in conjunction with the ward managers and ASMs) and approved by the Executive Director of Nursing and the Expert Nurse Advisor, DoH, and it has been presented to and supported by RQIA.
Safeguarding	
Area for improvement No. 2 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for adult safeguarding at MAH and ensure: a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations; b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively; c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care; d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding are improved. 2. Implement an effective process for oversight and escalation of matters relating to adult safeguarding across the hospital site; this should include ward sisters, hospital managers, BHSCT senior managers and / or the Executive team as appropriate. 3. Implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital.
	Response by the Trust detailing the actions taken: A detailed action plan was developed by the ASG and management team at MAH. There are 37 actions in place to ensure that the key 3 areas outlined in the QIP are achieved. At present 34 of these actions have been completed, the remaining 3 actions are currently on hold following advice from the PSNI not to proceed whilst the

	investigation is ongoing. There are plans in place to meet with the PSNI to discuss further. There are currently monthly ASG audits taking place on site to provide assurance that the changes implemented through the action planned are still in place and compliant.
CCTV	
Area for improvement No. 3 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for the management and monitoring of CCTV within MAH and ensure: a) that all staff understand the procedures to be followed with respect to CCTV; b) that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively; 2. Ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH.
	Response by the Trust detailing the actions taken: The CCTV policy has been reviewed, included update to forms included within the policy, the policy is currently with the Trust's Standard and Guidelines Committee for tabling. All staff have access to the initial policy approved in MAH. Further policy review and update is planned to improve the use of CCTV for safety monitoring. This is being progressed with the CCTV working Group and will be shared with staff when fully approved. There are agreed procedures within the hospital for monitoring and managing CCTV images, the template for requesting a download of footage has been updated. Work is required to improve the robustness, monitoring and functionality of the CCTV system on site. The Co-Director is awaiting quotes from Estate Services/ RadioContact and a business case will be developed. A CCTV working group has been set up (this includes a representation from ward staff, safeguarding staff, management, litigation and unions) to review the current use of use and the development of use within the hospital. Feedback surveys and processes have been developed to gather feedback on the current use and developed use of CCTV for safety monitoring within the hospital. Feedback is being sought from staff, families, carers, advocates and patients.

Restrictive Practices (Seclusion)	
Area for improvement No. 4 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1, 5.3.3) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must: 1. Undertake an urgent review of the current and ongoing use of restrictive practices including seclusion at MAH whilst taking account of required standards and best practice guidance. 2. Develop and implement a restrictive practices strategy across MAH that meets the required best practice guidance. 3. Ensure that the use of restrictive practices is routinely audited and reported through the BHSCT assurance framework. 4. Review and update BHSCT restrictive practices policy and ensure the policy is in keeping with best practice guidelines.
	Response by the Trust detailing the actions taken: MAH have implemented a suite of reports including a weekly patient safety report and a monthly governance report to ensure a clear statistical position for the use of restrictive practice is available for each setting. Reports are shared at both Executive Team and Trust Board. To date the use of seclusion and physical intervention have greatly decreased in the hospital. Audits have been implemented for the use of seclusion and patient observations, they are carried out on a monthly basis. The finding and actions from the audits are discussed at Pipa meetings and at the monthly Governance Committee. Restrictive Practices usage is discussed at a range of meetings, a Live Governance Call takes place each week when ward staff discuss the use of seclusion, Physical Intervention and use of PRN medication at patient level. The use of restrictive practice is included in the weekly Patient Safety Report and reviewed at the monthly Governance Committee. A Restrictive Practice Working group has been set up to provide a strategic overview of the use of and future use of Restrictive Practices within the hospital. The group has presentation of medical staff, ward staff, management, Safeguarding Staff, Governance, PBS and pharmacy. The suite of Restrictive Practice policies have been reviewed by an MDT within the hospital, an overarching Restrictive Practice Policy has been developed in line with best practice across the UK. MAH have formed a ‘critical friend’ relationship East London NHS Foundation Trust to act as critical friend to provide support and challenge in respect of all restrictive practices

Patient Observations	
Area for improvement No. 5 **Ref:** Standard 5.1 Criteria 5.3 (5.3.3) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must address the following matters in relation to patient observations: 1. Engage with ward managers and frontline nursing staff to ensure that a regular programme of audits of patient observations is completed at ward level. 2. Ensure that there is an effective system in place for assessing and managing patient observation practices, which is multi-disciplinary in nature and which enables staff to deliver effective care and learn collaboratively.
	Response by the Trust detailing the actions taken: A monthly audit process has been embedded across the hospital. The audit looks at the use of observations and reports compliance or non-compliance with the policy. The outcome of each audit is circulated to the management team, discussed at PiPa and reviewed at the Governance Committee meeting. Assessing and management of patient observation practices are reviewed through PiPa meeting with a MDT approach.
Management of Medicines	
Area for improvement No. 6 **Ref**: Standard 5.1 Criteria 5.3.1(f) **Stated:** First time **To be completed by:** 28 August 2019	The Belfast Health and Social Care Trust must strengthen arrangements for the management of medicines in the following areas: 1. Recruit a Pharmacy Technician to support stock management and address deficiencies (stock levels/ordering/expiry date checking) in wards in MAH to assist with release of nursing staff and pharmacist time. 2. Undertake a range of audits of (i) omitted doses of medicines (ii) standards of completion of administration records and (iii) effectiveness & appropriateness of administration of “when required” medicines utilised to manage agitation as part of de-escalation strategy. 3. Implement consistent refrigerator temperature monitoring recording (Actual/Minimum & Maximum) across all wards in MAH.
	Response by the Trust detailing the actions taken: 1. The existing registered pharmacist has agreed to increase hours from 0.5wte to 0.8 wte from the beginning of April 2020. The pharmacy technician post is in the early stages of recruitment. 2. The pharmacist reviews the kardexes for omitted does and completion of administration records at the PIPA meetings and any omissions or areas of concern raised at that time. With the increase in the Pharmacy hours, a more formalised approach can

	now be developed. A POMH audit on antipsychotic prescribing in ID patients, led by the Trust Pharmacy team will commence by the end of March 2020. 3. Each ward sister is responsible to ensuring that refrigerator temperature monitoring recording (Actual/Minimum & Maximum) is in place on their ward. This will be placed on the safety brief for daily checking. In addition the Pharmacist will audit the temperature monitoring when the Controlled drug audits are being undertaken.
Physical Health Care Needs	
Area for improvement No. 7 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must develop and implement a systematic approach to the identification and delivery of physical health care needs to: 1. Ensure that there is an appropriate number of suitability qualified staff to ensure that the entire range of patients physical health care needs are met to include gender and age specific physical health screening programmes. 2. Ensure that patients in receipt of antipsychotic medication receive the required monitoring in accordance with the hospital's antipsychotic monitoring policy. 3. Ensure that specialist learning disability trained nursing staff understand and oversee management of the physical health care needs of patients in MAH. 4. A system of assurance in respect of delivery of physical healthcare.
	Response by the Trust detailing the actions taken: A GP role has been recruited to the hospital to focus on physical health checks for all patients. There are 3 SHO positions within the hospital which are made up of one GP trainee and 2 psychiatry trainees. There is an out of hours GP available on site from 7pm-11pm each day with all other hours are covered by the onsite GP, the 3 SHOs and the psychiatry team for physical health care and queries. A lookback exercise has taken place to gather all physical health information for each patient including family history were available. This information is now stored on one template which is available on the PARIS system and in a physical health folder kept on each ward. Patients who meet the guidelines set out by Northern Ireland screening programmes have had their screening completed and added to the registers to ensure they are called appropriately with the general population. (Cervical cancer, Bowel screening, mammograms, AAA and diabetic eye. Each relevant patient now has an annual Chronic Health Condition review (Eye exams, asthma review, epilepsy

	review, hypertension review, testicular exams, breast exams and cervical screening. A review of all patients' health checks in regards to antipsychotic medication has been carried out. Each patient has an anti-psychotic monitoring chart which is reviewed by both a medical professional and a pharmacist. Six monthly (March & September) checks in line with Maudsley Guidelines is carried out, this includes bloods, ECG and all other relevant physical checks. All patient physical check information is stored on one template providing assurance that historical check information, family history and planned checks are available to all relevant staff. This provides assurance that all relevant checks have taken place or planned within the required timeframe. 1. All patients receive a physical examination within 24 hours of admission (ward trainee/on call trainee and nursing staff observations). We have ECG machines, physical observation equipment and venepuncture facilities available on site. 2. Past medical history and medicines reconciliation are confirmed within the first week (ward trainee/pharmacist) 3. Any initial concerns about physical health are followed up accordingly (ward trainee) 4. Longer term conditions and screening are managed by or GP locum doctor who also offers advice to trainees where required 5. For non-urgent physical concerns on the ward, the ward trainee is called 6. For urgent physical concerns, we have a duty bleep system for our site doctors and staff are aware to also contact NIAS in emergencies (as we have limited resuscitation facilities on site). Mandatory training for staff includes Life Support Training (at various levels depending on the grade/role of staff) accessed via the Trust HRPTS system 7. PIpA Visual Control Boards on each ward include prompts regarding physical healthcare, screening and antipsychotic monitoring. 8. We operate daily ward rounds (PIpA model) with focus days, one of which per week is about health promotion 9. All material pertaining to physical healthcare concerns are kept in manual files on the wards for easy access at PIpA and for out of hours doctors 10. Antipsychotic monitoring is performed as required and routinely every six months (March and September) now by our GP locum doctor and ward

	nursing staff. An audit of this across the site was carried out in December 11. Current completion of the POMH audit: Antipsychotic prescribing in people with a learning disability under the care of mental health services (4/2-27/3/20 period, all inpatients and a sample of community patients). To compare with previous audit findings 12. We have the facility to refer to podiatry, dietetics, SALT, physio, OT on site and to our visiting dentist. 13. We have close links with and advice from the lead AMH pharmacist. We also have a part time pharmacist on site. 14. Future plans to develop the role of our locum GP colleague in the 'ID Physician' model to bridge the knowledge gap between primary and secondary care and improve the quality of physical healthcare assessment for our patients with complex co morbidities
Discharge Planning	
Area for improvement No. 8 **Ref**: Standard 5.1 Criteria 5.3 (5.3.3(b)) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must ensure that ward staff have access to detailed and current information regarding patients who have completed their active assessment and treatment and are awaiting discharge from MAH.
	Response by the Trust detailing the actions taken: Patient level assessment and discharge information and plans are discussed at weekly PiPa meetings at ward level. Information from these meetings is shared appropriately at ward level by the ward representatives at Pipa. Patient transition plans are shared at ward level and there is an MDT approach for transition planning. The Transition team attend the ward managers meetings and the ASM meetings when there are updates to patient resettlement plans. A Quality Improvement project has been initiated involving staff from across the hospital to focus on standardising and improving the transition processes for patients resettling from hospital.

Strategic Planning & Communication	
Area for improvement No. 9 **Ref**: Standards 4.1 & 8.1 Criteria 4.3 (b, d and e), 8.3 (b) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must address the following matters to strengthen hospital planning: 1. Ensure that a comprehensive forward plan for MAH is developed, communicated, disseminated and fully understood by staff. 2. Ensure that stated aims and objectives for the hospital's PICU are developed and disseminated to frontline nursing staff so that there is clarity regarding both the unit and staff positions.
	Response by the Trust detailing the actions taken: A workshop (invite open to all MAH staff) is planned for the 26 Mar 2020 to discuss plans and development for the future of the hospital site. Monthly staff briefing meetings have been embedded within the hospital, these meetings aim to share information with staff across the site and respond to any questions. A weekly newsletter is distributed to all staff across the hospital, providing information updates and sharing news. The PICU is no longer in use and will not be restored to its previous function, this information has been communicated to staff. The workshop planned for March and future planning meetings will include discussion around the future use of the PICU space.
Hospital Governance	
Area for improvement No. 10 **Ref**: Standards 4.1 and 5.1 Criteria 4.3 (a) and 5.3.1.(f) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must review the governing arrangements in MAH and consider the following matters in order to strengthen the governance arrangements: 1. Enhance communication, staff knowledge and understanding of relevant committees and meetings to support local leadership and governance on the MAH site. 2. Embed the recently introduced Daily Safety Huddle (at ward level) and the Weekly Safety Pause (hospital level) meetings. 3. Implement an effective assurance framework.
	Response by the Trust detailing the actions taken: A governance framework has been developed within the hospital, this consists of a hierarchy of meetings which provide the space for discussion, challenge, review and assurance. There have been a suite of reports developed to provide statistics, analysis and oversight of key governance areas within the hospital. The governance meeting and reports framework has been illustrated in a flow chart and provided to staff to assist with understanding of the reports and meetings within / about the hospital. The daily safety huddle now takes place on a daily basis

	within each ward. A weekly live governance call has been embedded within the hospital, this meeting has multi-disciplinary representation and is led by ward level information. The assurance framework has been embedded, this has been built from ward level reports and meetings building into Hospital management meetings which feed into Executive and Trust Board level meetings.
Financial Governance	
Area for improvement No. 11 **Ref**: Standard 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must ensure: 1. That the BHSCT is appropriately discharging its full responsibilities, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986. 2. In respect of those patients in receipt of benefits for whom BHSCT is acting as appointee, that appropriate documentation is in place and that individual patients are in receipt of their correct benefits. 3. Implementation of a robust system to evidence and assure that all arrangements relating to patients' monies and valuables are operating in accordance with The Mental Health (Northern Ireland) Order 1986 and BHSCT policy and procedures; this includes: a) that appropriate records of patients' property are maintained; b) that staff with responsibility for patients' income and expenditure have been appropriately trained for this role; c) that audits by senior managers of records retained at ward level are completed in accordance with BHSCT policy; d) that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in MAH.
	Response by the Trust detailing the actions taken: A comprehensive action plan has been developed by the finance team and management team at MAH. The plan consists of 18 actions (8 completed, 9 in progress and 1 no longer applicable). The appointment of a Finance Liaison Officer has been very successful and enabled individual financial plans to be produced. The Trust has recently received a response from RQIA to our request to hold balances over £20k for 4 patients and we are currently addressing the questions raised and remain confident that the Trust is best placed to manage these monies on patient's behalf. The Trust has sought and received appropriate documentation including benefit entitlement for all patients we are appointee for with the exception of one patient that transferred to MAH from a Trust supported living

	accommodation – the documentation for this one patient is currently being followed up. The Trust Policy has been extensively reviewed and updated a number of times since the inspection and training has been delivered to all relevant staff. Although the current version of the Policy has been issued to staff it continues to be reviewed and updated in light of in-house monitoring findings. The BSO Internal Audit has now taken place and the Trust is due to meet with auditors on 25th March to discuss findings.

Name of person (s) completing the QIP	Gillian Traub		
Signature of person (s) completing the QIP	Gillian Traub	**Date completed**	12 March 2020
Name of Responsible Person approving the QIP	Gillian Traub		
Signature of Responsible Person approving the QIP	Gillian Traub	**Date approved**	18 September 2020
Name of RQIA Inspector assessing response	Wendy McGregor		
Signature of RQIA Inspector assessing response	Wendy McGregor	**Date approved**	18 September 2020

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Assurance, Challenge and Improvement in Health and Social Care

Unannounced Enforcement Inspection Report
10, 11 & 12 December 2019

Belfast Health & Social Care Trust

Type of Service: Mental Health and Learning Disability Hospital
Muckamore Abbey Hospital
1 Abbey Road
Antrim
BT41 4SH
Tel No: 028 9446 3333

Membership of the Inspection Team

Dr Lourda Geoghegan	Director of Improvement and Medical Director, Regulation and Quality Improvement Authority
Lynn Long	Assistant Director, Regulation and Quality Improvement Authority
Dr John Simpson	Medical Peer Reviewer, Regulation and Quality Improvement Authority
Alan Guthrie	Senior Inspector (Acting), Mental Health and Learning Disability Team, Regulation and Quality Improvement Authority
Carmel Treacy	Inspector, Mental Health and Learning Disability Team, Regulation and Quality Improvement Authority
Cairn Magill	Inspector, Mental Health and Learning Disability Team, Regulation and Quality Improvement Authority
Stephen O'Connor	Inspector, Independent Healthcare Team, Regulation and Quality Improvement Authority
Norma Munn	Inspector, Independent Healthcare Team, Regulation and Quality Improvement Authority
Joseph McRandle	Inspector, Finance Team, Regulation and Quality Improvement Authority
Dr Stuart Brown	ADEPT Fellow, Regulation and Quality Improvement Authority
Paulina Spychalska	Inspection Coordinator, Regulation and Quality Improvement Authority
Gary McMaster	Inspection Coordinator, Regulation and Quality Improvement Authority

Abbreviations

BHSCT	Belfast Health and Social Care Trust
BSO	Business Services Organisation
CCTV	Closed Circuit Television
DFC	Department for Communities
DAPO	Designated Adult Protection Officer
DoH	Department of Health
GP	General Practitioner
IN	Improvement Notice
MAH	Muckamore Abbey Hospital
MAPA	Management of Actual or Potential Aggression
MDT	Multi-disciplinary Team
MHO	Mental Health (Northern Ireland) Order 1986
NHS	National Health Service
NHSCT	Northern Health and Social Care Trust
NIASP	Northern Ireland Adult Safeguarding Partnership
OCP	Office of Care and Protection
PICU	Psychiatric Intensive Care Unit
PIpA	Purposeful Inpatient Admission
PRN	pro re nata “as needed”
QIP	Quality Improvement Plan
RQIA	Regulation and Quality Improvement Authority
SAI	Serious Adverse Incident
SEHSCT	South Eastern Health and Social Care Trust
SEA	Significant Event Audit
SMT	Senior Management Team
SITREP	Situation Report

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability Hospital managed by Belfast Health and Social Care Trust (BHSCT). The hospital provides inpatient care to adults 18 years and over who have a learning disability and require care and treatment in an acute psychiatric care setting. Patients are admitted either on a voluntary basis or in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).

MAH provides a service to people with a Learning Disability from BHSCT, Northern Health and Social Care Trust (NHSCT) and South Eastern Health and Social Care Trust (SEHSCT). There were 83 beds in the hospital at the time of the inspection. The Psychiatric Intensive Care Unit (PICU) temporarily closed on 21 December 2018 and has remained closed since that date.

At the time of the inspection there were five wards operational on the MAH site:

- Cranfield One (male assessment)
- Cranfield Two (male treatment)
- Ardmore (female assessment and treatment)
- Six Mile (forensic male assessment and treatment)
- Erne (long stay/re-settlement).

A hospital day care service was also available for patients.

During the inspection there were 53 patients receiving care and treatment in MAH.

3.0 Service details

Responsible person: Mr Martin Dillon	**Position:** Chief Executive Officer
Category of care: Acute Mental Health & Learning Disability	**Number of beds:** 83
Person in charge at the time of inspection: Bernie Owens, Director Neurosciences, Radiology and Muckamore Abbey Hospital, BHSCT	

4.0 Inspection summary

We undertook an unannounced inspection to MAH over three days commencing on 10 December 2019 and concluding 12 December 2019. Five wards were inspected over the course of the inspection which included a night time inspection on 11 December 2019 from 03:00 – 04:00 of all wards.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Mental Health (Northern Ireland) Order 1986 and the DHSSPSNI Quality Standards for Health and Social Care (March 2006).

On 16 August 2019 RQIA issued three Improvement Notices (INs) to MAH in respect to a failure to comply with minimum standards. This inspection sought to assess the level of compliance achieved in relation to the Improvement Notices. The areas identified for improvement and compliance were:

- IN000003 - management of staffing levels
- IN000004 - governance of patients' finances; and
- IN000005 - adult safeguarding arrangements.

The date by which compliance with the Improvement Notices must be achieved was 16 November 2019.

We found sufficient evidence to validate full compliance with Improvement Notice - IN000003 relating to the management of staffing levels.

We found evidence of improvement and acknowledge that progress had been made to address the required actions within the other two Improvement Notices, IN000004 relating to the governance of patients' finances and IN000005 relating to adult safeguarding arrangements. However, we did not find sufficient evidence to validate full compliance with these two Notices.

RQIA senior management held a meeting on 13 December 2019 and a decision was made that the date of compliance for Improvement Notices IN000004 and IN00005 should be extended. Compliance with these Notices must therefore be achieved by 19 March 2020. The extended Improvement Notices – IN000004E and IN000005E were issued on 19 December 2019.

We had previously raised serious concerns and identified areas for improvement during inspections in February and April 2019 in relation to restrictive practices (seclusion) and the management of patients' physical health needs. The Trust submitted information following the April inspection to provide assurance in relation the progress made to address these concerns and we also used the information provided as part of this inspection. We found that significant improvements had been made and the two areas for improvement had been fully addressed.

We reviewed an additional five areas for improvement that were made following the previous inspection in April 2019 which related to CCTV policy and procedures; the management of patients' observations; discharge planning; strategic governance; and hospital governance. We were able to evidence that sufficient progress had been made to fully address four of the areas for improvement, however, the area for improvement relating to CCTV policies and procedures was only partially met and has been stated for a third time.

One area for improvement in relation to medicines management was not reviewed as part of this inspection and is carried forward to the next inspection.

4.1 Inspection outcome

Total number of areas for improvement	6

Total number of Improvement Notices	2 (Extended)

There are six areas for improvement arising from this inspection, comprising of four new areas for improvement. The four new areas of improvement relate to developing and implementing a systematic approach to the documentation used throughout the hospital for the recording of patients' physical health checks; implementing a system of assurance in respect of delivery of physical health checks; reviewing the hospital's need to provide a seclusion room; and outlining a statement of purpose for the use of the "Low Stimulus Area".

One area for improvement in relation to medicines management identified during our inspection in February 2019 was not reviewed during this inspection and will be carried forward for review at a subsequent inspection. One area for improvement in relation to CCTV was assessed as only partially met and has been stated for a third time.

Ongoing enforcement action resulted from the findings of this inspection. As a result of this inspection the date of compliance with two Improvement Notices, IN000004 and IN000005 was extended to 19 March 2020.

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Improvement Notices for Health and Social Care Trusts are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children services.

Details of the inspections findings and QIP were discussed with MAH SMT on16 December 2019.

5.0 How we inspect

Prior to the inspection, we had a meeting with the MAH Senior Management Team (SMT) on 2 November 2019 in the office of RQIA. At this meeting the SMT presented the actions they had taken to address the improvements necessary in relation to restrictive practices and the management of staffing levels as set out in the Improvement Notice IN000003. We tested the information they provided during this inspection. We also reviewed a range of information relevant to the service including the following records:

- previous inspection reports;
- Serious Adverse Incident (SAI) notifications;
- written and verbal information received following the previous care inspection in April 2019 and the previous finance inspection in July 2019;
- adult safeguarding referrals; and
- complaints received by RQIA.

We assessed each ward using a standardised inspection framework. The methodology underpinning our inspections included; discussions with patients; observations of practice; interviews with staff; and a review of relevant documentation. We examined samples of records during the inspection which included: nursing care records; medical records; SMT and governance reports; minutes of meetings; duty rotas; and staff training records.

Posters informing patients, staff and visitors of our inspection were displayed while our inspection was in process.

We invited staff to complete an electronic questionnaire during the inspection. We did not receive any returned completed staff questionnaires following this inspection.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection from 15-16 April 2019

Areas for improvement from the previous inspection 15-16 April 2019		
Action required to ensure compliance with the DHSSPSNI Quality Standards for Health and Social Care (March 2006)		**Validation of compliance**
Area for Improvement 1 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for the management and monitoring of CCTV within MAH and ensure: 2. a) that all staff understand the procedures to be followed with respect to CCTV; b) that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively; 3. Ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH.	**Partially Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as partially met and has been stated for the third time, further detail is provided in section 6.3.1.	
Area for Improvement 2 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1, 5.3.3) **Stated:** Second time	The Belfast Health and Social Care Trust must: 1. Undertake an urgent review of the current and ongoing use of restrictive practices including seclusion at MAH whilst taking account of required standards and best practice guidance. 2. Develop and implement a restrictive practices strategy across MAH that meets the required best practice guidance. 3. Ensure that the use of restrictive practices is routinely audited and reported through the BHSCT assurance framework. 4. Review and update BHSCT restrictive practices policy and ensure the policy is in with	**Met**

	best practice guidelines. **Action taken as confirmed during the inspection:** This area for improvement has been assessed as met due to the substantial process made by the Trust to address these matters, however, a further area for improvement was made in respect of the environment used for seclusion and further detail is provided in section 6.3.2.	
Area for Improvement 3 **Ref:** Standard 5.1 Criteria 5.3 (5.3.3) **Stated:** Second time	The Belfast Health and Social Care Trust must address the following matters in relation to patient observations: 1. Engage with ward managers and frontline nursing staff to ensure that a regular programme of audits of patient observations is completed at ward level. 2. Ensure that there is an effective system in place for assessing and managing patient observation practices, which is multi-disciplinary in nature and which enables staff to deliver effective care and learn collaboratively. **Action taken as confirmed during the inspection**: This area for improvement has been assessed as met and further detail is provided in section 6.3.4.	**Met**
Area for Improvement 4 **Ref**: Standard 5.1 Criteria 5.3.1(f) **Stated:** First time	The Belfast Health and Social Care Trust must strengthen arrangements for the management of medicines in the following areas: 1. Recruit a Pharmacy Technician to support stock management and address deficiencies (stock levels/ordering/expiry date checking) in wards in MAH to assist with release of nursing staff and pharmacist time. 2. Undertake a range of audits of (i) omitted doses of medicines (ii) standards of completion of administration records and (iii) effectiveness & appropriateness of administration of “when required” medicines utilised to manage agitation as part of de-escalation strategy. 3. Implement consistent refrigerator temperature monitoring recording (Actual/Minimum & Maximum) across all wards in MAH.	**Carried forward to the next inspection**

	Action taken as confirmed during the inspection: Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next inspection.	
Area for Improvement 5 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time	The Belfast Health and Social Care Trust must develop and implement a systematic approach to the identification and delivery of physical health care needs to: 1. Ensure that there is an appropriate number of qualified staff to ensure that the entire range of patients physical health care needs are met to include gender and age specific physical health screening programmes. 2. Ensure that patients in receipt of antipsychotic medication receive the required monitoring in accordance with the hospital's antipsychotic monitoring policy. 3. Ensure that specialist learning disability trained nursing staff understand and oversee management of the physical health care needs of patients in MAH. 4. A system of assurance in respect of delivery of physical healthcare.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met and further detail is provided in section 6.3.5.	
Area for Improvement 6 **Ref**: Standard 5.1 Criteria 5.3 (5.3.3 (b) **Stated:** Second time	The Belfast Health and Social Care Trust must ensure that ward staff have access to detailed and current information regarding patients who have completed their active assessment and treatment and are awaiting discharge from MAH.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met and further detail is provided in section 6.3.6.	
Area for improvement 7 **Ref**: Standards 4.1 & 8.1 Criteria 4.3 (b, d and e), 8.3 (b) **Stated:** Second time	The Belfast Health and Social Care Trust must address the following matters to strengthen hospital planning: 1. Ensure that a comprehensive forward plan for MAH is developed, communicated, disseminated and fully understood by staff. 2. Ensure that stated aims and objectives for the hospital's PICU are developed and	**Met**

	disseminated to frontline nursing staff so that there is clarity regarding both the unit and staff positions.	
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met and further detail is provided in section 6.3.7.	
Area for Improvement 8 **Ref**: Standards 4.1 and 5.1 Criteria 4.3 (a) and 5.3.1.(f) **Stated:** Second time	The Belfast Health and Social Care Trust must review the governing arrangements in MAH and consider the following matters in order to strengthen the governance arrangements: 1. Enhance communication, staff knowledge and understanding of relevant committees and meetings to support local leadership and governance on the MAH site. 2. Embed the recently introduced Daily Safety Huddle (at ward level) and the Weekly Safety Pause (hospital level) meetings. 3. Implement an effective assurance framework.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met and further detail is provided in section 6.3.8.	

6.2 Inspection findings

Improvement Notice Ref: IN000003

STATEMENT OF MINIMUM STANDARDS

The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).

Standard 4.1:

The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.

Standard 5.1:

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS

4.3 Criteria

The organisation:

(i) undertakes systematic risk assessment and risk management of all areas of its work;

(j) has sound human resource policies and systems in place to ensure appropriate workforce planning, skill mix, recruitment, induction, training and development opportunities for staff to undertake the roles and responsibilities required by their job, including compliance with:

- departmental policy and guidance;
- professional and other codes of practice; and
- employment legislation.

(n) has a workforce strategy in place, as appropriate, that ensures clarity about structure, function, roles and responsibilities and ensures workforce development to meet current and future service needs in line with Departmental policy and the availability of resources.

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

(f) Has properly maintained systems, policies and procedures in place, which are subject to regular audit and review to ensure: protection of health, welfare and safety of staff.

5.3.3 Promoting Effective Care

The organisation:

(c) promotes a culture of learning to enable staff to enhance and maintain their knowledge and skills;
(d) ensures that clinical and social care interventions are carried out under appropriate supervision and leadership, and by appropriately qualified and trained staff, who have access to appropriate support systems.

In relation to this notice the following four actions were required to comply with the standards.

The BHSCT, Chief Executive, and Executive Team must:

1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at Muckamore Abbey Hospital, which:

a) is based on the assessed needs of the current patient population; and
b) incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements.

2. Implement an effective process for oversight and escalation of challenges relating to staffing across the hospital site; this should include ward sisters, hospital managers, Trust senior managers and/or the Executive Team as appropriate.

3. Implement effective mechanisms to evidence and assure its compliance with good practice in respect of the current staffing model and associated escalation measures.

4. Engage the support of, and work in partnership with, other HSC organisations (including the Health and Social Care Board, the Public Health Agency and HSC Trusts) to define future model(s) for nurse staffing in mental health and learning disability in-patient services / wards. The design and testing of future staffing models must be supported by appropriate assurance processes and tools.

6.2.1 Staffing

We gathered evidence in relation to the four action points contained within the Improvement Notice IN000003, to establish if the BHSCT, Chief Executive, and Executive Team had complied with the minimum standard and developed a model that would ensure nurse staffing at ward level and across the MAH site was planned and managed on the basis of assessed patient need. We established the following in relation to each action:

<u>Action Point 1</u>

The Belfast Health and Social Care Trust, Chief Executive, and the Executive Team must:

1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at Muckamore Abbey Hospital, which:

a) is based on the assessed needs of the current patient population; and
b) incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements.

Prior to the inspection we met with the SMT from BHSCT on 2 November 2019 in our offices. At this meeting the SMT presented to us a revised staffing model which incorporated the Telford model for calculating registered staff numbers. They informed us that the model was based on the assessed needs of the patient population in MAH, was patient centred, flexible and adaptable enough to meet the changing needs of the patients in the hospital. The model also enabled management to ensure that the skill mix of staff in each ward was appropriate to deliver the required care for patients.

During the inspection we visited the five wards and reviewed the implementation of the revised staffing model by reviewing staffing levels, skill mix and the assessed needs of patients on the each ward. We found the model had been implemented effectively and staffing levels were appropriate to meet the needs of patients on each ward. Staff reported to us that they were involved in the development of the model and this had helped raise staff morale. Staff told us that while delivering on the proposed skill mix does not always happen on every ward on every day, the numbers of staff required for each ward is as close as possible to the numbers required to meet the patients assessed needs. Staff told us that staffing levels had significantly improved since our last inspection.

Outcome of action point 1

We were assured by discussion with the SMT; review of documentation; discussion with staff; and review of rotas and skill mix in relation to assessed needs of patients that sufficient progress had been made to address the staffing levels in MAH. This action point has been addressed.

Action point 2

2. The Belfast Health and Social Care Trust, Chief Executive, and the Executive Team must:

Implement an effective process for oversight and escalation of challenges relating to staffing across the hospital site; this should include ward sisters, hospital managers, Trust senior managers and/or the Executive Team as appropriate.

Prior to the inspection the SMT informed us during the meeting on 2 November 2019, that a process had been implemented to ensure that senior staff were available 24 hours every day to support ward staff to escalate challenges relating to staffing levels; this included ward managers, lead nurses and members of the SMT. We were informed that both the operational and executive team have oversight staffing levels to ensure that they are safe.

During the inspection we reviewed the process in place for oversight and escalation of challenges relating to staffing levels. We found the role of the night time co-ordinator had been developed to include an oversight of staffing arrangements on each ward for each day to ensure that the staffing levels and skill mix met the assessed needs of patients on each ward. A report was produced by the night time co-ordinator each morning for the SMT to review.

We were informed communication had improved significantly across the site between wards and members of the SMT. We found that mechanisms were in place to ensure that relevant staff were informed well in advance (every month) and kept up to date regarding the availability of senior and medical staff for out of hours cover. Staff told us that incidents of staff shortages were responded to in a timely way.

We were informed that the same agency staff were generally booked for a block of shifts which provided consistency of care for patients and stability across the hospital. We found that agency staff were now more embedded into the overall staff team and it was reported that wearing the BHSCT uniform had helped with this integration process. The SMT told us that this had also helped patients understand that agency staff and trust employees were all part of the same team and all staff were equally responsible for ensuring the provision of their care. We established that agency staff undertake a rigorous induction programme which is delivered at Trust, site and ward level. We reviewed these induction programmes and determined that they were robust and covered all key areas.

We were informed that there has been a policy change in the Trust that enables agency staff who have worked on the site for some time to now take charge of a ward. A comprehensive and supportive framework was designed to ensure agency staff are assessed as competent in all the challenges that may arise when taking charge of a ward. Agency staff are signed off after completing each phase of the framework by the ward manager and night time coordinator. We reviewed one of these assessment frameworks and were satisfied that the assessment process was robust. Ward managers told us that agency staff being able to take charge of the ward had been invaluable. It had enabled senior ward staff to attend a variety of meetings which helped in progressing various pieces of quality improvement work and had contributed to the overall increase in staff morale.

Across all wards, managers, deputy managers, nurses, doctors and nursing assistants informed us that there was a more visible presence of members of the SMT. Staff who spoke with us were knowledgeable regarding which members of the SMT were responsible for the oversight of individual wards and particular pieces of work. Staff reported to us that members of the SMT are approachable and supportive. Staff told us that they felt empowered to share their concerns with SMT and believed that their concerns were heard and considered. Both front line staff and the SMT informed us that they welcomed the increased numbers of senior staff as this provided the required capacity to address any emerging challenges and issues identified.

We found that each week a designated member of the SMT produced a report that illustrated the percentage of shifts filled for each ward. This information along with the Situation Report (SITREP) was shared fortnightly with the ward managers across the hospital. Ward managers informed us that these reports coupled with the weekly safety brief and live governance meetings had been instrumental in helping each ward recognise and understand the pressures that other wards experienced at times across the hospital. This increased level of understanding by Ward Managers and staff, through the sharing of written data and reports, had contributed to a genuine desire in the staff to assist other wards during challenging periods. We were advised that there was also a shared understanding between the wards that this level of support will be reciprocated when required.

Ward staff informed us that all staff had the option to self-refer to the on-site staff counsellor and were offered the option of having counselling sessions on or off the hospital site, if they required additional support. Staff told us that reflective practice sessions are scheduled on a weekly basis and they considered the counselling and reflective practice sessions supportive.

Through discussion, we confirmed that all ward managers were aware of staff on their ward that were subject to a protection plan and/or supervision plan. These plans were in place to protect patients and staff while investigations of specific allegations remain ongoing.

During our previous inspections we identified that behaviour nurse specialists were subsumed into the staffing compliment of each ward and did not have protected time to review or devise positive behaviour support plans for patients.

Staff who spoke with us reported that the behaviour nurse specialists are no longer subsumed into the overall staffing compliment thus are able to focus on their original role. This has been beneficial for staff and patients because bespoke positive behaviour support plans are now in place and being actioned. We found that a new behaviour support assistant role had been created and assigned to each ward. Staff reported that this new role had a positive effect and was benefitting the overall patient experience. The behaviour support service is managed through the psychology department.

We established that each ward had a schedule of evening and weekend activities for patients to participate in. A number of art, music, beauty and specialist therapists visit the hospital to provide activities. Some of these are specific to patients, wards or provided as group activities. Staff reported that patients were now more engaged in meaningful activities which had reduced boredom leading to a decrease in incidents of aggression and assaults on staff. Although incidents of aggression and assaults can still occur, staff told us that the reduction had helped improve staff morale and reduced sickness and absenteeism.

Some staff who spoke with us advised that they had appreciated the opportunity to participate in the learning exchange programme with a Trust based in the UK. A team of multi-disciplinary professionals from MAH visited another Trust's low-secure ward for patients with learning disabilities and MAH agreed to host to an exchange visit. Staff reported that they found this opportunity invaluable and inspiring. They were able to see and experience how the other learning disability inpatient service managed similar challenges they were facing. Staff expressed that they would be keen for this learning exchange programme to continue as they could see the benefits for staff participating in this ongoing educational and shared learning environment.

We were advised that the hospital was facing an on-going challenge in relation to retaining and recruiting nurses and other staff. However there was a consensus among staff that the current SMT had made positive strides in stabilising the site; listening, responding to and acting on staff concerns; improving communication; being visible and approachable to staff; raising confidence; and re-establishing pride within the learning disability nursing profession in the hospital.

Outcome of action point 2

We found sufficient evidence to determine that this action point has been addressed.

Conclusion

We found sufficient evidence to validate that BHSCT had made the necessary improvements to achieve compliance with the Improvement Notice – IN000003.

Improvement Notice Ref: IN000004

STATEMENT OF MINIMUM STANDARDS

The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).

Standard 4.1:

The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.

Standard 5.1:

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

4.3 Criteria

The organisation:

(f) ensures financial management achieves economy, effectiveness, efficiency and probity and accountability in the use of resources;
(g) has systems in place to ensure compliance with relevant legislative requirements;
(h) ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory functions and in relation to inter-agency working;
(i) undertakes systematic risk assessment and risk management of all areas of its work.

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

(c) has policies and procedures in place to identify and protect children, young people and vulnerable adults from harm and to promote and safeguard their rights in general;

In relation to this notice the following four actions were required to comply with the standards.

The Belfast Health and Social Care Trust Board, Chief Executive and Executive Team must ensure:

1. That the Trust is appropriately discharging its full responsibilities, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986.

2. In respect of those patients in receipt of benefits for whom the Trust is acting as appointee, that appropriate documentation is in place and that individual patients are in receipt of their correct benefits.

3. Implementation of a robust system to evidence and assure that all arrangements relating to patients' monies and valuables are operating in accordance with The Mental Health (Northern Ireland) Order 1986 and Trust's policy and procedures; this includes:

a) that appropriate records of patients' property are maintained;

b) that staff with responsibility for patients' income and expenditure have been appropriately trained for this role;

c) that audits by senior managers of records retained at ward level are completed in accordance with Trust policy;

d) that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in Muckamore Abbey Hospital.

6.2.2 Financial Governance

Action point 1

The Belfast Health and Social Care Trust Board, Chief Executive and Executive Team must ensure:

1. That the Trust is appropriately discharging its full responsibilities, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986.

At the last inspection on 1 July 2019 we reviewed the draft policy in relation to the management of patients' monies and valuables. We identified several weaknesses within the policy and determined it was insufficient to ensure that the Trust met with all its responsibilities under the Mental Health (Northern Ireland) Order 1986. Through speaking we staff we identified that discussions with ward managers had commenced for the purpose of familiarising staff with the revisions of the policy however this did not constitute staff training.

We were advised, during this inspection, that the Patients' Finances and Private Property – Policy for Inpatients within Mental Health and Learning Disability Hospitals had been revised and implemented. The policy was used to form part of the training programme provided to members of staff in each ward. We reviewed the policy and determined it to be satisfactory.

We found evidence that staff were adhering to the new policies and procedures implemented by the Trust. We were informed that due to feedback from staff further revisions were being made to the policy and the Trust intends to implement the changes by January 2020.

Outcome of action point 1

We found sufficient evidence to determine that this action point has been addressed.

Action point 2

The Belfast Health and Social Care Trust Board, Chief Executive and Executive Team must ensure:

2. In respect of those patients in receipt of benefits for whom the Trust is acting as appointee, that appropriate documentation is in place and that individual patients are in receipt of their correct benefits.

We were shown evidence that the Trust had contacted the Department for Communities (DFC) requesting written confirmation that the Trust was the authorised appointee for the thirteen patients identified at previous RQIA inspections in April 2019 and July 2019 and that the patients were receiving the correct benefits owed to them. We reviewed the written replies from the DFC which confirmed that the Trust was the patients' appointee and that the patients were receiving the correct benefits. We noted that DFC also confirmed if patients had been over or under paid benefits during the period the Trust was the appointee. Discussions with the Trust and a review of records confirmed that one patient had been overpaid benefits for almost six years, however, as the Trust had notified the DFC at the time when the financial circumstances for the patient had changed, the DFC deemed the overpayment was non-recoverable.

We were informed that in addition to confirming appointeeship the Trust had entered into discussions with an external advisory organisation to provide advice to patients and their families in relation to managing their finances. This included ensuring that patients were receiving the full amount of social security benefits owed to them. At the time of our inspection the Trust was in the final stages of contracting with the independent advisor.

Outcome of action point 2

We found sufficient evidence to determine that this action point has been addressed.

Action point 3

The Belfast Health and Social Care Trust Board, Chief Executive and Executive Team must ensure:

3. Implementation of a robust system to evidence and assure that all arrangements relating to patients' monies and valuables are operating in accordance with The Mental Health (Northern Ireland) Order 1986 and Trust's policy and procedures; this includes:

e) that appropriate records of patients' property are maintained;

f) that staff with responsibility for patients' income and expenditure have been appropriately trained for this role;

g) that audits by senior managers of records retained at ward level are completed in accordance with Trust policy;

h) that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in Muckamore Abbey Hospital.

We were informed that a patient liaison officer had been appointed by the Trust and part of their duties was to coordinate monthly audits of patients' monies and liaise with patients' family members.

We were advised that financial planning meetings had been implemented since the previous RQIA inspection in July 2019. Review of records from the meetings showed that a member of the MDT from the Trust met with patients' family members to discuss the spending plan for patients with significant finances. There was evidence that the Trust was in regular contact with family members to provide updates on the planning process and to seek agreement for the planned expenditure from patients' monies. We found there was also evidence of the decisions made by the MDT in relation to financial matters for patients who had no next of kin.

We evidenced that members of staff within each ward had received training in relation to the handling of patients' monies. The records we reviewed showed the dates members of staff received the training and we were provided with a copy of the training programme provided to staff. We noted that in addition to the training provided by the Trust, training was also provided by the Directorate of Legal Services from the Business Services Organisation (BSO). This included an overview of the responsibilities for being a patient's appointee and other protective measures in place for safeguarding patients' finances.

We noticed a significant improvement within each ward in relation to the recording of transactions undertaken by members of staff on behalf of patients.

Following the finance inspection in July 2019 a new system for recording financial transactions was implemented by the Trust. We sampled a number of patients' records within each ward and evidenced that the full details of the transactions were recorded; two signatures were recorded against each of the transactions; good practice was observed as the amounts deducted to make the purchases and the remaining monies returned from the purchases were recorded separately; and receipts from the transactions were retained for inspection. A record of patients' personal property held for safekeeping within each ward was also found to up to date. We confirmed that in line with good practice, records of patients' monies and property held for safekeeping were checked on a weekly basis and signed by two members of staff.

We found that additional monthly checks of patients' monies held within each ward were undertaken by the assistant service managers. Records of the checks showed that any discrepancies were identified and addressed by the Trust immediately. We were informed that the outcomes of the findings from the monthly checks were discussed at the monthly governance meetings and any learning or actions required was disseminated among members of staff at ward level.

We found that patients' personal property held for safekeeping within the wards was not included in the monthly checks by the assistant service managers. We discussed this finding with the Trust and highlighted the benefits of including a review of patients' personal property in the monthly checks and future governance meetings.

We were provided with a copy of an audit assignment plan from the Internal Audit Service at BSO to audit the management of property and monies by the BHSCT on behalf of patients within MAH. The plan identified the scope of the audit to be undertaken and the planned date of commencement for the audit was 20 January 2020, however, we were informed that the audit may be delayed until February 2020.

Outcome of action point 3

As the audit of financial controls by the Internal Audit Service had not taken place by the time of this inspection we were unable to gather sufficient evidence to determine that this action point had been fully addressed.

Conclusion

We acknowledged the actions taken by BHSCT to achieve compliance with the minimum standards and the significant improvements made since the last finance inspection. However, as the audit of all financial controls has yet to take place, the improvement notice IN000004 was extended to 19 March 2020 to allow time for the findings from the BSO audit to be reviewed by the Trust and RQIA.

Improvement Notice Ref: IN000005

STATEMENT OF MINIMUM STANDARDS

The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).

Standard 5.1:

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

(a) has effective person-centred assessment, care planning and review systems in place, which include risk assessment and risk management processes and appropriate interagency approaches;
(c) has policies and procedures in place to identify and protect children, young people and vulnerable adults from harm and to promote and safeguard their rights in general;

In relation to this notice the following three actions were required to comply with the standards.

The Belfast Health and Social Care Trust Board, Chief Executive and Executive Team must:

1. Implement effective arrangements for adult safeguarding at Muckamore Abbey Hospital and ensure:

a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations;

b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively;

c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care;

d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding is improved.

2. Implement an effective process for oversight and escalation of matters relating to adult safeguarding across the hospital site; this should include ward sisters, hospital managers, Trust senior managers and / or the Executive team as appropriate.

3. Implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital.

6.2.3 Safeguarding

Action point 1

1. Implement effective arrangements for adult safeguarding at Muckamore Abbey Hospital and ensure:

a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations;

b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively;

c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care;

d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding is improved.

We were informed that staff had received training in adult safeguarding. Staff who spoke with us demonstrated a good awareness of the types and indicators of abuse and the actions to be taken in the event of a safeguarding issue being identified; including the need to make timely referrals. We found on that the training matrix for each ward evidenced that not all staff had received safeguarding training and there was no evidence to confirm the individual levels of training staff had received were in accordance with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016).

The Adult Safeguarding Lead for the hospital was aware of the deficit and informed us that they planned to be more involved in ensuring that training was up to date and provided to the correct level. We were further assured from our discussions with SMT that they were also aware of the gaps in safeguarding training and had made plans to address it.

We spoke with staff of different grades (including agency staff) and were satisfied that staff had a clear understanding of the process for making safeguarding referrals and their individual roles and responsibilities. From review of the care records, we evidenced that timely referrals were being made.

We were informed that all wards had access to copies of the BHSCT Safeguarding Policy, the regional Adult Safeguarding Prevention and Protection in Partnership policy (July 2015) and Adult Safeguarding Operational Procedures (2016) and these were easily accessible to staff. We observed that flow charts were displayed on each ward which provided guidance to staff about the process of referral to the Adult Safeguarding Team and on how to escalate concerns to the SMT.

We found that all wards had folders containing interim protection plans and MDT protection plans for patients. Samples of protection plans were reviewed and all were found to be appropriate, meaningful and corresponded to information contained in the patient's care plans and care records.

We evidenced that safeguarding incidents and referrals were being discussed at the daily safety brief and at some of the Purposeful Inpatient Admission (PipA) meetings. The Purposeful Inpatient Admission (PIpA) model was introduced by the Trust which provides an increased multidisciplinary review of each patient and involves shared decision making around care and treatment issues and risk assessment.

We observed that the protection plans are standardised throughout the hospital which enables staff to be quickly updated following a period of leave or when required to work in another ward at short notice.

Staff were aware of their responsibilities to be familiar with the content of the plans. Staff reported that having this information stored in one file, ensures they can quickly be updated with regards to the specific protection plans within each ward therefore maintaining the patients' safety. Staff spoke positively to us about the introduction of this process and can see its benefit. Staff were aware of the procedures around trigger points for a referral to safeguarding.

In relation to staff supervision plans, we found that ward managers had a good knowledge of which staff were subject to supervision plans and had a good understanding of what was required in relation to implementing the plans. This demonstrated a good balance between maintaining the appropriate supervision requirements and providing confidentiality, respect and support for those staff involved.

We examined care records and evidenced that family members and relevant professionals were being updated about safeguarding concerns in a timely manner. There was appropriate referral to PSNI and communication with RQIA when required. We found timely screening of safeguarding referrals at ward level and we were assured that the Designated Adult Protection Officers (DAPOs) had oversight of all referrals made, even the ones that had been screened out at ward level, which provided an additional level of scrutiny.

We noted an improved awareness of safeguarding generally throughout the hospital which was driven by discussion of safeguarding concerns at PIpA meetings, live governance meetings and daily safety briefs. We were told about the improved working relationships across disciplines by staff who reported feeling supported by the safeguarding team. We were informed that there are now weekly safeguarding MDT meetings on most wards. Staff reported a greater presence on the wards of the safeguarding team and felt confident in contacting the team outside of the planned meetings for advice and support. We were told that at the weekly meetings all new safeguarding referrals and interim protection plans were discussed and protection plans were formalised collaboratively. Existing safeguarding cases were reviewed and protection plans were updated as required. Staff who spoke with us knew the names of the relevant safeguarding personnel and how to contact them.

We spoke with the Adult Safeguarding Lead for the hospital and saw evidence of the monthly audit of the screening of safeguarding incidents which enabled trend analysis. This information was shared with the SMT and provided assurance of safeguarding oversight at this level. We were informed that the Adult Safeguarding Lead and the DAPOs meet weekly to discuss any concerns and a new Adult Safeguarding Forum is planned to commence which will allow for discussion of safeguarding cases and will serve to further improve and share learning outcomes.

We observed the complex nature of some of the patient behavioural challenges presented to staff. As previously discussed, staff reported to us the benefits of the increased activities for patients and the positive effect this had on individual behaviours.

A review of safeguarding incidents by the Trust found that many were due to clashes between patients or patients not having a sense of their own personal space. As a result of this review, ward environments had been creatively reconfigured to provide extra personal space for some patients to the extent that self-contained apartment type "pods" had been created. This had contributed positively to the overall safeguarding of patients and staff reported feeling supported by the current SMT in relation to safeguarding.

Outcome of action point 1

We were able to evidence that improvements had been made to address this action point.

Conclusion

We were able to evidence that the BHSCT had made significant improvements to achieve compliance with the minimum standards dictated within IN000005. However, in order to be assured that these improvements have been embedded into practice the notice will be extended until 19 March 2020 to provide time for such sustained assurance to be gained.

6.3 Review of areas for improvement from previous inspections

6.3.1 Close Circuit Television (CCTV)

We reviewed the arrangements in relation to the oversight and governance for the use CCTV within the hospital. We found that there was an effective process in place for contemporaneous monitoring and managing of CCTV images. We were informed by the SMT that monitoring of CCTV was undertaken by a MDT team and was used to demonstrate and share good practices with staff. It was also used as a mechanism for sharing learning outcomes and directing improvements.

Staff told us they understood the procedures to be followed in regards to CCTV and were able to describe the process for CCTV viewing after an incident. Some staff told us that they were fearful of the CCTV monitoring and shared with us their lack of ownership and understanding regarding the use of CCTV and some felt that it was not supporting them in their work.

We were advised that consideration is being given to how best to utilise the current CCTV footage as a learning tool to enhance quality improvement in the Management of Actual or Potential Aggression (MAPA) and related matters to obtain a better insight of events when screening safeguarding incidents.

We were advised that the hospital's CCTV policy and procedural guidance had been reviewed by the SMT; however, they had not updated the documents as they were waiting for the publication of national guidelines. We reviewed the policy and found that it did not reflect the current multiple uses for CCTV at MAH. As highlighted at previous inspections, this policy must be reviewed and updated to reflect current practice as it is used to inform and direct staff in relation to use of CCTV across the hospital.

We acknowledge that progress had been made in relation to the arrangements for the management and monitoring of CCTV, however further work was needed in relation to the CCTV policy and procedure; embedding the new practices; staff understanding the purpose and benefits of CCTV at MAH. An area for improvement in relation to CCTV has been stated for the third time.

6.3.2 Restrictive Practices (Seclusion)

Prior to this inspection we held a meeting with the MAH SMT at RQIA offices on 2 November 2019. At this meeting the SMT presented improvements they had made in relation to the use of restrictive practices. We tested the information provided at the meeting during this inspection.

We reviewed the use of restrictive practices including seclusion at MAH and found evidence of continued reduction and improvement in relation to the use of these practices. We noted the hospital's seclusion policy and procedure had been reviewed and updated.

We found the Trust had introduced an effective strong governance and assurance framework in relation to the use of seclusion. Restrictive practices were routinely audited and reported through the BHSCT assurance framework. We observed that restrictive practices were reviewed at ward level; by the MDT; at Live Governance meetings; by the SMT and also system wide by the MAH Directors Operational Group; by the Executive Team; and bi-monthly at the Trust Board meetings.

We found the Trust had developed and implemented a restrictive practice strategy and was continuing to embed a positive behavioural support culture and practice across the hospital. As previously discussed, behaviour assistants had been recruited and patients with the most challenging behaviours had a positive behaviour support plan in place and the Purposeful Inpatient Admission (PIpA) model was introduced. There was evidence that low stimulus areas were used as a means of deescalating behaviours rather than using seclusion.

We found the use of seclusion had significantly reduced across the site. In September 2019 we established there was a total of 23 seclusion events across the hospital site and we contrasted this with the previous year and found that there had been 120 seclusion events in September 2018. The number of seclusion events had further reduced to 10 in October 2019. We noted that seclusion events in September and October 2019 lasted less than four hours. We examined the audits in relation to the use of seclusion events during this period and found good compliance with the recording of seclusion events in line with the Trust's policy and procedure, the required standards and best practice. We were told about plans to perform a robust audit within the next twelve months in relation to the use of PRN medications to ensure that other forms of restrictive practice were not emerging.

We found good evidence in patient care plans of the decision making process relating to the use of restrictive practices including the use of seclusion. Staff told us that morale had improved, with staff feeling that they now have a better perspective and involvement in decision making on the use of restrictive practices. We found the need for the use of restrictive practices was continually discussed at patients' MDT meetings and during weekly MAH live governance meetings. We found that a report of contemporaneous CCTV viewing is also being produced and reported at governance meetings. It was good to note that the hospital had introduced a strong governance and assurance framework in relation to the use of seclusion and that this practice was being well led.

We observed that staff involved in managing patients with challenging behaviour (in particular patients for whom restraint and/or seclusion may be required) were being supported through structured debriefing and were being provided with the opportunity to discuss incidents. The introduction of the PIpA model was providing opportunities to identify and share learning with greater frequency and in a more timely way so that if changes to patients care plans were required this could be done quickly and with MDT input.

It was encouraging to note that ward managers across the hospital continued to closely monitor staff training including training in relation to the use of restrictive practices. Training records reviewed by us detailed that approximately 95% staff had completed up to date MAPA training. The remaining 5% had been scheduled to complete retraining in the near future.

However, we established that the seclusion room within MAH was accommodated in the PICU. As the PICU remains closed to its previous function the environments currently used for seclusion do not meet required standards. To manage some challenging behaviours in line with best practice the hospital requires access to an operational seclusion room when necessary for patient safety. The Trust should complete a review of the necessity for a functioning seclusion room taking into account the needs of the patients accommodated in the hospital, safety of patients and staff and the required standards and best practice guidance. An area for improvement was made in this regard.

6.3.3 Repurposing of PICU as low stimulus area

The Psychiatric Intensive Care Unit (PICU) temporarily closed on 21 December 2018 and has remained closed since that date in relation to its original function. We found that the Trust had repurposed the PICU as a low stimulus area for patients. We found that patients were being escorted from their wards by staff to the PICU for time limited periods to enable the provision of a low stimulus environment and the de-escalation of challenging behaviours.

We met with a patient experiencing low stimulus in the PICU and with the staff member supporting the patient. We were concerned that as the low stimulus area is some distance from the wards, the ratio of one patient to one staff member could become a safety issue and there could be potential patient safety and comfort issues when transferring patients to this area. If the previous PICU is to be used as a Low Stimulus Area a Statement of Purpose is needed to clearly show how and when the area would be used, taking into account all of the concerns that we raised. An area for improvement was made in relation to the repurposing of PICU as a low stimulus area for patients.

6.3.4 Patient Observations

We reviewed the systems in place for assessing and managing patient observations practices within MAH and found it to be effective. We were informed that the reasons for patients requiring enhanced observations is discussed and agreed by the MDT. We discussed if this was considered to be the least restrictive option and if this was proportionate to the presenting and current risks. We were informed that enhanced observations were reviewed every day by nursing staff and weekly or earlier if required by the MDT. We found that decisions were clearly made and rationales for enhanced observations being continued, reduced or discontinued were recorded in the patients risk assessment and care plan.

6.3.5 Physical Health Care of Patients

We reviewed how the hospital was identifying and meeting the physical health needs of the patients. We found the staff rotas evidenced there was an appropriate number of professionally qualified staff and good availability of the MDT to ensure that the entire range of patients physical health care needs could be met. This included patients accessing gender and age specific physical health screening programmes.

We were informed that the hospital had employed a locum GP since September 2019 who was undertaking work to compile every patient's medical history and current physical health needs into one summary document. Specific attention was being been paid to each patient's eligibility for general population screening and to any individual specific monitoring that may be required e.g. antipsychotic monitoring and diabetic retinopathy screening. This was good to note as some patients had been admitted to the hospital for many years and therefore many of these patients were not registered with a community GP and would not receive automatic general population screening reminders. In addition we found that many of the patients in the hospital presented with complex medical histories and an accessible summary of their physical health was beneficial in relation to meeting their assessed care needs.

We found these summaries were comprehensive, accessible and noted that they would be beneficial for medical staff that may be required to review the patient out of hours. We were advised that this work will continue to be completed across all wards on the site and a system was being built to ensure that any changes in staffing would easily identify the ongoing physical health needs (the general population and patient specific screening programmes) of the hospital's patients.

Review of the patient care records confirmed that patients who were prescribed antipsychotic medication were receiving the required monitoring in accordance with the hospital's antipsychotic monitoring policy. We observed from care records that one patient's daily fluid balance was being monitored and we found that this was completed regularly and in good detail.

As previously stated, the PIpA model has been introduced across the hospital and staff across the MAH spoke positively regarding the benefits it provided. This included more contact with the MDT which provided a more robust decision making process and promoted a culture of shared responsibility; which was welcomed by staff. We established that the multi-disciplinary nature of the PIpA model of care was working well and this enabled all staff to deliver effective care and learn collaboratively as a team.

However, we noted that its introduction had also presented some challenges on certain wards in relation to poor documentation about attendees at the PIpA reviews and also in relation to risk and management plans. One ward's documentation gave the impression that daily PIpA meetings were occurring daily, but on speaking with staff they reported that PIpA reviews were only occurring three days per week. Whilst we were not able to identify any direct impact on patient care, evidence of recent patient weights, monthly physical checks and blood sugars being completed or even offered to patients could not easily be found. We found the recording of this information was not standardised across the hospital and was not easily accessible. Staff told us this information is sometimes stored in a patient's daily progress notes which is not satisfactory and does not lend itself well to auditing for trend analysis. We established that other methods of capturing this patient information were included in the patient's nursing assessment on PARIS or on paper charts which were both more appropriate. In addition, we noted from review of care records that on some occasions when health checks are declined by patients, this is not recorded and there is no evidence to demonstrate that staff have returned at a later date to engage further with the patient in an attempt to encourage the patient to have the test completed.

An area for improvement was made in relation to improving and standardising the documentation used for recording monthly physical health checks across the hospital. A further area for improvement was made in relation to documenting when health checks are declined and ensuring that that there is ongoing collaborative engagement of patients to have health checks completed.

6.3.6 Discharge Planning

We reviewed the arrangements in relation to discharge planning for patients. We spoke with staff and reviewed care documentation relating to patients who had completed their care and treatment and were assessed as delayed in awaiting discharge. Staff informed us that they had access to required detailed information regarding each patient in relation to their discharge plan and assessed needs. Staff were aware of the resources and availability of services in the community which enabled them to ensure that appropriate placements for patients were found and then recorded in the patient's discharge care plans.

6.3.7 Hospital Planning

We reviewed the hospital's forward plan and found that all staff who spoke with us told us that the new management team's style was open, transparent and conducive to staff listening to and supporting one another. Staff reported that they felt supported by the current leadership and management structures.

Staff informed us that they were aware that a comprehensive forward plan for MAH was in development and that this would be communicated to staff, once available.

We were informed by the SMT that the aims and objectives for the hospital's PICU were being developed and this will be disseminated to frontline nursing staff so that there is clarity regarding both the current position of the unit and the staff positions. In the meantime PICU remains closed to its previous use but is repurposed as a low stimulus area. The previous area for improvement was met as all staff were aware that PICU was no longer being used in the way it previously would have been and were aware of its current purpose.

6.3.8 Hospital Governance

We assessed the progress made in relation to strengthening the hospital's governance arrangements. We were encouraged by the improvements in the governance arrangements which were in part, due to better sharing of information on a multi-disciplinary level which had greatly improved since the previous inspections. This was evident in the daily and weekly SITREP, live governance meetings, significant event audits (SEA's), MDT meetings and clinical improvement groups. In addition we found that the hospital governance structure was further strengthened by the strong clinical and managerial leadership team currently on site.

We found that the new interim management team confirmed the Trust's commitment to provide support to the staff and patients on the site. Their style of management was found to be open and transparent and was conducive to staff listening to and supporting one another. Staff feedback to us was positive about the current management team, with all staff confirming that they feel supported by the current leadership and new management structures. We acknowledged the speed and ease with which the majority of documentation or information requested by us was supplied to our inspection team.

Front line staff reported to us that communication across the site from senior management had greatly improved. Staff who spoke with us were knowledgeable about the purpose of the various governance committees and meetings to support leadership and understood the need to provide information for them. Staff told us that they felt involved in the daily and weekly SITREP; live governance meetings; significant event audits (SEA); MDT meetings; and clinical improvement groups.

The daily safety huddle (at ward level) was observed to be taking place on each ward. We found staff were knowledgeable about the benefits of the safety huddle and the additional level of communication it provided. Staff told us that the weekly safety pause (hospital level) meetings were scheduled in to the weekly timetable which provided us with assurance that these meetings were valued and embedded into the overall governance framework of the hospital.

We saw evidence that reporting of SEA's had increased and were being used by the MDT as a learning tool. This was further evidence of the strengthening of the governance arrangements in the hospital and the systems being used in a meaningful way to support staff in the delivery of patient care.

We established that the implementation of the Deprivation of Liberty (DoLS) safeguards process had begun. DoLS ensures people who cannot consent to their care arrangements in a hospital setting are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary and in the person's best interests. Representation and the right to challenge a deprivation are other safeguards that are part of DoLS. We found that the hospital had identified and prioritised those patients who were eligible for safeguards to be implemented under the under DoLS and a lead person had been appointed to undertake this task.

We found that quality improvement had been integrated well into the current governance systems. We noted that through a review of their systems and processes the staff and management teams had created space for themselves to have more opportunities for learning and development. We spoke with the Clinical Director, two consultants, two staff grades and a trainee separately and were told about plans to launch an improvement project next month in relation to reducing violence by patients towards both other patients and staff within the site.

We continue to have concerns regarding the regional work to review and refresh the model for learning disability patients in Northern Ireland, including the resources and availability of services in the community. It was acknowledged that whilst regional infrastructure work was ongoing, it's pace and focus was slow and impacted negatively on the flow of patients both into and out of hospital. The region's understanding of the arrangements relating to patients with severe learning disabilities who need admission to hospital remains a concern. Senior management in RQIA confirmed that we would be happy to advise; assist and support the Trust's management team with these ongoing challenges.

We discussed the interim management arrangements implemented by the Trust. We highlighted the need for a planned and staged approach to the withdrawal of the current interim management team and highlighted the potential negative impact this could have across the hospital if it was not effectively managed.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the SMT on 16 December 2019 as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

The Trust should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action.

It is the responsibility of the Trust to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas for improvement

Areas for improvement have been identified in which action is required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to meet the areas for improvement identified. The Trust should confirm that these actions have been completed and return the completed QIP to **BSU.Admin@rqia.org.uk** for assessment by the inspector by **18 August 2020**.

Quality Improvement Plan	
Action required to ensure compliance with the DHSSPSNI Quality Standards for Health and Social Care (March 2006)	
Area for improvement 1 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Third time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust must: 1. implement effective arrangements for the management and monitoring of CCTV within MAH and ensure: a) that all staff understand the procedures to be followed with respect to CCTV; b) that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively; 2. Ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH. **Ref**: **6.3.1**
	Response by the Trust detailing the actions taken: 1. A CCTV Working Group has been set up (this includes representation from ward staff, safeguarding staff, management, governance, litigation and staff unions) to review the current use of CCTV within the hospital. The group are finalising letters of explanation and surveys to family, carers, and patient advocates to capture their views on the current and future use of CCTV within the hospital. Letters and surveys have also been prepared for all staff. This process will further inform a further review of the CCTV Policy and feedback is being sought from patients with support from the Speech and Language Therapy Team.

	(a) The most up to date draft policy has been made available to all staff, including the procedures they should follow. A further review of this policy is currently taking place which will also take into consideration the survey feedback from staff, family, carers and patient advocates. (b) There are agreed procedures in place for the monitoring and management of CCTV images, the relevant templates have been updated and improved following feedback from the Contemporaneous CCTV Viewing Team and from staff. A business case was agreed and actioned in relation to replacing some aspects of the CCTV system in order to be able to retain footage. 2. The CCTV policy has been reviewed and updated to include previous addendums into the main body of the policy. This draft will be presented to the CCTV Working Group for comment following results of the survey mentioned in point 1 above. The updated draft policy now includes a broadened use of CCTV to incorporate training and reflection, support for transition teams in understanding patient support needs, etc. The policy will be presented to the Trust's Standards and Guidelines Committee in December 2020.
Area for improvement 2 **Ref**: Standard 5.1 Criteria 5.3.1(f) **Stated:** First Time **To be completed by:** 28 August 2019	The Belfast Health and Social Care Trust must strengthen arrangements for the management of medicines in the following areas: 1. Recruit a Pharmacy Technician to support stock management and address deficiencies (stock levels/ordering/expiry date checking) in wards in MAH to assist with release of nursing staff and pharmacist time. 2. Undertake a range of audits of (i) omitted doses of medicines (ii) standards of completion of administration records and (iii) effectiveness & appropriateness of administration of "when required" medicines utilised to manage agitation as part of de-escalation strategy. 3. Implement consistent refrigerator temperature monitoring recording (Actual/Minimum & Maximum) across all wards in MAH. **Ref**: **6.1**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection. On the 1 March 2020 Muckamore Abbey Hospital pharmacist hours were increased from 0.5wte to 0.8wte on a temporary basis until 31 December 2020. This will be reviewed in December 2020 to establish if the increased pharmacy hours is more appropriate for the site or if there is still a requirement for the recruitment of a Pharmacy Technician. 2. The Site Pharmacist has developed and carried out a full site audit to include omitted does of medicine and standards of completion of administration records. The findings from this audit have been

	communicated to Ward Managers. This audit will form part of a medication audit schedule going forward. The management team are working with the ward pharmacist to agree standards for the use of "when required medicines" utilised to manage agitation to enable an appropriate audit to be taken forward to monitor the effectiveness and appropriateness of its use as part of a de-escalation strategy. As part of medication monitoring, the site participated in the Prescribing Observatory for Mental Health (POMH) audit of monitoring of ID patients prescribed an antipsychotic and the results were received in August 2020. The Clinical Director for Intellectual Disability Services and the Trust Senior Pharmacist will co-present these results in October 2020. The results will be reviewed for learning and an action plan developed to progress any recommendations. 3. The Wards on site use the Trust's approved recording sheet for refrigeration monitoring daily checks. The site pharmacist is presently reviewing the last two months records for all wards as part of her medications audit.
Area for Improvement 3 **Ref**: Standard 5.3.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall complete a review of the necessity for a functioning seclusion room taking into account the needs of the patients accommodated in the hospital, safety of patients and staff and the required standards and best practice guidance. **Ref: 6.3.2**
	Response by the Trust detailing the actions taken: A monthly audit takes place reviewing all periods of seclusion and voluntary confinement that have taken place the previous month across all wards. Episodes of seclusion are discussed at PIpa meetings and MDT meetings. Seclusion episodes are detailed at PIpa, Live Governance and a separate MDT meeting is convened if required. Seclusion levels are reported in both the weekly Safety Report and reviewed bi-monthly at the Governance Committee to provide assurance and oversight to the hospital management team and the collective leadership. A Restrictive Practices Working Group had been set up to have oversight of all restrictive practices used within the hospital including the use of seclusion. The group was stood down during the initial months of the pandemic but will recommence in October 2020 as part of the site's recovery and rebuild plan. The Group will be led by the new Co-Director for Learning Disability services. The Restrictive Practice Working Group will agree a format and timescale of a review of how seclusion is provided on site including environmental assessment taking into account the safety of both patients and staff.

	This review will include a scoping exercise of best practice guidance and ensure that the dignity of our patients is at the centre of any decisions.
Area for Improvement 4 **Ref: Standard 5.3.1** **Stated: First Time** **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall outline a statement of purpose for the use of the PICU as a "Low Stimulus Area" taking account of the required standards and best practice guidance and ensuring the safety of patients and staff. **Ref: 6.3.3**
	Response by the Trust detailing the actions taken: The Restrictive Practice Working Group will develop a statement of purpose for the use of PICU as a "Low Stimulus Area" – during this exercise the group will take account of the required standards and best practice guidance and ensure the safety of patient and staff.
Area for Improvement 5 **Ref**: Standards 5.3 and 7.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall develop and implement a systematic approach to the documentation used throughout the hospital for the recording of patients' physical health checks. **Ref: 6.3.5**
	Response by the Trust detailing the actions taken: A GP role has been recruited to the hospital to focus on physical health checks for all patients. There are 3 SHO positions within the hospital which are made up of one GP trainee and 2 psychiatry trainees. A lookback exercise has taken place to gather all physical information for each patient including family history were available. This information is now stored on one template which is available on the PARIS system and in a physical health folder kept on each ward. All patient physical health information is stored on one template providing assurance that historical check information, family history and planned checks are available to all relevant staff. This provides assurance that all relevant checks have taken place or planned within the required timeframe.
Area for Improvement 6 **Ref**: Standards 5.3 and 7.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall ensure if physical health checks are declined by the patient, this must be recorded in the patient's care records and evidence retained of ongoing attempts to engage the patient. **Ref: 6.3.5**
	Response by the Trust detailing the actions taken: When patients decline physical health checks this is documented as "R" in red on the Visual Control Board (VCB) at PIPA with regular revisits (under bloods). If a patient refuses to have bloods done each incident is recorded on a form within the Physical Health Check folder, which tracks the number of times the patient has declined.

	The urgency of bloods / procedures is assessed (usually low), discussions are recorded on the patient notes and PARIS. The MDT consider various strategies with advice from Behaviour Therapists / psychology as to how to encourage this to happen. Ward staff use Social Stories to help patients understand the reason why the procedure is needed and how it happens. This also applies to dental procedures.

Name of person (s) completing the QIP	Gillian Traub		
Signature of person (s) completing the QIP	Gillian Traub	**Date completed**	25.09.20
Name of person approving the QIP	Gillian Traub		
Signature of person approving the QIP	Gillian Traub	**Date approved**	25.09.20
Name of RQIA inspector assessing response	Wendy McGregor		
Signature of RQIA inspector assessing response	Wendy McGregor	**Date approved**	29 September 2020

The Regulation and Quality Improvement Authority

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Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority

Announced Enforcement Inspection Report
02 – 16 April 2020

Belfast Health & Social Care Trust

Type of Service: Mental Health and Learning Disability Hospital
Muckamore Abbey Hospital
1 Abbey Road
Antrim
BT41 4SH
Tel No: 028 9446 3333

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

Membership of the inspection team

Lynn Long	Acting Deputy Director Improvement Regulation and Quality Improvement Authority
Wendy McGregor	Senior Inspector, Hospital Programme Team, Regulation and Quality Improvement Authority
Carmel Treacy	Inspector, Hospital Programme Team, Regulation and Quality Improvement Authority
Joseph McRandle	Inspector, Finance Team, Regulation and Quality Improvement Authority

Abbreviations

BHSCT	Belfast Health and Social Care Trust
BSO	Business Services Organisation
DAPO	Designated Adult Protection Officer
IN	Improvement Notice
IO	Investigating Officer
MAH	Muckamore Abbey Hospital
MHO	Mental Health (Northern Ireland) Order 1986
NHSCT	Northern Health and Social Care Trust
PICU	Psychiatric Intensive Care Unit
QIP	Quality Improvement Plan
RQIA	Regulation and Quality Improvement Authority
SEHSCT	South Eastern Health and Social Care Trust

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of the hospital

Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability Hospital managed by Belfast Health and Social Care Trust (the Trust). The hospital provides inpatient care to adults 18 years and over who have a learning disability and require care and treatment in an acute psychiatric care setting. Patients are admitted either on a voluntary basis or in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).

MAH provides a service to people with a Learning Disability from BHSCT, Northern Health and Social Care Trust (NHSCT) and South Eastern Health and Social Care Trust (SEHSCT). The Psychiatric Intensive Care Unit (PICU) had temporarily closed on 21 December 2018 and has remained closed since.

At the time of the inspection there were five wards operational on the MAH site:

- Cranfield One (Male assessment);
- Cranfield Two (Male treatment);
- Ardmore (Female assessment and treatment);
- Six Mile (Forensic Male assessment and treatment); and
- Erne (Long stay/re-settlement).

3.0 Service details

Responsible person: Ms Cathy Jack Belfast Health and Social Care Trust	**Position:** Chief Executive Officer
Category of care: Acute Mental Health & Learning Disability	**Number of beds:** 83
Person in charge at the time of inspection: Bernie Owens, Director, Neurosciences, Radiology and Muckamore Abbey Hospital, BHSCT.	

4.0 Inspection summary

We undertook an announced remote inspection of Muckamore Abbey Hospital (MAH) from 2 to 16 April 2020 to assess compliance with the outstanding action points contained within the extended Improvement Notice (IN) - IN000004E which related to the governance of patients finances and Improvement Notice - IN000005E which related to adult safeguarding. We did not visit MAH as part of this inspection due to the current impact on all services as a result of COVID-19. We determined that the information we required to confirm compliance could be provided to us electronically and reviewed remotely.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

On 16 August 2019 RQIA issued three Improvement Notices (INs) to MAH in respect to a failure to comply with minimum standards.

- IN000003 - staffing
- IN000004 - financial governance ; and
- IN000005 - adult safeguarding

During our unannounced inspection on 10, 11 & 12 December 2019 we found sufficient evidence to validate full compliance with Improvement Notice - IN000003 relating to staffing. However, while we found evidence of improvement and acknowledge that progress had been

made to address the required actions within the other two Improvement Notices, IN000004 relating to financial governance and IN000005 relating to adult safeguarding we did not find sufficient evidence to validate full compliance with these two Improvement Notices.

We were able to validate compliance with action points 1, 2, 3 (a), 3 (b) and 3 (c) contained within IN000004 and with action points 1 (a), 1 (b), 1 (c),1 (d) and 2 contained within IN000005. While significant progress had been made, we were unable to evidence that action point 3 (d) of IN000004 and action point 3 of IN000005 were fully addressed.

RQIA senior management held a meeting on 13 December 2019 and a decision was made that the date of compliance for Improvement Notices IN000004 and IN00005 should be extended. Compliance with the extended Improvement Notices must therefore be achieved by 19 March 2020. The extended Improvement Notices – IN000004E and IN000005E were issued on 19 December 2019.

This inspection sought to assess the level of compliance achieved in relation to the following outstanding action points:

- IN000004E – that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in Muckamore Abbey Hospital

- IN000005E – implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital

4.1 Inspection outcome

Total number of areas for improvement	6*

**Six areas for improvement generated as a result of the inspection undertaken on the 10, 11 and 12 December 2019 were not reviewed as part of this compliance inspection and will be carried forward to the next inspection. No new areas for improvement were identified during this inspection.

As a result of the findings of this inspection we determined the Trust had achieved compliance with the outstanding action points contained within the extended Improvement Notices - IN000004E and IN000005E.

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Enforcement notices for registered establishments and agencies are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

5.0 How we inspect

Prior to the inspection, we reviewed a range of information relevant to the establishment including the following records:

- written and verbal communication received since the previous inspection;
- notifiable events received since the previous inspection;
- the previous inspection report;
- the QIP from the previous inspection; and
- The extended Improvement Notices - IN000004E and IN000005E.

During our remote inspection we requested the following records from the Interim Co-Director for Intellectual Disability:

- findings of the financial audit carried out by BSO;
- records of adult safeguarding and DATIX training provided for Designated Adult Protection Officers (DAPOs), Investigating Officers (IOs), line managers and medical staff;
- minutes of the monthly adult safeguarding forum (January and February 2020);
- evidence of outcomes from analysis of adult safeguarding data;
- minutes of Clinical Governance Meetings (January and February 2020);
- evidence of governance arrangements in place for staff on supervision plans moving around wards;
- outcomes from audits of patient protection plans, all adult safeguarding referrals for January and February 2020 and evidence of compliance with the adult safeguarding referral process; and
- evidence of the development of a communication strategy with carers.

We examined the following areas:

- arrangements for financial governance;
- results of the financial audit completed in February 2020; and
- oversight and management of adult safeguarding arrangements.

The findings of the inspection were provided to the Senior Management Team (SMT) and to Ms Cathy Jack, Chief Executive, BHSCT at the conclusion of the inspection by letter.

6.0 The inspection

6.1 Review of areas for improvement from the last care inspection dated 10, 11 and 12 December 2019

As previously outlined in section 4.0 this inspection focused on evidencing compliance with the outstanding action points in IN000004E and IN000005E. Six areas for improvement from the last inspection on 10, 11 and 12 December 2019 were not reviewed as part of this inspection

and are carried forward to the next inspection. The QIP in section 7.2 reflects the carried forward areas for improvement.

6.2 Inspection findings

Improvement Notice Ref: IN000004E

STATEMENT OF MINIMUM STANDARDS

The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).

Standard 4.1:

The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.

Standard 5.1:

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

Failure to Comply:

4.3 Criteria

The organisation:

(f) ensures financial management achieves economy, effectiveness, efficiency and probity and accountability in the use of resources;
(g) has systems in place to ensure compliance with relevant legislative requirements;
(h) ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory functions and in relation to inter-agency working;
(i) undertakes systematic risk assessment and risk management of all areas of its work.

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

(c) has policies and procedures in place to identify and protect children, young people and vulnerable adults from harm and to promote and safeguard their rights in general;

Improvement necessary to achieve compliance:

The Belfast Health and Social Care Trust Board, Chief Executive and Executive Team must ensure:

- that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in Muckamore Abbey Hospital.

On 2 April 2020 the Trust's (SMT) provided an update to RQIA on the progress made to address compliance with the outstanding action points included in the Improvement Notices via a remote inspection. They informed us that a full audit of the arrangements for financial controls relating to patients had been completed by internal auditors from the Business Service Organisation (BSO) and that a 'satisfactory' rating had been achieved. They told us that there were no Priority 1 findings. The audit identified some Priority 2 findings with associated recommendations. We discussed the findings of the financial audit in detail with the SMT and they provided us with the actions they had taken or where taking to address the recommendations made by Internal Audit.

The Trust advised that BSO Internal Audit had confirmed to them that documentation was in place from the Social Security Agency (SSA) authorising the Trust to act as the appointee for certain patients and that the correct benefits were being received on behalf of those patients. The Trust also advised that Internal Audit had highlighted some minor issues that had arisen from the financial audit which they were addressing.

The SMT told us that Internal Audit had acknowledged that the Trust had sought approval from RQIA to hold balances of patients' monies and valuables in excess of £20,000 in line with article 116 of the MHO.

As the Trust received a satisfactory grade from BSO Internal Audit, we were advised that a mid and end of year assurance report will be required to be submitted by the Trust to Internal Audit. We were told that Internal Audit will review the recommendations from all the Trust reports at a point in time and provide an update in terms of implementation i.e. fully implemented, partially implemented or not implemented for the Trust's Audit Committee in October 2020.

It was good to note that many of the findings in the Internal Audit report concur with RQIA's findings from the unannounced inspection on 10, 11 and 12 December 2019.

We were informed that the SMT within MAH will take the lead in liaising with the Trust's Finance Directorate in order for the Finance Directorate to have the overarching accountability of the financial arrangements for patients within MAH**.** SMT told us they believed links with the Finance Directorate had been greatly strengthened because of the financial audit and that the Patient Finance Liaison Officer based in MAH was a key role in maintaining improvements. SMT advised that they were planning to permanently appoint a Patient Finance Liaison Officer.

On 9 April 2020 the final copy of the audit report was shared with RQIA and reviewed by our inspection team. This verified the information previously provided to us by on 2 April 2020.

Outcome

We found sufficient evidence to determine that this action point had been addressed.

Improvement Notice Ref: IN000005E

STATEMENT OF MINIMUM STANDARDS

The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).

Standard 5.1:

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

Failure to comply:

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

(a) has effective person-centred assessment, care planning and review systems in place, which include risk assessment and risk management processes and appropriate interagency approaches;
(c) has policies and procedures in place to identify and protect children, young people and vulnerable adults from harm and to promote and safeguard their rights in general;

Improvement necessary to achieve compliance:

The Belfast Health and Social Care Trust Board, Chief Executive and Executive Team must:

- Implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital.

During the teleconference on 2 April 2020, the MAH SMT provided a presentation to us outlining how they had embedded into practice the safeguarding improvements we observed during our unannounced inspection of MAH on 10, 12 and 12 December 2019. They described to us the senior management oversight arrangements for the management of safeguarding within the hospital. They shared with us the flow chart displayed on each ward which showed the process for escalating a safeguarding incident and which highlighted the various staff roles in the process.

The SMT told us about good practice improvements which have been implemented which included a comprehensive review of policies and procedures including the seclusion policy, the observation policy and the admission policy. They told us that patients are engaged in more meaningful activity on and off the hospital site in the evenings and at weekends. They also informed us that CCTV is now live across the site and learning from the Adult Safeguarding (ASG) team's viewing of the CCTV is shared at ward manager meetings and at the ASG Forum.

The Purposeful Inpatient Admission (PIpA) model, which provides an increased multidisciplinary review of each patient and involves shared decision making around care and treatment issues and risk assessment, had been further developed and embedded within the hospital. We were

informed that a link person for contact with the Police Service Northern Ireland (PSNI) had now been established and a Service Manager with ASG responsibilities has been recruited.

The SMT told us that action had been taken by the hospital social work team to raise safeguarding awareness among patients through the Keeping Yourself Safe Programme. The programme informs patients about what safeguarding is and what actions they could take if they had a safeguarding concern. We were advised that this will be an ongoing programme for patients.

We were advised that since January 2018, the Keeping Yourself Safe programme had been delivered to 45 patients in MAH and another 33 patients were either offered the programme and declined or had insufficient capacity to participate or have now been discharged from the hospital.

It was established that the programme was not able to sufficiently meet the needs of 22 patients who experienced significant communication difficulties without specialist input and training from the Association for Real Change (ARC) to enable them to participate. The social workers on site have now all been trained in Talking Mats to assist in more effective communication with patients.

We were told that ARC will complete a baseline report of the views of all patients in relation to how safe they feel in the hospital. This will be reviewed every six months. ARC will also complete a post safeguarding investigation questionnaire for any patient involved in a safeguarding investigation. Preparatory work has been completed for both pieces of work to commence as a pilot in one ward.

The SMT informed us that the safeguarding team are now completing pre and post safeguarding investigation questionnaires with carers/relatives and the learning outcomes will be disseminated via clinical governance meetings, safety briefs and the ASG Forum as appropriate. These questionnaires were analysed by the DAPO and will be used to inform future practice. From this analysis, the need for clearer communication with families following a safeguarding incident/referral had been identified and work was underway to develop a communication strategy to engage more effectively with carers.

We were told that the SMT had increased audit activity to embed safeguarding practices within the hospital. Auditing is being used to ensure compliance with and adherence to safeguarding recording standards by both ward staff and safeguarding staff. We were given examples of how these audits had informed improvements in the service provided and patient experience. The current audits shared with us showed good compliance with safeguarding recording standards. Auditing of the contemporaneous viewing of CCTV was ongoing on a weekly basis (each ward was monitored for a 4 hour shift per week) and a viewing sheet was retained. Examples of good practice and areas for improvement were highlighted by the viewing team and addressed through ward managers meetings and by the assistant service managers. We were advised that the contents of the CCTV viewing sheets form part of the hospital's safety report. We noted that one safeguarding incident was identified from the contemporaneous viewing of CCTV footage and appropriate action had been taken.

During our inspection on 10, 11 and 12 December 2019 we evidenced good staff knowledge and awareness of what constitutes a safeguarding referral and the process on how to make a referral. The SMT informed us that in order to be assured of the continued good level of safeguarding knowledge and awareness, audits were conducted within the hospital to test staff

(twenty eight staff in total) about their knowledge of the new safeguarding processes implemented; escalation plans; protection planning; how to refer in and out of hours to ASG; staff responsibilities; how safeguarding information is communicated; and the contact details of the safeguarding team. The result of the audit demonstrated that among all grades of staff knowledge was found to be good.

SMT told us that there is now monthly auditing of ward managers' decision making to screen out safeguarding referrals. This audit showed that no safeguarding referrals had been inappropriately screened out. The SMT informed us about a further monthly audit completed to ensure there was MDT input into protection planning. This audit identified a significant improvement in MDT input into protection planning and risk assessment from October 2019 (52% compliance) to January 2020 (100% compliance).

From the information reviewed and discussed on 2 April 2020, we found that the Trust had made good progress in embedding good practice in respect of adult safeguarding across the hospital. In order to support our decision making about compliance with the outstanding action within IN00005E we asked the Trust to provide the following evidence:

- records of adult safeguarding and DATIX training provided for DAPOs, IOs, line managers and medical staff since our last inspection in December 2019;
- minutes of the monthly adult safeguarding forum (January and February 2020);
- evidence of learning outcomes from the analysis of adult safeguarding data;
- minutes of Clinical Governance Meetings (January and February 2020);
- evidence of governance arrangements in place for staff on supervision plans moving around wards;
- outcomes from audits of patient protection plans;
- all adult safeguarding referrals for January and February 2020 and evidence of compliance with adult safeguarding referral process; evidence of the development of a communication strategy with carers.

The information requested was provided to us on 10 April 2020 and we found that this verified the discussions we had with the SMT on 2 April 2020. Review of the information showed an improvement in training compliance; live discussions around the need for ongoing safeguarding training; staff positivity in relation to the benefits of sharing learning via the ASG forum; and the impact of the improvements on care practices and restrictive practices.

We reviewed evidence of the governance arrangements in place for staff on ASG supervision plans who were moving around wards. This was clearly stated in the escalation policy and we were informed this had been tested by SMT to assure compliance. We were assured that appropriate measures were in place to ensure the safety of patients when staff members on ASG supervision plans are asked to provide relief on another ward.

We were able to verify that the information regarding the outcomes from audits accurately reflected what the SMT told us during the remote inspection and that the results from auditing in relation to patient protection plans led to an improvement in the compliance rating for the next audit. Evidence that improvements were being embedded was also seen in relation to how and where information was stored on the PARIS information system, templates being updated and how and with whom information was shared.

We were assured that steps were being taken to address the concerns raised by carers in relation to safeguarding. We reviewed a draft 10 point communication plan for families and found that a communication strategy was being developed in consultation with the Carer's Consultant to ensure a consistent approach when engaging with carers.

Outcome

We found sufficient evidence to determine that this action point had been addressed.

6.3 Conclusion

We found sufficient evidence was available to validate compliance with the outstanding action points in the extended Improvement Notices IN000004E and IN000005E.

7.0 Quality improvement plan

There were no new areas for improvement identified during this inspection. The attached QIP contains the areas for improvement carried forward from the last inspection on 10, 11 and 12 December 2019. The six areas for improvement will be reviewed at a subsequent inspection.

The Trust should note that if the action outlined in the QIP is not taken to comply with areas for improvement this may lead to further enforcement action. It is the responsibility of the Trust to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas for improvement

No new areas for improvement were identified during this inspection. The attached QIP includes six areas for improvement identified during the last inspection on 10, 11 and 12 December 2019.

7.2 Actions to be taken by the service

The Trust is not required to return a completed QIP for assessment by the inspector as part of this inspection process. The QIP reflects the carried forward areas for improvement from the inspection on 10, 11 and 12 December 2019.

Quality Improvement Plan

Action required to ensure compliance with the DHSSPSNI Quality Standards for Health and Social Care (March 2006)	
Area for improvement 1 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Third time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust must: 1. implement effective arrangements for the management and monitoring of CCTV within MAH and ensure: a) that all staff understand the procedures to be followed with respect to CCTV; b) that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively; 2. ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.**
Area for improvement 2 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First Time **To be completed by:** 28 August 2019	The Belfast Health and Social Care Trust must strengthen arrangements for the management of medicines in the following areas: 1. Recruit a Pharmacy Technician to support stock management and address deficiencies (stock levels/ordering/expiry date checking) in wards in MAH to assist with release of nursing staff and pharmacist time. 2. Undertake a range of audits of (i) omitted doses of medicines (ii) standards of completion of administration records and (iii) effectiveness & appropriateness of administration of “when required” medicines utilised to manage agitation as part of de-escalation strategy. 3. Implement consistent refrigerator temperature monitoring recording (Actual/Minimum & Maximum) across all wards in MAH. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.**
Area for Improvement 3 **Ref**: Standard 5.3.1 **Stated:** First Time	The Belfast Health and Social Care Trust shall complete a review of the necessity for a functioning seclusion room taking into account the needs of the patients accommodated in the hospital, safety of patients and staff and the required standards and best practice guidance.

To be completed by: 1 October 2020	**Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.**
Area for Improvement 4 **Ref:** Standard 5.3.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall outline a statement of purpose for the use of the PICU as a "Low Stimulus Area" taking account of the required standards and best practice guidance and ensuring the safety of patients and staff.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.
Area for Improvement 5 **Ref**: Standards 5.3 and 7.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall develop and implement a systematic approach to the documentation used throughout the hospital for the recording of patients' physical health checks.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.
Area for Improvement 6 **Ref**: Standards 5.3 and 7.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall ensure if physical health checks are declined by the patient, this must be recorded in the patient's care records and evidence retained of ongoing attempts to engage the patient.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.

The Regulation and Quality Improvement Authority

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Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority

Unannounced Inspection Report
27 and 28 October 2020

Belfast Health & Social Care Trust

Type of Service: Mental Health and Learning Disability Hospital
Muckamore Abbey Hospital
1 Abbey Road
Antrim
BT41 4SH
Tel No: 028 9446 3333

Membership of the inspection team

David McCann	Assistant Director, Improvement Directorate, Regulation and Quality Improvement Authority
Wendy McGregor	Acting Assistant Director, Improvement Directorate, Regulation and Quality Improvement Authority
Carmel Treacy	Lead Inspector, Hospital Programme Team, Regulation and Quality Improvement Authority
Cairn Magill	Inspector, Hospital Programme Team, Regulation and Quality Improvement Authority
Maire-Therese Ross	Inspector, Hospital Programme Team, Regulation and Quality Improvement Authority
Jillian Campbell	Inspector, Hospital Programme Team, Regulation and Quality Improvement Authority
Joseph McRandle	Finance Inspector, Regulation and Quality Improvement Authority
Gerry Lynch	Medical Peer Reviewer, Regulation and Quality Improvement Authority
Paula Weir	Inspection Coordinator, Regulation and Quality Improvement Authority

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability Hospital managed by Belfast Health and Social Care Trust (the Trust). The hospital provides inpatient care to adults 18 years and over who have a learning disability and require care and treatment in an acute psychiatric care setting. Patients are admitted either on a voluntary basis or in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).

MAH provides a service to people with a Learning Disability from the Trust, the Northern Health and Social Care Trust (NHSCT) and South Eastern Health and Social Care Trust (SEHSCT) areas. The Psychiatric Intensive Care Unit (PICU) closed on 21 December 2018 and has remained closed to that purpose since. It has now being used as a low stimulus area and the hospital's seclusion room.

At the time of the inspection, there were five wards operational on the MAH site:

- Cranfield One (male assessment);
- Cranfield Two (male treatment);
- Ardmore (female assessment and treatment);
- Six Mile (forensic male assessment and treatment); and
- Erne (long stay/re-settlement).

On the day of the inspection, there were 50 beds operational in the hospital, 45 patients who were accommodated in the hospital; three patients who were on trial resettlement leave; and two patients who were on extended home leave.

3.0 Service details

Responsible person: Dr Cathy Jack Belfast Health and Social Care Trust	**Position:** Chief Executive Officer
Category of care: Acute Mental Health & Learning Disability	**Number of beds:** 50
Person in charge at the time of inspection: Tracy Kennedy, Co-Director Learning Disability	

4.0 Inspection summary

An unannounced inspection was undertaken to all five wards located in MAH which commenced with an onsite inspection from 27-28 October 2020. The inspection was completed on 10 December 2020 following family and advocate engagement. Feedback from the inspection was delivered to the Trust's senior management team on 11 December 2020.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Mental Health (Northern Ireland) Order 1986 and the DHSSPSNI Quality Standards for Health and Social Care (March 2006).

During August 2019 we served three improvement notices to the Trust in relation to adult safeguarding arrangements, staffing and the governance of patients' finances. Compliance with the improvement notice for staffing was determined in December 2019 and in April 2020 for adult safeguarding arrangements and the governance of patients' finances. The focus of this inspection included our determination whether the improvements made by the Trust since April 2020 had been maintained and embedded in practice at the hospital. In addition the areas for improvement identified in the previous Quality Improvement Plan (QIP) from December 2019, were examined during this inspection.

We were pleased to see good practice in relation to:

- the hospital's ethos of using the least amount of restrictive practices to manage patients' behaviours that challenge;
- the management and monitoring of patient's physical healthcare needs;
- the oversight of medicines management within the hospital; and
- the updated operational policy reflecting the varied use of close circuit television (CCTV) within the hospital.

We were concerned that:

- communication of information relayed to families by the adult safeguarding team was not clearly shared with ward staff;
- some families were not content with the level of communication from the ward/hospital/adult safeguarding team about their relative;
- staff were unsure about the actions to take if the ward's medicine refrigerator was found to be outside of the safe temperature range; and
- some patients had not received an audit of their finances by a senior manager.

4.1 Inspection outcome

Total number of areas for improvement	4

There were four new areas for improvement arising from this inspection. These are detailed in the QIP.

Details of the QIP were discussed with the senior management team (SMT) at an online feedback session on 11 December 2020, as part of the inspection process. The timescales for implementation of these improvements commence from that date. Findings of our inspection are outlined in the main body of the report.

This inspection did not result in enforcement action.

5.0 How we inspect

Prior to this inspection, a range of information relevant to the service was reviewed, including the following records:

- previous inspection reports;
- review of the previous returned QIP;
- Serious Adverse Incident (SAI) notifications;
- information about complaints; and
- other relevant intelligence received by RQIA.

Each ward was assessed using an inspection framework. The methodology underpinning this inspection included discussion with patients, staff, relatives, observation of practice, and review of relevant documentation. Records examined during the inspection included nursing care records; medical records; senior management and governance reports; minutes of meetings; duty rotas; and training records.

Areas for improvement identified during previous inspections were reviewed and an assessment of achievement was recorded as met, partially met or not met.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection from 02-16 April 2020

The announced inspection from 02 -16 April 2020 was undertaken remotely to assess compliance with two extended Improvement Notices relating to the governance of patients' finances and adult safeguarding arrangements. Full compliance with the extended Improvement Notices was achieved in April 2020. The QIP generated from the unannounced inspection from 10-12 December 2019 was not reviewed during the April 2020 inspection and was reviewed during this inspection.

6.2 Review of areas for improvement from the previous inspection from 10-12 December 2019

<table>
<tr><th colspan="2">Areas for improvement from the previous inspection</th><th>Validation of compliance</th></tr>
<tr><td>Area for improvement 1

Ref: Standard 5.1
Criteria 5.3 (5.3.1)

Stated: Third time

To be completed by:
1 October 2020</td><td>The Belfast Health and Social Care Trust must:

1. implement effective arrangements for the management and monitoring of CCTV within MAH and ensure:

a) that all staff understand the procedures to be followed with respect to CCTV;
b) that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively;

2. ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
This area for improvement has been assessed as met. Further detail is provided in section 6.3.1.</td></tr>
</table>

Area for improvement 2 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First Time **To be completed by:** 28 August 2019	The Belfast Health and Social Care Trust must strengthen arrangements for the management of medicines in the following areas: 1. Recruit a Pharmacy Technician to support stock management and address deficiencies (stock levels/ordering/expiry date checking) in wards in MAH to assist with release of nursing staff and pharmacist time. 2. Undertake a range of audits of (i) omitted doses of medicines (ii) standards of completion of administration records and (iii) effectiveness & appropriateness of administration of "when required" medicines utilised to manage agitation as part of de-escalation strategy. 3. Implement consistent refrigerator temperature monitoring recording (Actual/Minimum & Maximum) across all wards in MAH.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.3.2.	
Area for Improvement 3 **Ref**: Standard 5.3.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall complete a review of how seclusion is provided on the site taking into account the safety of both patients and staff. The Trust should also take into account the dignity of patients and best practice guidance.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.3.3.	
Area for Improvement 4 **Ref:** Standard 5.3.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall outline a statement of purpose for the use of the PICU as a "Low Stimulus Area" taking account of the required standards and best practice guidance and ensuring the safety of patients and staff.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.3.4.	

Area for Improvement 5 **Ref**: Standards 5.3 and 7.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall develop and implement a systematic approach to the documentation used throughout the hospital for the recording of patients' physical health checks.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.3.5.	
Area for Improvement 6 **Ref**: Standards 5.3 and 7.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall ensure if physical health checks are declined by the patient, this must be recorded in the patient's care records and evidence retained of ongoing attempts to engage the patient.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.3.6.	

6.3 Inspection findings

6.3.1 Close circuit television (CCTV)

We reviewed the arrangements in relation to the oversight and governance for the use of CCTV within the hospital. We found that there was an effective process in place for contemporaneous monitoring and management of CCTV images. We were provided with records of contemporaneous CCTV viewing from 09 March to 20 October 2020. We found that CCTV viewing occurs, at various times over the 24 hour period of each day, 7 days a week, and across different wards including day care.

We reviewed the minutes of three live governance meetings (01- 15 October 2020) and found that the CCTV viewer's findings were discussed. The CCTV viewer's records evidenced where good practice was highlighted and where poor practice or incidents, which met the criteria for an adult safeguarding referral, demonstrated appropriate action was taken.

We reviewed patients' care records and adult safeguarding multidisciplinary team (MDT) protection plans. We saw evidence that CCTV images were used to assist in decision making if there was uncertainty about staff's use of Management of Actual or Potential Aggression (MAPA) restraints and in relation to making referrals to adult safeguarding.

We were informed that Assistant Service Managers (ASMs) and Designated Adult Protection Officers (DAPOs) were provided with CCTV viewing records every week to review and triangulate information relating to their wards. We found evidence that this was an effective process and found that adult safeguarding or practice issues were dealt with in a timely manner.

We reviewed the draft CCTV policy. The policy incorporated new areas relating to staff training and reflection and increasing the understanding of patient support needs. The SMT informed us that a CCTV working group had been set up to review the current use of CCTV within the hospital which included representation from staff of varying grades and disciplines, litigation services and trade unions. The group were finalising a survey seeking the views of patients, family, carers, patient advocates and staff on the current and future use of CCTV within the hospital. We were informed that Speech and Language therapists were supporting patients to provide their feedback to the working group about the use of CCTV. We were advised that the feedback obtained from the survey would further inform the final draft of the CCTV Policy.

Whilst the current CCTV policy remains in draft form, it has been made available to all staff pending further review when feedback from all relevant parties is considered. It is planned that the final draft of the policy will be presented to the Trust's Standards and Guidelines Committee in December 2020 for approval. We determined that this addresses the previous area for improvement outlined in section 6.2.

6.3.2 Medicines management

We reviewed how the Trust had strengthened arrangements for the management of medicines since the previous inspection. We found that the hospital's pharmacist hours had been increased from a 0.5 whole time equivalent (wte) to a 0.8 wte on 01 March 2020, for a temporary period until 31 December 2020. We were informed that plans were in place to review the increase of the pharmacy service in December 2020 and a decision will be made to either recruit a pharmacy technician or permanently increase the pharmacist's hours.

We spoke with staff on the wards and they were very positive about the pharmacist's input. They told us that the pharmacist attends the Purposeful Inpatient Admission (PIpA) meetings regularly and provides their specialist knowledge, which is welcomed. The PIpA model introduced by the Trust provides an increased multidisciplinary review of each patient and involves shared decision making around care and treatment issues and risk assessment. We reviewed audits that had been undertaken in relation to omitted doses of medicines; standards of completion of administration records; and the effectiveness and appropriateness of the administration of "when required" medicines, that are utilised to manage agitation as part of a de-escalation strategy. The SMT informed us that their plans to implement an audit schedule to provide the ongoing assurance of the high standards we observed was delayed due to the impact of the Covid-19 pandemic, however, they expected this audit schedule to become operational soon.

Ward staff informed us that the pharmacist provides a level of scrutiny over missed doses of medications and advice regarding drug interactions and cross titration of antipsychotic medications. The pharmacist also calculates the combined antipsychotic medication daily dose for individual patients to ensure this falls within safe limits. Staff told us that the pharmacist's input during the Covid-19 pandemic surge period regarding intravenous fluids and oxygen was invaluable. They also reported that the increase in the pharmacy service within the hospital has made the process of prescriptions for patients going on leave from the hospital much more refined, thereby reducing delays.

We reviewed a sample of 20 medicine kardexes and found a good standard of prescribing. We noted that recording of medicine administration was well completed and the patients' allergy status was documented on all kardexes reviewed. Antibiotic prescriptions included indications for use and treatment lengths were documented.

There was a minimal amount of multiple antipsychotic prescribing and a clear rationale was described by the Consultant in these cases. We found evidence that as and when required (PRN) medication was prescribed in the context of any regular prescriptions of the same medication. PRN medication usage was discussed daily at PIpA meetings and weekly live governance meetings for trend analysis. We found that PRN medication usage was proportionate, judicious, and fell within maximum dose limits which indicated that PRN medications were not used as a form of restrictive practice.

We reviewed the daily records for medicine refrigerator temperature monitoring to ensure these accurately reflected the actual, minimum, and maximum refrigerator temperatures. We found evidence that these checks were being completed daily and that records were being kept on all wards. We determined that the previous area for improvement outlined in section 6.2 had been met.

We spoke with staff about the actions to take on occasions when the medicine refrigerator temperature fell outside of the required temperature and found there was a lack of clarity about the correct actions to take. We established there was no advice available for staff to guide them on the appropriate steps to take to ensure the integrity of the medications contained in the refrigerator. An area for improvement is stated to ensure that an escalation procedure for managing temperature variances in medicine refrigerators is developed which guides staff to take the appropriate actions if medicine refrigerators fall outside the permitted temperature range.

6.3.3 Review of how seclusion is provided on the site

We reviewed the arrangements in place to provide seclusion on the site. The SMT informed us that a Restrictive Practices Working Group had been established to have oversight of all restrictive practices used within the hospital. The group was stood down during the initial months of the Covid-19 pandemic but had recommenced in October 2020 as part of the site's recovery and rebuild plan.

We saw clear evidence of where seclusion was used; as a last resort; proportionate to the risks presented by the patient and; after all deescalating techniques, as recorded in the patients' positive behaviour support plan, were implemented. These approaches include encouraging patients to avail of low stimulus areas with their agreement, within designated low stimulus areas designed to promote a calm environment for patients who have difficulty in managing their emotions and who require support during times of emotional dysregulation and distress. Patients can avail of therapeutic one to one time with a staff member allowing them to explore their feelings in an area that protects their dignity.

Staff described the use of voluntary confinement. This is the term used to describe requests from patients to be confined to their bedroom and to have the door locked as part of their behavioural support plans. Voluntary confinement, as part of an agreed care and treatment plan, is only in place for specific patients who have used this as an approach to manage their behaviour over a significant period of time. We established that the patients who use this approach to self-manage their behaviour can exit their voluntary confinement at any time of their choosing. We determined that when a patient requests voluntary confinement they are subject to the same level of support and observation levels that a patient would otherwise have, had they been in seclusion. We saw evidence that the decision making and care planning for voluntary confinement involves significant MDT discussion and consultation with family. We saw evidence of a care plan for a patient who uses voluntary confinement which was subject to regular review. We were satisfied that all appropriate safeguards were in place which included consideration for the patients' human rights.

Seclusion occurs when a patient is formally placed in a specifically designated room for the short-term management of disturbed/violent behaviour. We saw evidence of care planning for patients who may require this intervention which had been agreed by the MDT and shared with their family. The care plan and the seclusion policy outlined the strict monitoring and observation procedures to be followed by nursing and medical staff with the aim of ending seclusion at the earliest opportunity. It was good to see that the hospital applied the same monitoring and governance standards to all of these interventions.

All episodes of voluntary confinement/low stimulus/seclusion are discussed at PIpA meetings, MDT, and live governance meetings. A monthly audit is undertaken across all wards taking account of all episodes of voluntary confinement/low stimulus/seclusion use. We saw evidence that this information is reported in the weekly Safety Report reviewed by SMT and are reviewed bi-monthly at the Director's Governance Committee. We were assured by the systems and processes in place and determined that the SMT had good oversight and governance of restrictive practices including the use of voluntary confinement/low stimulus/seclusion within the hospital.

We observed that the site continues to have one operational seclusion room which is located in the former PICU. The PICU closed to its previous function on 21 December 2018. It is now being used as a Low Stimulus Area along with accommodating the seclusion room. The Restrictive Practice Working Group carried out a review of how seclusion was provided on the site and concluded that the current facilities available to patients were appropriate in meeting their needs to required standards.

We reviewed audits and found evidence that the use of low stimulus/voluntary confinement/seclusion on the site had reduced significantly and SMT told us they are committed to an ethos of least restriction. We determined that area for improvement as outlined in section 6.2 had been met.

6.3.4 Statement of Purpose for the "Low Stimulus Area"

A draft Statement of Purpose (SoP) for the Low Stimulus Area was provided by the Trust following the inspection. The draft clearly outlined the rationale for the provision of this area and considered how it would be provided within the former PICU and in Sixmile ward. The Trust planned to consult with staff, patients, their families and other stakeholders to ensure a wide range of feedback on the SoP could be considered. They plan to add to the SoP so that robust guidelines will be developed to direct staff about the required operational procedures to be followed when this area is to be used. We determined that the area for improvement as outlined in section 6.2 had been met.

6.3.5 Standardised documentation of physical health care records

We reviewed the arrangements in place for the management of patients' physical health care needs. We examined a sample of patient care records and evidenced that all patients had a robust medical history completed by a General Practitioner (GP), which included a comprehensive family history. These histories along with antipsychotic medication monitoring checks were located in one folder on each ward which made it easy for all staff to be quickly apprised of any specific patient's physical health care status. All care records reviewed also evidenced that anti-psychotic monitoring was up to date.

Population screening programmes have a key role to play in the early detection of disease and a range of programmes are currently available in Northern Ireland.

The SMT informed us that patients who meet the criteria set out by the Public Health Agency for population screening have had their screening completed and have been added to the registers to ensure they are appropriately called in line with the general population. Population screening programmes include abdominal aortic aneurysm screening and surveillance monitoring; routine breast screening; bowel cancer screening; cervical screening; and routine diabetic eye screening and surveillance monitoring.

We found that patients' physical health care histories were also stored on the PARIS electronic care records system. We found evidence that patients' physical health care was discussed daily at the PIpA meetings and all wards were documenting this information in the same way. We were assured that there were robust systems in place for the oversight and management of patients' physical health care needs and determined that the previous area for improvement as outlined in section 6.2, had been met.

6.3.6 Ongoing engagement of patients who decline physical health care checks

We reviewed how the hospital was identifying and meeting the physical health care needs of the patients and in particular what action was taken when a patient declined physical health care checks. We reviewed a sample of patient care records, ward diaries, and physical health care folders and saw evidence that when patients' decline a physical health care check this is recorded in their care record, the physical health care folder, and the ward diary to alert staff of the ongoing need to encourage the patient to participate in this check. We found an example of good practice and patient centred care in one ward where the ward manager allocated a blood sample to be taken on a specific day as the staff member on duty had a particularly good rapport with the patient. The ward manager had recognised that this professional rapport with the identified staff member could help to put the patient at ease during the procedure and reduce any anxiety or distress.

We were informed that the psychology department works closely with ward staff to help better understand the patient's rationale for declining a physical health care check. There was evidence that the MDT considers various strategies and collaborates with the behaviour therapists to encourage patients to accept necessary physical health care checks. Social Stories were used by ward staff and behaviour therapists to help patients understand the reason a procedure may be required and what the procedure may entail. This also applied to patients requiring dental care and treatment.

We were told that some wards have electronic visual control boards for use during PipA meetings and when patients on these wards decline a physical health care check/procedure it is highlighted in red on the board. The number of times the patient has declined the check is also recorded. We found evidence within the patients' care records that the urgency of requested blood samples or other procedures was assessed and discussed by the MDT. We determined that this addresses the previous area for improvement outlined in section 6.2.

6.3.7 Patients finances

We reviewed the arrangements in place for the management of patients' monies and valuables. We found that, in line with the Trust's policies and procedures, ASMs randomly selected records of monies and valuables held for two patients, per ward, per month. Staff confirmed that as these audits were random the monthly sample could include patients that had already been selected for an audit the previous month. We found that two patients, across all wards, had not been subject to an audit by the ASMs since April 2019.

We asked the Trust to prioritise these patients at the next monthly audit and to ensure that all patients are subject to an ASM audit at least annually. An area for improvement was made relating to the ASM's monthly audit of patients' monies and valuables.

Ward staff were adhering to the Trust's policy of two staff checking patients' ledgers at each handover. Most ward managers were randomly auditing patients' ledgers weekly, in addition to the daily checks.

We were informed by the Patients' Finance Liaison Officer (PFLO) that the ward managers receive patients' monthly transaction reports, which are forwarded from the Trust's cash office. The monthly reports detail the transactions undertaken on behalf of patients during the month and the balance of monies held for each patient at the end of the month. The ASMs include these transaction reports in their monthly audits of patients' monies and valuables. A copy of the monthly audit reports is forwarded to the PFLO who, along with the ASMs, compares them against the previous month's reports, notes any discrepancies/issues and if required, follows up with the service managers. This was found to be in line with the Trust's policies and procedures.

In relation to Patients' Private Property (PPP) accounts we saw evidence that patients' accounts were reconciled, and continue to be reconciled, to the benefits received on behalf of each patient, which the Business Services Organisation (BSO) Internal Audit had confirmed in February 2020.

The PFLO confirmed that SMT reviewed and approved the Policy for Patients' Finances and Private Property, however, the policy had yet to be approved by the Trust's Policy Committee. Discussions with ward staff also confirmed that they were adhering to the procedures for patients' cash within the new policy; however, the checks on patients' property were still performed annually rather than quarterly as per the new policy.

BSO Internal Audit had recommended that the procedure for patients' property to be checked quarterly, in line with the new policy, should be implemented by 31 December 2020. We will review this procedure at the next inspection of MAH.

We were informed by the PFLO that additional training materials for patients' finances and property were recently developed. The layout of the training materials was being finalised and this would be available for ward staff on the Trust's e-learning system in the near future.

Discussions with the PFLO confirmed that financial support plans had been developed for all patients in MAH. We reviewed a sample of the support plans and confirmed that the plans included the details of the current financial arrangements for patients, the financial support provided to patients and the details of the staff member within the Trust authorised to manage the patients' finances. The plans also provided details of the weekly/monthly income received for each patient and a breakdown of the estimated weekly/monthly expenditure for each patient.

Discussions with the PFLO confirmed that the Trust had a contract with an independent advice centre that assisted patients or their representatives with social security benefits. Patients were offered a full review of their benefits to ensure that they receiving the appropriate benefits. We were informed that four patients had not received a review offered by the advice centre. Of the four patients that did not receive a review, three had family members who acted as their appointee and they had declined the offer. The remaining patient's appointee was a member of staff from another Health and Social Care Trust. The BHSCT had contacted the other Trust however it had not received a reply accepting or declining the review.

A review of records evidenced that BSO Internal Audit had confirmed that all patients for whom the Trust manages patients' monies and valuables, in excess of 20k, had received consent from us to hold these monies and valuables for each patient in line with the legislation.

In general, we were satisfied that the processes for managing patients' finances and property had significantly improved from previous inspections in 2019. The practices and documentation developed and implemented by the Trust could be used as a benchmark for good practice by other Trusts managing patients' finances and property.

6.3.8 Staffing

We reviewed the staffing arrangements to ensure that they meet the assessed needs of the current patient population. We were provided with copies of each ward's Telford staffing model. This model considers patient acuity and dependency which in turn determines the level of staffing required to safely care for patients. The model was developed by the SMT, in conjunction with ward managers. The model can be used to respond quickly to temporary or unplanned variations in patients' assessed needs and/or service requirements.

We were informed by the SMT and ward staff that ward staffing levels were reviewed daily and on Fridays, there is a review of the requirements for the weekend. We were informed that there is an out of hours (OOH) Co-Ordinator who can review staffing levels and address any deficits on site during the OOH period. Staff were knowledgeable about the process of escalating staffing issues to the SMT and OOH Co-Coordinator. Staff told us about the on call rota for medical and senior management cover and reported that they felt very supported. Staff understood the need to assist other wards across the site if those wards were short staffed and they demonstrated a willingness to do so. They told us that the improved communication across the hospital helped them to understand the pressures each ward faced daily and we found that staff morale was good.

We reviewed the ward duty rotas and found that staffing levels were appropriate to meet the assessed needs of the patients accommodated and the staff informed us that prescribed patient observation levels could be met. The hospital continues to rely on agency staff to fill staff vacancies. Many of the agency staff had accepted block bookings which provides consistency of care to patients and demonstrates their greater level of commitment to MAH. One former member of agency staff had recently been recruited to a permanent Band 7 post. We determined that significant progress has been made to ensure agency staff were fully integrated into the day to day running of the hospital

We reviewed the induction plans and competency frameworks for staff taking up posts and found evidence of a structured plan which covered the required competencies. Additional competencies required for staff who take charge of the ward are in place. We sought assurances regarding agency staff training and were informed that staff at the hospital site do not have direct access to the agency staff member's training records. The SMT informed us that assurances relating to agency staff's training forms part of the contract the Trust has with the agency and that the responsibility for providing appropriate training lay with the agency. The process for booking agency staff includes the Trusts stipulation of the level of experience and training required, for example, MAPA and adult safeguarding, and the agency subsequently provides suitably qualified staff. However, the SMT did recognise the need to strengthen the governance arrangements with respect to agency staff training records and had begun to seek these assurances with the assistance of the Trust's Nurse Bank.

The SMT indicated that they were willing to offer agency staff access to the Trust's training programmes to make it easier for them to access updates. We were informed that the Trust had provided an adult safeguarding training session for agency staff the previous week.

Ward managers told us when they are planning staffing levels for the ward they take into account the impact of staff who remain subject to supervision plans due to the ongoing investigations into the historic allegations of patient abuse. Since the inspection we have been engaged in work with the Trust, PSNI and the Department of Health seeking ways to strengthen the assurance processes with respect to this cohort of staff.

6.3.9 Adult safeguarding

We examined the management of adult safeguarding arrangements within the hospital. We reviewed eight incidents that had resulted in referrals to adult safeguarding and found evidence that patient protection plans were in place, if required, and were held centrally on the ward. We spoke with staff and found they were knowledgeable about the content of the protection plans. We found evidence that information regarding protection plans and incidents were communicated at every handover, recorded on the daily safety briefs, documented in the patient's care records, and discussed with the MDT at the PIpA meetings.

The staff we spoke with, including agency staff, knew what would constitute a referral to adult safeguarding. They were able to describe the process of how to escalate incidents to the nurse in charge and how to make a referral to adult safeguarding, if necessary.

We were told by the SMT and ward staff that a Nursing Development Lead had conducted an adult safeguarding training session on the site the previous week. Most of the staff were aware of the terms DAPO (Designated Adult Protection Officer) and IO (Investigating Officer) as outlined in the Northern Ireland Adult Safeguarding Partnership: Adult Safeguarding Operational Procedures (2016). The staff that we spoke with knew who the aligned social worker was for the ward and the names of the DAPOs. We could see from a review of the competency framework, which allows agency nurses to take charge of a ward upon successful completion, that knowledge of safeguarding and the ability to make a referral to adult safeguarding was included.

We spoke with ward managers who were aware of the process of escalating allegations of staff abuse of patients to the SMT and of the requirement to inform the Trust's Nurse Bank if the staff member involved was agency staff so that the relevant agency would be notified. Ward managers were knowledgeable about staff whose practice was restricted until the adult safeguarding investigations were completed. They demonstrated good awareness about the requirement to inform other ward managers of the nature of the restrictions if the staff member was asked to provide cover on another ward.

We were informed that there was a weekly adult safeguarding team meeting which provided an opportunity for the team to discuss any new incidents, changes required to protection plans or to plan strategy meetings.

In some incidents we reviewed we were unable to establish if or when the patient's next of kin (NOK) had been notified about the incident. We were informed by ward staff that if an incident occurs during working hours the adult safeguarding team has the responsibility of informing the NOK. We found that there was potential for inconsistent communication of incidents to the NOK. An area for improvement has been stated to develop a clear and robust communication plan providing clarity to all groups of staff about the information provided to the NOK following an incident, the date and by whom the information was provided, the NOK's response to the

information and the follow up arrangements planned. This information should be recorded in a standardised manner across the hospital site.

6.3.10 Restrictive practices

We undertook a review of how restrictive practices are managed within the hospital to ensure that it was in line with best practice guidance. We reviewed the minutes of three of the hospital's live governance meetings (01/10/20 – 15/10/20), three of the hospital's weekly Safety Reports (28/09/20 – 08/10/20), three of the monthly Director's Oversight Meetings (June – August 2020), and the Trust Board Meeting for 02 July 2020. We saw evidence that the use of restrictive practices; seclusion; physical interventions; enhanced observations; and the use of PRN medication was discussed and monitored for trend analysis at these meetings.

We reviewed 12 patient care records and found evidence that a restrictive practice care plan was in place for each patient outlining the restrictions that the patient was subject to. In all the records sampled, we saw evidence that the rationale for the restrictive practice was recorded and there was evidence of MDT input during the assessment phase and review of the restrictions.

The 12 patients care records we reviewed had a positive behaviour support (PBS) plan in place which was reviewed regularly at PIpA meetings. These plans offered staff guidance on the most effective ways to provide support to patients who may be using a particular behaviour as a means of communication. These PBS plans were developed using a psychological formulation. In addition to the PBS plans, we found that every patient had a shortened version of that plan (the "grab sheet") which was available for staff to quickly understand the actions they should take to support the patient to de-escalate their behaviour. The "grab sheet" formed part of a pack that could be sent with any patient requiring emergency medical attention at another hospital to quickly inform staff who were unfamiliar with the patient's behaviours and how best to support them to reduce the likelihood of resorting to restrictive practices.

We spoke with ward staff who informed us that the focus of one PIpA meeting per week is to look more closely at restrictive practices. We observed staff supporting patients who were experiencing high levels of distress in a caring and compassionate way. The staff we spoke with demonstrated good knowledge about the range of practices that constituted a restriction and there was evidence of a culture of using the least restriction possible to effectively manage patient's behaviours. Staff told us that they felt supported through the structured debriefing sessions that followed incidents.

We examined audits in relation to the use of low stimulus/voluntary confinement/seclusion episodes and found good compliance with the recording in line with the Trust's policy and procedure, the required standards, and best practice. In one ward, we were provided with evidence of a substantial reduction in seclusion episodes for one patient and we were informed that the patient's quality of life had improved as a result. The patient now leads a more independent life and is able to engage in a wider variety of activities at locations outside of the hospital. We reviewed the care records of a patient who uses voluntary confinement and we were satisfied that this was being treated as seclusion and managed appropriately.

From our review of the restrictive practice audits, we saw evidence that the use of physical interventions had also reduced. We reviewed patient care records and could clearly see an ethos of attempts to de-escalate behaviours and use least restrictive options to support patients. We determined that the Trust had a robust governance and assurance framework regarding the use of restrictive practices.

6.4 Engagement

6.4.1 Patient engagement

We provided questionnaires to patients. Three patient questionnaires were completed, returned to us, and analysed following the inspection. All indicated a good level of satisfaction with the care provided to them in the hospital. However, a patient commented that changes to their personal care team were not communicated with them and another patient commented that the food was poor quality, particularly the meat. We provided this feedback to the SMT to address.

6.4.2 Engagement with relatives/carers

Due to the impact of the Covid-19 pandemic, restrictions to visiting were in place during our on-site inspection and as a result we did not have the opportunity to meet with the relatives/carers of patients. To ensure we captured relative/carer views we wrote inviting them to engage with us to share their opinions about the care and treatment provided to their relative in the hospital.

We received 12 completed returns from the relatives/carers we contacted. Of the 12 responses, 50% of the respondents were entirely satisfied with the care and treatment provided to their relative, 33% returned mixed feedback and 17% were unhappy with most of the care and treatment provided to their relative in the hospital. We raised the specific concerns, highlighted by relatives/carers, with the SMT who sought further information from the relevant ward managers. The SMT provided a timely, robust account of actions that had been taken. We were assured that they had previous knowledge of all of the issues which were highlighted to us and that appropriate actions were undertaken or were being taken to address the relatives'/carers' concerns.

We were informed by one relative/carer about the excellent communication strategy between themselves and the Trust. The result of which meant that their relative was able to access home leave two days every week which was a positive outcome for the patient and their family.

From the feedback we received, we found that whilst some families are very happy about the communication they have with the hospital, others either stated that it has been a long journey to reach the currently acceptable level of communication or that they had ongoing difficulties. One relative stated that all she wanted was a two minute phone call each day, particularly during the Covid-19 pandemic surge and the subsequently restricted visiting, to be updated on how their relative's day had gone. Another relative expressed how it was more beneficial for them to know how the patient's mood was than the more high level information about safeguarding referrals or medical information. A relative/carer also told us that they did not want to feel they were being a burden to staff by contacting the ward.

During our inspection, one of the ward managers was able to provide an example of an individual communication strategy that had been agreed with a patient's relatives. We commended this as good practice.

We determined that a blanket communication policy for all relatives/carers would not address their specific, individual requirements as the information they wanted regarding their relative varied greatly in type and level of detail.

An area for improvement has been stated in relation to developing and implementing a communication strategy that will ensure that relatives/carers receive their requested level of communication about their relative's care and treatment. The agreed communication strategy should be documented and accessible to relevant staff.

6.4.3 Staff engagement

During the inspection, we spoke with staff and also invited them to complete an electronic questionnaire, however, no completed staff questionnaires were returned to us.

6.4.4 Advocacy Services

We spoke with the two advocacy service managers who provide the advocacy service to patients in MAH and both reported a positive relationship with all staff on the hospital site and advised that members of the SMT are easily accessible. They told us that advocacy provision is a well-established service and that hospital staff ensure that referrals to the service are made promptly and that patients are facilitated in accessing this service.

We were told that patients are able to access the advocacy service upon admission to the hospital. Patients who are deemed not to have capacity or who have no verbal communication are routinely allocated an advocate. The advocacy service managers confirmed that the advocates are invited to appropriate meetings and feel empowered to challenge staff if required. It was positive to hear that the advocacy arrangements within MAH have been strengthened.

The advocacy service managers informed us that whilst face to face contact had been temporarily suspended, in March 2020, due to the impact of the Covid-19 pandemic advocates could maintain their role, to a degree, by participating in online video call review meetings and were provided with updates from ward staff at least every week for patients who had reduced verbal communication. We were advised that face to face contact has gradually resumed with some good infection prevention controls in place. The advocacy service managers did not have any concerns about the current care and treatment of any patients they are in contact with.

They informed us that most of the advocate's work relates to the resettlement of patients to accommodation outside of the hospital. We were told that the issue causing the most frustration currently for patients, carers, and staff is the slow pace of the resettlement of the patients.

Advocacy staff told us about the compassionate practice of ward staff in involving patients in the resettlement process. This included patients visiting the site of their new accommodation to help them understand the building process as they may be unable to understand it viewing the plans alone. This was commended as good practice.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the SMT, as part of the inspection process, on 11 December 2020. The timescales for implementation of these improvements commence from the date of the inspection feedback.

The Trust should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further action. It is the responsibility of the Trust to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas for improvement

Areas for improvement have been identified and action is required to ensure compliance with The Mental Health (Northern Ireland) 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

The Trust must ensure the following findings are addressed:

Communication between teams

Area for improvement 1 **Ref:** Standard 5.1 Criteria 5.3.2 (d) **Stated:** First Time **To be completed by:** 31 March 2021	The Belfast Health and Social Care Trust shall ensure that a communication plan is developed which provides clarity to all staff about the information provided to the NOK following an incident, the date and by whom the information was provided, the NOK's response to the information, and the follow up arrangements planned. This information should be recorded in a standardised manner across the hospital site. **Ref:** 6.3.9
	Response by the Trust detailing the actions taken: An escalation plan is in place outlining whose responsibility it is to notify the next of kin of an incident during working hours and outside working hours following an Adult Safeguarding referral. To ensure consistency of the information being shared with next of kin by ward staff, the Adult Safeguarding team has developed guidance which has been shared with the Service Manager, Assistant Service Managers and ward staff. In addition, the Adult Safeguarding team along with the operational management are in the process of agreeing a template, which will be completed and placed in the patient's file and on the electronic PARIS record. This will include the details of what information has been shared with the next of kin following an adult safeguarding incident, by whom, the date of the incident, the date the contact with the next of kin was made, the response of the carer and what follow up arrangements have been in place - by whom and by when.
Engagement with relatives/carers	
Area for improvement 2 **Ref**: Standard 6.1 Criteria 6.3.2 **Stated:** First time **To be completed by:** 31 March 2021	The Belfast Health and Social Care Trust shall develop and implement a communication strategy that will ensure that relatives/carers receive their requested level of communication about their relative's care and treatment in Muckamore Abbey Hospital. The agreed communication strategy should be documented and accessible to relevant staff. **Ref:** 6.4.2
	Response by the Trust detailing the actions taken: The Trust has been developing a commitment to carers statement and a communication agreement template. This has been developed in conjunction with staff, a number of carers and advocacy services through the Carers Forum.

	This includes details of the next of kin's preferred method of keeping in touch, frequency of contact etc. This information will be recorded in the agreed template which will be kept in each patient's file within the ward and on the electronic PARIS system. A key contact information sheet containing the contact details of staff involved in each patient's care has also been developed. This will also be recorded in the agreed template which will be kept in each patient's file within the ward and on the PARIS system. There are plans for this to be rolled out.
Escalation procedure for temperature variances in medicine refrigerators	
Area for improvement 3 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First time **To be completed by:** 31 March 2021	The Belfast Health and Social Care Trust shall ensure that an escalation procedure for temperature variances in medicine refrigerators is developed to guide staff in Muckamore Abbey Hospital to take the appropriate actions if medicine refrigerators fall outside the permitted temperature range. **Ref:** 6.3.2
	Response by the Trust detailing the actions taken: An escalation procedure has been agreed and a flowchart developed to provide guidance to staff to ensure they are aware of what action is required when temperature variances occur in medicine refrigerators. The flowchart has been laminated and attached to each refrigerator. The flowchart is accessible to all staff and staff will be taken through the procedure as part of medication training.
Monthly audit of patients' monies and valuables	
Area for improvement 4 **Ref**: Standard 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1) **Stated:** First time **To be completed by:** 31 March 2021	The Belfast Health and Social Care Trust shall ensure that all patients in Muckamore Abbey Hospital are subject to the Assistant Service Manager's monthly audit of monies and valuables at least annually. **Ref:** 6.3.7
	Response by the Trust detailing the actions taken: A process has been implemented to ensure that a different patient's records each month forms part of the financial audit. A schedule has been developed per ward listing each patient and recording the date of when their financial records were last audited and the date they will audited next. This process will ensure that each patient's financial records including monies and valuables are audited at least annually.

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

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Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority

Unannounced Inspection Report
21 January 2021

Belfast Health & Social Care Trust

Type of Service: Mental Health and Learning Disability Hospital
Erne Ward
Muckamore Abbey Hospital
1 Abbey Road
Antrim
BT41 4SH
Tel No: 028 9504 2087

Membership of the inspection team

Wendy McGregor	Acting Assistant Director, Improvement Directorate, Regulation and Quality Improvement Authority
Carmel Treacy	Inspector, Hospital Programme Team, Regulation and Quality Improvement Authority
Lorraine O'Donnell	Inspector, Hospital Programme Team, Regulation and Quality Improvement Authority
Stephen O'Connor	Inspector, Independent Health Care Team, Regulation and Quality Improvement Authority

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Erne is a ward within Muckamore Abbey Hospital (MAH). MAH is a Mental Health and Learning Disability Hospital managed by the Belfast Health and Social Care Trust (the Trust). The ward provides inpatient care to male adults 18 years and over who have a learning disability and require rehabilitative care and treatment in a psychiatric care setting. Patients are admitted to the ward from other wards in MAH either on a voluntary basis or in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).

The ward provides a service to people with a Learning Disability from the Belfast Health and Social Care Trust (BHSCT), the Northern Health and Social Care Trust (NHSCT) and the South Eastern Health and Social Care Trust (SEHSCT).

On the day of the inspection, there were nine beds operational in Erne ward, eight patients were accommodated on the ward and one patient was on a period of extended leave.

3.0 Service details

Responsible person: Dr Cathy Jack Belfast Health and Social Care Trust	**Position:** Chief Executive Officer
Category of care: Acute Mental Health & Learning Disability	**Number of beds:** 9
Person in charge at the time of inspection: Ward Manager	

4.0 Inspection summary

An unannounced inspection was undertaken to Erne on 21 January 2021. The inspection commenced at 05:00hrs and finished at 17:00hrs. Feedback from the inspection was delivered to the Trust's senior management team (SMT) on 26 January 2021.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Mental Health (Northern Ireland) Order 1986 and the DHSSPSNI Quality Standards for Health and Social Care (March 2006).

We undertook this inspection in response to intelligence we received about Erne ward on 18 January 2021. We examined a number of areas to support our findings including; decision making and patient risk management, supporting patients who present with challenging behaviours, attending to patient's personal care needs, medical intervention following an incident, privacy and dignity of patients, management of continence, staffing, staff morale, infection prevention and control (IPC) and the ward environment.

On review of the information received, we determined that the concerns regarding neglecting to attend to a patient's personal care needs and providing an appropriate level of medical intervention after an incident met the threshold for onward referral to the Trust's Adult Safeguarding Gateway team for investigation under the Northern Ireland Adult Safeguarding Partnership: Adult Safeguarding Operational Procedures (2016). These referrals were made by us on 18 January 2021 and we have attended the subsequent Adult Safeguarding strategy meetings. We will continue to attend the strategy meetings and receive updates as the investigation progresses.

The previous Quality Improvement Plan (QIP) generated from the inspection of Erne on 24 October 2017 was reviewed during the previous inspections of the entire hospital site undertaken on 15 April 2017 and 27 October 2020. We will continue to monitor progress with that QIP during forthcoming multi-disciplinary team hospital inspections.

We were pleased to see good practice in relation to:

- how nursing staff were observed treating patients with dignity and respect;
- how patients were being listened to and asked for their consent and opinion;
- adherence to good hand hygiene;
- the level of information and signage about social distancing due to Covid-19 displayed; and
- an evidence of a culture of openness and transparency among staff.

We were concerned that:

- some incidents were inappropriately graded on the incident recording system (DATIX);
- there was a lack of debriefing for staff following incidents;
- there were a limited number of staff trained in a Learning Disability speciality;
- whilst mattress audits were being completed, there was no record of what actions were being taken to address issues found;
- whilst IPC support was available to the ward, there were no formal records of visits or outcomes retained by the IPC team or the ward;
- the ward staffing levels were not sufficient to allow time for staff supervision/appraisals and ward meetings;
- there were issues with working relations between agency and permanent Trust staff; and
- there was the potential for patient comfort and safety to be compromised because environmental issues were not being addressed in a timely manner.

4.1 Inspection outcome

Total number of areas for improvement	8

There were eight new areas for improvement arising from this inspection. These are detailed in the QIP.

Details of the QIP were discussed with the senior management team (SMT) at a feedback session on 26 January 2021. The timescales for implementation of these improvements commence from that date. Findings of our inspection are outlined in the main body of the report.

This inspection did not result in enforcement action.

5.0 How we inspect

Prior to the inspection, a range of information relevant to the ward was reviewed. This included the following records:

- previous hospital inspection reports;
- QIPs returned following previous hospital inspections;
- Serious Adverse Incident (SAI) notifications;
- information about complaints; and
- other relevant intelligence received by RQIA.

The ward was assessed using an inspection framework. The methodology underpinning this inspection included; discussions with patients, day and night staff, members of the Multi-Disciplinary Team (MDT) and domestic support staff; observations of practice; and review of relevant documentation. Records examined during the inspection included nursing care records; medical records; senior management governance reports; minutes of relevant meetings; duty rotas; and Datix incidents.

Posters informing patients and staff of our inspection were displayed while our inspection was in progress.

We invited staff to complete an electronic questionnaire during the inspection. No questionnaires were received by RQIA.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection of MAH from 27-28 October 2020

The previous Quality Improvement Plan (QIP) generated from the inspection of Erne on 24 October 2017 was reviewed during the previous inspections of the entire hospital site undertaken on15 April 2019 and 27 October 2020. We will continue to monitor progress with the entire hospital site QIP during forthcoming multi-disciplinary hospital inspections.

6.2 Inspection findings

6.2.1 Decision making and patient risk management

The information we received prior to the inspection alleged that some patient's risk management plans were not fully implemented and that some decisions were taken without a full MDT discussion. We reviewed care records, risk assessments and care plans relating to four patients. There was evidence of frequent MDT involvement and informed decision making at the daily Purposeful Inpatient Admission (PIpA) meetings. The PIpA model provides a good multidisciplinary review of each patient and involves shared decision making around care and treatment issues and risk assessments. Risk assessments were updated in a timely fashion and appropriately reflected the discussion and decision making when risks had changed. There was good input from the MDT with the Speech and Language Therapy and Occupational Therapy service also involved in decision making.

We observed the handover from night staff to day staff and were satisfied that patient's risk management plans were shared and discussed with all staff on commencement of their shifts.

We found evidence that staff were adhering to patient's risk management plans and patients were appropriately prescribed enhanced observation levels in order to maintain their safety. We determined that the general focus of staff on the ward was to maintain patient safety, with less attention being given to engaging patients with therapeutic and leisure activities as detailed in patient's positive behaviour support plans (PBS). (See section 6.2.2 for more detail)

6.2.2 Support of patients who present with behaviours that challenge

On review of the patient's records and discussions with the multi-disciplinary team we found that there were appropriate onward referrals to other primary health care services and good monitoring of physical health by the hospital's General Practitioner (GP) and medical staff if patient's presented with any changes to their behaviours.

The majority of staff on duty did not have Learning Disability speciality training. We determined that this was having an impact on the implementation of patient's positive behaviour support (PBS) plans. We raised this issue with the behaviour support staff and the hospital SMT who told us of plans to train agency staff in the use of PBS plans. The PBS nurse attends the ward to undertake assessments, review patients and support staff with the implementation of PBS plans and is also involved in patient resettlement work supporting service users who have moved to the community.

SMT told us that the PBS policy is currently under review and will be adopted as a framework within the hospital and become more embedded in practice.

All of the patients in Erne present with very complex challenging behaviours and there has been a noted deterioration in some patients' behaviours recently. The Trust should progress the training of agency staff in PBS plans as soon as possible to benefit both patients and staff. The Trust should also review the resource allocation of PBS nursing staff to enable support to be provided to patients currently residing in the hospital and those undergoing resettlement to the community. The additional support and training would support the decrease of the risks/incidents which result from behaviours that challenge. An area for improvement has been made.

During our inspection in October 2020 we made an area for improvement regarding family involvement in patient care planning. The records we reviewed identified improvement in this area and evidenced family being informed when incidents had occurred. Ward staff and the SMT outlined ongoing family engagement work to improve communication with families in these areas. This will be reviewed on the next inspection.

6.2.3 The privacy and dignity of patients

The information we received prior to inspection alleged that patients' privacy and dignity was not always maintained. We spent time observing staff delivering care to patients, some of whom were extremely distressed for prolonged periods of time. Throughout our observation patients were being treated with dignity and respect and were being listened to.

In one patients' area the bathroom door had been removed, resulting in privacy not being maintained during personal care. This area was only accessed by the patient and staff. The patient recently moved to this area, following MDT agreement. It was envisaged that the move would provide the patient with a quieter space and reduce the number of recurring incidents, as the patient previously shared an area with another patient. The rationale for this move was appropriate, however, the new environment had not been fully adapted to meet the patient's needs. As this patient displayed challenging behaviours they required reinforced doors, the non-reinforced doors had been removed and had not been replaced with reinforced doors at the time of this inspection. The ward manager, PBS nurse and SMT agreed to ensure the doors were replaced as a matter of urgency. This will be reviewed at the next inspection.

6.2.4 Management of continence

Information received prior to the inspection alleged that some staff were not appropriately managing the continence needs of some patients. We reviewed care records of four patients who required support with their continence needs. All records included a continence assessment and care plan and evidenced that patients were being supported with their continence needs. There were no malodours evident in the ward and there was no evidence to support inappropriate management of patients continence needs.

6.2.5 Infection Prevention Control (IPC)

The information we received prior to the inspection alleged that there was poor compliance with IPC measures by staff. We reviewed the ward environment and observed staff who demonstrated good hand hygiene and the use of Personal Protective Equipment (PPE). Staff also demonstrated good knowledge on the management of waste.

We reviewed the IPC and environmental cleanliness audits and determined that the scores for both were good. Staff told us that IPC team support is available to the ward. The IPC team confirmed they last visited the ward on 19 January 2021. The IPC team told us they did not complete any formal records of their visits to the ward. We determined that records of these visits were required to highlight any actions required following their visit. An area for improvement has been made.

Hospital Support services were only available during office hours. Outside of these hours there is a reliance on nursing staff to undertake some cleaning tasks, mainly in relation to mopping bathroom floors following patient use. In those areas we found cleaning equipment left with used water in place. Staff awareness of the IPC management of cleaning equipment, disinfectant dilution rates and procedures to follow when removing blood requires improvement. The ward manager assured us that this would be addressed.

An appropriate amount of signage was displayed throughout the ward reminding staff, patients and visiting staff about the importance of social distancing due to the ongoing Covid-19 pandemic. A designated isolation area was available should a patient begin to show signs of being infected with Covid-19. If the patient returns a positive Covid-19 test result, they are supported as per the hospital policy and temporarily transferred to a ward identified for patients who are Covid-19 positive. A Track and Trace system was in place at the main entrance of the ward. During the day we noted staff enter and exit the building from doors throughout the building which did not have a Track and Trace system in place making oversight of people entering and exiting ward difficult. An area for improvement has been made.

6.2.6 Ward environment

The information we received prior to inspection alleged that elements of the ward environment did not adequately provide a safe and comfortable environment for patients. An environmental check found poor temperature control in some areas in the ward. The water running from many of the hand washing sinks took a prolonged period of time to run warm and in some sinks remained cold. There were no working handwashing facilities in three bathrooms and nursing staff confirmed that staff and patients access water from the bath taps to facilitate hand hygiene in these areas. These issues had been reported to the estates department and we determined they had not been addressed in a timely way.

We observed much wear and tear throughout the ward; enamel chipped on a bath, chipped paint on some doors and walls, stained floor covering and damaged furniture. Some areas were cluttered and disorganised and following discussion with ward manager were addressed. There were items stored in boxes on the floors of store rooms making it difficult to clean effectively. These issues were highlighted to the ward manager and domestic supervisor and addressed by them on the day of the inspection. We observed a build-up of lime scale on some taps and there was dust and debris on items in the domestic store. The internal and external window glass required cleaning. An area for improvement has been made to address the above findings.

The ward environment was difficult to navigate and could cause issues for staff who were not familiar with the ward layout. Patient accommodation was spaced out throughout the entire ward with some patients having their own “pod” area. These areas were often reached through a series of self-locking doors. Staff highlighted to us that there have been episodes of accidental seclusion because staff were unfamiliar with the geography of the ward, and had on occasions left a specific area of the ward without realising the exit door they had used automatically locked behind them. We found evidence that when this had occurred it was, for a very short period of time and they had been reported as an incident and referred to the Adult Safeguarding team. The SMT told us they were aware of the issue and some actions had been taken action to address the problem including posters displayed reminding staff to be vigilant about the potential for accidental seclusion of patients. We have asked the Trust to keep this issue under careful review.

6.2.7 Staffing

The information we received prior to the inspection led us to review ward staffing arrangements and determine if patient needs were being met including patients’ prescribed enhanced observation levels. We were content that the model of staffing was in the main, known to staff, being achieved and had effective escalation arrangements when this wasn’t the case. These systems were effective in addressing the deficit in staffing levels on the ward on a daily basis.

The current ward manager has been acting up into the role since September 2020 and the two supporting deputy ward manager posts were vacant. The SMT told us that one of the deputy ward manager posts had been recruited and the Trust was waiting on pre-employment recruitment checks being completed.

We were informed about recruitment challenges across the region and the Trust’s rolling recruitment advert for registered nurses and health care assistants. On a positive note three registered nurses and fifteen health care assistants had recently been recruited for the hospital.

Staff we spoke with told us that staff appraisals, supervision and staff/ward meetings had not been taking place for a prolonged period of time. Whilst, in the main there were enough staff to meet the needs of patients’ there was insufficient staff to facilitate additional staff development and peer support requirements such as clinical supervision sessions, appraisals and staff/ward meetings. An area for improvement has been made.

It was positive to note that over the Christmas holidays and, in light of the resurgence of Covid-19 cases in the community and on the site, staffing was, on the whole well managed.

6.2.8 Staff morale

The information we received prior to the inspection alleged poor morale amongst agency staff as a result of being treated less favourably.

Permanent and agency staff told us that the ward manager and assistant services manager were very supportive, listened to any concerns they raised, were visible on the ward and complete regular walk arounds. Staff also said they are well supported by other members of the MDT.

It was good to observe on arrival to the ward at 05.00hrs the hospital site night sisters, supporting ward staff as some patients were particularly unsettled.

We reviewed staff duty rotas and determined that the ward is reliant on both agency staff and staff from other wards, 60% of the staff on duty were agency staff. We spoke with Trust staff and agency staff. Agency staff said they felt welcomed by the hospital; part of the team and morale was good however this was not the case for Trust staff who told us they felt morale was low amongst permanent staff. As a result of discussions with Trust staff and agency staff we determined that further work is needed to address the reasons for low morale amongst Trust staff. These findings were shared with the SMT at the inspection feedback.

6.3 Other findings

6.3.1 Incident management

We reviewed all Datix incidents from 01 October 2020 to 21 January 2021 and found many of the incidents had been graded as low and reflected the outcome of the incident in many cases and not the inherent risk. We saw that the frequency with which some types of incidents occurred, for example assaults on staff, was not reflected in the grading of the risk. We determined that this reduced the opportunity for the Trust to identify action and share learning to prevent or reduce the likelihood of similar incidents occurring. We saw evidence that some incidents were being discussed through various governance systems but we determined that low grade risks were not always escalated for review at a more senior governance level. An area for improvement has been made.

Staff told us that there was no debriefing structure in place following incidents and subsequently the opportunity for staff learning was being missed. Improvements are required in providing the opportunity for debriefing for all staff involved in the management of incidents. An area for improvement has been made.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the SMT, as part of the inspection process, on 26 January 2021. The timescales for implementation of these improvements commence from the date of the inspection feedback.

The Trust should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further action. It is the responsibility of the Trust to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas for improvement

Areas for improvement have been identified and action is required to ensure compliance with The Mental Health (Northern Ireland) 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

The Trust must ensure the following findings are addressed:

Support of patients who present with behaviours that challenge	
Area for improvement 1 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) (a) (5.3.3) (d) **Stated:** First Time **To be completed by:** 26 July 2021	The Belfast Health and Social Care Trust shall ensure all patients on Erne ward have appropriate and timely access to the positive behaviour support service. **Ref:** 6.2.2 **Response by the Trust detailing the actions taken:**
Area for improvement 2 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) (a) (5.3.3) (d) **Stated:** First Time **To be completed by:** 26 July 2021	The Belfast Health and Social Care Trust shall ensure that all staff working on the ward have the skill and knowledge to effectively support patients who present with behaviours that challenge, including implementation of each patient's positive behaviour support plans. **Ref:** 6.2.2 **Response by the Trust detailing the actions taken:**
Infection Prevention Control (IPC)	
Area for improvement 3 **Ref:** Standard 5.1 Criteria 5.3.1 (f) **Stated:** First Time **To be completed by:** 26 July 2021	The Belfast Health and Social Care Trust shall ensure the Trust IPC team record all visits to wards in MAH. Actions arising from the visit should be shared with the ward manager, disseminated to appropriate ward staff and actioned accordingly. This may include sharing any actions with the Trust's estates department. **Ref:** 6.2.4 **Response by the Trust detailing the actions taken:**

Covid-19 Track and Trace	
Area for improvement 4 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First time **To be completed by:** 26 July 2021	The Belfast Health and Social Care Trust shall ensure a robust track and trace system is in place in Erne ward which takes account of its multiple entrances and exits. **Ref:** 6.2.4 **Response by the Trust detailing the actions taken:**
Environmental Issues	
Area for improvement 5 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First time **To be completed by:** 26 July 2021	The Belfast Health and Social Care Trust shall ensure that all patients in Erne ward have access to a comfortable, clean, and warm, living area. This should include robust audits of the ward environment and timely repair of broken items by the Trust's estates department. **Ref:** 6.2.5 **Response by the Trust detailing the actions taken:**
Staffing Levels	
Area for improvement 6 **Ref**: Standards 4.1 Criteria 4.3 (l) **Stated:** First time **To be completed by:** 26 July 2021	The Belfast Health and Social Care Trust shall ensure that staffing levels allow for staff clinical supervision sessions, staff appraisals and the facilitation of regular ward/staff meetings. **Ref:** 6.2.6 **Response by the Trust detailing the actions taken:**

Incident Management	
Area for improvement 7 **Ref**: Standard 5.1 Criteria 5.3 (5.3.2) (a)(c) **Stated:** First Time **To be completed by:** 26 July 2021	The Belfast Health and Social Care Trust shall ensure that a robust system is in place to ensure that all incidents are graded appropriately to reflect the inherent risk rather than the outcome. The system should include audits of incidents and implementation of learning arising from the audits. **Ref: 6.3.1**
	Response by the Trust detailing the actions taken:
Debriefing System	
Area for improvement 8 **Ref:** Standard 5.1 Criteria 5.3 (5.3.2)(a)(b)(c) **Stated:** First Time **To be completed by:** 26 July 2021	The Belfast Health and Social Care Trust shall ensure that a local incident debrief policy and procedure is implemented so that: • learning arising from incidents is shared across MDT's and across the MAH site in a timely manner; • trends are identified; • records are maintained for all incident debrief sessions details the actions required and the persons responsible for ensuring the action is completed. **Ref:** 6.3.1
	Response by the Trust detailing the actions taken:

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

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Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority

Inspection Report

28 July 2021-19 August 2021

Belfast Health and Social Care Trust

Mental Health and Learning Disability Hospital
Muckamore Abbey Hospital
1 Abbey Road,
Antrim,
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1.0 Service information

Organisation/Registered Provider: Belfast Health and Social Care Trust (BHSCT)	**Responsible Person:** Dr. Cathy Jack Chief Executive, BHSCT
Person in charge at the time of inspection: Ms.Tracy Kennedy, Co-Director, Learning Disability	**Number of beds:** There are 6 wards operating within MAH:
Categories of care: Acute Mental Health and Learning Disability	**Number of beds occupied in the wards on the day of this inspection:** 41

Name of ward:	No of patient's accommodated:
Cranfield 1	9
Cranfield 2	7
Sixmile	10
Killead	9
Donegore	6
Erne	Since closed

Brief description of the accommodation/how the service operates:
Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability (MHLD) Hospital managed by the Belfast Health and Social Care Trust (the Trust). The hospital provides inpatient care to adult's aged18 years and over who have a learning disability and require assessment and treatment in an acute psychiatric care setting. MAH provides a service to people with a Learning Disability from the BHSCT, Northern Health and Social Care Trust (NHSCT) and South Eastern Health and Social Care Trust (SEHSCT). Patients were admitted either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO). The Psychiatric Intensive Care Unit (PICU) has remained closed since 21 December 2018. Admissions to any other ward within the hospital is significantly restricted, any decision to admit new patients is risk assessed on an individual patient basis and alternative options fully explored before an admission is facilitated.

2.0 Inspection summary

An unannounced inspection of MAH commenced on 28 July 2021 at 09:00 and concluded on 19 August 2021 with feedback to the Senior Management Team (SMT).

All wards were inspected by a team comprised of care inspectors (nurses and social workers) and administration staff, supported remotely by pharmacists, a medical practitioner and a finance inspector.

This inspection focused on eight key themes: staffing; patient's physical health care needs; discharge and resettlement; environment; restrictive practices; incident management and safeguarding; patient's finances; and governance and leadership. The inspection also sought to assess progress with issues raised during the previous inspections of MAH in October 2020 and Erne Ward in January 2021.

The inspection identified good practice in relation to resettlement planning, with evidence of good Multi-Disciplinary Team (MDT) and family involvement. 'In reach' staff visit the patients, to become familiar with their needs and begin to develop a relationship with them prior to transitioning to the community.

The Trust have employed a General Practitioner (GP) service to ensure the physical health care needs of patients can be managed in a timely manner, and to ensure patients have access to the appropriate general population screening programmes.

It was noted that the use of restrictive practices were proportionate to the assessed risks and reviewed regularly by the MDT.

MAH continues to experience a number of challenges to maintaining service delivery. These relate to staff shortages, a lack of skilled and experienced learning disability speciality staff and the ongoing management of adult safeguarding incidents. Further information is detailed in the main body of this report.

Staff morale was low in some areas. Staff indicated that this was due to the impact experienced from the historical adult safeguarding concerns and the imminent Public Inquiry.

At the time of our inspection an Adult Safeguarding File Review was in progress. The review had been commissioned by the Department of Health in response to concerns about the numbers of Early Alerts implicating staff in alleged abuse of patients. Findings from the review have been shared and discussed with RQIA and the Trust. RQIA will ensure that the findings of this review are considered in future inspections of MAH.

3.0 How we inspect

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 service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

During the inspection we observed and reviewed patient care and treatment, engaged with the MDT and senior management team and reviewed relevant patient and governance documentation. Experiences and views were gathered from staff, patients and their families.

Evidence was gathered to compliment the intelligence already gained through our contemporaneous scrutiny of all safeguarding notifications involving staff, which RQIA has undertaken since July 2019.

Opportunities to speak with relatives during the course of the inspection were limited as a result of the Covid-19 visiting restrictions; consequently, questionnaires were sent to each family/carer to establish their opinions of the care and treatment provided to their relative.

4.0 What people told us about the service

Posters and patient leaflets were placed throughout wards inviting staff and patients to speak with inspectors and feedback on their views and experiences.

Several staff interviews with nurses and nursing assistants were conducted. These included Trust and Agency staff across all of the wards. Staff spoke openly about the intensity of the scrutiny that they felt and commented that this contributes to low morale amongst all staff. Despite this, staff remained committed to delivering safe, effective and therapeutic care and treatment.

The feedback from patients indicated that they were satisfied with their care and treatment. Patients told us they 'liked their bedrooms and the nurses and doctors looked after them well.' Other patients described how they enjoyed going to the Cosy Corner Café situated on the hospital grounds and going on outings to Antrim Town.

RQIA are aware of a number of families who continue to raise important concerns about their loved ones care. For some families, the historical safeguarding concerns and pending Public Inquiry continue to impact on their confidence in the service provided within MAH. However, several relatives reported a good experience and high degree of confidence in the professionals providing that care. The care observed during the inspection was compassionate and responsive to meeting patient's needs.

Family feedback highlighted that Covid-19 has proved challenging, as the Government restrictions have resulted in families no longer attending meetings on site. It was noted that the Trust have devised a communication strategy to ensure effective sharing of information with families, with several families commenting that they found this helpful.

5.0 The inspection

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

The last inspection to MAH was undertaken on 27-28 October 2020 and Erne Ward was inspected on 21 January 2021. The tables below outline the Area's for Improvement (AFI) that were identified during these respective inspections and evidences our assessment of work the Trust has completed to meet the AFIs.

Areas for improvement from the last inspection to Muckamore Abbey Hospital on 27-28 October 2020		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)		**Validation of compliance**
Communication with Next of Kin		
Area for Improvement 1 **Ref:** Standard 5.1 Criteria 5.3.2 (d) **Stated:** First Time	The Belfast Health and Social Care Trust shall ensure that a communication plan is developed which provides clarity to all staff about the information provided to the next of kin (NOK) following an incident, the date and by whom the information was provided, the NOK's response to the information, and the follow up arrangements planned. This information should be recorded in a standardised manner across the hospital site.	**Met**
	Action taken as confirmed during the inspection: A communication plan was in place for each patient's NOK that provides clarity to all staff regarding the information which should be provided to the NOK following an incident. The communication plan provided information on what level of detail the family would like, who the family would like to receive the information from and how, for example, by phone or email.	
Engagement with relatives/carers		
Area for Improvement 2 **Ref**: Standard 6.1 Criteria 6.3.2 (a) (b) **Stated:** First time	The Belfast Health and Social Care Trust shall develop and implement a communication strategy that will ensure that relatives/carers receive their requested level of communication about their relative's care and treatment in Muckamore Abbey Hospital. The agreed communication strategy should be documented and accessible to relevant staff.	**Met**
	Action taken as confirmed during the inspection: A communication strategy has been developed that ensures relatives/carers receive the requested levels of communication about their relatives care and treatment. These communication plans were available and up to date at the time of inspection.	

Escalation procedure for temperature variances in medicine refrigerators		
Area for Improvement 3 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First time	The Belfast Health and Social Care Trust shall ensure that an escalation procedure for temperature variances in medicine refrigerators is developed to guide staff in Muckamore Abbey Hospital to take the appropriate actions if medicine refrigerators fall outside the permitted temperature range.	**Met**
	Action taken as confirmed during the inspection: An escalation procedure for temperature variances in the medication refrigerators has been developed and shared with each ward for displaying on the refrigerator.	
Monthly audit of patients' monies and valuables		
Area for Improvement 4 **Ref**: Standard 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1) **Stated:** First time	The Belfast Health and Social Care Trust shall ensure that all patients in Muckamore Abbey Hospital are subject to a monthly financial audit of monies and valuables by the Assistant Service Manager (ASM).	**Met**
	Action taken as confirmed during the inspection: There was evidence of audits being completed each month by the ASM.	

Areas for improvement from the last inspection to Erne Ward on 21 January 2021		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)		**Validation of compliance**
Support of patients who present with behaviours that challenge		
Area for Improvement 1 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) (a) (5.3.3) (d) **Stated:** First Time	The Belfast Health and Social Care Trust shall ensure all patients on Erne Ward have appropriate and timely access to the positive behaviour support service.	**Met**
	Action taken as confirmed during the inspection: Erne Ward has a Behaviour Specialist Practitioner and a Behaviour Assistant assigned to the ward. They attend Purposeful Inpatient Admission (PIpA) meetings, support with resettlement and complete Positive Behaviour Support Plans for all patients assessed as requiring input.	
Area for Improvement 2 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) (a) (5.3.3) (d) **Stated:** First Time	The Belfast Health and Social Care Trust shall ensure that all staff working on the ward have the skills and knowledge to effectively support patients who present with behaviours that challenge, including implementation of each patient's positive behaviour support plans.	**Met**
	Action taken as confirmed during the inspection: Staff, including agency were knowledgeable about all patient's behaviours and appeared confident in de-escalation techniques. Behavioural Support Plans were available for patients. These were person centred and completed in accordance with evidenced based practice.	

Infection Prevention Control (IPC)		
Area for Improvement 3 **Ref:** Standard 5.1 Criteria 5.3.1 (f) **Stated:** First Time	The Belfast Health and Social Care Trust shall ensure that records of the Trust IPC team visits to wards in MAH contain evidence of escalation by IPC nurse to the ward manager/nurse in charge following any IPC visit and the actions taken to address issues identified. This may include detail of collaborative work with the Trust's Estates Department and The Patient Client Support Services (PCSS) team for MAH.	**Met**
	Action taken as confirmed during the inspection: The recently appointed deputy ward manager was unable to recall or provide a record of the most recent Infection Prevention Control visit to Erne Ward; however, there was evidence that the Nurse Development Lead (NDL) had undertaken an environmental walk around. From this there was evidence of escalation and work having commenced to address the environmental/IPC concerns. There was evidence of collaborative working with the Trust's Estates Department and PCSS.	
Covid-19 Track and Trace		
Area for Improvement 4 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First time	The Belfast Health and Social Care Trust shall ensure a robust track and trace system is in place in Erne Ward which takes account of its multiple entrances and exits.	**Met**
	Action taken as confirmed during the inspection: There was good signage relating to safety precautions around Covid-19 and recommendations of safe practices were displayed in the foyer and around the ward. There is a 'signing in' book in the foyer and all staff/visitors are required to have temperature checks, sign in and provide contact details.	

Environmental Issues		
Area for Improvement 5 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First time	The Belfast Health and Social Care Trust shall ensure that all patients in Erne Ward have access to a comfortable, clean, and warm, living area. This should include robust audits of the ward environment and timely repair of broken items by the Trust's estates department.	**Not Met**
	Action taken as confirmed during the inspection: The inspection team continued to identify significant environmental issues within Erne Ward. We raised our concerns with the SMT who informed us that they were in the process of transitioning the remaining patients from Erne Ward to other wards across the hospital site. Following the successful transition Erne Ward would be closed. We received confirmation from the Trust that Erne Ward closed on 26 August 2021. This area for improvement had not been met, but will not be carried forward as Erne Ward is no longer operational.	

Staffing Levels		
Area for Improvement 6 **Ref**: Standards 4.1 Criteria 4.3 (l) **Stated:** First time	The Belfast Health and Social Care Trust shall ensure that staffing levels allow for staff clinical supervision sessions, staff appraisals and the facilitation of regular ward/staff meetings.	**Not Met**
	Action taken as confirmed during the inspection: The ward manager responsible for providing supervision, appraisals and coordinating staff meetings has been off on extended leave. The Trust were in the process of seeking to fill this position on a temporary basis. The deputy ward manager has not been in a position to complete these managerial tasks as a result of staffing pressures across the site. This area for improvement had not been met, but will not be carried forward as Erne Ward is no longer operational.	
Incident Management		
Area for Improvement 7 **Ref**: Standard 5.1 Criteria 5.3 (5.3.2) (a)(c) **Stated:** First Time	The Belfast Health and Social Care Trust shall ensure that a robust system is in place to ensure that all incidents are graded appropriately to reflect the inherent risk rather than the outcome. The system should include audits of incidents and implementation of learning arising from the audits.	**Met**
	Action taken as confirmed during the inspection: We reviewed the arrangements for the management of incidents and determined that incidents were being well managed in line with the Trusts policies and procedures. Further detail in relation to incident management can be found in the incident section of the report.	

Debriefing System		
Area for Improvement 8 **Ref:** Standard 5.1 Criteria 5.3 (5.3.2)(a)(b)(c) **Stated:** First Time	The Belfast Health and Social Care Trust shall ensure that a local incident debrief policy and procedure is implemented so that: • Learning arising from incidents is shared across MDT's and across the MAH site in a timely manner; • Trends are identified; • Records are maintained for all incident debrief sessions details the actions required and the persons responsible for ensuring the action is completed.	**Partially Met**
	Action taken as confirmed during the inspection: In Erne Ward learning from incidents was shared appropriately and trends identified, however, post incident debriefs were not happening in Erne Ward. This matter was discussed with members of the SMT for action at the time of inspection. Learning from incidents, including post incident debriefs were in place across the other hospital wards. As outlined previously we received confirmation from the Trust that Erne Ward closed on 26 August 2021. This area for improvement had been partially met, but will not be carried forward as Erne Ward is no longer operational.	

5.2.1 Staffing

Staff shortages remain a challenge within MAH. At present 73% of registered nurses and 35% of health care assistants are provided by nursing agencies. In addition, the majority of registered nursing staff are Registered Mental Health Nurses as opposed to Registered Learning Disability Nurses. Registered Learning Disability Nurses bring specialist knowledge and unique skills in relation to the management of complex and challenging behaviours. In seeking to manage the impact of the staffing shortages in Registered Learning Disability Nurses the Trust has increased their behavioural support team resource.

It was established that staffing shortages present challenges for staff at all levels within the hospital. Staff told us that staffing shortages negatively impacts on their role as the majority of their time is spent on 'task orientated' duties. This limits the scope for innovation and the ability to deliver on quality improvement initiatives.

Ward managers were visibly present on the wards, interacting with patients and supporting staff with various clinical and non-clinical tasks.

RQIA welcomes the closing of Erne Ward, and anticipate that having patients accommodated in the "core" hospital will help somewhat in managing staffing deficits. The process of moving patients to more appropriate wards such as Cranfield wards, Killead and Donegore in accordance to their assessed needs had commenced prior to the inspection.

Covid-19 has added pressures to an already exhausted workforce, due to staff contracting the virus and requiring sick leave, close contact isolation and shielding. Throughout all of these challenges all grades of staff and disciplines have continued to navigate their way through the pandemic while supporting patients who present with complex needs and some who have significant challenging behaviours.

There were notable staff shortages amongst all disciplines. The SMT informed us that recruitment has been particularly difficult and cited both the historical and current adult safeguarding concerns and the pending Public Inquiry as having an impact. Despite this it was observed that staff are committed to providing safe and effective care and treatment.

The Trust are supporting several healthcare assistants to complete their Learning Disability Nursing via the Open University. This will bring specialist skills and knowledge to MAH and improve practice.

5.2.2 Physical Health Care

Physical health care needs were comprehensively assessed by the MDT, with individualised, up to date care plans in place that met the needs of each patient. It was encouraging to see evidence of specific care pathways for patient's prescribed Clozapine therapy and for those who had contracted Covid-19.

Nursing staff demonstrated a good understanding of patient's physical healthcare needs, identifying signs, symptoms and changes in behaviours that may indicate when a patient's physical health is deteriorating. There was evidence of patient's attending Emergency Departments for review and treatment as necessary.

Patients have access to an onsite GP who co-ordinates physical health checks, medication and chronic disease monitoring; this includes yearly Electrocardiogram (ECG) testing and six monthly ECG's for patients who require antipsychotic medication monitoring.

Some patients did not have an up to date ECG because they had difficulty coping with this examination, however, medical staff endeavour to explore other, more suitable options, with these patients.

During the December 2019 assurance was provided that all patients had access to a GP service to ensure they had appropriate routine general population screening. On reviewing the evidence, patients did have access to general population screening; however, this information was not easily accessible. An AFI has been identified recommending that the Trust develop a robust system for sharing information between medical and nursing staff to ensure all relevant staff are kept informed and up to date in relation to patients physical health screening.

5.2.3 Discharge/Resettlement Planning

Since the last inspection a number of patients have been discharged or resettled into the community successfully.

At the time of the inspection 39 of the 42 patients in the hospital where delayed in their discharge. There was evidence of ongoing resettlement planning work through the MDT and good communication with placement providers and patient's families. A lack of available placements within the community to accommodate the assessed needs of the patients is creating delays in successful discharges/resettlements.

Community placements have been identified for some patients; however, the expected date of discharge is sometime in 2022/2023, as these placements are under construction and staff need to be recruited and trained.

Covid-19 has had an impact on the resettlement of patients from MAH, patients were unable to visit their identified placements prior to transition and staff from the identified placements were unable to provide in-reach. Since the restrictions have eased, in-reach has recommenced.

Some patients confirmed they did not wish for the MDT to actively seek a resettlement placement, as their preference is to remain in MAH. A working group has been established to look at how the wishes of this small group of patients can be met.

RQIA would advise that all Trusts and the Health and Social Care Board (HSCB) urgently expedite efforts to support the resettlement of patients. This process should identify clear options that provide better alternatives for the large majority of patients, and fully consider the needs of individuals.

5.2.4 Environment

The wards within the hospital are spacious, bright, clean and clutter free. Patients had their own bedroom and ensuite. Patients had access to 'quiet rooms' away from the main communal areas.

Most of the wards had 'pod' areas for patients who have been assessed as requiring this type of environment. Staff are always present in the patient's pod area and the need for the patients to be cared for in these environments is clearly documented in the patient's risk assessments and care plans and reviewed regularly by the MDT. The pods usually consisted of four rooms, a bedroom, bathroom, quiet living area and a dining area.

At the time of the inspection Erne Ward remained operational. Erne Ward is an old ward and the environment was not conducive in meeting the therapeutic needs of patients, due to the layout and the internal fabric of the building. Despite the challenges provided by the ward environment, it was evident that ward staff were doing the best they could to promote therapeutic intervention, patient engagement and maintain patient and staff safety. RQIA were informed by the SMT that the planned closure of Erne Ward has been expedited to the end of August 2021. Following our inspection we were informed that Erne Ward closed on 26 August 2021 and all patients have been relocated to the most suitable wards to meet their assessed needs.

Ligature Risk Assessments, Fire Risk Assessments, Mattress Audits and Environmental Cleanliness Audits were reviewed. There was evidence of good compliance levels and any issues identified were raised with the ward managers on the day of inspection for escalation and action.

5.2.5: Restrictive Practices

The main restrictive practices in use across the hospital were: a locked environment; patients detained under the Mental Health (NI) Order 1986; the use of enhanced observations; the use of physical intervention; money/high valuable items locked securely; the use of self-seclusion and restrictions on certain items.

Restrictive practices were managed in line with the Trust Policy. Staff knowledge was good and restrictive practices were proportionate, used as a last resort, carefully reviewed by the MDT and reduced or discontinued when necessary.

There was good up to date record keeping in relation to restrictive practices and evidence of good MDT decision making.

5.2.6: Incident Management & Adult Safeguarding

There was a good level of detail in the incident reports examined and incidents were appropriately graded, in accordance with the Trust's policies and procedures.

There was a high level of reporting evident; with action plans created for every incident which are reflected in patient's care plans. It was evident that similar types of incidents were recurring as a result of the unpredictability of the environment and complexities of the patients.

It was encouraging that Serious Event Audits (SEA's) were being completed for recurring incidents and it is hoped that learning from these SEA's will be implemented in an attempt to not only reduce the likelihood of incidents recurring but also reduce the overall number of incidents.

There was evidence of post incident debriefs for staff working within the core hospital. A post incident debrief is a supportive mechanism for staff to encourage reflection on what worked well and what could be managed differently in the future.
There were variations in how post incident debriefs were conducted, low level incidents usually taking the form of informal conversations, with higher level incidents resulting in formal debriefs with minutes recorded.

On reviewing a number of incidents in relation to self-injurious behaviours, on some occasions the first line of management recorded was the administration of PRN (as and when required) medication. Acknowledging that the MDT had a sound knowledge of the patients and their needs, this may have been the most appropriate response to these significant behaviours.

There were some areas of good practice in relation to Adult Safeguarding (ASG). Inspectors found the system in place afforded good protection. Staff had a good knowledge of the referral process and there was evidence of interim protection plans and good recording of MDT discussions and decision making.

Staff highlighted significant challenges as a consequence of continued scrutiny and reported hyper-vigilance in respect of safeguarding referrals. Staff highlighted a disharmony between the safeguarding team and ward staff in relation to appreciating the value of each other's roles. An AFI has been identified, recommending that the Trust take action to improve the working relationships between the adult safeguarding team and ward staff with a particular focus on variation in practice and decision making in protection planning.

Outside of periodic inspection, inspectors review all incidents involving staff which has led to a safeguarding referral being made to the ASG team. Review of a number of these safeguarding incidents, particularly, those involving agency staff, has identified a gap in the skills and experience of agency staff in relation to the management of patient's needs. An AFI has been identified, recommending that the Trust develop a specific training programme for agency staff that will develop knowledge and skills to support staff to safely and effectively meet the needs of the patients within MAH.

The safeguarding team, including Designated Adult Protection Officers (DAPO's), was under resourced and this was having an impact on the timeliness of communication between ASG teams and ward staff. Plans were underway to increase the resource available in the ASG team.

RQIA recognise that there is a growing number of staff on protection plans which, from an operational perspective, is challenging. The recent protection plans are reviewed regularly by the ASM and the DAPO on site and protection plans relating to Historical CCTV investigations are reviewed 3 weekly at the Muckamore Abbey Hospital Operational Group meeting.

5.2.7 Finance

The finances within the hospital were well managed. Ward staff were adhering to the Trust's policy with nursing staff and managers completing relevant checks and audits. Transactions were managed appropriately with patients confirming that they could access their money when they required it. Staff had a good knowledge and understanding of the financial processes in place.

The ASM completed financial audits of patient's monies and high value items on each ward on a monthly basis. Following review of completed audits there were some minor discrepancies relating to the recording of high value items, this was raised with the SMT during the inspection and actioned accordingly.

5.2.8 Governance & Leadership

Good governance systems were in place to monitor safety on the site which included daily safety briefs, weekly live risk and governance meetings, clinical improvement meetings and ward managers meetings. There was evidence of appropriate sharing of information between the SMT, the Trust's Executive Management Team, the DoH and Trust Board.

The availability and experience of ward managers across the site was impacting on the consistency and quality of leadership. RQIA highlighted this with SMT and were assured that the Trust were providing support to newly appointed ward managers.

There is a Governance Lead appointed within MAH who alongside Senior Trust staff collated data and themes which are shared with ward managers. This informs wards of their performance and improvements, enhancing a collective ownership of the Trust's goals.

Each ward has an assigned ASM in place. At the time of the inspection there was a reduction in the availability of the ASMs which was having an impact on the ability to provide timely support to staff and maintain governance oversight in some areas such as auditing.

In February 2021 The Muckamore Abbey Carers Questionnaire was devised by the Trust and disseminated to families/carers of those who reside in MAH. A total of 48 Questionnaires were sent with a total of 19 families availing of the opportunity to respond. Following review of the responses two thirds of families were satisfied with several aspects of the service, with one third of carers feeling dissatisfied. The majority of carers found staff approachable, respectful and valued carers' input. There was a less positive response when it came to staff responding quickly and proactively to concerns.

Some carers suggested that improvement was required in respect of the support provided to them. Some described that carers' needs had not been reviewed and that they did not have sufficient information about supports available to them. Some carers suggested that work should be undertaken with carers to ensure they are aware of the supports available, including the access to the advocate, and that they receive regular/annual reminders of this resource. A further suggestion was that the service should work with carers to develop and build trust and confidence. The SMT are currently developing an action plan to implement the recommendations emerging from these findings.

6.0 Conclusion

Since the previous two inspections there was evidence of numerous improvements having been made across the site. However, it remains the case that there continues to be a shortage of staff on all levels within MAH, especially staff trained in a Learning Disability speciality; it is welcomed that the Trust are supporting several health care assistants to undertake their Learning Disability Nurse training.

It was evident that the staff continued to endure a challenging working environment due to the impact of the historical safeguarding concerns and the pending Public Inquiry. Despite this, staff remained committed to their patients and keen to deliver high quality services to patients and restore public confidence in the hospital.

RQIA remained concerned about the future sustainability of the site in view of the high dependency upon agency staff. The working experience of staff had deteriorated from previous inspections and there are a growing number of protection plans. In view of this RQIA remain concerned about the pace of progress of resettlement.

RQIA would like to take this opportunity to thank the hospital staff, patients and families for taking time to engage with the inspection team, enabling us to complete this inspection which aims to support improvement for patients and develop a more supportive working culture for staff.

Three areas for improvement have been made in relation to physical health care and adult safeguarding. Details can be found in the Quality Improvement Plan (QIP).

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with: **The Mental Health (Northern Ireland) 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).**

	Regulations	Standards
Total number of Areas for Improvement	N/A	3

There are a total of three AFIs set out in the Quality Improvement Plan (QIP) relating to physical health care and adult safeguarding.

The AFI's and details of the QIP were discussed with the SMT as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Mental Health (Northern Ireland) 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).	
Area for improvement 1 **Ref:** Standard: 8.1 Criteria: 8.3 **Stated:** First time	The BHSCT shall develop a robust system for sharing information between medical and nursing staff to ensure all relevant staff are kept informed and up to date in relation to patient's general/physical health screening. Ref 5.2.2
To be completed by: 01 January 2022	**Response by registered person detailing the actions taken:** The BHSCT have developed a robust system for sharing information between medical and nursing staff to ensure all relevant staff are kept informed and up to date in relation to patient's general / physical health screening. A small project team consisting of the onsite GP, a Ward Manager and an Assistant Service Manager has been established. The working group has developed the agreed system and are now working to implement the changes across the hospital site.
Area for improvement 2 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time	The BHSCT should ensure action is taken to improve the working relationship between the adult safeguarding teams and the ward staff with a particular focus on variation in practice and decision making in protection planning. Ref 5.2.6
To be completed by: 01 January 2022	**Response by registered person detailing the actions taken**: BHSCT will ensure that action is taken to improve the working relationship between the adult safeguarding teams and the ward staff with a particular focus on variation in practice and decision making. This work will be commissioned by the Interim Director with a focus on joint review of existing policies, procedures and flowcharts to ensure teams are working to agreed processes and policies. Facilitated team building sessions will be arranged to allow the two teams to spend time together discussing the challenges each face and how they can work as team to ensure patient safety and best practice. Due to vacant posts within the Adult Safeguarding team which are currently progressing through the recruitment process and the upcoming Christmas holidays, this work will commence in 2022.

Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3.3 **Stated:** First time **To be completed by:** 01 January 2022	The BHSCT should develop a specific training programme for agency staff that will develop knowledge and skills to support them to safely and effectively meet the specific needs of the patients within MAH. Ref 5.2.6
	Response by registered person detailing the actions taken: BHSCT has commenced the development of a specific training programme for agency staff that will develop knowledge and skills to support them safely and effectively meet the specific needs of the patients within MAH. This training programme will be delivered to existing agency staff and any new agency staff commencing employment within the hospital. This work will be led by the Nurse Development Lead (NDL) supported by the Service Manager and Divisional Nurse.

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Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority

Inspection Report

02 - 31 March 2022

Belfast Health and Social Care Trust

Mental Health & Learning Disability Hospital
Muckamore Abbey Hospital
1 Abbey Road
Antrim
BT41 4SH
Tel no: 028 9446 3333

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Belfast Health and Social Care Trust (BHSCT)	**Responsible Individual:** Dr. Cathy Jack Chief Executive, BHSCT
Person in charge at the time of inspection: Tracy Kennedy, Co-Director, LD Services	**Number of registered places:** There are 5 wards operating within Muckamore Abbey Hospital
Categories of care: Acute Mental Health and Learning Disability	**Number of beds occupied in the wards on the day of this inspection:** 42

Name of ward:	No of patient's accommodated:
Cranfield 1	8
Cranfield 2	8
Six Mile	11
Killead	10
Donegore	5

Brief description of the accommodation/how the service operates:
Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability (MHLD) Hospital managed by the Belfast Health and Social Care Trust (the Trust). The hospital provides inpatient care to adult's aged18 years and over who have a learning disability and require assessment and treatment in an acute psychiatric care setting. MAH provides a service to people with a Learning Disability from the BHSCT, Northern Health and Social Care Trust (NHSCT), South Eastern Health and Social Care Trust (SEHSCT), Western Health and Social Care Trust (WHSCT) and Southern Health and Social Care Trust (SHSCT). Patients are admitted either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO). The Psychiatric Intensive Care Unit (PICU) has remained closed since 21 December 2018. Admission to any other ward within the hospital is significantly restricted, any decision to admit new patients is risk assessed on an individual patient basis and alternative options fully explored before an admission is facilitated.

2.0 Inspection summary

An unannounced inspection of MAH commenced on 02 March 2022 at 09:00 and concluded on 31 March 2022, with feedback to the Senior Management Team (SMT). All wards were inspected by a team comprised of four care inspectors with support from administration staff.

The inspection focused on five key themes: discharge and resettlement; patient's physical health care needs; staffing; incident management and safeguarding; and governance and leadership. The inspection also sought to assess progress with areas for improvement (AFI) identified during the previous inspection in July 2021.

The inspection identified good practice in relation to resettlement planning, with evidence of good Multi-Disciplinary Team (MDT) and family involvement. Progress has been made in relation to identifying suitable community placements to enable patients to leave hospital.

Significant progress has been achieved in the management of patient's physical health care, and health screening. A Trust employed General Practitioner (GP) is available on site four days per week.

MAH continues to experience a number of challenges to maintaining service delivery. The Public Inquiry into the historical abuse of patients in MAH commenced in October 2021, the impact of which is felt by patients, families and staff across the site. MAH continues to experience challenges with staff vacancies, a lack of skilled and experienced learning disability speciality staff, and the ongoing management of adult safeguarding incidents. Further information is detailed in the main body of this report.

During the course of our inspection we were informed of the Trust's decision to implement changes within the Senior Leadership Team at MAH. We determined that this change will support and enhance service delivery and continuity.

3.0 How we inspect

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 service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

During the inspection we observed patient care and treatment, engaged with the MDT and Senior Management Team (SMT), and reviewed relevant patient and governance documentation. Experiences and views were gathered from staff, patients and their families.

Evidence was gathered to compliment the intelligence already gained through our contemporaneous scrutiny of all safeguarding notifications involving staff, which RQIA has undertaken since July 2019.

4.0 What people told us about the service

Posters and patient easy read leaflets were placed throughout wards inviting staff and patients to speak with inspectors and feedback on their views and experiences. We received six completed patient questionnaires during the inspection.

Feedback from patients about the staff and the care they received was for the most part positive.

Opportunities to speak with relatives during the course of the inspection were limited as a result of the Covid-19 visiting restrictions; consequently, we offered all families the opportunity to engage with us via a telephone call. Nineteen families availed of this opportunity. Some family members gave their permission to share their opinions with the SMT during the inspection.

Several staff interviews were conducted, including both Trust and agency staff, across the wards. Staff spoke openly about the concerns they had in relation to disparities between Trust and agency staff and the impact of the Public Inquiry. Despite this, staff remained committed to delivering safe and effective care.

5.0 The inspection

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

The last inspection to MAH, which was an MDT inspection, was undertaken on 28 July 2021 to 19 August 2021. Three areas for improvement were identified.

<table>
<tr><td colspan="2">Areas for improvement from the last inspection to Muckamore Abbey Hospital 28 July to 19 August 2021.</td><td></td></tr>
<tr><td colspan="2">Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).</td><td>Validation of compliance</td></tr>
<tr><td colspan="2">PHYSICAL HEALTH CARE</td><td></td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard: 8.1
Criteria: 8.3

Stated: First time

To be completed by:
01 January 2022</td><td>The Belfast Health and Social Care Trust shall develop a robust system for sharing information between medical and nursing staff to ensure all relevant staff are kept informed and up to date in relation to patient’s general/physical health screening.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A robust system for sharing information between medical and nursing staff in relation to patient's general / physical health was in place. Patient</td></tr>
</table>

	records reflected consideration and/or completion of physical health screening. All disciplines were recording in patient PARIS records.	
ADULT SAFEGUARDING		
Area for improvement 2 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 01 January 2022	The Belfast Health and Social Care Trust should ensure action is taken to improve the working relationship between the adult safeguarding teams and the ward staff with a particular focus on variation in practice and decision making in protection planning. **Action taken as confirmed during the inspection:** There was evidence of a good working relationship between the adult safeguarding team and the ward staff. Staff at ward level followed the Adult Safeguarding (ASG) process and procedure with evidence of input and support from the adult safeguarding team. A review of the information confirmed that ward staff were making appropriate referrals to the ASG team.	**Met**
STAFF TRAINING (AGENCY STAFF)		
Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3.3 **Stated:** First time **To be completed by:** 01 January 2022	The Belfast Health and Social Care Trust should develop a specific training programme for agency staff that will develop knowledge and skills to support them to safely and effectively meet the specific needs of the patients within MAH. Ref 5.2.6 **Action taken as confirmed during the inspection:** Limited progress had been made in this area. There was no evidence of an agency specific training programme. There were no assurances that agency staff had the required level of knowledge or skill to safely and effectively meet patient needs. This area for improvement has not been met and will be stated for the second time.	**Not Met**

5.2 Inspection findings

5.2.1 Discharge/Resettlement Planning

The discharge planning processes for patients across all wards were reviewed. At the time of the inspection there were 42 patients on MAH site, 40 of whom were delayed in their discharge. A lack of suitable community placements and a lack of suitably skilled / experienced staff and environments were cited as contributing factors to some of the delays in progressing timely discharge.

MAH have a dedicated resettlement team to lead patient resettlement. Their role is to identify suitable community placements based on each individual patient's assessed needs. Five patients have been successfully resettled during 2021-2022, with resettlement advanced in the process for a further three patients. A number of the other patients, who are delayed in their discharge, have an identified community placement; however, the expected dates for discharges remain uncertain as they are reliant on construction of the facilities and the recruitment of appropriately qualified/skilled staff. It was positive to see evidence of staff employed by prospective care providers working on the hospital wards with patients (inreach) and also Trust employed staff supporting patients to transition to new accommodation (outreach) where appropriate. The resettlement team have good oversight of all patients and maintain a database to track the resettlement plans for individual patients. The resettlement team work collaboratively with the MDT, patients and families to identify placements. The resettlement team and the SMT have co-operated fully in the ongoing review of resettlement arrangements. The recommendations falling out of this review will further enhance the resettlement of patients from MAH.

Families spoke positively of their involvement in discharge planning, including decision making for placement, and for some, engagement with the prospective new service provider. Some families of patients who had not yet had a placement in the community identified remained positive that options were being explored, and understood that the complexity of their relative's needs may further delay identifying the most appropriate placement. We were assured that the resettlement team had oversight of all resettlement plans and were adopting a multi-disciplinary approach to discharge planning.

5.2.2 Physical Health Care

The physical healthcare provision for patients across all wards was reviewed. All patients had a robust health care pathway in place, and there was evidence that patients had routine blood tests and clinical observations completed, and also blood tests for specific reasons based on individual need. A full review of antipsychotic medicines was completed by the hospital psychiatrist in collaboration with the nursing staff twice yearly. There was evidence that these medicines were regularly reviewed during clinical ward rounds which has led to improved outcomes for patients regarding reduction in medication.

Patients have access to an onsite GP four days per week who co-ordinates physical health checks, medication and chronic disease monitoring; this includes six monthly electrocardiography (ECG) for patients who require antipsychotic medication monitoring (where patients had difficulty coping with an ECG, medical staff had explored other, more suitable options, with those patients). We found the GP provision to be a positive resource that met the needs of the patients.

Communication between medical and nursing staff in relation to physical health care had improved since the last inspection. All disciplines are now recording contemporaneously in patient electronic notes and there was evidence of physical health care discussed during MDT meetings twice weekly. There was clear evidence of the patients' journey in relation to physical healthcare needs.

5.2.3 Staffing

We reviewed the staffing arrangements at MAH through the analysis of staffing rotas, discussions with staff, and review of staffing model. The site is using the Telford model to determine staffing levels, which is a tool to assist staff in defining staffing levels based on patient acuity.

Staffing shortages remain a challenge; this is largely attributed to the regional shortage of registrants with Learning Disability specialism and the historical safeguarding investigation and subsequent Public Inquiry. These unprecedented issues are having an impact on the Trusts ability to secure and maintain adequate levels of substantive staffing. The site was operating at approximately 63% agency staffing, 29% substantive staffing and the remainder of the staff were working on a bank basis or additional hours. Less than 20% of agency staff registrants were Registered Nurse Learning Disability (RNLD); a Registered Learning Disability Nurse brings specialist knowledge and unique skills in relation to the management of complex and challenging behaviours. It was good to note that the majority of agency staff had committed to long term contracts which supported continuity of care for patients.

Processes and procedures were in place for escalation when staffing deficits were not met. The SMT work proactively to secure safe staffing levels across the site; a review of staffing rotas indicated the numbers of staff working on the majority of shifts was found to be above the expected level in relation to Telford. Staff skill mix was concerning as a limited number of staff were experienced in Learning Disability specialism and we were not assured that a number of these staff , namely those who were employed by an agency, were being utilised to their full potential to enable effective care delivery. An AFI has been identified.

There was a significant gap in senior nurse leadership roles across all of the wards. These leadership roles are critical in leading staff teams and overseeing care and treatment of patients. At the time of this inspection only one ward had a substantive Band 7 ward manager in post. The other four wards had a peripatetic manager or a Band 6 deputy manager acting up into the Band 7 ward manager role. The instability in the current Band 7 ward manager posts has led to disharmony amongst staff teams and a lack of collaborative working amongst the nursing staff.

We reviewed staff training records for Trust and agency staff. With respect to MAPA (Management of Actual or Potential Aggression) and Adult Safeguarding training; agency staff compliance was considerably higher than that for Trust staff. An AFI has been identified.

Three Nurse Development Leads (NDL) work in MAH. Their role is to improve patient care by facilitating, enabling and supporting the nursing workforce in the delivery of high quality, evidence based, person centred care. There was limited evidence of the impact the NDLs were having on the development and support for nursing staff. NDL were not ward based. Given the current gaps in leadership at Band 7 ward manager level across a number of wards we discussed the benefits of reviewing the NDL roles with a view to becoming more ward based to support the ward leadership and enhance nurse development. An AFI has been identified.

There were inconsistencies in management support provided to ward staff. Staff reported that they felt unsupported by management attributing to low morale. We discussed this with members of the Trust SMT during the inspection and were assured that actions had been taken, and further proposals were to be considered, to address the issues raised by staff. An AFI has been identified.

MDT input into the care and treatment of patients was reviewed. It was good to note that all wards had dedicated Positive Behavioural Support staff and access to two consultant psychiatrists. There is no dedicated Occupational Therapists or Social Workers, and limited input from Psychology professionals, which has potential to impact on and further delay the resettlement of patients. The Trust continues to proactively seek to recruit all grades and disciplines of staff with ongoing workforce plans in place.

5.2.4 Adult Safeguarding / Incident Management

Adult Safeguarding arrangements were reviewed. Adult Safeguarding (ASG) is the term used for activities which prevent harm from taking place and which protects adults at risk (where harm has occurred or likely to occur without intervention).

Staff at ward level demonstrated a good understanding and knowledge of adult safeguarding processes, including the threshold for making a referral to the ASG team.

We reviewed the Trust incident process in line with ASG reporting procedures and we evidenced that Datix incident forms were in the main graded appropriately. A small number of incidents that may have constituted an ASG referral were identified. We sought assurances from the ASG team regarding these incidents and plans were in place to undertake a review of the incidents alongside the ASG referrals for quality assurance purposes.

The Regional ASG Policy was not fully adhered to in relation to protection planning. Delayed communication between the operational and ASG teams had resulted in delayed protection planning for a small number of patients. This was escalated to the SMT who gave assurances they had been aware of the same concerns and were taking the necessary steps to investigate same, the Trust have agreed to share the findings with RQIA. An AFI has been identified.

Team building sessions between the operational and ASG teams described as planned in the returned Quality Improvement Plan from the previous inspection had not progressed. It is recommended these be expedited with consideration to inclusion of senior Trust staff. The focus of these sessions should be patient safety and protection by all staff through the application of the Regional ASG Policy. An AFI has been identified.

Staff reported they found out they were on a protection plan from information contained in a folder available to all staff at ward level. This led us to determine that protection plans may not always have been implemented in a timely manner. We escalated our concerns around these folders to the SMT and they were removed from all wards during the course of the inspection.

5.2.5 Governance / Leadership

Governance arrangements were assessed through a range of meetings with the SMT and documentation relating to these meetings. It was positive to note the Trust had been aware of issues impacting leadership across the site and had taken measures to address these; including reconfiguration of senior staff to strengthen governance and leadership within MAH. It is acknowledged these changes need time to embed. The Trust has developed an action plan as a means of assurance regarding the necessary improvements required on the site and have agreed to share this with RQIA.

We reviewed a range of governance reports to include a weekly Hospital Safety Report, minutes of meetings and Live Governance report. We found the Hospital safety report to be a robust mechanism that captured a wide range of themes to include, resettlement, ASG, incident management, CCTV monitoring, staffing, restrictive practices and family engagement. Weekly incidents and the use of restrictive practices were detailed in this report. There was evidence of analysis of incidents with trends and themes identified to reduce reoccurrence.

Governance relating to ASG systems and processes was evident. The Divisional Lead for ASG had a clear programme of audit, gathered monthly per ward which provided the ASG team with assurances around the level of reporting.

There was evidence of appropriate sharing of information between the SMT, the Trust's Executive Management Team, the DoH and Trust Board.

Whilst we found the governance processes to be positive we could not evidence the impact of these at ward level; the lack of nursing leadership in all wards may have contributed to the information not being shared. Nursing and medical staff told us that the SMT did not have a visible presence on the wards; additionally we could not evidence a program of visits from ASM, or SMT or an outcome of any leadership walk rounds to improve culture and govern practice.

5.2.6 Patient Engagement

We met with five patients during the inspection; we also left questionnaires across all wards to allow patients the opportunity to engage with us. Feedback from patients in relation to their care and treatment and the staff delivering it, was for the most part, positive. Some patients took the opportunity to share individual issues they were experiencing, which, with their agreement, were passed onto ward staff for action.

5.2.7 Family Engagement

We sought contact with all families/carers of patients to establish their opinions about the care their relative received. Nineteen families/carers gave their opinions. Some families spoke highly of the care and treatment and praised staff; however, some families had a negative experience. One issue raised by a family member constituted an ASG referral which has since been made. A meeting was convened between RQIA and the SMT to discuss the opinions given during feedback, including the negative issues that had been raised. The SMT spoke directly with a number of families/carers that had raised concerns, with actions planned to address the issues.

5.2.8 Staff Engagement

We met with a number of staff, some of whom advised staff morale was low, citing disparities between substantive and agency staff as an area of concern. Both substantive and agency staff spoke openly about tensions amongst staff teams and the pressures they experienced while striving to deliver safe and effective care, namely the level of scrutiny they felt they were under and the negative media interest in the site. Despite this, staff remained committed to delivering safe and effective care.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Mental Health Order (Northern Ireland) 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

	Regulations	Standards
Total number of Areas for Improvement	N/A	6

The total number of areas for improvement includes one that has been stated for a second time and five which have been stated for the first time.

Areas for improvement and details of the Quality Improvement Plan were discussed with the SMT, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Mental Health Order (Northern Ireland) 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

Area for improvement 1 **Ref:** Standard 5.1 Criteria: 5.3.3 **Stated**: Second time	The Belfast Health and Social Care Trust should develop a specific training programme for agency staff that will develop knowledge and skills to support them to safely and effectively meet the specific needs of the patients within MAH. Ref: 5.1
To be completed by: 30 June 2022	**Response by registered person detailing the actions taken:** The BHSCT Trust has developed a training plan for RMNs working on the hospital site as agency staff. This has been developed in partnership with the Trust's Clinical Educator from QUB. The Trust will use a practice development approach for implementation of the programme. They will work alongside staff at ward level, also with RMN staff currently working in the hospital and during the first month of employment with the new starts.
Area for improvement 2 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should ensure and support a collaborative approach to nursing care, and promote working well together. Agency staff should be embedded within the staff teams and their skills effectively utilised in the delivery of patient care. Ref: 5.2.3
	Response by registered person detailing the actions taken: The Belfast Trust held listening exercises for all staff working in MAH during April 2022. As an outcome the Trust plans to undertake values based team building, initially for senior leaders then followed by a roll out for all staff. Dates for these sessions are currently being confirmed. Two agency staff were promoted to Band 6 deputy managers in May 2022.
Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3.3 **Stated:** First time	The Belfast Health and Social Care Trust should develop an effective mechanism to monitor staff compliance with relevant training requirements and take the necessary actions to address any identified deficits. Ref: 5.2.3

To be completed by: 30 June 2022	**Response by registered person detailing the actions taken**: Training requirements are now recorded on the e-rostering system which is monitored by the ward manager's assistant. They alert the ward manager and staff member to any training that is about to expire. The roster will remain in alert status until training is updated as complete.
Area for improvement 4 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should review the role of the Nurse Development Leads and consider the utilisation of this resource to strengthen leadership and management at ward level and support the development of nursing staff within each ward. Ref: 5.2.3
	Response by registered person detailing the actions taken: The role of the Nurse Development Leads in the BHSCT is well established. The Nurse Development Leads in Learning Disability Services cover the MAH site, Iveagh and Community. There is currently one NLD employed within this role and an additional post is vacant. The NDLs will assist with leadership and development within the wards in MAH, alongside balancing other key aspects of their role.
Area for improvement 5 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust Senior Management Team for MAH should seek opportunities to engage with staff to determine how best to support them. Consideration should be given to: 1. A schedule of leadership walk rounds with a report to evaluate the outcome of the visit. 2. ASM & SMT having a visible presence across all wards to support staff and govern practice Ref: 5.2.3
	Response by registered person detailing the actions taken: The Belfast Trust held listening exercises for all staff working in MAH during April 2022. There are weekly reflective practice sessions in Donegore ward. There is an on-site counsellor with information sent to staff on self-care and signposting to services both internal and external to the Trust. There is a regular presence from ASMs and CLT on the wards. On MAH site from March 21 there were two safety quality visits from members of Executive Team, another is planned for 2/07/22. The CLT regularly communicate with staff- side representatives discussing staff views and experiences from working on site.

	The CLT have a template for recording leadership walk-arounds which will be introduced in July 22.
Area for improvement 6 **Ref:** Standard 5.1 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should ensure the Adult Safeguarding Regional Policy is adhered to by staff at all levels, including the SMT. Consideration should be given to: 1. A review of operational ASG processes and if required steps to address any identified gaps. 2. Prioritising team building sessions between operational and ASG team to promote a collective approach to patient safety and protection in line with the Adult Safeguarding Regional Policy. Ref: 5.2.4
	Response by registered person detailing the actions taken: In MAH an Adult Safeguarding audit is underway in relation to compliance with operational ASG processes. Upon completion all identified actions will be taken forward. A weekly operational Adult Safeguarding huddle is in place. The ASG and the Hospital Management Teams provide updates and share information in relation to ASG cases. A monthly ASG assurance group attended by ASG and Hospital SMT is in place to review and monitor ASG referrals, themes and trends. Current ASG data sets are under review. The CLT team has undertaken a shared learning event with ASG and Hospital management teams promoting more effective working. MAH specific Adult Safeguarding Training has been delivered in June 2022 to staff inclusive of ASG and Hospital leaders.The Trust plans to undertake values based team building work with all Leaders in Learning Disability, this will include Hospital and ASG staff. Dates for these sessions are currently being confirmed.

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Assurance, Challenge and Improvement in Health and Social Care

Inspection Report

01 - 29 July 2022

Belfast Health and Social Care Trust

Mental Health & Learning Disability Hospital
Muckamore Abbey Hospital
1 Abbey Road
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1.0 Service information

Organisation/Registered Provider: Belfast Health and Social Care Trust (BHSCT)	**Responsible Individual:** Dr. Cathy Jack Chief Executive, BHSCT
Person in charge at the time of inspection: Natalie Magee, Co-Director, LD Services	**Number of registered places:** There are five wards operating within Muckamore Abbey Hospital
Categories of care: Acute Mental Health and Learning Disability	**Number of beds occupied in the wards on the day of this inspection:** 37

Name of ward:	No of patient's accommodated:
Cranfield 1	Seven
Cranfield 2	Eight
Six Mile	Nine
Killead	Seven
Donegore	Six

Brief description of the accommodation/how the service operates:
Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability (MHLD) Hospital managed by the Belfast Health and Social Care Trust (the Trust). The hospital provides inpatient care to adult's aged 18 years and over who have a learning disability and require assessment and treatment in an acute psychiatric care setting. MAH is a regional service and as such provides a service to people with a Learning Disability from across Northern Ireland. Patients are admitted either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO). The Psychiatric Intensive Care Unit (PICU) has remained closed since 21 December 2018. Admission to any other ward within the hospital is significantly restricted, any decision to admit new patients is risk assessed on an individual patient basis and alternative options fully explored before an admission is facilitated.

2.0 Inspection summary

An unannounced inspection of MAH commenced on 01 July 2022 at 04:00am and concluded on 29 July 2022, with feedback to the Trust's Senior Leadership Team (SLT). All wards were inspected at least once during this period. The inspection team comprised of care inspectors, a senior inspector, assistant directors and a director.

The decision to undertake this inspection (following so soon after the inspection in March 2022) was based on intelligence detailed in Early Alerts received by RQIA in June 2022.

RQIA has a statutory responsibility under the Mental Health (Northern Ireland) Order 1986 and the Health and Social Care (Reform) Act (Northern Ireland) 2009 to make inquiry into any case of ill-treatment, deficiency in care and treatment, improper detention and/or loss or damage to property.

The inspection identified limited progress towards meeting the areas for improvement (AFI) identified during the inspection in March 2022. Additionally, RQIA found that staffing/workforce and adult safeguarding arrangements were inadequate and had impacted on the care and treatment of patients. RQIA escalated these concerns to the Trust's Chief Executive and SLT at the conclusion of the inspection. The Trust accepted RQIA's findings. RQIA has also escalated these concerns to the Department of Health and with the Strategic Performance and Planning Group. A number of AFI have been made.

MAH continues to experience a number of challenges to maintaining service delivery. The Public Inquiry into the historical abuse of patients in MAH is ongoing, the impact of which is felt by patients, families and staff. There are continued challenges with high levels of staff vacancies, a lack of skilled and experienced learning disability speciality staff, and the ongoing management of adult safeguarding incidents.

Following this inspection, RQIA met with the Trust's Chief Executive and SLT on 4 August 2022 to discuss our intention to issue two Improvement Notices relating to staffing/workforce and adult safeguarding. During this meeting RQIA received assurances as to the actions taken and planned by the Trust to address each of the areas of concern. RQIA will closely monitor the Trust's progress in this regard. Further information is detailed in sections 5.2.1 and 5.2.2 of this report.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect performance at the time of our inspection, highlighting both good practice and any AFI. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

The inspection focused on eight key themes: staffing/workforce; adult safeguarding; governance and leadership; assessment and treatment/resettlement; patient experience; patient engagement; family engagement; and staff engagement.

During the inspection we observed patient care and treatment, and the lived experience of patients in the wards. We conducted unannounced visits at different times of day and night to ensure patient care was observed on every ward across the full 24 hour period. We observed staff practice and reviewed staffing arrangements in all wards, including the profile of staff. We engaged with the multi-disciplinary team (MDT) and Senior Leadership Team and reviewed relevant patient and governance documentation. Experiences and views were gathered from staff, patients and their families.

Evidence was gathered to supplement the intelligence already gained through the contemporaneous scrutiny of all safeguarding notifications involving staff, which RQIA has undertaken since July 2019.

4.0 What people told us about the service

Posters and easy read leaflets were placed throughout wards inviting staff and patients to speak with inspectors and feedback on their views and experiences.

We received two completed questionnaires from patients, both which reflected that they thought care was good and staff were kind, however, they stated the ward was not organised, nor did they feel safe. We shared this feedback with staff on duty. We spoke with a small group of patients on one ward and with four patients who requested to speak with inspectors. Some patients expressed concern about staffing while others expressed anxiety about the behaviours of other patients.

Opportunities to speak with relatives during the course of the inspection were limited as a result of the Covid-19 visiting restrictions; consequently, we were supported by ward staff to make direct telephone contact with patients' relatives. Twelve families availed of this opportunity and provided a range of views based on their experiences of visiting the wards and engaging with hospital staff. While some relatives expressed high levels of satisfaction with the standard of care provided, others advised of their concern about staffing levels, communication, safeguarding and availability of activities.

Several staff requested to speak with inspectors in private and other opportunities were taken to speak with staff during visits to each of the wards. Staff spoke openly about the concerns they had. We did not receive any completed staff questionnaires; however, staff did contact us following the inspection to discuss concerns they had in relation to the safety of patients and staff.

5.0 The inspection

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

The previous inspection to MAH was undertaken on 02 – 31 March 2022. We assessed the progress made towards achieving compliance with the six AFI identified at the last inspection and identified that insufficient progress had been made to meet the Quality Standards. Our findings are as follows:

Areas for improvement from the last inspection to Muckamore Abbey Hospital 02 – 31 March 2022		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 5.1 Criteria: 5.3.3 **Stated**: Second time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should develop a specific training programme for agency staff that will develop knowledge and skills to support them to safely and effectively meet the specific needs of the patients within MAH.	**Not met**
	Action taken as confirmed during the inspection: An agency specific training programme had not been developed. Additional concerns were also identified in relation to the skills and competencies of agency staff. Further detail is provided in Section 5.2.1. This AFI has not been met and has been subsumed into a new AFI.	
Area for improvement 2 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should ensure and support a collaborative approach to nursing care, and promote working well together. Agency staff should be embedded within the staff teams and their skills effectively utilised in the delivery of patient care.	**Not met**
	Action taken as confirmed during the inspection: There was insufficient evidence that efforts had been made to embed agency staff within staff teams and further evidence indicated continued relationship difficulties amongst staff groups. Further detail is provided in Section 5.2.1. This AFI has not been met and has been subsumed into a new AFI	

Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3.3 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should develop an effective mechanism to monitor staff compliance with relevant training requirements and take the necessary actions to address any identified deficits.	**Not met**
	Action taken as confirmed during the inspection: Issues were identified in relation to compliance with mandatory and service specific staff training. Effective mechanisms to monitor staffs' compliance with relevant training and take necessary actions to address deficits were not in place. This was concerning given the risks associated with the competence, skills and knowledge of staff. Further detail is provided in Sections 5.2.1 and 5.2.2. This AFI has not been met and has been subsumed into a new AFI.	
Area for improvement 4 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should review the role of the Nurse Development Leads (NDL) and consider the utilisation of this resource to strengthen leadership and management at ward level and support the development of nursing staff within each ward.	**Not met**
	Action taken as confirmed during the inspection: The NDL resource had reduced since the last inspection. As a result it was not possible to determine the impact the NDL role was having. This is discussed further in Section 5.2.8. This AFI has not been met and has been subsumed into a new AFI.	

Area for improvement 5 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust Senior Management Team for MAH should seek opportunities to engage with staff to determine how best to support them. Consideration should be given to: 1. A schedule of leadership walk rounds with a report to evaluate the outcome of the visit. 2. ASM & ST having a visible presence across all wards to support staff and govern practice.	**Partially met**
	Action taken as confirmed during the inspection: The presence of the SLT on wards to support staff during incidents was noted. We identified gaps in provision of consistent and continuous support to staff at ward level from the middle management team which was having a direct impact on the effective delivery of care. This is discussed further in Section 5.2.8. This AFI has been partially met and has been subsumed into a new AFI.	
Area for improvement 6 **Ref:** Standard 5.1 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should ensure the Adult Safeguarding Regional Policy is adhered to by staff at all levels, including the SMT. Consideration should be given to: 1. A review of operational adult safeguarding processes and if required steps to address any identified gaps. 2. Prioritising team building sessions between operational and adult safeguarding team to promote a collective approach to patient safety and protection in line with the Adult Safeguarding Regional Policy.	**Not met**
	Action taken as confirmed during the inspection: Issues in relation to implementing effective and suitably protective adult safeguarding arrangements continue. This is discussed further in Section 5.2.2. This AFI has not been met and has been subsumed into a new AFI.	

5.2 Inspection findings

5.2.1 Staffing / Workforce / Staff Profile

The staffing arrangements at MAH were reviewed through the analysis of staffing rotas, discussions with staff, observation of staff on shift, and review of the staffing model. Staffing levels on the MAH site have been determined using the Telford model, which is a tool to assist staff in defining staffing levels based on patient acuity.

The safety and well-being of patients in MAH was directly affected by the current staffing arrangements. The staffing concerns were not, in the main, related to the numbers of staff on duty. MAH as a site, was operating continuously with 83% to 85% agency nursing and health care staff in addition to ad hoc shifts being covered by bank staff and staff from other areas, across all of the wards. This had an impact on the continuity of care for patients.

There were significant gaps in the level of competence, skills and knowledge required to support patients who have a learning disability, who require support with communication, and present with complex and distressing behaviours.

We noted that staffing levels, in line with the Telford model, was often not being achieved and that the rotas did not accurately reflect the actual staff on shift.
Staffing was not based on the assessed needs of the current patient population. Staffing levels had reached a critical point with difficulty in retaining and recruiting appropriately experienced staff, across all grades.

Staffing levels were not adequate to respond to temporary or unplanned variations in the assessed needs of patients and staff were frequently redeployed to provide cover in other wards when incidents occurred. Some planned visits and outings with family members had been cancelled at short notice due to staffing arrangements.

Robust arrangements were not in place to oversee and assure the supply and deployment of agency staff across the site. This directly impacts patients' safety and contributes to poor patient outcomes. There was evidence that agency and other staff were self-selecting shifts and not following the correct procedure for booking shifts leading to inadequate oversight of the staffing arrangements and in one instance significant safeguarding concerns. The Trust took immediate action to address this risk when highlighted.

Agency staff were working excessively long shifts, often consecutively and without any breaks or sufficient rest periods between shifts. We have taken separate actions to address these concerns with the registered providers of the relevant agencies. Such working patterns are known to impact adversely on both the health and wellbeing of the staff, and on the quality and safety of care provided to patients. We found that staff morale was poor and there was evidence of conflict amongst staff groups.

The current staffing arrangements were detrimentally affecting the resilience and wellbeing of staff and their ability to provide safe, effective and compassionate care, often in very challenging circumstances and therefore must be urgently taken into account in organising staffing at MAH.

Staff training records for Trust and agency staff identified deficits in a number of areas including; Adult Safeguarding Training, Positive Behaviour Support (prn) and Management of Actual or Potential Aggression (MAPA). There was no agency specific training programme to develop agency staff knowledge and skills to support them to safely and effectively meet the specific needs of the patients in MAH. There was limited evidence of an effective mechanism to monitor staff compliance with relevant training requirements or actions taken to address any identified deficits. Individual staff training records were not up to date and an accurate summary of staff training compliance was not available.

There was no evidence of the promotion of a PBS culture in wards. PBS is a person centred approach to supporting people with a learning disability; it is based on assessment of the social and physical environment in which the behaviour happens and includes the views of the individual. A PBS model if used effectively would contribute to a reduction in incidents. Bespoke PBS plans were available and documented in patient care records; however, staff had limited understanding of these and were reluctant to implement the PBS model. This increases the risk of a reliance on the use of restrictive practices to manage patients' behaviours.

Staff reflected feelings of fear and an inability to safely manage patients when they present with distressed or challenging behaviours. Staff were focused on managing and predicating the outcome of distressed or challenging behaviours rather than on proactive action to avoid escalation of behaviours

There was evidence, on occasions, of an over-reliance on the use of PRN medication (PRN medication is medication administered as needed, to support patients with regulating their behaviours) to manage the presentation of some patients and we were concerned to note that some administration times coincided with shifts where there were staffing deficits, and when staff on duty were not familiar with the patients' needs. The Trust committed to undertaking an urgent review of all patients' prescribed medications.

Effective post-incident debrief and support was lacking and as a result opportunities to reflect on and learn from incidents are missed. Some staff reported that their behaviour support staff colleagues did not visit the wards.

Staff providing front-line care displayed resilience and should be commended for their dedicated service to patients and patients' families.

On 8 August 2022 RQIA wrote to the Department of Health (DoH) under Article 4 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (the Order), to inform the DoH of the significant concerns in relation to workforce and staffing arrangements, and submitted our views under Article 35 (1) (d), Article 35 (3) (d) and Article 35 (4).

We invited the Trust's SLT to a meeting on 4 August 2022 in which we discussed our intention to serve an Improvement Notice in relation to the staffing/workforce arrangements. This meeting was attended by the Trust's Chief Executive and members of the SLT.
At this meeting the Trust's Executive Management Team, presented a comprehensive action plan describing their plans to address the staffing/workforce concerns arising from the inspection. They informed us of the recent recruitment of nine new staff, five of which are newly qualified registrants, and gave an overview of further plans to recruit and retain staff at all levels.

Additional workforce resources have been secured from within the Trust including senior and middle management levels, a significant number of who will work within the adult safeguarding team. The Trust provided a clear commitment to enhance the leadership within MAH, assurance arrangements through the Executive Management Team, and up to Trust Board level, and also through the engagement of external expert support. As a result of the assurances provided and the comprehensive action plan, RQIA decided not to take enforcement action at that time and will monitor the delivery of the Action Plan outlined.

5.2.2 Adult Safeguarding

Adult safeguarding is the term used for activities which prevent harm from taking place and which protects adults at risk (where harm has occurred or likely to occur without intervention).

In some instances ward staff demonstrated a poor understanding and knowledge of adult safeguarding processes, including the threshold for making a referral to the adult safeguarding team. There was limited evidence regarding adult safeguarding training delivered to substantive staff members and we could not assess if agency staff had the necessary adult safeguarding training as training records for this group were not readily available.

There was limited assurance that incidents of a safeguarding nature were being responded to in a timely way. Delays in reporting incidents to the adult safeguarding team have resulted in delayed patient protection planning.

Staffing shortages within the adult safeguarding team have led to delays in the adult safeguarding process, with a large volume of adult safeguarding investigations not completed. A lack of Designated Adult Protection Officers (DAPOs) is leading to ineffective management of new adult safeguarding concerns, ongoing adult safeguarding concerns and any actions as a result of the ongoing historical safeguarding concerns.

Patients involved in adult safeguarding incidents were subject to a protection plan, however; there was no evidence that the protection plans were reviewed or updated regularly. Staff involved in adult safeguarding incidents were also subject to protection plans which we found in some cases to be unrealistic with poor oversight and management. Staff told us they feel at risk due to the level of scrutiny and are fearful for their professional registration.

There were fewer than expected occasions of debrief and robust incident management oversight resulting in insufficient learning and improvement post incident. There was limited evidence of the effectiveness of audit and analysis of incidents with opportunities to reduce risk and improve patient care missed.

As a result of our significant concerns we wrote to the Department of Health (DoH) under Article 4 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (the Order), to advise the DoH of serious concerns we identified in relation to adult safeguarding, and submitted our views under Article 35 (1) (d), Article 35 (3) (d) and Article 35 (4).

We invited the Trust's SLT to a meeting on 4 August 2022 in which we discussed our intention to serve an Improvement Notice in relation to the adult safeguarding arrangements. This meeting was attended by the Trust's Chief Executive and members of the Trust's SLT. At this meeting the Trust presented a comprehensive action plan describing their plans to address the adult safeguarding concerns arising from the inspection. They advised additional adult safeguarding team resources that have been secured and additional managerial oversight was in place to enable outstanding adult safeguarding work to progress.

The Trust has provided a clear commitment to enhance the leadership within MAH, assurance arrangements through the Executive Management Team, and up to Trust Board level, and also through the engagement of external expert support. As a result of the assurances provided by the Trust, and the comprehensive action plan, RQIA decided not to take enforcement action at that time and will monitor the delivery of the Action Plan outlined.

5.2.3 Assessment and Treatment / Resettlement

Assessment and treatment for patients was assessed through the observation of patient care, discussions with patients, and their relatives, with ward staff and from the review of patients' care documentation.

There were 37 patients in MAH, a small number of whom are receiving active care and treatment. This is a reduction from 39 (-2) since January 2022.

A lack of suitable community placements with appropriately skilled staff are some of the contributing factors that have hindered discharge plans for several patients. Some patients, who were preparing for discharge, had in reach staff.
In reach staff are supplied from a prospective care provider, to support patient care on site to enable patients to have a smoother transition into the community when they are discharged.

Assessments for those patients in receipt of active care and treatment were of poor quality and had not been regularly reviewed; some assessments were incomplete. This has led to ineffective care and treatment planning. Care delivered was based on a medical model and MDT meetings were focused on describing incidents and lacked evidence of meaningful decision making about changes in care planning. This has impacted on the effectiveness of the MDT's input into patient care.

Restrictive practices were not being effectively reviewed and patients were subject to restrictions that impacted on their freedom of movement. Enhanced observations (used when staff have assessed that the risk of self-harm or risk to others is increased) were not being reviewed regularly and there was no evidence that consideration had been given to reduce observation levels in a timely manner.

5.2.4 Patient Experience

Patient experience was assessed by directly observing patients lived experiences on the wards and by speaking with patients, ward staff and patients' relatives. Observations were completed across a range of day and night time periods.

The focus on patients' human rights was limited. Care, at times, lacked dignity and respect, and there was little consideration for patients' right to a private and family life. Communal living alongside other patients with complex needs created difficulties for some patients, for which there were very limited options.

Ward environments were for the most part, noisy with limited quieter spaces available for patients to avail of. Some patients who were trying to rest or sleep were disturbed by others. Noise levels on some wards were noted to be high and persistent. This had the potential to cause other patients to not want to use communal spaces. Other noise impacts include the staff alarm system, the patient mix and environmental factors associated with communal living. This is not a therapeutic environment that supports patients' mental wellbeing and their enjoyment of private and family life.

Two patients stated they were concerned about staff safety, and about the impact of the behaviours of other patients on their own wellbeing.

All of the wards visited are locked wards; and patients rely on staff availability and cooperation to support any off ward activity. While some patients were noted to have regular access to the grounds, day care and outings, not all patients can avail of these. Staffing shortages were noted to impact on a planned outing, a family visit and on individualised work with patients.

Staffing arrangements impacted directly on patient activities as not all patients received the necessary support to structure their day, promote their independence, and develop skills enabling them to manage and self-regulate their emotional wellbeing.
Patient Activity Schedules were, for the most part, not implemented, with patients largely dependent on day care staff for activities. Staff demonstrated limited purposeful engagement with patients and tended to stand in groups with, or talk to other staff.

There was no structure to the patients' day or ward based activities resulting in boredom and an increase in incidents of challenging behaviour.

In line with some patients assessed needs and to support their individual care they have been allocated a pod area within the ward footprint. Pod areas are a suite of rooms allocated specifically for one patient, and closed off to other patients. The configuration of some pod areas creates a heavily reliance on staff availability and cooperation to support the patients to access required areas outside of their pod. Staffing shortages and patient acuity were impacting staff's ability to provide individualised care. This has the potential to impact patient dignity, their physical and mental health and their ability to retain their independence and personal care skills.

We observed meal time experiences for patients. Staff demonstrated limited interaction with patients and did not provide a dignified meal time experience for some. Staff stood beside seated patients whilst assisting them with their meal and spoke to other staff rather than the patient they were assisting.

We observed examples of compassionate care to individual patients. This included supporting patients to participate in activities of their choosing both on site and off site. Staff were also observed responding compassionately to patients who were experiencing distress, offering them comfort and reassurance.

5.2.5 Patient Engagement

We observed patients seeking out and engaging with some staff in a positive way. Some patients called for staff by name, whilst others smiled and looked happy to see staff who were familiar to them. We observed patients responding negatively to staff who were unfamiliar to them.

Four patients requested to meet with inspectors. One patient expressed concerns about the safety and wellbeing of ward staff and reported that staff had been assaulted by other patients. Three patients expressed anxiety relating to the behaviours of other patients and reported feeling bullied by other patients. A small group of patients on one ward expressed concerns about the inconsistency in staffing.

Two patients completed questionnaires; both reflected that care was good and staff were kind, however, they both stated the ward they were in was not organised, nor did they feel safe there.

5.2.6 Family Engagement

We sought contact with all families/carers of patients to establish their opinions about the care their relative received. Twelve families/carers gave their opinions. Common themes are detailed as follows:

Staffing
Families had mixed views on staffing. Several reported wards were short staffed and staff had poor understanding of patient needs, while others praised staff, stated they were doing the best they could under difficult circumstances and felt staff were not recognised enough for the good work they do. Several families praised individual staff and identified them by name.

Communication
Several families raised poor communication with staff at all levels as an issue. They raised concerns about site management and the lack of contact they had with them. Additionally, some families described good communication with ward staff and commended staff.

Adult Safeguarding
Several families spoke of their concerns in relation to adult safeguarding processes. They stated they were not provided with updates about ongoing investigations and had no confidence that they would be informed of any outcome from the investigations. Some families stated that it was positive that issues were being reported to the adult safeguarding team.

Food
A small number of families had concerns about food supplied to the patients. They did not think the food was of a good standard and some felt the need to provide take away food to supplement the meals provided.

Activities
The majority of families stated there were not enough activities for patients and had concerns about how patients spent their day. Some families correlated the lack of activities with incidents of challenging behaviours. Several families stated they would like increased use of the onsite swimming pool for the patients.

Visiting
Families expressed an understanding and appreciation of the restrictions in place during the Covid-19 pandemic; however, they raised issues not impacted by these restrictions. Some had negative experiences when attempting to visit including a pre-planned visit cancelled at short notice due to staffing shortages.

5.2.7 Staff Engagement

We met with a number of staff who spoke openly about the concerns they had.

Some staff stated morale was poor and they did not feel supported. They spoke about the high level of injuries sustained by staff during incidents that occurred during their shifts, the impact this had on them, and the lack of debrief and opportunity to discuss it.

Staff were confused and concerned about the future of the hospital and what this would mean for patients and themselves. They reported feeling traumatised, anxious and on edge in relation to the level of scrutiny the hospital was under and the negative portrayal of the hospital in the media.

Despite the issues described by some staff, the staff continue to work at the site and show commitment and dedication to the patients, many providing additional hours beyond their contracted hours and some working whilst retired.

5.2.8 Governance – Leadership and Management

Governance arrangements were assessed through a review of SLT meeting records, discussions with senior staff and observations of care delivery.

Leadership, management and overall governance arrangements need to be strengthened. We determined that poor patient outcomes in relation to patient safety, quality of life, and experience were attributed to a lack of leadership at a middle management level across the site, and suitable management arrangements on the wards. Some wards did not have a dedicated manager, and the 'nurse in charge' was responsible for overall management of the ward, in addition to fulfilling their duties as a member of the team on shift. Staff described disharmony amongst teams and lack of cohesion between substantive and agency staff. There was limited evidence of the effectiveness of the NDL role to support shortfalls in staff development and ward management.

The Trust's oversight of agency staff supply and deployment across the site was not robust, which resulted in discrepancies between staff on rota to work and the actual staffing on shift. The staffing records provided were not a reliable source of information to determine the activity and location of staff members on any given shift, day or night.

They did not clearly or accurately outline the deployment of staff, as observed and did not provide an overview of staff movement across the site during shifts. We evidenced that the fluidity of staffing across the site has impacted on the delivery of safe and effective care to patients.

There is one night coordinator on site, with access to senior management through on call arrangements. The Trust have clarified that the night co-ordinator resource is proportionate to the number of patients accommodated in the hospital.

Staff who were involved in, or who had witnessed incidents of challenging behaviour were not routinely in receipt of a post incident de-brief. This reduces the opportunities to learn from incidents, and to provide necessary emotional support to staff, some of whom have sustained significant injuries while at work.

The absence of appropriate oversight of the staffing arrangements has impacted on patient safety and on the quality of care patients received. We observed staffing levels on the wards to be focussed on the numbers of staff; the skills and experience of staff members was a secondary consideration.

The Trust presented a comprehensive action plan describing their plans to address the leadership and management concerns raised with them during the inspection feedback meeting. They gave an overview of plans to recruit and retain staff at all levels, and described additional workforce resources that have been secured from within the Trust, including senior and middle management levels.

The Trust must provide strong operational leadership to bring stability to the service. The wider Health and Social Care system could support the Trust in achieving stabilisation, which RQIA recommend should be driven by a clear and transparently communicated vision for the future of MAH, shared with all stakeholders, with a fixed period of transition to its achievement. A commitment to assisting with workforce needs during that transition should be secured from other HSC providers with access to appropriately skilled and experienced staff.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Mental Health Order (Northern Ireland) 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

	Regulations	Standards
	N/A	9

Areas for improvement and details of the Quality Improvement Plan were discussed with the SLT, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Mental Health Order (Northern Ireland) 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).	
Area for improvement 1 **Ref:** Standard 5.1 Criteria: 5.3.3 **Stated**: Third time **To be completed by:** 31 October 2022	The Belfast Health and Social Care Trust must urgently undertake a review of the induction, training and ongoing development needs of all staff supplied to work in MAH, including those who are supplied at short notice. A training and development plan must be implemented that sets out the range of mandatory and other relevant training to be undertaken by staff. Training plans must be specific and records maintained of when training was provided, by whom and the date of any update or refresher.
	Response by registered person detailing the actions taken: A senior nurse has been authorised to lead on induction of all staff and the E-Roster is reviewed weekly by the Lead Nurse in line with patients' needs and locked down as "agreed". E-roster training and management for Lead Nurse, Ward Sisters and Charge Nurses has been completed to ensure effective roster management to meet the needs of the patients. The process for booking agency staff has been circulated to all registrants regarding the agreed process to book agency staff and the clear message no one is to be booked outside of this process. Work continues with BHSCT Nurse Bank to replace Agency staff who have moved. Consistent regular review of staffing resource is ongoing in line with patient needs. The daily staffing template is reviewed by the Assistant Service Managers.

	A presentation and a Question & Answer session was delivered to the newly appointed Band 6 and Acting Band 7 staff in relation to roles and responsibilities associated with Good Rostering Practice, Policy and clear Key Performance Indicators to reinforce training. Evidence of induction is signed off by Lead nurses prior to undertaking any "nurse in charge" role. Leadership training is being arranged with BHSCT & Leadership Centre. The Nurse Development Lead (NDL) is coordinating training schedules consisting of LD skills, relational security and Positive Behaviour Support (PBS), bespoke ASG with a combination of direct teaching and ward based coaching on engagement. PBS training is included as standard in the Safety Intervention Training as part of the induction and SI update. Training plan: • Introduction to LD and key concepts • Behavioural approaches in LD care • Communication styles • Ethical and legal considerations in LD care • Forensic Nursing in LD • ASD in adults with LD • Relational Security This will close gaps in PBS, relational security, safety intervention training. Training needs analysis for safety interventions is underway and will be completed in line with the action plana specific training and development plan will be put in place with Crisis management plans for each patient, and plan shared when complete. Safeguarding training assisted by Central Nursing Team and ASG Link Nurses have been identified per ward across site. ASG training level 3 provided for senior staff 4 in July and 4 in September 2022 This will increase confidence and prevent staff from "feeling unsafe" to deliver necessary interventions. Value based training is being rolled out as above and a Service plan being produced. As part of the contract with Direct HealthCare one of the essential components of the contract is that each individual staff member has completed level 2 AS training prior to commencement of working on the ward and production of evidence of a programme and training data.

	. Band 7 role authorised to manage all new starts, complete inductions and alert all staff to new starts (agency and trust-deployed staff) to allocated wards. This information is shared with the site coordinators to ensure they are aware of all new starts. Five newly qualified RNLD nurses have commenced preceptorship, induction and training on 19th September 2022 (commencing with Safety Intervention training). There is consistent support throughout their induction and preceptorship, including a Psychology led staff support group presently in place. A “Going Home” checklist is in place in each ward for staff and Occupational health referrals are made where appropriate. Band 6 Deputy Ward Sister/s due to commence Mid October 2022.

Area for improvement 2 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 31 October 2022	The Belfast Health and Social Care Trust must urgently review the staffing arrangements to ensure there are at all times sufficient numbers of adequately skilled and experienced staff available to meet the needs of patients. The Trust must implement a staffing model to determine staffing levels which must be consistent with the changing needs of patients and the challenges associated with the use of agency staff.
	Response by registered person detailing the actions taken: Ongoing staff recruitment & induction of staff new staff supported by band 7 senior nurse an Nurse development lead. Five new registered RNLDs have taken up post, they will be supported in perceptership by lead nurses and our clinical tutor. these staff will have the opportunity to rotate in community teams to enhance skills for the future workforce community model . There are ongoing Listening sessions by Chief Executive, Director of Nursing and Director with Trade Union colleagues open to all staff. A "Going home" checklist is in place in each ward. Staff support groups are being rolled out on each ward. The Ward Sister/Charge Nurse or Deputy Ward Sister/Deputy Charge Nurse advertisements have yielded no appointments in the past however we have recently recruited 2 band 6 psots from our contracted agency. Lead nurses have been supported to deliver on agreed work plans due to the reduced number of senior ward based staff on site. The Lead nurses also deliver direct support to ward based staff. The Senior nurse managers are providing direct leadership, coaching and mentoring on site in line with Trust values and a focussing on patient safety. Leadership training being completed by all middle management staff and training in relation to roles and responsibilities associated with Good Rostering Practice, policy and KPIs delivered. Staffing pressures are identified and escalated to BHSCT and with the other HSCT through the workforce appeal process. There is consistent monitoring of staffing both daily and weekly. 4 Nurse Agency registrants commenced employment 8th August 2022. 4 additional Nurse Agency registrants are due to commence post in October 2022. At the Weekly review of overall staffing, staff are reminded of Staff care, Occupational Health and on site counselling with a tools guide or with support developed and shared. Additional staff will need time for induction and upskilling. Lead nurses and Senior site staff have reached out to all staff over the

	summer months. The Senior staff are visible on site, and there is a rota in place over 7 day period & on call senior manager with links to Clinical Director and Director on call Band 7 site coordinators are to be increased x 2 due to vacancies. it is important to note that student nurses on placement in the hospital consistently report an effective and well supported learning environment in routine educational audits. they are supported by the NDL and the practice education team and our clinical lecturer jointly appointed with QUB There is ongoing patient experience and patient safety thermometer audits completed and shared fortnightly with CLT and staff. Service plan to be produced and Site co-coordinators offer senior support to the wards out of hours. On Call rota, On Call rota/Daily Huddles are in place. Staff deployment Is managed in advance but review is carried out daily by site coordinator and further at site wide morning safety huddles for the site each day to cover unexpected gaps. Daily safety brief reviews and plan patient safety issues across site using Charles Vincent model for safety through the implementation of Daily Huddles/Staff planning/Daily Safety Briefs. The ward staff have been engaged in patient focused activity. The patient observation policy is under review in line with care and support themes. An increase in day care provision planned for onsite residents as currently day care is 40% below capacity due to staff sickness and vacancies and there is currently a sickness absence management process in place. Replacement posts have been offered and appointees took up posts September 2022. Protection plans are shared with night coordinators for patient safety reasons but respecting confidentiality. Site coordinators on site 7 nights per week and days at the weekend, current gaps due to vacant posts are filled with additional Hours/Bank staff. 2 site coordinator posts re-advertised in Oct 2022 with closing date 20 October 2022. Day and night shift safety briefs shared with all staff. The rationale for any staff movement across site/service is documented and reviewed on the staff shift allocation sheet daily and reviewed by lead nurse. There is currently a Daily staff monitoring spreadsheet. The Senior Nurse Managers took up post 19th September 2022 to providing direct leadership and support to all staff. Unfortunately the Ward sister/charge Nurse interview 12th September 22 was not successful and is being readvertised Oct

	2022. Recruitment & induction of Staff continues despite challenges. Review of staffing and structure takes place as resettlements progress. The Staffing report with deficits is sent to senior staff and CLT daily, reviewed and actions taken to maintain safety on site.
Area for improvement 3 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 31 August 2022	The Belfast Health and Social Care Trust must put in place arrangements for the effective oversight of staff supply and deployment across the site. This will include the establishment and implementation of robust protocols relating to the supply of agency and new staff, their fitness and suitability to practice, and the management and oversight of records relating to staff supplied.
	Response by registered person detailing the actions taken: Roster management by 8A lead nurses in line with E-roster Policy. A Lead Nurse (8A) has been recruited for 6 months to specifically lead on patient safety and training matrix in a specific ward. Model of care for all individuals is under review in line with resettlement. Through the appointment of 2 Senior Nurse roles, additional support is being provided to staff through enhanced onsite visibility of management team. Process to strengthen Incident Management review and learning is to be implemented. A senior nurse has been allocated to lead on induction of all staff and the E-Roster is reviewed weekly by the Lead Nurse in line with patients' needs and locked down as "agreed". E-roster training and management for Lead Nurse, Ward Sisters and Charge Nurses has been completed to ensure effective roster management to meet the needs of the patients. Sickness absence management process in place Leadership training to be completed by all middle management staff. HR to facilitate Values based team development to be carried out. System settings re-configured to facilitate Ward management teams to assign block booked agency staff direct to the roster, Documentation and guidance in relation to this has been shared and communicated with ASM's for dissemination to ward teams.Safety Interventions Training: Training need analysis for safety interventions to be completed and a plan out in place with Crisis management plans for each patients and plan will be shared when complete. Management structure has been reviewed and shared with RQIA.

Area for improvement 4 **Ref:** Standard 5.3 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 31 November 2022	The Belfast Health and Social Care Trust must urgently review the care and treatment plans of all patients to ensure that their assessed needs are adequately outlined and that a plan is in place to meet their needs. The Trust must ensure that appropriately skilled staff have oversight of each patient's plan, that the patient and their relatives are involved in its development, and that there are arrangements in place for plans to be reviewed regularly by the multi-disciplinary team.
	Response by registered person detailing the actions taken: All PBS plans are under review with the TSS team taking a lead in this with the MDT and in line with individual resettlement plans. PBS plans are discussed at weekly PIPa meetings and in nurse handovers. Patient Activity audit sheet developed and circulated. Model of care for all individuals is under review in line with resettlement. All assessments have been indexed and reviewed as part of accelerated resettlement plans. An increase in day care provision planned for onsite residents as currently day care is 40% below capacity due to staff sickness and vacancies. A project plan lead by divisional nurse and chair of Division which includes: • The Trust have commissioned a review of the use of PRN by consultant psychiatrist and lead nurse from outside the care delivery Unit commenced July 2022. Terms of reference have been shared. *The clinical lecturer and psychologist provides weekly reflective practice to allow staff the space to consider on PBS approaches.

Area for improvement 5 **Ref:** Standard 5.3 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 30 November 2022	With the current focus on resettlement of patients from MAH resulting in a reduction in numbers of patients across each of the five wards, the Belfast Health and Social Care Trust must keep under review each patient's living areas to ensure that patients are receiving care and treatment in the most therapeutic environment. The review should take account of matters relating to excessive noise, restrictions in freedom of movement, or incompatibility with other patients and should be developed with the patient and where appropriate, their relatives.
	Response by registered person detailing the actions taken: There is review of staffing and structure as resettlements progress. Model of care for all individuals is under review in line with resettlement Review of staffing and structure as resettlements progress The senior nurse mangers meeting with the Lead nurses weekly to review environmental and governance issues moving patients as appropriate to make the best use of space to reduce incompatibility issues and restrictions.
Area for improvement 6 **Ref:** Standard 7.1 Criteria: 7.3 **Stated:** First time **To be completed by:** 31 October 2022	The Belfast Health and Social Care Trust must put in place arrangements to promote the wellbeing of all staff. A staff wellbeing plan must be developed which sets out the Trust's arrangements for staff to access and receive support and guidance.
	Response by registered person detailing the actions taken: Listening sessions by Chief Executive, Director of Nursing and Director with Trade Union colleagues open to all staff.Going home checklist in place in each ward. Staff support groups to be rolled out on each ward. Lead nurses have support provided to deliver on agreed work plans due to the reduced number of senior ward based staff on site Lead nurses are delivering direct support to ward based staff Senior nurse managers are providing direct leadership coaching and mentoring on site in line with Trust values and a focus on patient safety. Leadership training to be completed by all middle management staff. page tiger for self care and sign posting has been developed and shared Staff are reminded of Staff care, Occupational Health and on site counsellor with a tools guide or support developed and shared. Through the appointment of 2 Senior Nurse roles additional support is being provided to staff through enhanced onsite visibility of management team. Staff sessions with psychology have provided a safe space for staff. The staff induction role is led by one senior staff member, this is their main job role.

	A “Going Home” checklist is in place in each ward for staff and Occupational health referrals are made where appropriate.
Area for improvement 7 **Ref:** Standard 5.3 Criteria: 5.3.1 **Stated:** Second time	The Belfast Health and Social Care Trust must urgently undertake a review of the Adult Safeguarding Operational Procedures in Muckamore Abbey Hospital in line with Regional Policy. An action plan must be developed to address the deficits in the implementation of the regional Policy, the measures to be taken to address these, and the timescales for completion.
To be completed by: 30 September 2022	**Response by registered person detailing the actions taken:** The Belfast Health and Social Care Trust has put in an action plan, and has taken the following action: -Put in place a single point of referral for all adult safeguarding referrals in MAH, this ensures compliance with AS Policy, consistency of thresholds, proportionate alternative safeguarding responses and timely protection planning. -RQIA are invited to all strategy meetings -System in place for the ongoing review of protection plans -Audit systems in place to monitor timeliness of referrals -Plan for the management of 4 workstreams underway -Undertaken a piece of work to clarify thresholds and processes for managing alternative safeguarding responses. The Trust has reviewed its guidance to staff in relation to threshold, and has commenced training with all ward staff in relation thresholds and the use of PARIS. -Redeployment of DAPO's and recruitment of administrative staff has occurred -Adult Safeguarding Service Manager has been appointed -Full implementation of the use of APP1 PARIS forms under way -Updated datasets and monthly oversight meeting in place for the review of Adult Safeguarding Trends A programme of AS training is being rolled out as part of an action plan supported by central nursing and the CEC. Review process for all Form 2s in place with RQIA Inspector and ASG Service manager The Trust is still bound by regionally agreed criteria that requires a lower threshold for referral to AS Team for incidents involving staff in that all incidents involving staff must be reffered to the AS team and there is no discretion for the line manager to screen the refferal. once received by the AS team the regional policy applies. this results in occassions in refferals that in other settings may not reach the threshold for refferal to the team. the impact in staff feeling that the threshold is unfair. However, the AS Team have been working to bring a proportionate response to Adult Safeguarding referrals, with a view to increasing Alternative Safeguarding Responses.

Area for improvement 8 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time	The Belfast Health and Social Care Trust must put in place suitable arrangements for the effective delivery and oversight of adult safeguarding policy and procedures. These arrangements should include an ongoing evaluation of the effectiveness of the safeguarding arrangements on MAH site and the impact the adult safeguarding process has on patients, relatives and staff.
To be completed by: 30 September 2022	**Response by registered person detailing the actions taken:** Adult Safeguarding action plan in place for the strengthening of the Adult Safeguarding Team which includes: -Monthly oversight arrangements in place, to identify trends, risk and analysis of Adult Safeguarding with oversight arrangements by the EDSW And NED commencing -New data sets established for the purpose of analysing trends, informing actions and areas of focus - Mechanisms developed to collect patient and service user experience in relation to Adult Safeguarding -Live Governance arrangements in place for review of incidents for ASG and incidents moderate or above -A single point of referral for all adult safeguarding referrals in MAH, enables more contemporaneous identification of emerging themes and trends -Audit undertaken to identify those patients most at risk of Adult Safeguarding referrrals with ongoing development of a peer review system to enable second line assurance of efficacy of protection plans -Six monthly audit process in relation to Adult Safeguarding has been put in place -System in place for the ongoing review of protection plans -Audit systems in place to monitor timeliness of referrals -Redeployment of DAPO's and recruitment of administrative staff has occurred -Adult Safeguarding Service Manager has been appointed -Full implementation of the use of APP1 PARIS forms under way which assists in reporting and analysis

Area for improvement 9 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 31 October 2022	The Belfast Health and Social Care Trust must urgently take steps to strengthen the leadership and governance arrangements in MAH taking account of the clinical leadership and middle management structures. The outcome of this process must be shared with RQIA and must set out clearly any revisions to the management structure, roles and responsibilities and accountability arrangements.
	Response by registered person detailing the actions taken: Lead nurses have support provided to deliver on agreed work plans due to the reduced number of senior ward based staff on site. Lead nurses are delivering direct support to ward based staff. Senior nurse managers are providing direct leadership, coaching and mentoring on site in line with Trust values with a focus on patient safety.Senior Nurse Mangers to took up post 19 September 2022 to provide direct leadership and support to all staff nurse structure revised and in place with additional leadership posts this has been shared with RQIA with the last action plan Clinical structure in place with Clinical director and Chair of Division

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

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Assurance, Challenge and Improvement in Health and Social Care

Belfast Health and Social Care Trust
caring supporting improving together

Muckamore Abbey Hospital Weekly Safety Report 39
For Chair / Co-D Sign-off – 28/11/19 - Draft V0.1

Date:	**Information w/e Wednesday 27/11/2019**
Lead:	**Dr Joanna Dougherty**
Email:	[redacted]
Tel:	[redacted]
Alternative contact:	**Gillian Traub**
Email:	[redacted]
[redacted]	[redacted]
Weekly Report Number - 39	

1) Key Patient Activity Issues

1.1 MAH Inpatient Numbers

No admissions or discharges took place this week, however one patient on trial resettlement returned to Muckamore Abbey Hospital (a) and one patient (b) currently on trial resettlement and due for discharge, has had their discharge postponed. **The total number of patients in residence is therefore now 54.**

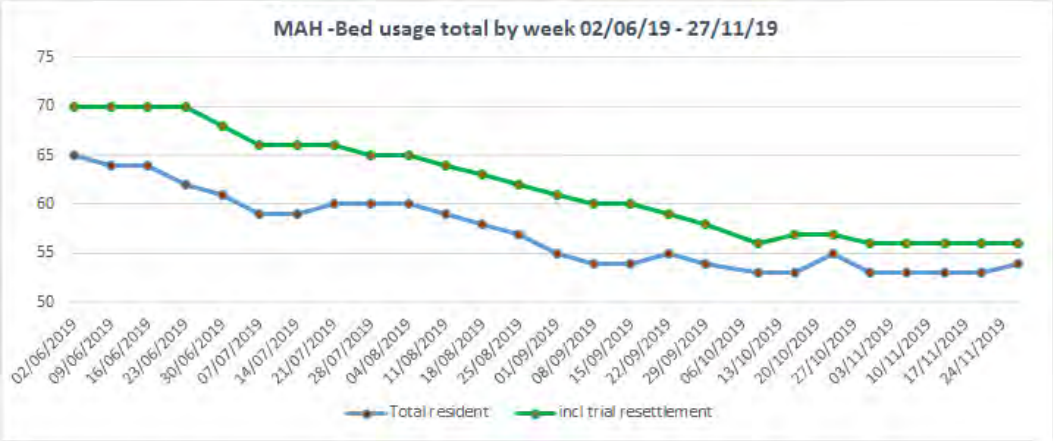
(a) 26 November 2019 – Return of Patient to Ardmore Ward

Patient returned from trial resettlement in Cherry Hill to Ardmore Ward on 26 November 2019 following a period of very unsettling and challenging behaviour. In the immediate period prior to return, the patient had required the input of all staff on shift in Cherry Hill and one of the other tenants had become unsettled due to his support not being available. Escalation of behaviour had extended outside the house and other tenants and neighbours in surrounding houses were aware of the commotion. Plans are being put in place to prepare the patient's return to Cherry Hill. These plans will include some environmental adaptations, review of PBS/CRA plan, an enhanced activity plan and 1:1 Dialectical Behaviour Therapy. Patient herself keen to return to Cherry Hill.

(b) 24 November 2019 – Discharge following Trial Resettlement Deferred

Patient in the Mews was due to be discharged on 24 November 2019. Ward staff had discovered on 20 November that the patient had been receiving an incorrect dose (under dose) of his Quetiapine medication. On further investigation, it became apparent that he was also receiving a smaller dose of Sertraline than his prescribed dose. As a result, 3 week plan required to address medication issues and return to correct dosage. Director of Cedar Foundation keen that discharge would not be agreed until the New Year in view of ongoing concerns with patient's behaviour, and ongoing requirement for the expert knowledge of the hospital team to remain. It was agreed that a review would take place in 3 weeks.

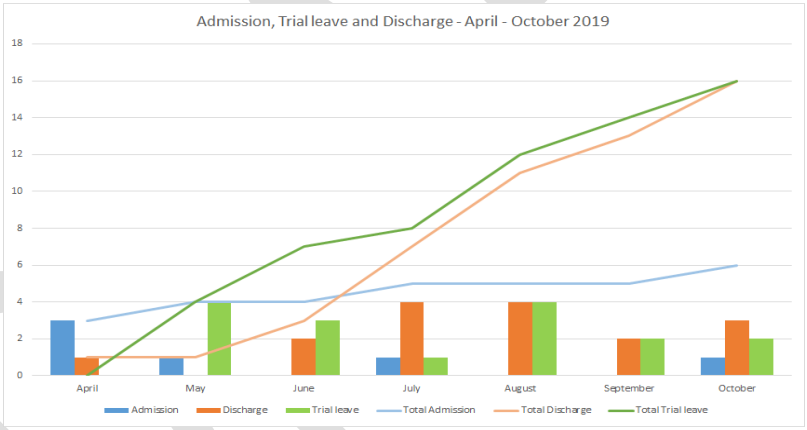
The graph below displays the number of inpatients resident in Muckamore Abbey Hospital in the last 6-month period, as well as the number of patients (2) on trial resettlement.



One patient continues to be a patient in Ward 5 AMHIC. The placement location to Mourne View has now been ruled out due to change in physical health of patient. Alternative options for placement are now being assessed (position at 21 Nov 2019).

1.2 Monthly MAH Admissions, Trial Resettlements and Discharges

The graph below plots the monthly, and year to date, number of patients who are admitted, discharged, or on trial resettlement.



(2) Progress on Review of CCTV - Historic Safeguarding Issues

2.1 Figures for completed viewing of historic CCTV are correct as at 15 November 2019 and relate to the hours viewed by location :

PICU- 100%
Cranfield 1- 71%
Cranfield 2- 40%
Sixmile Assessment- 90%
Sixmile Treatment- 39%
Overall – 68%

(3) Current Safeguarding Referrals

3.1. Patient on Patient Adult Safeguarding Referrals – w/e 27 November 2019

One referral was recorded for w/e 27 November, and two referrals were added relating to w/e 20th November :

27/11/2019

Ward	ASP 1	Type	No. of victims	No. of Alleged Perpetrators
Cranfield 1	1	Physical	1	1
Ardmore	1	Physical	1	1
Sixmile Treatment	1	Physical	1	1
Total	**3**		**3**	**3**

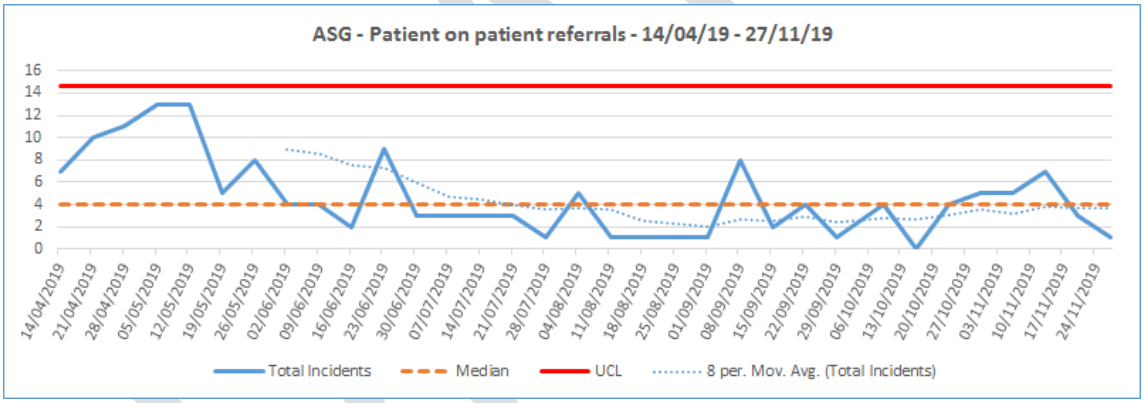
More detail on these referrals is set out below :

27/11/2019							
Location	Victim	Date	Time band	ASP1	DAPO	Outcome	Type
Ardmore	1	19/11/2019	12-4pm	same day	same day	screened out	Physical
Sixmile T	1	20/11/2019	12-8am	same day	same day	not entered	Physical
CF 1	1	22/11/2019	4-8pm	same day	same day	not entered	Physical

*Please note **ASGR (PP)** means Adult Safeguarding Referral (Protection Plan)*

The incidents in Sixmile and Cranfield 1 remain under investigation.

Trend Analysis for Patient on Patient ASG Referrals, April 2019 to date :



3.2 Staff on Patient Adult Safeguarding Referrals – w/e 27 November 2019

One referral was recorded on the system for this period (following an anonymous call), however it relates to an unspecified period in the past and a patient who was in a ward which no longer exists on MAH site - this is why no location has been entered.

27/11/2019							
Location	Victim	Date	Time	ASP1	DAPO	Outcome	Type
not entered	1	not known	not known	20/11/2019	+1 day	Screened out	Physical

(4) Weekly governance review - incidents, seclusion, complaints, risk register, ongoing CCTV monitoring.

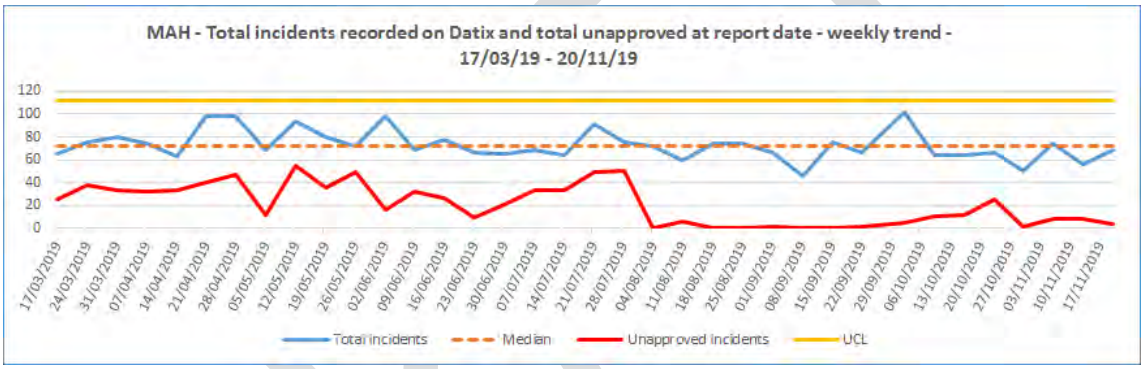
4.1 Incidents

Incidents are reported for w/e 20 November 2019, as approved at 27 November 2019.

A total of **69** incidents was recorded, of which **4** across all wards / areas remain unapproved. This analysis covers the **65** approved incidents. The following table shows approval status by ward / location of incident :

Approval status 14/11/19 - 20/11/19 (app. 27/11/19)	Ardmore	Car Park	CF 1	CF 2	Erne	General walkways, grounds etc	Moyola Day Care	Portmore Daycare (Workskills)	Sixmile A	Sixmile T	Total
Unapproved, not viewed	0	0	0	1	0	0	0	0	0	0	1
Unapproved, viewed	0	0	2	0	0	0	0	1	0	0	3
Approved, investigation ongoing	0	0	1	0	0	0	0	0	0	1	2
Approved, investigation complete	19	1	12	10	7	1	2	0	8	3	63
Total	**19**	**1**	**15**	**11**	**7**	**1**	**2**	**1**	**8**	**4**	**69**

The chart below shows incidents recorded on Datix across a 35-week period.



Only the **65** 'approved' incidents can be further categorised by **those affected in the incident, by severity, by day of the week and by category/ type of incident.**

a) Those affected

Those affected 14/11/19 - 20/11/19 (app. 27/11/19)	Organisational	Patient	Staff	Total
Actual self harm	0	3	0	3
Administration to Patient - Incorrect timing of dose	0	1	0	1
Insufficient numbers of non professional healthcare staff	1	0	0	1
Other self harming behaviour	0	2	0	2
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm) - Physical	0	2	0	2
Inappropriate/Aggressive Behaviour - Physical contact	0	9	31	40
Inappropriate/Aggressive Behaviour - Physical threat (no contact)	0	3	7	7
Self harm attempt/gesture	0	1	0	1
Witnessed Slips/Trips/Falls (includes faints) - Standing up/sitting down	0	1	0	1
Stubborn/uncooperative physical Behaviour	0	1	0	1
Verbal abuse with racial content	0	0	1	1
Witnessed Slips/Trips/Falls (includes faints) -Walking	0	2	0	2
Total	**1**	**25**	**39**	**65**
	2%	**38%**	**60%**	

b) Severity - the classification of the **48** approved incidents is shown in the table below.

Incidents by Severity 14/11/19 - 20/11/19 (app. 27/11/19)	Insig-nificant	Minor	Moderate	Major	Cata-strophic	Total
Totals:	**35**	**29**	**1**	**0**	**0**	**65**
	54%	**45%**	**2%**			

There was one incident graded moderate in this period.

Ardmore 16 November 2019

Incident Description
Staff member reported that they were sitting in chair covering night supervision when without warning, a patient ran into the day space and pounced on top of a staff member.

Staff member reported feeling immediate pain. Staff member activated her alarm and the patient immediately dropped themselves to the floor. The staff member left duty to attend Antrim Area Hospital Emergency Department to have their injuries assessed. Staff were able to re-direct the patient to another area. Patient was offered but declined PRN medication. Level of staffing increased until patient fell asleep.

Outcome of Review/Investigation
Patient normally presents as agitated prior to being aggressive towards staff, on this occasion patient had just got up from bed and ran into area that staff were in, care plan reflects positive measures to support the patient and attempt to reduce occurrence of these behaviours. Investigation complete.

c) Incidents by Day by Location

Incidents by day	Ardmore	Car Park	CF 1	CF 2	Erne	General walkways, grounds etc	Moyola Day Care	Sixmile A	Sixmile T	Total
Monday	1	0	4	2	0	0	0	1	2	**10**
Tuesday	1	1	0	0	1	0	1	0	0	**4**
Wednesday	4	0	1	0	1	1	1	3	1	**12**
Thursday	2	0	3	4	1	0	0	3	0	**13**
Friday	2	0	2	0	3	0	0	0	0	**7**
Saturday	3	0	2	2	0	0	0	1	1	**9**
Sunday	6	0	1	2	1	0	0	0	0	**10**
Total	**19**	**1**	**13**	**10**	**7**	**1**	**2**	**8**	**4**	**65**

Highlighted locations with >3 incidents in a day

d) Type / Category/Location – 'the following table shows incidents by type, location and severity.

Incidents by Severity 14/11/19 - 20/11/19 (app. 27/11/19)	Insig-nificant	Minor	Moderate	Major	Cata-strophic	Total	% of Incidents
Ardmore	**12**	**6**	**1**	**0**	**0**	**19**	**29%**
Inappropriate/Aggressive Behaviour - Physical contact	4	6	1	0	0	11	
Inappropriate/Aggressive Behaviour - Physical threat (no contact)	4	0	0	0	0	4	
Other self harming behaviour	2	0	0	0	0	2	
Witnessed Slips/Trips/Falls (includes faints) - Standing up/sitting down	1	0	0	0	0	1	
Witnessed Slips/Trips/Falls (includes faints) - Walking unassisted	1	0	0	0	0	1	
Car Park	**0**	**1**	**0**	**0**	**0**	**1**	**2%**
Inappropriate/Aggressive Behaviour - Physical contact	0	1	0	0	0	1	
Cranfield 2	**7**	**3**	**0**	**0**	**0**	**10**	**15%**
Inappropriate/Aggressive Behaviour - Physical contact	7	3	0	0	0	10	
Cranfield 1	**4**	**9**	**0**	**0**	**0**	**13**	**20%**
Inappropriate/Aggressive Behaviour - Physical contact	2	7	0	0	0	9	
Actual self harm	1	1	0	0	0	2	
Stubborn/uncooperative physical Behaviour	0	1	0	0	0	1	
Administration to Patient - Incorrect timing of dose (premature)	1	0	0	0	0	1	
Erne	**3**	**4**	**0**	**0**	**0**	**7**	**11%**
Inappropriate/Aggressive Behaviour - Physical contact	1	2	0	0	0	3	
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm) - Physical	1	0	0	0	0	1	
Actual self harm	0	1	0	0	0	1	
Insufficient numbers of non professional healthcare	1	0	0	0	0	1	
Witnessed Slips/Trips/Falls (includes faints) - Walking unassisted	0	1	0	0	0	1	
General walkways, grounds etc	**0**	**1**	**0**	**0**	**0**	**1**	**2%**
Inappropriate/Aggressive Behaviour - Physical contact	0	1	0	0	0	1	
Moyola Day Care	**0**	**2**	**0**	**0**	**0**	**2**	**3%**
Inappropriate/Aggressive Behaviour - Physical contact	0	2	0	0	0	2	
Sixmile Assessment	**8**	**0**	**0**	**0**	**0**	**8**	**12%**
Inappropriate/Aggressive Behaviour - Physical contact	2	0	0	0	0	2	
Inappropriate/Aggressive Behaviour - Physical threat (no contact)	6	0	0	0	0	6	
Sixmile Treatment	**1**	**3**	**0**	**0**	**0**	**4**	**6%**
Inappropriate/Aggressive Behaviour - Physical contact	0	1	0	0	0	1	
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm) - physical	0	1	0	0	0	1	
Self harm attempt/gesture	1	0	0	0	0	1	
Verbal abuse with racial content	0	1	0	0	0	1	
Totals:	**35**	**29**	**1**	**0**	**0**	**65**	
	54%	**45%**	**2%**				

Other Self Harming Behaviour

Ardmore, 14 November 2019

Incident Description
Patient placed part of her pad in her mouth. Encouraged to remove, same achieved. Patient ingested the pieces of pad stuck around the side of her mouth. Staff observed for any obstruction. Duty doctor contacted. Actions as above.

Ardmore, 15 November 2019

Incident Description
Patient ripped incontinence pad and held some of the padding in her mouth, spat some out but also swallowed some of it. Staff removed the pad and encouraged patient to spit it out. Patient monitored for signs of bowel obstruction. Patient under ongoing review by behaviour services and MDT as this is increasingly frequent behaviour.

4.2 Incidents of Physical Intervention (PI)

Of the 69 datix-recorded incidents, **41**% required physical intervention.

Use of Physical Intervention 21/11/19 - 27/11/19 (based on all incidents - approved/not approved (28/11/19)	NO - None used	YES - Holding only	YES - Dis-engagement only	YES - Dis-engagement and Holding	Total
Ardmore	11	8	0	0	19
Cranfield 1	6	6	1	1	14
Cranfield 2	7	2	0	0	9
Erne	8	0	1	0	9
Moyola Day Care	3	0	0	0	3
Sixmile Assessment	5	9	0	0	14
Sixmile Treatment	1	0	0	0	1
Total	**41**	**25**	**2**	**1**	**69**
	59%	**36%**	**3%**	**1%**	

4.3. Use of Rapid Tranquilisation during PI.

0 use of rapid tranquilisation reported for this period (Sixmile Assessment)

4.4 Use of Prone Restraint

0 use of prone restraint reported for this period

4.5 Medication Incidents

1 medication incident within approved incidents for this period

Cranfield 1, 15 November 2019 : Administration to Patient – Incorrect Timing of Dose

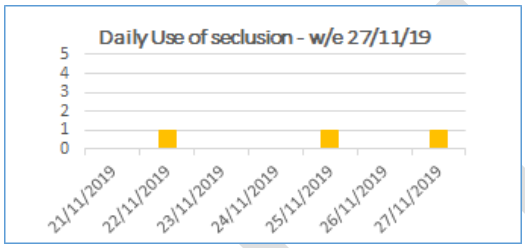
Student nurse was completing the morning medication round with agency staff member and administered promethazine at 08:30hrs when it was prescribed for 17:30hrs. Error released immediately after administration. Discussed with Nurse in Charge, discussed at PIpA, clinical observations offered but refused by patient. Staff to monitor patient. NOK informed and had no issues due to patient appearing to have suffered no ill effects. Kardex observed, appropriately completed, no issues from a prescribing perspective. Human error - student nurse to complete a reflective piece of the incident. NIC spoke to agency staff re. supervision of students when completing medication round.

4.6 Seclusion

Seclusion was utilised on **3 occasions** in the period, in the management of **1** patient.

- Shortest duration of voluntary confinement –1 hour 15 minutes
- Longest duration of voluntary confinement – 2 hour 25 minutes
- Earliest commencement of confinement was 11:55am
- Latest conclusion of confinement was 18:00pm

The chart below show the number of instances of seclusion per day of the week



Voluntary Confinement occurred on **11 occasions** in the period**, all relating to the same patient as above**.

- Shortest duration of voluntary confinement –15 minutes
- Longest duration of voluntary confinement – 1 hour 59 minutes
- Earliest commencement of confinement was 9:20am
- Latest conclusion of confinement was 23:20pm

Seclusion numbers (including voluntary confinement) are the highest since w/e 1 September 2019 and have risen for 4 consecutive weeks.

Analysis by patient of Seclusions

27/11/2019				
Patient ID	**Ward**	**Seclusion Area**	**Reason**	**No. of seclusions**
MAH002	Sixmile A	Patients bedroom	Aggression	3

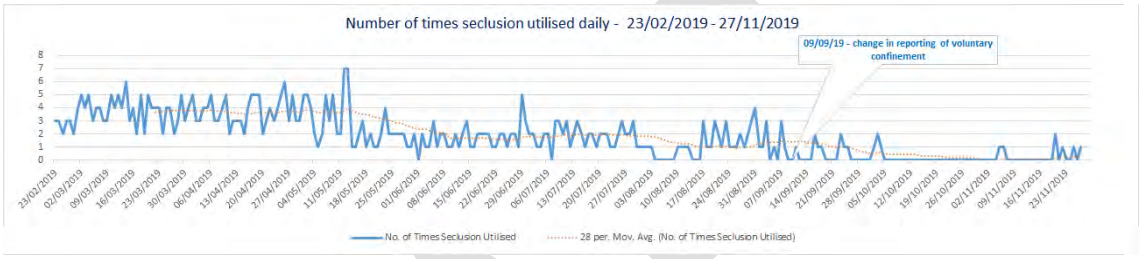
The table below details the number of seclusion episodes - no episode ended later than 6.00pm and the earliest episode started at 11:55am.

27/11/2019					
Time Seclusion Ended	7am - 12noon	12 noon - 5pm	5pm - 11 pm	11pm-7am	**Total**
No. of Seclusions	0	2	1	0	3

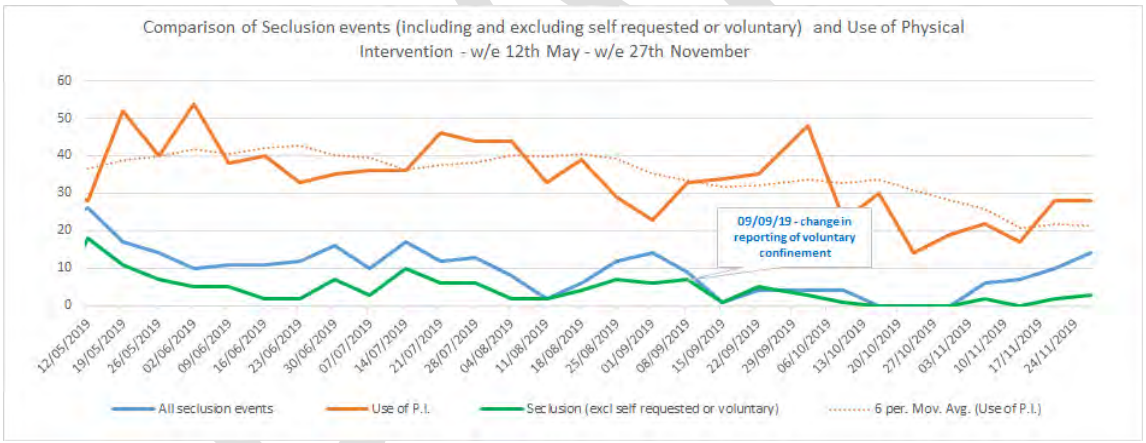
In terms of the length of time seclusion was utilised, the table below details for each patient the length of time seclusion lasted on each occasion by time band. The average seclusion time was 1 hour 55 minutes for the period.

27/11/2019							
Pt. ID.	**<30mins**	**30 mins - 1 hr**	**1 - 2 Hrs**	**2 - 3 Hrs**	**3 - 4 Hrs**	**> 4 Hours**	**Total**
MAH002	0	0	1	2	0	0	**3**
Total	**0**	**0**	**1**	**2**	**0**	**0**	**3**

Daily Seclusion Trend (excludes voluntary confinement)

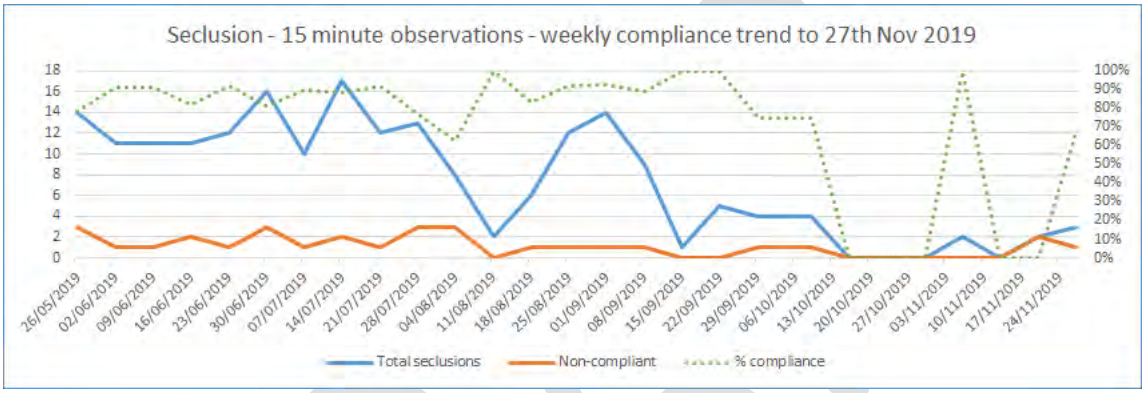


Comparison of Seclusion Events and Use of Physical Interventions



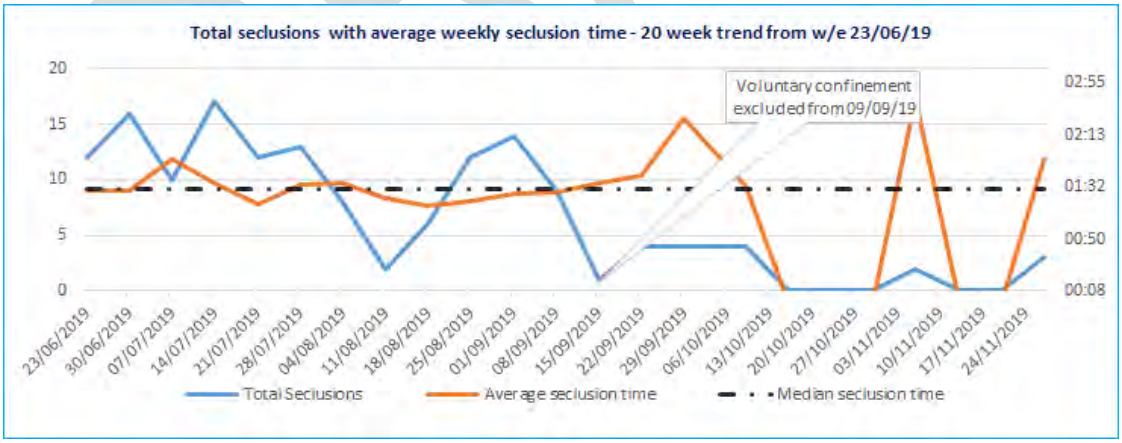
Seclusion Review Compliance

Seclusion Review Compliance - w/e 27/11/19					
Total seclusions	Total Vol Confinement	15 min obs	4 hr medical assess	1 hr medical assess	Issue
3		3 of 3 compliant		3 of 3 compliant	
	11	11 of 11 compliant	-	8 of 11 compliant	1 review within 1hr was 10mins late 1 review within 1hr was 15mins late 1 review did not take place All 3 were OOHS, the on call Dr was not onsite.
3	11	14	NA	14	3



Seclusions with Average Weekly Seclusion Time

The graph below shows the trend of average weekly time in seclusion per seclusion event :



Seclusion Audit– Summary of September and October 2019 Audit Results - full audit results available on request

October 2019
10 seclusion events in October 2019 compared to 107 seclusion events in October 2018

Key Findings

- 4 seclusion events (3 patients)
  - 3 patients secluded in designated seclusion room
- 6 voluntary confinement events (1 patient)
- All seclusions < 4 hours
- 6/10 (60%) seclusion events were recorded by RN within 15 min interval (4/10 - maximum at 10 mins)
- 7/10 (70%) medical review completed within 1 hour
- Of the 3 where medical review was not completed within 1 hour :
  - 2 were voluntary confinement and occurred out of hours

4.7 Complaints

No complaints reported in the period.

4.8. Risk Register Position – August 2019

Risk status - Aug 2019	MAJOR	MODER	MINOR	Grand Total
ALCERT	1	1	1	3
LIKELY	2	1	2	5
POSS		1	1	2
Grand Total	**3**	**3**	**4**	**10**

The 3 major risks on the register relate to staffing levels, bed availability for admission and CCTV viewing. All risks are reviewed 3-monthly or earlier if required.

4.9. CCTV Viewing – Good Practice

Ward	Date and Time	Areas for Further Consideration	Comments
Cranfield 1	25 November 2019 15.00 to 19.00	N/A	-Ward appears calm and relaxed. Two health professional visitors to ward. C33 at 4.20 visiting health professional possibly social worker talking with patient and appears to be filling in form. C33 at 16.58 visiting health professional behind staff base, possibly medical staff. -Staff were observed regularly engaging directly with patients e.g. C29 at 15.06 nurse 1:1 engaging with patient, C25 at 15.11 two nurses engaging with two patients, C25 at 15.50 nurse talking 1:1 with patient seated at table and then escorts them outside the ward? Day care C29 at 16.58 doctor behind staff base talking to nurse. -No MAPA interventions/holds observed. -Student nurse observed assisting patient at meal times C25 at 16.50.

Cranfield 2	24 November 2019 20.00 to 12.00 midnight	N/A	-Staff observed talking 1:1 with patient e.g. C27 at 20:51. -Nurse talking 1:1 with patient at staff base C33 at 21.45. -No MAPA interventions observed/holds observed. -Ward appears quiet, agency staff observed as part of workforce.
Sixmile	21 November 2019 20.00 – 02.00	N/A	-Period of night duty. Visitor to ward around 20.30 nothing untoward observed. Very calm period of observation. Patients watching TV and retiring to bed. -No MAPA interventions observed. -Meal times appeared to have been appropriately managed.
Ardmore	22 November 2019 12.00 midnight to 04.00	N/A	-Period of night duty within Ardmore. Nothing significant observed. Ward appeared reasonably well settled just with same patients getting up from bed. Staff regularly checked on patients with rooms/areas observed. -One patient was up for a period of one hour within the four hour viewing-patient spent some time in activity room observed by staff member. -Patients who appeared restless or agitated during the night appeared to be well attended to by staff.
Cranfield 1	18 November 2019 10.00-14.00	N/A	-Staff observed engaging with patients on a number of occasions in TV room, dining and staff base. -Ward Manager visible on ward on a number occasions during shift e.g. C29 at 10.04 and C29 at 11.06 -No MAPA intervention/holds observed -Ward Manager spending time talking to patients. Specialist Nurse spending time in ward on 1:1 basis with patients.
Cranfield 2	19 November 2019 15.00-19.00	N/A	-Overall ward observed to be very settled and calm environment. Good presence of staff (two un-uniformed staff present engaging with patients). In evening time against attended ward, initially engaging with two patients but one left sessions soon after commencement. -Ward manager very visible during this period. Attended to and stayed with patient who appeared agitated. -No MAPA intervention observed. One other patient observed to be mildly agitated, displacing chairs but situation observed to be well managed.
Erne 2	23 November 2019	N/A	-Very quiet shift only three (with possible four) patients observed C1 at 13.07, two maintenance persons C17 at 11.21 and C13 at 13.52. Visiting relatives C5 at 12.20-All patients appear to be 1:1 observation.

	10.00-14.00		-C9 at 10.00 staff pulled screens around patient who was undressing in view of other patient. C8 at 10.06 staff giving patients breakfast. C4 at 11.10 staff encouraging patient to drink, C4 at 10.01 staff trying to engage patient in activities. -Ward Sister seen on quite a few occasions walking through room, C1 at 10.09, C7 at 10.14, C9 at 10.14, C8 at 12.08, sat with patient and relative conversing for long time C1 at 12.26. -Nutrition is encouraged for all patients-fluids given out at regular intervals.

(5) Operational response - safety briefings per ward, Safety Quality Visits, issues arising from weekly patient/ carer feedback

5.1. Safety Brief
Ongoing on a daily basis on each ward, using agreed template.

5.2. Safety Quality Visits
The Assistant Service Manager has daily walkabouts on the wards. No issues raised.

5.3 Weekly Live Governance meetings ongoing
Chaired by Clinical Director and involving all wards.

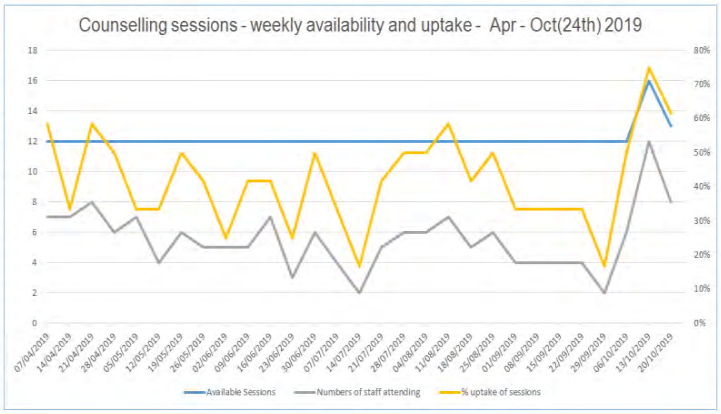
5.4 Monthly ward clinical improvement groups:
These will have a patient safety focus.

5.5 Patient Feedback
Talking mats already used to good effect in the Day Therapeutic Service. In process of being rolled out across all wards.

(6) Service continuity and staffing issues, training levels, induction levels of agency, staff engagement and support, scenario training etc.

6.1. Staff Counsellor Sessions – 12 Sessions offered per week. Apr-Oct (24th) 2019

Week ending (Sunday)	Available Sessions	Sessions Not Used	Numbers of staff attending	% uptake of sessions
07/04/2019	12	5	7	58%
14/04/2019	12	8	7	33%
21/04/2019	12	5	8	58%
28/04/2019	12	6	6	50%
05/05/2019	12	8	7	33%
12/05/2019	12	8	4	33%
19/05/2019	12	6	6	50%
26/05/2019	12	7	5	42%
02/06/2019	12	9	5	25%
09/06/2019	12	7	5	42%
16/06/2019	12	7	7	42%
23/06/2019	12	9	3	25%
30/06/2019	12	6	6	50%
07/07/2019	12	8	4	33%
14/07/2019	12	10	2	17%
21/07/2019	12	7	5	42%
28/07/2019	12	6	6	50%
04/08/2019	12	6	6	50%
11/08/2019	12	5	7	58%
18/08/2019	12	7	5	42%
25/08/2019	12	6	6	50%
01/09/2019	12	8	4	33%
08/09/2019	12	8	4	33%
15/09/2019	12	8	4	33%
22/09/2019	12	8	4	33%
29/09/2019	12	10	2	17%
06/10/2019	12	6	6	50%
13/10/2019	16	4	12	75%
20/10/2019	13	5	8	62%



On average over the 7 month period 7 sessions of 12 each week were unused. Staff also have available Be Well services and Occupational Health – discussions have been initiated regarding what other mechanisms of support may be helpful for staff.

6.2 Information from MAH Senior Nursing Team

Staffing rosters are reviewed daily by Ward Sisters/Charge Nurses, and reviewed collectively at weekly Ward Sister/Charge Nurse meetings in conjunction with senior management team.

(7) Emerging issues

1. The Mews - is currently experiencing a high turnover of staffing at a senior level. They currently have no manager or deputies and have a number of team leaders who have tendered their resignation. Their Service Manager has also left and a new Service Manager has just started in the last couple of weeks. In addition, they employ many agency staff and have 20 vacant posts at support worker level. There have been on-going reports surrounding the quality of the service from individual family members and more recently from a Bryson House Advocate. These reports focus on lack of cleanliness of apartments, poor communication, patients not being supervised as per agreed levels and medication errors. Due to the current high turnover of staff and concern about the complexity of patients and their ability to be managed at the current time, a meeting between senior management in BHSCT and the Cedar Foundation (Mews) has been arranged for 12 December 2019 to discuss these issues.

2. Meeting with RQIA held on Friday 22 November to update RQIA on the Improvement Notice (Nursing) position and seclusion practices.

3. Careful clinical discussions ongoing to agree non-use of seclusion outside the designated seclusion facility. Documentation around this has been discussed. To date, 87% of registrants and 73% non registrants have received Seclusion training.

4. Mental Capacity Act – initial meeting took place w/c 18 November 2019 regarding readiness for implementation. Test case patient was presented to the panel on 28 November and learning shared. Now instituting fortnightly MCA meetings to oversee progress.

5. Christmas rotas – final rotas now available for the Christmas and New Year period such that all teams have a handle on where additional cover is required. This is in a small number of clinical areas on particular days and nights, notably night duty cover on Sixmile Ward. We anticipate being able to maintain safe staffing levels over the holiday period.

6. A meeting is taking place on Monday 2 December 2019 with Marie Roulston in relation to admission pathways for patients in the context of Muckamore Abbey Hospital's staffing constraints which preclude admission.

(8) Media and communications – FOIs, media enquiries etc.

As of 27 November 2019:

- No media enquiries outstanding
- No constituency enquiries outstanding
- No Departmental enquiries outstanding
- No FOI requests outstanding

(9) Finance

Individual financial planning meetings are being arranged with each patient (and family) for each of the patient's identified to have balances over £20k. First meeting took place w/c 18 November 2019. Two further meetings took place w/c 25 November 2019.

(10) Next Steps/forward look – wider strategy update

(11) Other Issues requiring escalation for advice and senior decision making

1. All registered and non registered nursing staff have been made aware of the 15% pay uplift. Clarification is still required regarding a number of queries in relation to implementation – inclusions/exclusions. It is imperative that clarification on this is achieved so that we can deliver this for staff in time for Christmas.

2. SEHSCT and NHSCT have both identified staff who are available to work in MAH. However clarification is still awaited on a number of queries in order for arrangements to be finalised. This cannot progress without formal clarification out to all Trusts.

3. There is a considerable amount of annual leave outstanding for a large number of MAH registered and non registered staff relating to 2018/19. A paper will be tabled at Executive Team outlining proposals for how this could be addressed. Again it would be important to have this addressed prior to Christmas.

Weekly safety report

What does it tell us and what do we need to know

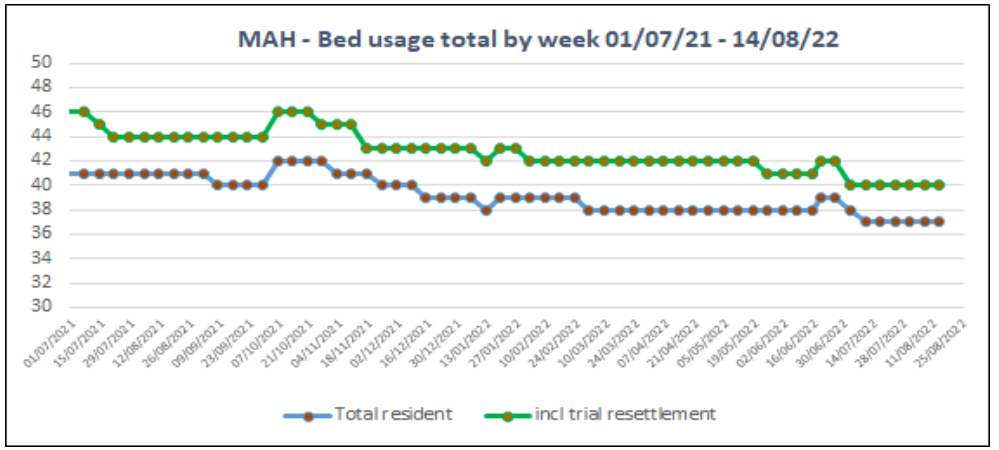
Gaps and analysis need to be added

Rate at which we are reducing bed usage

1.MAH Inpatient Numbers

The number of patients in residence remains at **37.** There are **3** patients on trial resettlement placements, and **1** patient continues on extended home leave at the request of family.

The graph below displays the number of inpatients resident in Muckamore Abbey Hospital and the number of patients on trial resettlement:-



Patients in Muckamore Abbey Hospital by Trust of Residence are as follows : -

Number of individuals on site per trust

Trust of Residence	Number of Inpatients	Number of Patients on Trial Resettlement
Northern HSC Trust	14	1
Belfast HSC Trust	15	1
South Eastern HSC Trust	7	0
Southern HSC Trust	1	0
Western HSC Trust	0	1
Total	37	3

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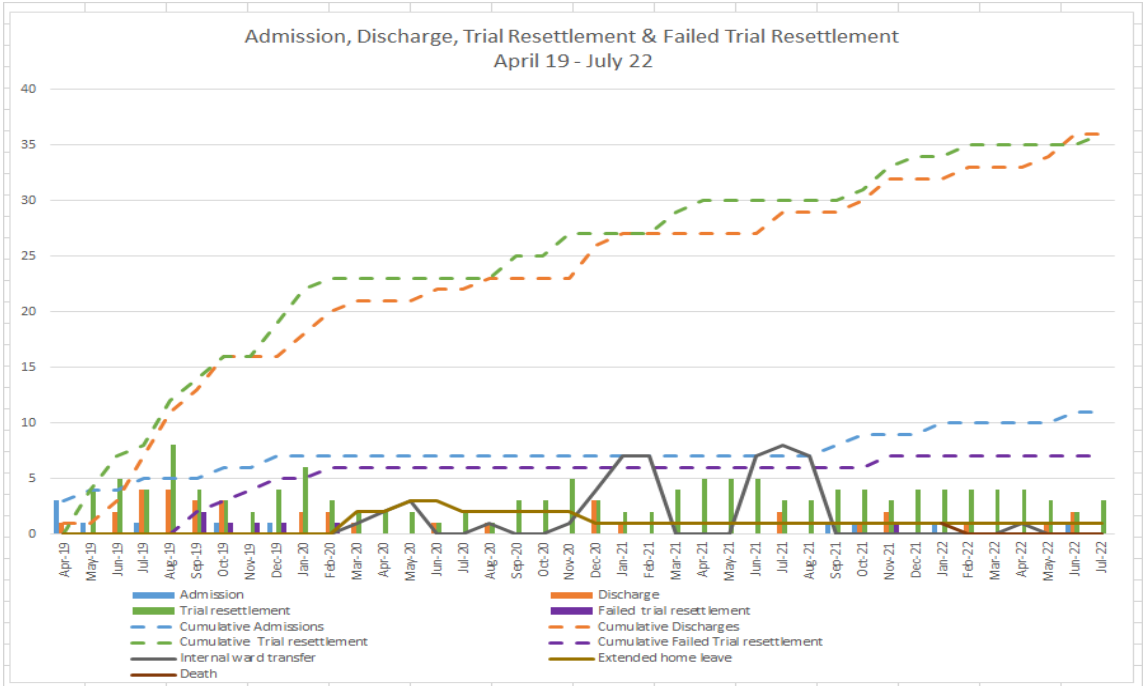
Monthly MAH Admissions, Trial Resettlements and Discharges

The graph below plots the monthly, and year to date, number of patients admitted, discharged, on trial resettlement or having returned from an unsuccessful trial resettlement.



Admission: admitted during month
Discharge: discharged during month
Trial resettlement: pts on TR on last day of month (not included if discharged/failed trial resettlement during the month)
Failed TR: Returned to MAH during the month
Cumulative Admissions: Number of actual patients
Cumulative Discharges: Number of actual patients
Cumulative Trial resettlements: Number of actual patients
Cumulative failed TR: Number of actual patients
Internal ward transfer: No of pts transferred within the month
Extended home leave: Pts on EHL on last day of the month

Rate of Resettlement – 2021/22

The table below shows the year to date position for 2021/2022 :

	2021/22			
	Successful Resettlement - patient discharged	Failed Resettlement - patient returned	Ongoing Resettlement	Success Rate
BHSCT	3	1	1	75%
NHSCT	4	0	1	100%
SEHSCT	0	0	0	-
WHSCT	0	0	1	-
Total	7	1	3	88%

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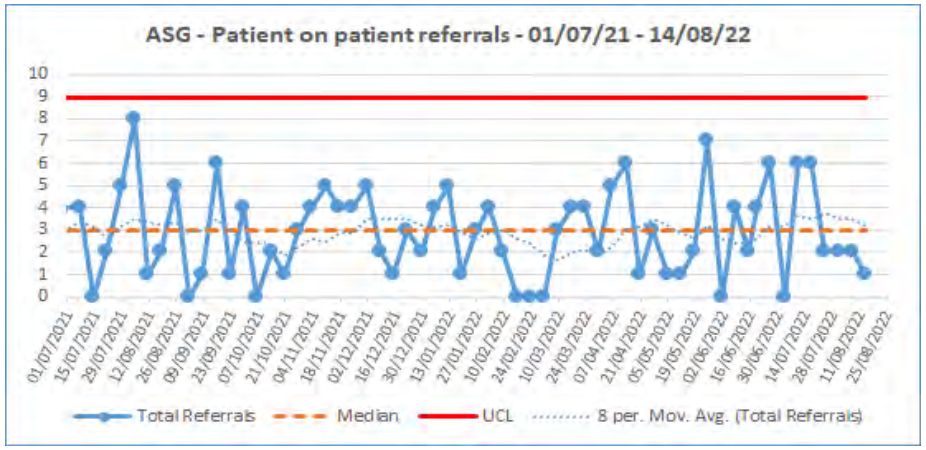
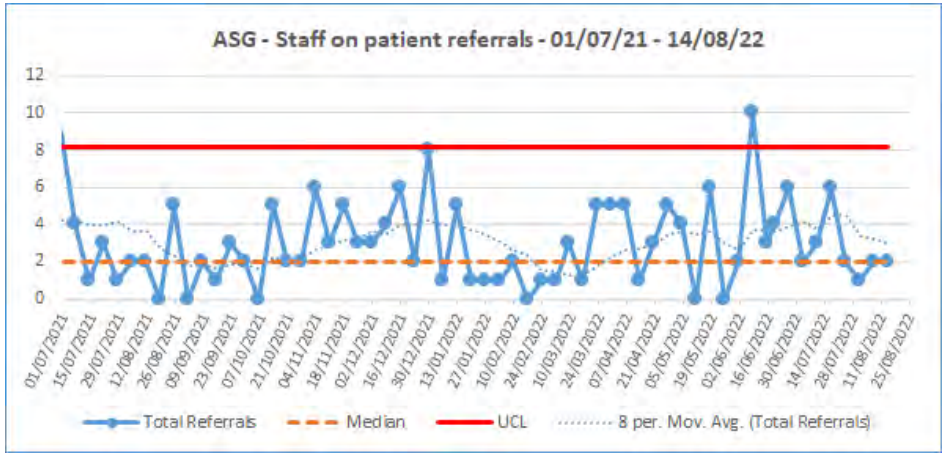
Need to use this better for analysis
Dec & June spikes and what are we doing about it





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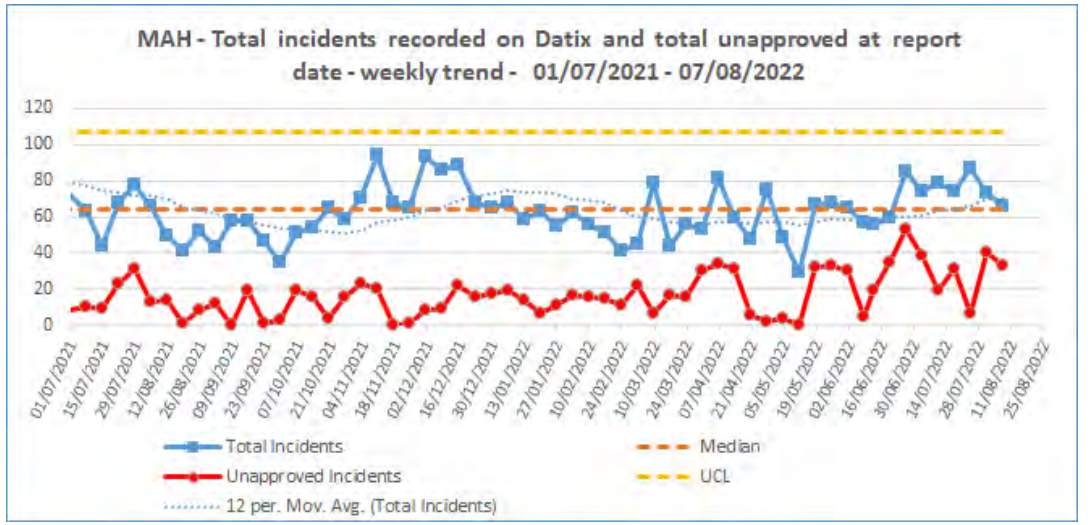
This report is incidents per week since the start of the year but not types or any analysis added at certain points



Incident by type and to whom for the week

Those affected 01/08/2022 - 07/08/2022 (app 16/08/2022)	Patient	Staff	Organisational	Total
Actual self harm	1	0	0	1
Administration to Patient - Administered but drug chart not signed	2	0	0	2
Insufficient numbers of healthcare professionals	0	0	1	1
Choking/Inhalation/Aspiration - Of foods/fluids	1	0	0	1
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm) - Physical	3	0	0	3
Physical contact	1	7	0	8
Physical threat (no contact)	2	3	0	5
Self harm attempt/gesture	8	0	0	8
Stubborn/uncooperative physical behaviour	1	0	0	1
Witnessed Slips/Trips/Falls (includes faints) - Walking unassisted	2	0	0	2
Total	**21**	**10**	**1**	**32**

Severity and location in the week

•**Severity**

The classification of the approved incidents for the period as detailed in the table below.

Incidents by Severity 01/08/2022 - 07/08/2022 (app 16/08/2022)	Insignificant	Minor	Moderate	Major	Catastrophic	Total
Totals:	27	5	0	0	0	32
	84%	16%				

•**Incidents by Day by Location**

Incidents by day of the week - 01/08/2022 - 07/08/2022 (app 16/08/2022)	CF 1	CF 2	Donegore	Killead	Sixmile A	Sixmile T	Physiotherapy Dept	Total
Monday	0	2	0	0	2	2	1	7
Tuesday	0	0	2	1	1	1	0	5
Wednesday	0	1	2	0	0	1	0	4
Thursday	1	0	0	0	0	0	0	1
Friday	0	1	1	0	0	2	0	4
Saturday	0	1	2	0	1	2	0	6
Sunday	0	1	1	1	0	2	0	5
Total	**1**	**6**	**8**	**2**	**4**	**10**	**1**	**32**

Incidents requiring further detail – who decides – what is useful to know?

Incidents by Severity 01/08/2022 - 07/08/2022 (app 16/08/2022)	Insignificant	Minor	Moderate	Major	Catastrophic	Total	% Incidents
Cranfield 1	**1**	**0**	**0**	**0**	**0**	**1**	3%
Actual self harm	1	0	0	0	0	1	
Cranfield 2	**6**	**0**	**0**	**0**	**0**	**6**	19%
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm) - Physical	1	0	0	0	0	1	
Insufficient numbers of healthcare professionals	1	0	0	0	0	1	
Witnessed Slips/Trips/Falls (includes faints) - Walking unassisted	1	0	0	0	0	1	
Physical contact	2	0	0	0	0	2	
Physical threat (no contact)	1	0	0	0	0	1	
Donegore	**8**	**0**	**0**	**0**	**0**	**8**	25%
Physical contact	5	0	0	0	0	5	
Physical threat (No contact)	3	0	0	0	0	3	
Killead	**1**	**1**	**0**	**0**	**0**	**2**	6%
Choking/Inhalation/Aspiration - Of foods/fluids	1	0	0	0	0	1	
Witnessed Slips/Trips/Falls (includes faints) - Walking unassisted	0	1	0	0	0	1	
Sixmile Assessment	**3**	**1**	**0**	**0**	**0**	**4**	13%
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm) - Physical	1	0	0	0	0	1	
Self harm attempt/gesture	0	1	0	0	0	1	
Administration to Patient - Administered but drug chart not signed	1	0	0	0	0	1	
Physical contact	1	0	0	0	0	1	
Sixmile Treatment	**7**	**3**	**0**	**0**	**0**	**10**	31%
Physical threat (No contact)	1	0	0	0	0	1	
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm) - Physical	0	1	0	0	0	1	
Self harm attempt/gesture	5	2	0	0	0	7	
Administration to Patient - Administered but drug chart not signed	1	0	0	0	0	1	
Physiotherapy Dept	**1**	**0**	**0**	**0**	**0**	**1**	3%
Stubborn/uncooperative physical	1	0	0	0	0	1	
Totals:	**27**	**5**	**0**	**0**	**0**	**32**	
	84%	16%					

Useful but needs analysis points over time and patterns

- Medication Incidents
- = **0** medication incidents reported during the period w/e **14 Aug 2022**.
- 3.3 Use of Rapid Tranquilisation during Physical Intervention.
- **= 0** use of rapid tranquilisation reported during the period w/e **14 Aug 2022**.
- 3.4 Use of Prone Restraint
- **= 0** use of prone restraint reported during the period w/e **14 Aug 2022**.
    - Use of Supine Hold
- **= 1** use of supine hold reported during the period w/e **14 Aug 2022**.

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Incidents of Physical Intervention (PI)
There were **16** incidents involving the use physical intervention w/e **14 Aug 2022**, equating to **30%** of all incidents.

1.Incidents of Physical Intervention (PI)
There were **16** incidents involving the use physical intervention w/e **14 Aug 2022**, equating to **30%** of all incidents.

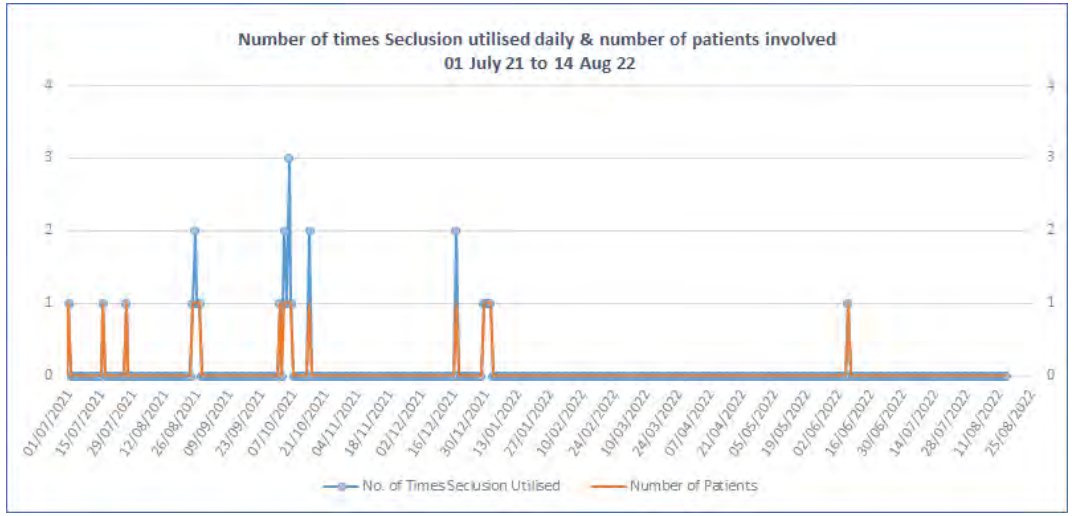
Use of Physical Intervention 08/08/2022 - 14/08/2022 (based on all incidents - approved/not approved 16/08/2022)	NO - None used	YES - Holding only	YES - Disengagement and Holding	Total	No of Patients	Total Use of PI	% Use of PI of Total Incidents	% of ALL Physical Interventions
Cranfield 1	6	1	0	7	1	1	2%	6%
Cranfield 2	9	3	2	14	2	5	9%	31%
Donegore	8	4	0	12	2	4	7%	25%
Killead	5	1	0	6	1	1	2%	6%
Sixmile Assessment	3	1	1	5	1	2	4%	13%
Sixmile Treatment	6	3	0	9	1	3	6%	19%
Total	**37**	**13**	**3**	**53**	**8**	**16**	**30%**	**100%**
	70%	24%	6%				53 = Total Incidents	16 = Total Physical Interventions

Seclusion

Seclusion was Seclusion was **NOT** utilised during the period w/e **14 Aug 2022.**

Daily Seclusion Trend (excludes voluntary confinement)

further analysis has been carried out on seclusion

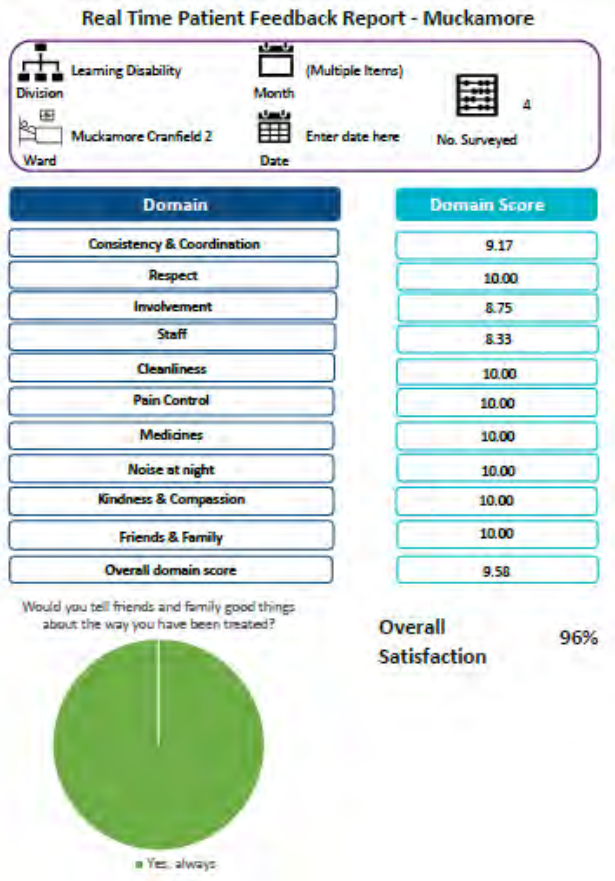


The remaining sections

- Complaints
- Risk register
- CCTV viewing – what do we want to know from this?
- Issues form live governance
- Clinical improvements
- Staffing
- Safety quality visits
- Patient experience feedback

Real Time Patient Feedback

Following development of new tools with staff and Speech and Language Therapy and in conjunction with the MAH Patient Council and TILII to create Talking Mats, the Real Time Patient Feedback Team come to the Hospital every 2 weeks. The combined 7 July and 4 August 2022 is below



- Next steps
- Actions

Report on Listening Groups Muckamore Abbey

Background

At the inaugural meeting of the Muckamore Task and Finish Improvement Group, the acting Head of Learning Disability Services commissioned a series of focus groups / listening sessions for staff. The purpose of the groups was to provide staff with a confidential forum to discuss any issues of concern.

The focus groups were facilitated by:

Jacqui Austin (JA), Senior Manager for Service Improvement and Governance

Aisling Pelan (AP), Senior Manager Nursing Workforce

Brenda Armour (BA), Administration Manger Muckamore Abbey.

Methodology

The invitation to participate in the focus groups was extended to all staff working within ward environments in Muckamore Abbey Hospital, including medical staff, nursing staff, professions allied to health and patient and client support staff. Early morning sessions were scheduled to facilitate night staff attendance. The focus groups were scheduled to take place in a room outside the ward environment but when staffing challenges posed difficulties with staff release the facilitators held the sessions at ward level. .

There were several “open sessions” to accommodate the Multidisciplinary team and these were held in central locations.

The purpose and details of all sessions were communicated widely by email.

Staff were assured at the beginning of each session of confidentiality, they were provided with an explanation of the “rules” of the group and were informed of how the process would feed into the task and finish group.

Rather than create multiple questions the facilitators created three very generic opening questions, used to open the conversation.

- What motivates you to come to work?
- What frustrates you about working here?
- What ideas do you have to make things better?

The structure of each session was the same with either Jacqui Austin or Aisling Pelan facilitating the conversations and Brenda Armour recording notes.

Findings

The positive comments in response to the first question indicated a very clear passion staff had for working with Learning Disability patients and an enjoyment of working within their own specific team. Where there was clear leadership it was evident that this impacted on the whole team and this was referenced in discussions. Where there are vacant posts there was concern expressed. Most people who participated had relatively long working careers in Muckamore, and were passionate about it and saw it as “a good place to work”. However, there was quite a bit of reflection on how things “used to be”, it was difficult to get people to expand on when and what the changes were but for the most part the changes in recent years were not seen as positive.

There were very clear themes emerging from all the sessions:

The impact of staff shortages

This was clearly articulated in all areas and had a definite impact on various aspects of working in Muckamore.

The staff related that quite often they do not get adequate meal breaks, as there is not enough cover to allow staff away from the ward.One staff member told us that she completed a 13-hour shift and at the end of it, she brought her breakfast, lunch and tea home with her. Another staff member reported staying on for more than 3 hours after the end of a long day to deal with a particularly challenging situation, not leaving until almost midnight. She requested to come in later the next morning and was asked by management how she would make the time up.

Many of the staff mentioned that one of the most frustrating parts of staff shortages was that patients did not get the opportunity to go on outings. Reference was made to the lack of equity for patients regarding outings – some wards seemed to regularly have outings for patients cancelled while others did not.

When there are staff shortages the wards are not in a position to release staff for training resulting in cancelled training sessions and poor compliance with mandatory training. The staff also expressed concern that reduced staffing levels made them feel that they didn’t get the time to care for patients as well as they would like to.

Staff training and Professional Development

There is no career pathway within LD nursing – if nurses don't "go into management" there are limited opportunities for professional development.

Staff are having to leave Muckamore in order to develop. Many staff have left recently to undertake Health Visiting training and many have left to take up posts on 'general' wards within the Ulster Hospital.

Muckamore was not perceived by the staff as a place for career progression.

The training of student nurses was highlighted as an issue. It was related by a Band 6 that a new registrant had joined the ward having never completed a hospital ward placement during her training. This new registrant left within a short timescale.

Linked in with this is the fact that some wards have poor experience mix, with too many inexperienced staff starting in one area at the same time.

The disconnect between ward staff and senior management

All wards mentioned that until recently and with the exception of one person, senior managers are not visible on the wards and only appear when there is a problem. Staff perceive that there is a blame culture rather than a culture of support or leadership. There were comments that there is a notable difference in how things used to be, which was leading to a feeling of "them and us".

One person stated that there is a basic lack of respect and courtesy, referring to the fact that they had sent a senior manager an email to raise concerns and did not get a reply.

One member of staff stated they did not feel comfortable expressing concerns because they had previously been told, "bring me solutions not problems".

In most wards, at least one person stated that they did not feel valued. We had specific examples of staff going the extra mile yet they received no recognition or expression of appreciation from managers.

Staff Support

In Muckamore, there is a very obvious physical demand on staff when dealing with challenging behaviour. This can often involve the use of physical restraint for a prolonged period and require huge mental and physical effort on behalf of the nursing staff but staff are not offered "timeout" to recover from their ordeal. They are just expected to get on with it. Staff do not feel that the Zero Tolerance of Abuse policy is working in Muckamore.

Staff referred to the lack of support received during investigations, particularly when they are placed on precautionary suspension.

The process of staff "being moved" from ward to ward.

The movement of nursing staff between wards caused anxiety at all levels among the nursing staff. There were two different processes discussed: the permanent staff transfer process within Muckamore (1) and the movement of staff on a day-to-day basis to provide temporary cover (2).

(1) There is a staff transfer process within Muckamore whereby nursing staff can be moved on a permanent basis to another ward. This was referred to by many of the participants. The staff being moved are not involved in the decisionmaking process and there is no opportunity to discuss the reasons for the move. Some staff referred to inequity, with some staff having to move on many occasions during their career while others have never had to move. One member of staff recounted how they were just phoned at home before their next shift and told they are being moved to a new ward the next day. Another staff member spoke about being moved 7 times in 11 years. This process of moving made staff feel very undervalued.

(2) Staff regularly move from their ward to provide cover in other wards. It appears to staff that particular wards are targeted in relation to this while other wards never have to move staff. This is particularly frustrating for staff when they offer to do additional hours (bank shift) to provide cover for their own ward and when they arrive in work they are told to move to another ward.

The system currently in place for ward staff covering the nursing office

Many staff referred to the current system of "covering the nursing office" both within core hours and out-of-hours. The staff questioned the need for cover in core hours as there is a person appointed to that role specifically. Staff also felt the governance with this arrangement is flawed, e.g. a Band 7 working a shift on her own ward may have to report concerns to the office and the person covering the office could be the Band 6 from that ward.

The Cosy Corner

The Cosy Corner was referred to by many staff when recounting how much better things were in previous years, with great food and ambience provided in days gone by. Staff now felt the choice of food on offer is not of good quality nor does it provide value for money and said that it was much cheaper to drive to a local garage and purchase a sandwich.

The Roster

There were a number of issues highlighted in relation to the roster. Staff referred to not receiving their offduty in enough time each month and the limit in the number of requests that they are allowed to make. These issues affected their work/life balance. There was reference made to unfairness and inequity between the application of roster rules with some wards seeming to have more control of their offduty than others. Staff felt that it was helpful to have more information on how the roster works as a result of the work of the roster team.

Information Technology and Infrastructure

Staff recounted limited access to computers and the slowness of the PCs. This had a particular impact on e-learning.

There were other issues raised by a minority of staff that do not fit into the categories above such as the amount of administrative work and having to record so much onto electronic systems such as PARIS

Conclusion

Overall staff were welcoming and very receptive of the process. The staff who took the opportunity to attend the sessions engaged well with the facilitators and had a very clear idea of what they wanted to say.

There was excellent participation from the core ward/daycare staff (both from registered and unregistered nurses and daycare workers and from patient client support services) and from a small number of medical staff and AHPs. There was no engagement from senior management.

Flawed communication and engagement processes within Muckamore have resulted in staff feeling unsettled and undervalued. While there were examples of excellent nursing leadership reported, with particular reference to 2 individuals, there is generally a perceived lack of nursing leadership within Muckamore Abbey Hospital .

During the focus sessions, we had the opportunity to ask staff who were just about to leave why they were leaving and the two most common answers were staff shortages and better career opportunities elsewhere. We asked staff for ideas on things that would improve their working lives and all ideas centred on recruitment and retention, with a resulting effect of enabling patients to get out more and support their recovery. It is recommended that consideration be given to ways of maximising recovery plans for patients.

There is an obvious need for recruitment of new staff and investment in and support for current staff to stabilise the workforce to prevent burnout. A workforce and education plan for Muckamore Hospital should be developed to support this.

Staff also mentioned that they would welcome more support when dealing with traumatic events and would really appreciate some recognition for their work.

There was recognition that the presence of the new Head of Learning Disability Services has brought positive change, which was very welcome

Recommendations

ACTION	BY WHOM
Recruitment and Retention/Workforce and Education Plan This must be a priority for the whole site. When staffing levels are adequate it will ensure that staff do not reach burn out as quickly as is apparent at the minute	Senior staff
Recognition policy. Muckamore is a relatively small environment and when there has been challenging situations eg a particularly unsettled patient or an RQIA visit staff should be recognised for their contribution.	Senior management
Team building across the site At present there is a feeling of “them and us”. Team building and focus on the development of a collective leadership culture should help restore relationships. The “smiley face” machine would be a good way to identify priority areas	Senior Management
Dedicated staff for the nursing office There should be dedicated staff for the nursing office to enable Ward Sisters and Charge Nurse to focus on the provision of supervision, leadership and support within their teams.	Senior management

Stabilising the workforce While it is recognised that there will be occasions when staff may need to be deployed to other areas to provide safe levels of nursing care, it is important that this is done in a fair and equitable way. It is recommended that there is a review of the process relating to the permanent movement of staff and that there is full engagement with the teams and individuals affected.	Senior management
Improved communication site wide The geographical layout and relatively small size of Muckamore could enable positive teamwork and effective communication and there should be immediate attention to the development of these within a culture of collective leadership. Initiatives such as an onsite newsletter, a suggestion box in the admin office that staff can use to suggest improvement ideas, monthly meetings with Head of Service for ward sisters/charge nurse and a professional nurse forum open to all levels of nursing for shared learning and training should be explored.	Senior Management

Appendices

Appendix 1 – Questions used for the focus groups

Appendix 2 – typed notes from the focus groups

Appendix 3 – Timetable of focus groups

Listening Groups

Muckamore Abbey Hospital

Background

- At the inaugural meeting of the Muckamore Task and Finish Improvement Group, the acting Head of Learning Disability Services commissioned a series of focus groups / listening sessions for staff. The purpose of the groups was to provide staff with a confidential forum to discuss any issues of concern.
- The focus groups were facilitated by:
- Jacqui Austin, Senior Manager for Service Improvement and Governance
- Aisling Pelan , Senior Manger Central Nursing Workforce team
- Brenda Armour, Administration Manger Muckamore Abbey.

Methodology

- The focus groups were held in all wards and accommodation was made for night staff. Where possible the staff were invited to a room outside the ward environment away from patients. However, there were occasion when the facilitators had to go into the ward because of staff shortages.
- There were several “open sessions” to accommodate the Multidisciplinary team and these were held in central locations.
- All sessions were “advertised” widely by email.
- Staff were assured at the beginning of each session of confidentiality, provided with an explanation of the “rules” of the group and informed of how the process would feed into the task and finish group.
- Rather than create multiple questions the facilitators created three very generic opening questions, used to open the conversation.
- What motivates you to come to work
- What frustrates you about working here
- What ideas do you have to make things better
-

Task and Finish Group

Listening Sessions

- **What motivates you to come into work?**
- **What frustrates you about working here?**
- **What ideas do you have to make things better?**

What motivates you to come into work?

- Enjoy work, meeting people, no day the same, made to feel part of the nursing team.
- Particularly fond of patients.
- Since Band 6's appointed, starting to see improvements i.e. staff are being listened too, opinions respected
- A good staff team
- Care for patients
- Really enjoy work – good team, good atmosphere, feel valued, encouraged to discuss and challenge, asked what do you think? , allowed to take a lead. Recently involved in a project – thoroughly enjoyed this project also included involvement from the patients, great support from Ward Consultant and staff team – resulted in less incidents on the ward.
- Chose Learning Disability Nursing as a career
- Change in Ward Manager – for the better
- The job is rewarding.
- This is a good place to work – good atmosphere, good staff team and manager
- Love for learning disability and the hospital

What Frustrates You about Working Here?

- Staffing levels (never get keeping numbers always working down)
- If a ward has their full complement of staff, staff are then taken away to work in other wards.
- Staff Shortages – not only nursing staff but psychology and medical staff.
- When you have specifically come on duty to help your own ward then taken away to work in another.
- If you are on a ward that you like and enjoy there is always the uncertainty that you won't get staying.
- Ward changes – staff feel dictated too, just told they are moving. (eg a staff moved 7 times in 11years)
- Staff changes impact on patients – no stability for patients
- Too many inexperienced staff starting at one time.
- Length of time it takes to get a new start actually onto the ward.
- The better you are at your job the more you are given to do.
- A lot of recording for Band 5's i.e. PARIS, not enough laptops.

What Frustrates you about Working Here?

- E-rostering is a reason why people are leaving i.e. only having 4 requests a month (used to be 2 a week possibly more) relying on other staff to swap with you.
- Not enough support for staff from Senior Management
- Dealing with aggression and verbal abuse daily - some staff are reaching breaking point, mentally and physically draining.
- Delayed Discharges (seeing patients ready for community but no places available)
- Amount of paperwork to be completed takes away from time spent interacting with patients.
- No medical or GP cover
- Not feeling valued.
- Don’t always get breaks e.g. have taken breakfast, lunch and dinner breaks home again. Can’t leave the ward environment.
- Unsafe staffing levels
- No beds for new admissions

What Frustrates You About Working Here?

- Zero Tolerance Policy doesn't work here.
- On a constant for a 13hr shift
- Not enough support services staff
- Held accountable 'blame culture', never told when you have done good.
- Management out of touch with wards and what is going on – no recognition of challenges faced daily.
- If involved in physical restraint for a period of time this can be particularly draining. No time out given afterwards, just expected to get on with things.
- Role of Ward Manager has changed – so much admin work to complete i.e. (HR role) also can work as a band 5 because of staff shortages.
- People leaving – a lot of experienced staff also a lot of good young new nurses
- Appears to be a gap between Ward Managers and Management

What Frustrates You about Working Here?

- A job at Muckamore Abbey was always a hard job but appears to be being made harder.
- Ward Managers feel the best support they get is from their Ward Consultant
- Lack of basic courtesy and respect e.g Consultant sent email to Senior Manager re a particular issue and never received a reply.
- Everyone likes praise e.g. good RQIA report received, praise from direct line manager forthcoming but no recognition from Senior Management.
- Don't have enough time to care for our patients.
- Frustration e.g. 2 x Band 6 nurses allocated to each ward but lost Band 5's
- Duty Officer's role - recruited for duty officer but Band 7's still have to cover, periodically Band 6's have to cover at weekends. Eg. Band 6 covering nursing office and a Band 7 has to report to them.
- Made to feel like a moaner if highlighting problems 'Bring me solutions not problems'
- Not enough Speech & Language sessions
- Not enough Occupational Therapist sessions
- Not always feeling part of the MDT because not on site everyday.
- PARIS system
- No paper files makes finding historical information difficult.
- Block on annual leave requests over the Christmas period in some wards not all.

What Ideas Do You Have to Make Things Better

- Try to keep experienced staff.
- Preceptorship for newly qualified staff
- Staff should have experience of working with lower ability first before being moved into wards with higher ability patients.
- Breaktimes – 30mins for lunch, 30mins for tea on a 13hr shift not enough.
- Having enough staff to allocate to take patients out on social outings
- Less staff changes
- Good management team – happy staff
- Permanent contracts

What Ideas do You Have to Make Things Better

- When being moved to another ward would value being told personally. (e.g. a staff was on annual leave and received a phone call to say that when they returned they were to report to another ward).
- Someone impartial to be available to support staff who are involved in investigations.
- More support for staff who have been involved in traumatic incidents
- Great to have the capacity to take patients out
- More IT equipment – not enough computers, also systems are very slow
- Getting a thank you
- More Speech & Language input
- More Occupational Therapy input
- More training – protected time for training
- Improvement felt more recently as the Head of Learning Disability Services is on site their presence is felt very beneficial.

Findings

- The Impact of Staff shortages
- The disconnect between ward staff and senior management
- The process of staff being moved from ward to ward
- Poor recognition or acknowledgement of staff by senior management
- Covering the Nursing Office
- The Cosy Corner

Conclusions

- Overall staff were welcoming and very receptive of the process. The staff who took the opportunity to attend the sessions engaged well with the facilitators and had a very clear idea of what they wanted to say.
- There was excellent engagement from nursing staff and only a fair engagement from medics and AHPs. There was no engagement from senior management.
- It is very apparent that there has been a lack of communication at all levels and in all ways in Muckamore, this has resulted in staff feeling unsettled and undervalued.
- There is an obvious need for recruitment of new staff and investment in current staff to stabilise the workforce. Staff do not appear to have proper meal breaks; this will undoubtedly lead to “burnout”.
- We asked staff for ideas to improve their working lives and all ideas centred on recruitment and retention, which would allow patients to get out more. Staff also mentioned that they would welcome more support when dealing with traumatic events and would really appreciate some recognition for their work.
- There was recognition that the presence of the new Head of Learning Disability Services has brought positive change, which was very welcome

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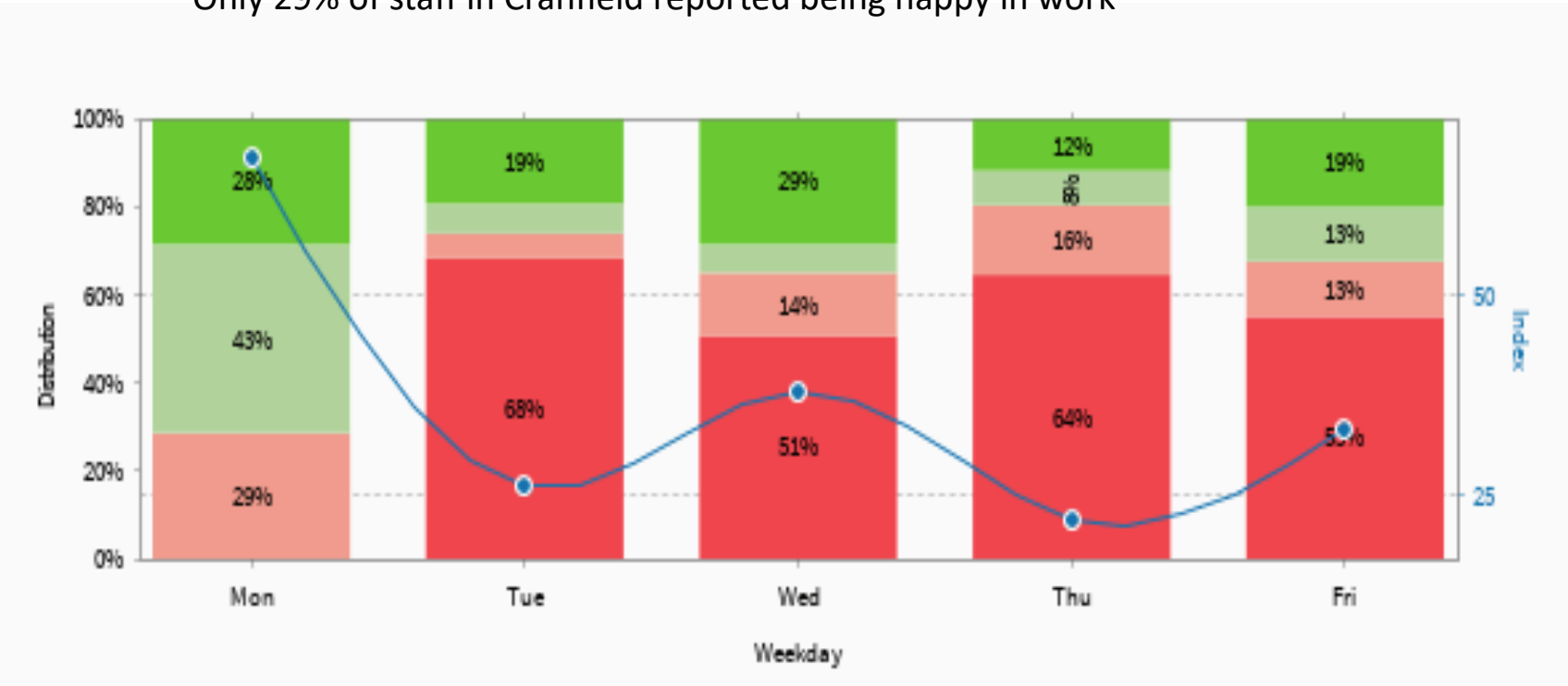
Only 29% of staff in Cranfield reported being happy in work



Recommendations

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Stabilising the workforce While it is recognised that there will be occasions when staff may need to be deployed to other areas to provide safe levels of nursing care, it is important that this is done in a fair and equitable way. It is recommended that there is a review of the process relating to the permanent movement of staff and that there is full engagement with the teams and individuals affected.	Senior management
Improved communication site wide The geographical layout and relatively small size of Muckamore could enable positive teamwork and effective communication and there should be immediate attention to the development of these within a culture of collective leadership. Initiatives such as an onsite newsletter, a suggestion box in the admin office that staff can use to suggest improvement ideas, monthly meetings with Head of Service for ward sisters/charge nurse and a professional nurse forum open to all levels of nursing for shared learning and training should be explored.	Senior Management

	What has or is happening?	Further Action/Questions	Time scale	Responsibility
Staff shortages and the use of agency staff.				
Staff reported that sometimes wards were working with only 50% of the staff requirement. *This is linked to the 2017 finding number 1. That a recruitment and retention/ workforce and education plan must be a priority for the whole site. When staffing levels are adequate it will ensure that staff do not reach burn out as quickly as is apparent at the minute.* *Also linked to the 2017 finding number 5 in relation to stabilising the workforce: while it is recognised that there will be occasions when staff may need to be deployed to other areas to provide safe levels of nursing care, it is important that this is done in a fair and equitable way. It is recommended that there is a review of the process relating to the permanent movement of staff and that there is full engagement with the teams and individuals affected.*	Staffing levels & stabilising the workforce The nursing model was developed in conjunction with a Telford exercise to identify the staffing requirement to manage the existing patient population in MAH. Observations are reviewed at PiPA and then the nursing model is updated. The nursing model is reviewed weekly and reported on to senior management and stakeholders in DoH. The OOH Co-Ordinator reviews rosters for the following day and then there are daily conversations between the ward sisters/charge nurses and ASMs where there are gaps staff are asked to move to those areas of need. Staff allocation sheets are maintained to make sure there is equitable movement. Any longer terms moves/promotional moves have been undertaken using the interview process. A report that wards are working with 50% of the staff requirement is not accurate. Back fill against the model is generally higher than 90% across the site. Sept 2019 Senior nurse Advisor Francis Rice was appointed to support MAH site.	Staff need to see the nursing model and understand how staffing levels are determined. The nursing model and backfill should be available for staff. Ensure SNA and RNs are represented at PiPA Work needs to be done to show the effects of continued resettlement on the staffing requirement for the existing patients population Admission and Treatment beds are required to be determined (numbers and location and whether we are a regional/semi regional/ trust only service) This will inform a future workforce plan. A training needs analysis is required to inform th		SM/ASM/Ward Sisters/Charge Nurse

	2019 Nov 2019 DoH agreed 15% uplift to salaries to provide an "incentive" to staff working directly with patients. Nov 2019 DoH requested each Trust release 5 wte band 5 to work in MAH. This was not as successful as predicted with less than 5wte staff in total being released. The DN and ASM have been involved in early discussions for "Delivering Care phase 9 Learning Disability inpatient settings". Work on hold due to COVID-19 DN reports on workforce to Deputy Director of Workforce and Exec DON. We are currently supporting 3 OU students with a further 7 staff starting their OU nursing course in Sept 2020.			
Staff noted that the use of agency staff brought its own problems. They noted that if a patient became challenging and required intervention, the agency staff would stand back and expect the permanent staff to intervene, stating that they did not know the patient. This would happen regularly, even when they had been working in that ward for several month and despite the fact that the permanent staff might be new to the ward. *This is linked to the 2017 finding number 3: <u>Team building across the site</u> At present there is a feeling of*	Some of our agency colleagues have worked with us more than one year and are likely to be required to support MAH for at least another 12 months. Regular PiPA meetings were established early 2019 giving all members of the team to have a team focussed approach to care of patients. This ihs been reviewed favourably. Clinical Improvement groups had been established in 2019 which were an opportunity for the MDT to reflect	Are the roles of the staff who have been working with us via the agency clearly understood? Are there incident debriefs where each persons role is reviewed? Are all staff MAPA trained? Has this view been addressed with our agency colleagues and		SM/ASM/Ward Sisters/Charge Nurse

"them and us". Team building and focus on the development of a collective leadership culture should help restore relationships. *The "smiley face" machine would be a good way to identify priority areas*	on specific concerns they may have as a team. These have been stood down due to COVID 19 Reflective practice sessions were in place from 2019 but stood down due to COVID-19. Collective leadership team has a presence on site (Co-D and Clinical Director and Divisional Nurse) ASMs and SM and DN have been undertaking walk arounds and listening to staff. Staff meetings organised with TU involvement. Engagement with TUs, who have an office on site which is manned 1xweekly. Listening event organised (which resulted in this action plan) March 2020 We have not placed a smiley face machine on site.	with the nurse bank team? How are our agency colleagues integrated into the teams? Engage with agency colleagues. Find out how long our colleagues have worked with us. Can we reinstate the Clinical Improvement groups/reflective practice sessions?		
Staff felt that the agency staff, who were employed and paid as nurses, were only working as HCA and did not contribute to nursing duties leaving additional hardship and stress on the permanent nurses.	In order to maintain safe staffing levels RNLD/RNMH agency staff are used to provide levels of observation. Levels of Observation is an RN task which can be delegated to a Senior Nurse Assistant. We are in process of recruiting permanent RNLDS and SNAs through our revised MAH band 5 & Band 3 rolling adverts.	Is this in relation to Levels of Observation? Have our agency colleagues been through the competency frame work? Are the agency staff who are "block booked" on the various IT systems?		SM/ASM/Ward Sisters/Charge Nurse

In one particular ward, when a patient required to be specialled, staff were expected to stay with that patient for their entire shift; they would only be relived for their breaks. Staff found this to be mentally draining. Staff were aware that in other wards a rotational system was in place, where staff would only be expected to remain with the same patient for two and a half hours before being rotated to another patient. Staff felt this was more productive and they got to know all the patients in the ward. In this same ward, staff advised that it is the patients who dictate which staff care for them. If the patient doesn't like a certain member of staff or a certain type of staff they refuse to be cared for by them. This poses problems for staff rotation, shift cover and knowledge of patient's care plan.	Staff are allocated to specific patients on a shift by shift basis. This is to maintain the levels of observation that have been put in pace following	Are some clinical areas doing things slightly differently, can there be standardisation or is this due to a person centred approach? What is the therapeutic value for the patient? How is this being communicated to staff? Are staff clear about why they are working with a particular patient and what activities are the staff able to do with the patient? How are staff allocated? Are staff rotated through the shifts? Are the staff getting breaks? How are we ensuring that the patient has time to become familiar with staff?		Ward Sisters/Charge Nurse
In a number of wards in MAH, Positive Behaviour Support Programmes are used for patients who have challenging behaviour. However, in one ward, no such programmes are used. This has resulted in staff getting hurt and patients continuing with their behaviours without challenge. Staff felt that they were no longer in a position to challenge		Can we identify the gaps for this particular ward area? How have PBS programmes been rolled out? Is this be part of induction?		SM/ASM/ Psychology/ Behaviour Team

patients for their behaviour as this could misconstrued negatively on the 'cameras'.				
Disconnect between ward staff and senior management.				
When issues did arise, staff felt unsupported by senior management, who never ask if they are ok or come to the ward to see them. This is linked to *2017 number 4:* Dedicated staff for the nursing office There should be dedicated staff for the nursing office to enable Ward Sisters and Charge Nurse to focus on the provision of supervision, leadership and support within their teams.	Senior Management on site consists of Ward Sisters and Charge Nurses, ASMs, SM and the Collective Leadership team (Co-Director, DN, DSW and Clinical Director). A "nursing office" is no longer in existence in MAH. The funding for 3 ASM posts was identified in 2020 and each of the ASMs have a dedicated area of responsibility allowing them to support the Ward Sisters and Charge Nurse and the teams in that area. They also support each other by covering each others area during times of leave. Posts currently being filled by 1 perm post holder, and 2 temporary post holders. Recruitment process to permanently appoint is underway. Ward Sisters, Deputy Ward Sisters, are available on each of the wards usually daily. There are senior nurses who provide cover in the OoH visiting each area nightly and basing them selves where there is the most need (ie: An area that is unsettled) At weekends the ward sisters and Deputy ward sisters identify who is senior nurse on site. T This is supported by a robust Senior Manager/Senior Nurse on call system which can be accessed by the senior nurse on site or the Ooh Co-ordinators. ASMs are based on the wards and are in their clinical areas daily.	Can we clarify who the teams believe are the "Senior management"?		Ward Sisters/Charge Nurse

	The SM is based on site visits clinical areas on average 3-4 times a week. The DN is based on site and undertakes a weekly team call and visits clinical areas 1x weekly/fortnightly. Trade Union colleagues re- established their office on site and are on site 1x weekly to meet staff.			
Staff felt that the cameras are constantly being monitored by senior management, to watch staff's behaviours, but never used to support staff who have just been involved with a patient's challenging behaviour or an incident.	There is contemporaneous CCTV viewing by independent viewers. The policy under which the CCTV viewing is currently being managed, only allows for incidents to be reviewed. There is a CCTV working group set up to review the policy. The group membership is multi-disciplinary and includes a Senior nurse assistant and Ward Sister. The work of this group will involve sending out questionnaires to staff and families to engage their views on how the policy could be updated. The work of the group has currently stalled due to COVID-19.	Questionnaires to be sent out.		
Staff felt that senior management never say thank you, nor do they recognise the contribution of the health care assistants. *This is linked to the 2017 finding number 2 Recognition policy. Muckamore is a relatively small environment and when there has been challenging situations eg a particularly unsettled patient or an RQIA visit staff should be recognised for their contribution*.	Any walk around undertaken by the Divisional team/SM/ASM staff are thanked for their hard work. All the COVID-19 team calls involved thanking people for all of their hard work. These were chaired by Co-D and/or Divisional Nurse. The Weekly newsletter which was operational until April 2020 thank staff for work on site. Including specific newsletters dedicated to the nursing family around International Year of the Nurse.	Do we know how the Senior Nursing assistants wish to be recognised? What are their expectations? Can there be a recognition at the end of every shift?		Ward Sister/Charge Nurse

	On International day of the nurse all members of the nursing family have been recognised and thanked. Treats were delivered to all areas. From October 2019 Staff briefings were held every 2 months. These were led by the Director responsible for MAH, the Co-Director and the DN. Staff were thanked there. The newly appointed Chief Exec visited MAH in her first 2 weeks (early 2020) and met with representatives from all groups of staff and thanked staff for all their hard work. Our DoN has been visible on site until COVID, has had a team call with our nurses and has requested another Team call to talk and engage with staff.			
In one ward, the health care assistants do not have access to the patients care plan, yet they are expected to provide the care.	There had been training for PARIS taken forward l\ate 2019/early 2020 by the NDL and Research/Audit Nurse. This training was impacted by COVID.	We will review all SNA access to care plans to make sure they are able to input to the care plan Reinstate training		Ward Sister/Charge Nurse
It was felt that the learning disability students were not being offered placements in MAH and it was reported that some students had completed their whole training and had never been to MAH.	We accommodate student placements in our clinical areas. There are approx. 25 RNLD nursing students in each yearly intake in QUB. Our Practice education facilitator is regularly on site and we have completed in the early part of 2020 our educational audits. Feedback from students is largely positive.	Seek clarity from our PEF on this statement.		Divisional Nurse

	We are active members of the QUB partnership chaired by Head of School Prof L Marsh. We do have sign off mentors on site and do accommodate student placements. We are also getting ready to implement the new Future Nurse Future Midwife standards. We currently have 7 transition students working on site and are expecting a group of placement 6 student in the next few weeks. We are also supporting 3 OU Year 2 student nurses and are accommodating a further 7 OU students (5 LD pathway, 1 MH and 1 Adult pathway commencing Sept/Oct 2020)			
In general, staff felt constantly on edge. They felt that the negative media coverage of MAH was having an impact on them personally. They felt ashamed to say they worked in MAH due to perceived or actual public reactions.	There is no doubt that the negative press has a huge impact on staff morale which has an impact on retention and recruitment. We have made some inroads into producing good new stories on social media. Also we have linked in with our corporate comms team to make sure that good news stories are "pushed" out by the Belfast trust accounts (Facebook/twitter) in the main. We have also "reported" negative stories on twitter. It's important that staff have an opportunity to safely reflect on the current position in MAH. Reflective practice sessions have been in place on site but there	Re- establish reflective practice sessions. Re- establish Clinical improvement group sessions. Continue to promote stories on social media		Divisional Nurse/SM

	was poor uptake in general. One ward area had been having some success in having reflective practice sessions as a team and the ward teams Clinical improvement groups allowed the MDT to reflect on issues and concerns pertaining to MAH. These sessions have been put on hold due to COVID-19.			
They felt unsure about their own future and about the future of MAH; this was both distressing and worrying for them. This is linked to 2017 finding number 6 Improved communication site wide: The geographical layout and relatively small size of Muckamore could enable positive teamwork and effective communication and there should be immediate attention to the development of these within a culture of collective leadership. Initiatives such as an onsite newsletter, a suggestion box in the admin office that staff can use to suggest improvement ideas, monthly meetings with Head of Service for ward sisters/charge nurse and a professional nurse forum open to all levels of nursing for shared learning and training should be explored.	Communication from the current Health Minister has determined that MAH will not be closing. There needs to be clear direction about what the future plan is for MAH. Staff briefings were being held every 2 months where questions could be asked. These were stopped due to COVID. Weekly Newsletter also stopped for a period of time over COVID Ward sisters & Charge Nurse meeting weekly with SM/DN (stood down due to COVID-19) now reinstated. Leadership walkabouts by ASM/SM to try to engage with staff and gain feedback. Professional Learning Forum x 2 in February 2020 in relation to Legal aspects of record Keeping (facilitated by Rosemary Wilson)	Reinstate Staff briefings. Reinstate Weekly Newsletter Reinstate Professional Forum		Divisional Team

MAHI - STM - 102 - 11764

Belfast Health and Social Care Trust

Local Ref No: _____

GENERAL RISK ASSESSMENT FORM AS REQUIRED BY THE MANAGEMENT OF HEALTH & SAFETY REGULATIONS (NI) 2000 as amended

Facility/Ward/Department: Muckamore Abbey Completed By: Trish McKinney

Date: 28th August 2020 (updated 2nd September 2020 & 7th September 2020) (Names/Titles)

Brief Description of activity, location or equipment: Stabilisation of the MAH workforce

Description of Hazards	Persons Affected by the Work Activity and How	Existing Controls	Likelihood	Severity / Consequence	Risk Rating
A cessation of the temporary 15% incentive may impact on morale and ultimately staffing levels on site due to a reduced ability to recruit and retain staff.	Patient Staff	**Management of risk of immediate reduction to staffing levels due to the cessation of 15% incentive** 1. Staff understand the temporary nature of the 15% incentive. Staff are aware that the 15% will come to an end at the end of October 2020. Ward sisters/Charge Nurse and ASMs have been asked if staff are discussing this and it would appear that staff are not. 2. In the event of an immediate reduction we would refer to the MAH contingency plan to manage the site in the event of significant reduced staffing levels (overview below). • Use of day care staff • Requests to staff on annual leave • Requests recently retired staff • Use of agency staff • Communicate with other Trusts to assist. • Communicate with families. **Staff Morale & Culture & Team work** 1. Listening exercises have been held on site March 2020 to determine; • What motivates you to come into work? • What frustrates you about working here? • What ideas do you have to make things better? (report available) Findings: Staff (N=4) who attended were dedicated and stated that they enjoyed their work, especially when a patient responded well to their treatment. But they were concerned about perceived Staff shortages and the use of agency staff and a perceived disconnect between ward staff and senior management. These findings reflect other findings from a similar exercise in 2017.	2	4	8

Belfast Health and Social Care Trust

Local Ref No: _____

2. Formal staff meetings held in partnership with trade union colleagues. Staff report that they are concerned about the ongoing safeguarding investigation and impact on the site, the future of the site, the management of challenging behaviour from patients, how incidents are followed up, the impact of COVID, the use of CCTV, some interpersonal issues between teams and perceptions as to how agency staff work.
3. We are working closely with HR to plan some sessions around values, team work, resilience and interpersonal working relationships on site
4. We promote good new stories on social media. Also we have linked in with our corporate comms team to make sure that good news stories are "pushed" out by the Belfast trust accounts (Facebook/twitter) in the main. We report false/inaccurate stories on twitter.
5. Clinical Improvement groups were established 2019 which were an opportunity for the MDT to reflect on specific concerns they may have as a team. These have been stood down due to COVID 19 but are in process of being reinstated.
6. Reflective practice sessions were in place from 2019 but stood down due to COVID-19.

Staffing levels & stabilising the workforce

1. The nursing model was developed in conjunction with a Telford exercise to identify the staffing requirement to manage the existing patient population in MAH. See below for Week of 17th August 2020.

	Patient numbers	Plan		
		Reg	Non Reg	Total
Cranfield 1	9	8.96	26.13	35.09
Cranfield 2	8	8.96	34.35	43.31
Ardmore	10	8.96	35.47	44.43
Sixmile	12	16.24	16.8	33.04
Erne	8	8.96	37.7	46.67
Total	**47**	**52.08**	**150.45**	**202.53**

2. Observations are reviewed at PiPA and then the nursing model is reviewed weekly and reported on to senior management and stakeholders in DoH.
3. The OOH Co-Ordinator reviews rosters for the following day and then there are daily conversations between the ward sisters/charge nurses and ASMs where there are gaps staff are asked to move to those areas of need. Staff allocation sheets are maintained to make sure there is equitable movement.
4. Current substantive staffing position in MAH. Correct on 27/08/2020

	Staff in post		
	Reg	Non Reg	
CF1	6.59	14.38	Inc 2 SL and 1 ML

Belfast Health and Social Care Trust

Local Ref No: _____

CF2	5.39	22.95	Inc 6.22 SL and 1 ML
Ardmore	5.64	26.65	Inc 5.12 SL and 2.83 ML
Sixmile	7	11.31	Inc 3.53 SL
Erne	6.2	31.79	Inc 4.78 SL and 0.74 ML
Total	**30.82**	**107.08**	

5. Back fill against the model is generally higher than 90% across the site.
6. Work is underway with e roster team to review all rosters to ensure safe rostering of staff.
7. Work in partnership with Nurse bank to ensure sustainable levels of block booked bank and agency staff.
8. Currently circa 50 block booked agency staff who have been here longer than 6 months.
9. Agreed SLA for further 12 months with Direct Health care nurse agency for up to 50 wte registrant staff (to maintain stability coming into Winter 2020/21).
10. Continue to work to integrate the agency staff into teams.

Stabilisation of Management/Leadership Staff (added in 7th September)

Collective Leadership team

11. Permanent Co-Director appointed and took up post April 2020.
12. Previous Interim Co-Director has been promoted to Interim Director. Her portfolio includes Learning Disability Services. This has provided a level of continuity and support for the team.
13. Permanent Divisional Social Worker in post for circa 3 years.
14. Permanent Clinical Director in post.
15. Interim Divisional Nurse in post for 11 months.

MAH Senior Management team

16. There are 3 fully funded Assistant manager posts. All 3 posts are now recruited to. 1 post the post holder has been in post for circa 2 years. 1 postholder had previously held a temporary post as ASM since January 2020 but was successful in getting the permanent post. A third post has been offered and the new person starts November 2020.
17. We have successfully appointed a day care manager and a deputy day care manager.
18. All Clinical Areas have a permanent band 7 appointed since December 2019.

Belfast Health and Social Care Trust

Local Ref No: _____

Staffing requirements & resettlement

19. Predicted patient population July to November 2020

	End Aug		End Sept		End Oct		End Nov	
Ward	**Inpt No.s**	**Trial Leave**	**Inpt No.s**	**Trial Leave**	**Inpt No.s**	**Trial Leave**	**Inpt No.s**	**Trial Leave**
Cranfield 1	9	0	9	0	9	0	9	0
Cranfield 2	8	0	8	0	8	0	8	0
Ardmore	10	1	8	3	7	4	6	5
Sixmile	12	2	12	2	12	2	11	3
Erne	8	1	7	2	7	2	7	2
Total	**47**	**4**	**44**	**7**	**43**	**8**	**41**	**10**

20. Resettling these 6 patients successfully this will reduce our staffing requirement at MAH by approximately 15.0 wte band 3 Senior nurse assistants.
21. Resettling these 6 patients may allow for an opportunity to review the living arrangements on site to reduce the number of clinical environments to be staffed.

Recruitment

22. New start data from HRPTS indicates recruitment is reduced from last year. This data is for all new starts.

Year	H/C New Starts
2018/2019	46
2019/2020	67
2020/2021 (March to June)	14
Grand Total	133

23. QUB recruitment fair Feb/March 2020 students were aware of the 15% incentive.
24. 8.0 wte band 5 registrant posts were offered in recent recruitment exercises. 5.0wte have taken up post. The remaining 3 cited other reasons than pay for taking posts elsewhere.
25. We continue to have a specific rolling advert for registrants and Senior nurse assistants. A further 6.0wte SNA posts have been offered August 2020.
26. Recruitment underway for additional band 6 staff to improve senior decision making across a higher proportion of the working day.

Managerial/Leadership Support & Communication

Belfast Health and Social Care Trust

Local Ref No: _____

		27. Further increased visibility of Senior Management on site which consists of Ward Sisters and Charge Nurses, ASMs, SM and the Collective Leadership team (Co-Director, DN, DSW and Clinical Director). The funding for 3 ASM posts was identified in 2020 and each of the ASMs have a dedicated area of responsibility allowing them to support the Ward Sisters and Charge Nurse and the teams in that area. They also support each other by covering each others area during times of leave. All 3 posts have been permanently recruited to. 28. Ward Sisters, Deputy Ward Sisters, are available on each of the wards usually daily. 29. There are senior nurses who provide cover in the OoH visiting each area nightly and basing them selves where there is the most need (ie: An area that is unsettled) At weekends the ward sisters and Deputy ward sisters identify who is senior nurse on site. 30. This is supported by a robust Senior Manager/Senior Nurse on call system which can be accessed by the senior nurse on site or the OoH Co-ordinators. 31. ASMs are based on the wards and are in their clinical areas daily. The SM is based on site visits clinical areas on average 3-4 times a week. The DN is based on site and undertakes a weekly team call and visits clinical areas 1x weekly/fortnightly. 32. From October 2019 Staff briefings were held every 2 months. These were led by the Director responsible for MAH, the Co-Director and the DN. 33. The newly appointed Chief Exec visited MAH in her first 2 weeks (early 2020) and met with representatives from all groups of staff and thanked staff for all their hard work. 34. Our DoN has been visible on site until COVID, has had a team call with our nurses and has requested another Team call to talk and engage with staff. 35. Trade Union colleagues re- established their office on site and are on site 1x weekly to meet staff. **Learning and Development** 36. We have a permanent NDL for Learning Disability who supports practice development on site. 37. We are proving opportunities to develop in Quality improvement and a team are undertaking a QI project supported by SQB. 38. There are opportunities to develop skills for example: MAPA trainers, ILS trainers, Peer vaccinators, Positive behaviour work. 39. New roles have been piloted and are in process of evaluation: for example: Behavioural support staff. 40. Students are placed in all clinical areas supported by their mentors and sign off mentors. We are also getting ready to implement the new Future Nurse Future Midwife standards. The Practice education facilitator is regularly on site and we have completed in the early part of 2020 our educational audits. Feedback from students is largely positive. 41. We are active members of the QUB partnership chaired by Head of School Prof L Marsh. There will be a Joint appointment for LD nursing advertised in coming months. 42. We are also supporting 3 OU Year 2 student nurses and are accommodating a further 7 OU students (5 LD pathway, 1 MH and 1 Adult pathway commencing Sept/Oct 2020) **Leavers** 43. Exit questionnaires undertaken with leavers. Highest reason for leaving is determined as location of work closer to home.			

Belfast Health and Social Care Trust

Local Ref No: _____

44. HRPTS data would indicate that the number of leavers has been reduced this year in comparison to last. This data refers to all leavers.

Count of MAH Turnover	Apr-18	Mar-19	April 18 - March 19 Leavers	Turnover %
2018/2019	496	480	78	15.98%

Count of MAH Turnover	Apr-19	Mar-20	Leavers	Turnover
2019/2020	479	470	80	16.86%

Count of MAH Turnover	Apr-20	Jun-20	Leavers	Rolling Turnover %
2020/2021	464	458	6	1.30%

Future workforce planning

45. Communication from the current Health Minister has determined that MAH will not be closing. However there still needs to be clear direction about what the future plan is for MAH/LD services.
46. Senior team involved in strategic meetings
47. Workshop planned by BHSCT senior management team to determine vision and direction for the service.
48. Work planned to review the remaining patients care needs are and whether or not we are working with the appropriate correct model of care.
49. Senior nursing team involved in phase 9 of Delivering care.

NOTE: There are also specific risk assessment forms for specific Health & Safety issues such as Substances Hazardous to Health (COSHH), Display Screen Equipment Self Assessment Form, Manual Handling Risk Assessment Form (which includes Patient & Load Handling) for particular clients or clinical issues.

Belfast Health and Social Care Trust

Local Ref No: _____

Action Plan

Sources of Information / Persons Consulted	Further Action if necessary to control the Risk	Person/s responsible for Co-Ordinating implementation of the Action.	Recommended Timescales	Date Completed	Revised Risk Rating
Brenda Creaney Gillian Traub Tracy Kennedy Catherine Shannon Paula Forrest Owen Lambert Jacqui Austin Francis Rice (Report on Professional Nursing assurance 2019/20) Frances Maguire Rhonda Scott Paul Magowan	**Staff Morale & Culture & Team Work** 1. Plan further listening exercises with staff. 2. Continue with formal staff meetings held in partnership with trade union colleagues *(also referenced in Rice report 2019/20)* 3. Confirm dates for HR Team values sessions. 4. Continue to promote good news stories on social media and with Corporate Comms teams. 5. Re-instate clinical Improvement groups*(also referenced in Rice report 2019/20)* 6. Re-instate reflective practice sessions.	Senior team	Listening sessions dates to be identified by end of September 2020 Date for HR team values sessions to be identified by End of September 2020. Clinical Improvement groups to be re-instated by end of September2020 Reflective practice sessions to be reinstated by end of October 2020		
	Staffing levels & stabilising the workforce & recruitment 1. Continue all efforts to recruit registrants and SNAs. 2. Recruit band 6 Deputy ward sister posts *(also referenced in Rice report 2019/20)* 3. Continue to promote visibility and accessibility of senior team. 4. Fully recruit to the OoH co-ordinators posts to cover weekends *(also referenced in Rice report 2019/20)* 5. Ensure the agency nurses are fully integrated into ward teams *(also referenced in Rice report 2019/20)*	Senior team	Recruitment exercise for Band 6 staff to be commenced September 2020. Recruitment exercise for OOH Co-ordinator staff to be commenced September 2020.		

Belfast Health and Social Care Trust

Local Ref No: _____

	Resettlement 1. Successful resettlement of 6 patients 2. Resettlement oversight group established *(also referenced in Rice report 2019/20)*	Senior team (inc resettlement team)	End November 2020		
	Managerial/Leadership Support & Communication 1. Planned Leadership walksrounds/team meetings. *(also referenced in Rice report 2019/20)* 2. Planned Exec DoN meeting with MAH staff. 3. Re-instate staff briefings & communication *(also referenced in Rice report 2019/20)* 4. Re-instate Newsletter.	Senior team	Leadership walkarounds to be in place by End Sept 2020 Planned meeting with Exec DoN 1st September 2020 Staff briefings to be re-instated Sept/October 2020 Newsletter to be reinstated Sept 2020		

Belfast Health and Social Care Trust

Local Ref No: _____

	Learning & Development 1. Integrate QI into all areas of MAH 2. Fully evaluate the role of behavioural support and determine commissioning of same. 3. Implement the new Future Nurse Future Midwife standards. 4. Promote and support the joint appointment for LD nursing. 5. Continue to support OU progression.	Senior team & Business support	QI projects to be reviewed by end of Sept 2020 Behaviour support role to be reviewed by end March 2021 FNFM standards to be implemented October/Nov 2020. Joint appointment to be advertised Autumn 2020 (QUB responsible)		
	Leavers 1. Continue to monitor exit questionnaires.	Senior team	Ongoing		
	Future Workforce planning 1. Senior team involved in strategic meetings. Clear direction about what the future plan is for MAH/LD services. 2. Workshop planned by BHSCT senior management team to determine vision and direction for the service. 3. Work planned to review the remaining patients care needs are and whether or not we are working with the appropriate correct model of care. 4. Senior nursing team involved in phase 9 of Delivering care *(also referenced in Rice report 2019/20)*	Senior team and Central nursing team	1. Strategic meetings commence in September 2020. 2. Divisional Workshop to be planned by end of October 2020. 3. Representation at Delivering care meetings when they recommence.		

Please ensure that you:

1. Communicate this risk assessment with the staff and others affected by the work assessed.
2. Monitor the implementation of any further action identified.
3. Monitor the continued implementation of existing controls.
4. Revise the Risk Rating when additional actions have been implemented.

Belfast Health and Social Care Trust

Local Ref No: _____

5. Retain this Risk Assessment in your Health & Safety Policy & Documentation folders.
7. Review your risk assessment at least every two years or more frequently if required. In certain circumstances it will be necessary to undertake a new assessment eg. following an Accident/Incident, new legislation/guidance/best practice, changes in work activities/location, new hazards/activities identified.
6. When further action has been identified it is good practice to set a date shortly after measures are likely to be implemented. This will enable you to assess their effectiveness in reducing risk.

KEY TO RISK RATING: Likelihood x Severity/Consequence = Risk Rating

Likelihood	Severity / Consequence
1 Rare	1 Insignificant
2 Unlikely	2 Minor
3 Possible	3 Moderate
4 Likely	4 Major
5 Almost Certain	5 Catastrophic

Risk Rating **(See Risk Management Strategy**
Low Risk (Green) **on Belfast Trust Intranet for**
Medium Risk (Yellow) **Risk Rating Tables)**
High Risk (Amber)
Extreme Risk (Red)

Line Manager Signature _____ **Date** _____

Initial Review Date: _____

Belfast Health and Social Care Trust

Local Ref No: _____

GENERAL RISK ASSESSMENT FORM AS REQUIRED BY THE MANAGEMENT OF HEALTH & SAFETY REGULATIONS (NI) 2000 as amended

Facility/Ward/Department: Muckamore Abbey Completed By: Trish McKinney

Date: 22nd September 2021 updated 29th September 2021 updated 5th October 2021(Names/Titles)

Brief Description of activity, location or equipment: **Stabilisation of the MAH workforce**

Description of Hazards	Persons Affected by the Work Activity and How	Existing Controls	Likelihood	Severity / Consequence	Risk Rating
MAH nurse staffing remains tenuous for the following reasons. • Sickness absence • Low morale • Recruitment/Other Trusts recruitment • Retention • Clarity of purpose of services LD workforce requirement to care for the existing patient population and actual staff in post **Plan** / **Actual Staff in post**	Patient Staff	**In the event of an immediate reduction of staff refer to the MAH contingency plan to manage the site in the event of significant reduced staffing levels (overview below).** • **Use of day care staff** • **Requests to staff on annual leave** • **Requests recently retired staff** • **Use of agency staff** • **Communicate with other Trusts to assist.** • **Communicate with families.** **Patient population** There are 40 patients living on site. Two patients are described as being in active treatment. The rest of the	2	4	

Belfast Health and Social Care Trust

Local Ref No: _____

	Reg	Non Reg	Total	Reg	Non Reg	Total
Cranfield 1	8.96	26.32	35.28	4.8	14.01	18.81
Cranfield 2	8.96	27.25	36.21	3.68	11.9	15.58
Donegore	8.96	18.85	27.81	4.84	25.33	30.17
Killead	8.96	17.92	26.88	6.75	21.71	28.46
Sixmile	16.24	15.68	31.92	4	8.26	12.26
Total	**52.08**	**106.03**	**158.11**	**24.07**	**81.21**	**105.28**

Nurse vacancies (Sept 2021)

Vacancies based on the plan required to care for the existing patient population

	Vacancies (As a % against what is required to deliver th plan)
Registrants:	53%
Non registrant	23%

patients are waiting for their forever homes. The last patient admitted to MAH was in September 30th 2021.

Ward	Inpatients	Trial Leave
Cranfield 1	9	1
Cranfield 2	7	0
Donegore	5	0
Killead	9	1
Sixmile	10	3
Total	**40**	**5**

We have closed Erne ward (significant difficulties staffing this area due to staff shortages and the environment very poor for the care of patients) which has allowed staff movement across site.

Gaps in rotas due to Vacancies/sick leave/mat leave are supplemented with circa 50 wte block booked agency registrants.

Currently circa 20 wte block booked agency staff who have been here longer than 6 months.

Most of the agency staff are mental health trained but circa 8 have RNLD qualifications. numbers of agency staff who are mental health and LD back ground

Working in partnership with Nurse bank to ensure sustainable levels of block booked bank and agency staff. Work continues

Belfast Health and Social Care Trust

Local Ref No: _____

Sick leave (Sept 2021)

	Sick leave (as a% of the actual staff in post)
Registrants:	33%
Non registrant	21%

Maternity Leave (Sept 2021)

	Maternity leave (as a% of the actual staff in post)
Registrants:	4%
Non registrant	3%

with e roster team to review all rosters to ensure safe rostering of staff.

Agreed SLA for 12 months with Direct Health care nurse agency for up to 50 wte registrant staff is being reviewed October 2021 for further 9-12 months.

Back fill against the model is generally higher than 90% across the site.

Continue to work to integrate the agency staff into teams.

The OOH Co-Ordinator reviews rosters for the following day and then there are daily conversations between the ward sisters/charge nurses and ASMs where there are gaps staff are asked to move to those areas of need. Staff allocation sheets are maintained to make sure there is equitable movement.

Observations are reviewed at PiPA and then the nursing model is reviewed weekly and reported on to senior management and stakeholders in DoH.

Area specific work:

<u>Cranfield 1 & Cranfield 2:</u>

There are 1.8 wte band 6 on unplanned & planned sick leave.
Review of Telfords by end of October 2021. E-Roster team to work with the ward managers following Telford exercise

<u>Actions to address:</u>

- Band 8a is based in the area
- Absence is managed in accordance with the trust policy.

Local Ref No: _____

Belfast Health and Social Care Trust

		• There will be a new registrant recruit assigned to Cranfield 1. • We are reviewing our block booked agency staff input. • We will continue to re-advertise for our band 3 and 5 rolling recruitments and will undertake a further band 6 recruitment to try to attract and bolster the numbers across site. **Sixmile** There are 4 BHSCT staff working in Sixmile (1 band 7, 1 band 6, and 2 band 5s). They are supported by circa 1.0 wte bank RNLD and 5.0 wte Band 3. There are also block booked agency staff supplementing these numbers. One staff nurse has handed in her notice and there are unplanned and planned absences now and in the future amongst the others. **Actions to address** • Our band 8a is based in the area • We have placed a temporary band 7 full time in the area. • We have 2 band 6 applicants to be interviewed both of whom will be placed in Sixmile if they are successful at interview in the next 2 weeks. We have a new band 5 RNLD starting in the next couple of weeks. We are reviewing our block booked agency staff input. • Review of Telfords by end of October.E-Roster team to work with the ward managers following Telford exercise • We will continue to re-advertise for our band 3 and 5 rolling recruitments and will undertake a further band 6 recruitment to try to attract and bolster the numbers across site. **Killead & Donegore**			

Local Ref No: _____

Belfast Health and Social Care Trust

- Work has commenced on determining the correct workforce model for the people living in Killead. Steering group has met and there is support from the Central nursing team to develop a model of sub-acute care for this group of patients.

Absence Management

Absence is managed in accordance with the trust policy.

Staffing requirements & resettlement

Predicted patient population November 2021

	End Sept 2021			
Ward	**Inpatients**	**Trial Leave**	Inpatients	Trial Leave
CF 1	8	1	7	1
CF 2	7	0	7	0
Donegore	5	0	5	0
Killead	9	1	8	2
Sixmile	10	3	9	4
Total	**39**	**5**	**36**	**7**

Resettling these 3 patients successfully this will reduce our staffing requirement at MAH by approximately 6.0 wte band 3 Senior nurse assistants.

Admission of patients:

Local Ref No: _____

Belfast Health and Social Care Trust

		We carefully manage and review all admission requests. There are not enough registrants with a Learning disability qualification to manage additional admissions. However this position should be kept under review as there are further resettlements. **<u>Stabilisation of Management/Leadership Staff</u>** **Collective Leadership team** Interim Director appointed August 2021 Permanent Co-Director appointed and took up post April 2020. Permanent Divisional Social Worker in post for circa 3 years. Interim Clinical Director appointed September 2021 Interim Divisional Nurse in post for 2 years **MAH Senior Management team** Permanent Service manager Appointed April 2020 There are 3 fully funded Assistant manager posts. There are 2 ASMS in post. A temporary ASM post is being advertised to cover for the 3rd ASM who is undertaking project work in Community. All but one of the Clinical Areas have a permanent band 7 appointed since December 2019. The remaining Clinical area has a temporary band 7 in post. **<u>Managerial/Leadership Support & Communication</u>** Visibility of Senior Management on site which consists of Ward Sisters and Charge Nurses, ASMs, SM and the Collective Leadership team (Co-Director, DN, DSW and Clinical Director). The funding for 3 ASM posts was identified in 2020 and each of the ASMs have a dedicated area of responsibility allowing them to support the Ward Sisters and			

Local Ref No: _____

		Charge Nurse and the teams in that area. They also support each other by covering each others area during times of leave. Ward Sisters, Deputy Ward Sisters, are available on each of the wards usually daily. There are senior nurses who provide cover in the OoH visiting each area nightly and basing them selves where there is the most need (ie: An area that is unsettled) At weekends the ward sisters and Deputy ward sisters identify who is senior nurse on site. This is supported by a robust Senior Manager/Senior Nurse on call system which can be accessed by the senior nurse on site or the OoH Co-ordinators. ASMs are based on the wards and are in their clinical areas daily. The SM is based on site visits clinical areas on average 3-4 times a week. The DN is based on site and undertakes a weekly team call and visits clinical areas 1x weekly/fortnightly. Trade Union colleagues re- established their office on site and are on site 1x weekly to meet staff. **Recruitment** 3.0 wte band 5 registrant posts were offered in recent recruitment exercises. We continue to have a specific rolling advert for registrants and Senior nurse assistants. Recruitment underway for additional band 6 staff to improve senior decision making across a higher proportion of the working day. Other Trusts recruitment: the NHSCT is opening a 3 bedded unit. They will be recruiting 1.0 wte Band 7 and 2.0 wte band 6, circa 5.0wte band 5 and circa 5.0 wte Band 3 staff on a permanent basis. There is a likelihood that some of these staff will come from MAH. The DN is a member of the steering group for the opening of these beds to ensure that			

Local Ref No: _____

		the NHSCT understands that this depletion of staff may destabilise MAH and need to go carefully. New monies from Delivering care may also attract existing staff with those qualifications and further deplete staff. **Learning and Development** We have a permanent NDL for Learning Disability who supports practice development on site. Recruitment underway for a second NDL (interviews September 2021) We are proving opportunities to develop in Quality improvement and a team are undertaking a QI project supported by SQB. There are opportunities to develop skills for example: MAPA trainers, ILS trainers, Peer vaccinators, Positive behaviour work. New roles have been piloted and are in process of evaluation: for example: Behavioural support staff. Students are placed in all clinical areas supported by their mentors and sign off mentors. We have implemented the Future Nurse Future Midwife standards. The Practice education facilitator is regularly on site and we have completed in the early part of 2020 our educational audits. Feedback from students is largely positive. We are active members of the QUB partnership chaired by Head of School Prof L Marsh. The Joint appointment for LD nursing has been appointed. We are also supporting a total of 14 OU nurse students from our own Band 3 workforce. **Future workforce planning** Communication from the current Health Minister has determined that MAH will not be closing. However there still needs to be clear direction about what the future plan is for MAH/LD services. Senior team involved in strategic meetings Workshop planned by BHSCT senior management team to determine vision and direction for the service.			

Local Ref No: _____

		Work underway to review the remaining patients care needs are and whether or not we are working with the appropriate correct model of care. Senior nursing team involved in phase 9A of Delivering care. **Staff Morale & Culture & Team work** Listening exercises are planned with staff over Autumn/Winter 2021. Formal staff meetings held in partnership with trade union colleagues. Staff report that they are concerned about the ongoing safeguarding investigation and impact on the site, the future of the site, the management of challenging behaviour from patients, how incidents are followed up, the impact of COVID, the use of CCTV, some interpersonal issues between teams and perceptions as to how agency staff work. Support mechanisms for staff who are either directly or indirectly involved in the CCTV investigation are being reviewed formally with Management/TU/Central Nursing and HR. We are working closely with HR to plan some sessions around values, team work, resilience and interpersonal working relationships on site We promote good new stories on social media. Also we have linked in with our corporate comms team to make sure that good news stories are "pushed" out by the Belfast trust accounts (Facebook/twitter) in the main. We report false/inaccurate stories on twitter. Clinical Improvement groups continue Some areas have formal reflective practice sessions.			

NOTE: There are also specific risk assessment forms for specific Health & Safety issues such as Substances Hazardous to Health (COSHH), Display Screen Equipment Self Assessment Form, Manual Handling Risk Assessment Form (which includes Patient & Load Handling) for particular clients or clinical issues.

Belfast Health and Social Care Trust

Local Ref No: _____

Action Plan

Sources of Information / Persons Consulted	Further Action if necessary to control the Risk	Person/s responsible for Co-Ordinating implementation of the Action.	Recommended Timescales	Date completed	Revised Risk Rating

Belfast Health and Social Care Trust

Local Ref No: _____

Brenda Creaney Gillian Traub/Moira Kearney Tracy Kennedy Paula Forrest Owen Lambert Francis Rice (Report on Professional Nursing assurance 2019/20) Emma Pringle Rhonda Scott Paul Magowan	**Staff morale** 1. Listening exercises for staff with senior team and external facilitators. 2. Support mechanisms for staff who are either directly or indirectly involved in the CCTV investigation are being reviewed formally with Management/TU/Central Nursing and HR. 3. All areas to have formal reflective practice sessions. 4. Continue to promote good news stories on social media and with Corporate Comms teams. 5. Raise the issue of additional incentives with senior teams/DoH.	1. Senior MAH management team 2. Collective leadership team, Service Manager/ Management/TU/Central Nursing and HR. 3. Senior MAH management team 4. Senior MAH management team 5. Collective leadership team/Senior MAH management team	1 Autumn/Winter 2021. 2 December 2021 3 December 2021 4 Ongoing 5 September 2021		

Belfast Health and Social Care Trust

Local Ref No: _____

	Staffing levels & stabilising the workforce & recruitment 1. Continue all efforts to recruit registrants and SNAs. 2. Recruit remaining Ward manager post on a permanent basis 3. Recruit remaining band 6 Deputy ward sister posts *(also referenced in Rice report 2019/20)* 4. Work in partnership with Nurse bank to ensure sustainable levels of block booked bank and agency staff. Review SLA with Direct Health care. 5. Work continues with e roster team to review all rosters to ensure safe rostering of staff. 6. Continue to promote visibility and accessibility of senior team. 7. Fully recruit to the OoH co-ordinators posts to cover weekends on a permanent basis *(also referenced in Rice report 2019/20)* 8. Ensure the agency nurses continue to be fully integrated into ward teams *(also referenced in Rice report 2019/20)*	Senior management team MAH	Review quarterly (November 2021)		
	Resettlement 1. Successful resettlement of 3 patients	Senior team (inc resettlement team)	End October 2021		

Belfast Health and Social Care Trust

Local Ref No: _____

	Managerial/Leadership Support & Communication 1. Interim Director position to be permanently recruited 2. Interim Divisional Nurse position to be permanently recruited. 3. A temporary ASM post is being advertised to cover for the 3rd ASM who is undertaking project work in Community. 4. Identify monies and permanently recruit to the OOH to cover nights and weekend days. 5. Continue planned Leadership walksrounds/team meetings. *(also referenced in Rice report 2019/20)* 6. Re-instate staff briefings & communication *(also referenced in Rice report 2019/20)* 7. Re-instate Newsletter.	Collective Leadership team Senior management team MAH	End December 2021		
	Learning & Development 1. Recruit 2nd NDL post. We are about to recruit a second NDL (interviews 2. Continue to support OU progression for SNA to RNLD (aim for 5 per calendar year)	Senior management team MAH	1. End Septembe r 2021 2. Review yearly		
	Future Workforce planning 1. Senior team involved in strategic meetings. Clear direction about what the future plan is for MAH/LD services. 2. Plan for 3 admission beds to open. 3. Workshop planned by BHSCT senior management team to determine vision and direction for the service. 4. Work planned to review the remaining patients care needs are and whether or not we are working with the appropriate correct model of care.	Senior management team MAH and Central nursing team	1. Vision statement created by December 2021 2. ? when could admission beds reopen		

Belfast Health and Social Care Trust

Local Ref No: _____

	5. Senior nursing team involved in phase 9 of Delivering care *(also referenced in Rice report 2019/20)*		3. End December 2021 4. End December 2021 5. Review quarterly		

Please ensure that you:

1. Communicate this risk assessment with the staff and others affected by the work assessed.
2. Monitor the implementation of any further action identified.
3. Monitor the continued implementation of existing controls.
4. Revise the Risk Rating when additional actions have been implemented.
5. Retain this Risk Assessment in your Health & Safety Policy & Documentation folders.
6. When further action has been identified it is good practice to set a
7. Review your risk assessment at least every two years or more frequently if required. date shortly after measures are likely to be implemented. This will enable you to assess their effectiveness in reducing risk.

In certain circumstances it will be necessary to undertake a new assessment eg. following an Accident/Incident, new legislation/guidance/best practice, changes in work activities/location, new hazards/activities identified.

KEY TO RISK RATING: Likelihood x Severity/Consequence = Risk Rating

Likelihood	Severity / Consequence
1 Rare	1 Insignificant
2 Unlikely	2 Minor
3 Possible	3 Moderate
4 Likely	4 Major
5 Almost Certain	5 Catastrophic

Risk Rating

Low Risk (Green)
Medium Risk (Yellow)
High Risk (Amber)
Extreme Risk (Red)

(See Risk Management Strategy on Belfast Trust Intranet for Risk Rating Tables)

Line Manager Signature _____ **Date** _____

Initial Review Date: _____

Belfast Health and Social Care Trust

Local Ref No: _____

Belfast Health and Social Care Trust

Local Ref No: _____

GENERAL RISK ASSESSMENT FORM AS REQUIRED BY THE MANAGEMENT OF HEALTH & SAFETY REGULATIONS (NI) 2000 as amended

Facility/Ward/Department: Muckamore Abbey Completed By: Trish McKinney, Tracy Kennedy, Owen Lambert

Date: 10th January 2022 (Review of previous Risk Assessment dated October 2021)

Brief Description of activity, location or equipment: **Stabilisation of the MAH workforce**

Description of Hazards	Persons Affected by the Work Activity and How	Existing Controls	Likelihood	Severity / Consequence	Risk Rating
MAH nurse staffing remains tenuous for the following reasons. • Sickness absence • Low morale • Recruitment/Other Trusts recruitment • Retention • Clarity of purpose of services • Historical Investigation • Public Inquiry • Adult safeguarding protection plans • On call • Requests for admissions	Patient Staff	**In the event of an immediate reduction of staff refer to the MAH contingency plan to manage the site in the event of significant reduced staffing levels (overview below).** **1. Use of day care staff** **2. Requests to staff on annual leave** **3. Requests recently retired staff** **4. Use of agency staff** **5. Communicate with other Trusts to assist.** **6. Communicate with families.** **Patient population** There are 37 patients living on site. Two patients are described as being in active treatment. The rest of the patients are waiting for their forever homes. The last patient admitted to MAH was November 2021.	4	4	

Belfast Health and Social Care Trust

Local Ref No: _____

LD workforce requirement to care for the existing patient population and actual staff in post (updated 10th January 2022)

	Plan			Actual Staff in post		
	Reg	Non Reg	Total	Reg	Non Reg	Total
Cranfield 1	8.96	24.08	33.04	4.6	12.7	17.3
Cranfield 2	8.96	27.25	36.21	4	12.9	16.9
Donegore	8.96	20.35	29.31	4.53	24	28.53
Killead	8.96	29.12	38.08	4.16	20.71	24.87
Sixmile	16.24	20.91	37.15	5	9.85	14.85
Total	**52.08**	**121.71**	**173.79**	**22.29**	**80.16**	**102.45**

Ward	Inpatients	Trial Leave
Cranfield 1	8	1
Cranfield 2	7	0
Donegore	5	0
Killead	8	1
Sixmile	9	3
Total	**37**	**5**

Staffing

We will continue to re-advertise for our band 3 and 5 rolling recruitments and will undertake a further band 6 recruitment to try to attract and bolster the numbers across site.

E Roster team was on site December 2021 and nurse model was reviewed in each area January 2022.

Work has commenced on determining the correct workforce model for the people living in Killead. Steering group has met and there is support from the Central nursing team to develop a model of sub-acute care for this group of patients. Paper in development.

Erne ward was closed at end of August 2021 (significant difficulties staffing this area due to staff shortages and the environment very poor for the care of patients) which has allowed staff movement across site.

Gaps in rotas due to Vacancies/sick leave/mat leave are supplemented with circa 50 wte block booked agency registrants.

Belfast Health and Social Care Trust

Local Ref No: _____

Nurse vacancies (Jan 2022)

Vacancies based on the plan required to care for the existing patient population

	Vacancies (As a % against what is required to deliver the plan) Sept 2021	Dec 2021	Predicted March 2022
Registrants:	53%	57%	60%
Non registrant	23%	35%	35%

Currently circa 20 wte block booked agency staff who have been here longer than 6 months.

Most of the agency staff are mental health trained but circa 5 have RNLD qualifications. numbers of agency staff who are mental health and LD back ground

Working in partnership with Nurse bank to ensure sustainable levels of block booked bank and agency staff. Work continues with e roster team to review all rosters to ensure safe rostering of staff.

Agreed SLA for a further 12 months agreed with Direct Health care nurse agency for up to 50 wte registrant staff in October 2021.

Back fill against the nurse model is generally higher than 90% across the site based on current patient population.

Continue to work to integrate the agency staff into teams.

There is an OOH Co-ordinator (Band 7 nurse) every night 7 nights a week and weekend days and public holidays.

The OOH Co-Ordinator reviews rosters for the following day and then there are daily conversations between the ward sisters/charge nurses and ASMs where there are gaps staff are asked to move to those areas of need. Staff allocation sheets are maintained to make sure there is equitable movement.

Observations are reviewed at PiPA and then the nursing model is reviewed weekly and reported on to senior management and stakeholders in DoH.

Resettlement & Discharge

Belfast Health and Social Care Trust

Local Ref No: _____

Sick leave

	Sick leave (as a % of the actual staff in post) Sept 2021	December 2021
Registrants:	33%	27%
Non registrant	21%	39%

Maternity Leave

	Maternity leave (as a% of the actual staff in post) Sept 2021	Maternity (as a% of actual sta post) Dec
Registrants:	4%	13%
Non registrant	3%	7%

Other Trusts recruitment:
The NHSCT is opening a 3 bedded unit. They will be recruiting 1.0 wte Band 7 and 2.0 wte band 6, circa 5.0wte band 5 and circa 5.0 wte Band 3 staff on a permanent basis. There is a likelihood that some of these staff will come from MAH. The DN is a member of the steering group for the opening of these beds to ensure that the NHSCT understands that this depletion of staff may destabilise MAH and need to go carefully.

Delivering care

There are advanced plans for 2 people to be discharged by the end of February 2022.

Resettling these 2 patients successfully this will reduce our staffing requirement at MAH by approximately 4.0 wte band 3 Senior nurse assistants.

Absence Management

Absence is managed in accordance with the trust policy.

COVID guidelines on returning staff (following COVID diagnosis & Close contact status) were implemented 1st January 2022.

Stabilisation of Management/Leadership Staff

Collective Leadership team
Interim Director appointed August 2021
Permanent Co-Director appointed and took up post April 2020.
Permanent Divisional Social Worker in post for circa 3 years.
Interim Clinical Director appointed September 2021
Interim Divisional Nurse in post for 2 years. Recruitment process underway.

MAH Senior Management team

Permanent Service manager Appointed April 2020
There are 3 fully funded Assistant manager posts. There are 2 ASMS in post. A temporary ASM post is being advertised to cover for the 3rd ASM who is undertaking project work in Community.
All but one of the Clinical Areas have a permanent band 7 appointed since December 2019. The remaining Clinical area has a temporary band 7 in post.

Managerial/Leadership Support & Communication

Local Ref No: _____

Belfast Health and Social Care Trust

New monies from Delivering care may also attract existing staff with those qualifications and further deplete staff. **Other emerging Issues:** **Cranfield** 1 ASM 8a will be going on Maternity leave March 2022 1 Band 7 Ward Sister was successful in interview for the 8a met leave (temporary) will leave her post mid Feb 2022. 1 band 7 Charge Nurse is leaving to take up a post in another trust. 2 band 6 post holders have indicated they are applying for posts in other trusts. (NHSCT) **Sixmile** 1 Band 7 will go on maternity leave March/April 2022 1 Band 6 will go on maternity leave March/April 2022 **Donegore** Substantive band 7 ward sister is on LTS; one of the band 6 post holders is acting into this role. 1 band 6 has indicated they are applying for post in NHSCT. **Killead** Temporary band 7 has indicated they are applying for posts elsewhere.		Visibility of Senior Management on site which consists of Ward Sisters and Charge Nurses, ASMs, SM and the Collective Leadership team (Co-Director, DN, Clinical Director). The funding for 3 ASM posts was identified in 2020 and each of the ASMs have a dedicated area of responsibility allowing them to support the Ward Sisters and Charge Nurse and the teams in that area. They also support each other by covering each others area during times of leave. Ward Sisters, Deputy Ward Sisters, are available on each of the wards usually daily. There are senior nurses who provide cover in the OoH visiting each area nightly and during the weekend day time basing them selves where there is the most need (ie: An area that is unsettled) At weekends the ward sisters and Deputy ward sisters identify who is senior nurse on site. This is supported by a Senior Manager/Senior Nurse on call system which can be accessed by the senior nurse on site or the OoH Co-ordinators. ASMs are based on the wards and are in their clinical areas daily. The SM is based on site visits clinical areas on average 3-4 times a week. The DN is based on site and undertakes a weekly team call and visits clinical areas 1x weekly/fortnightly. Trade Union colleagues re- established their office on site and are on site 1x weekly to meet staff. **<u>Recruitment</u>** We continue to have a specific rolling advert for registrants at band 5 & 6 and Senior nurse assistants. Delivering care recruitment underway.			

Belfast Health and Social Care Trust

Local Ref No: _____

Divisional Nurse Divisional Nurse leaves at the end of March 2022. Recruitment exercise underway. **Historical Investigation** The court cases have commenced in December 2021 and adjourned until January 2022. There is a number of staff who are related to those staff who are appearing in court. We are not sure how this will impact their availability to be in work. There are over 30 staff working in MAH with an IPP in place as a result of the historical investigation. Some recent suspensions have had a negative impact on retention with staff citing the length of time of the investigation and that they are on the IPPs for a very long period of time as a reason for leaving. Sometimes these plans include a work related adjustment, which has a direct impact on how a clinical are can be managed. **Public Inquiry** The public inquiry will be commencing in Spring 2022. There is some anxiety amongst staff in relation to what will be expected of them. **Contemporaneous Adult Safeguarding** There are staff on protection plans for long periods of time due to lengthy ASG investigations (some due to joint protocol investigations). Often these plans include a		**Learning and Development** We have 2 permanent NDLs for Learning Disability who supports practice development on site. We are proving opportunities to develop in Quality improvement and a team are undertaking a QI project supported by SQB. There are opportunities to develop skills for example: MAPA trainers, ILS trainers, Peer vaccinators, Positive behaviour work. New roles have been piloted and are in process of evaluation: for example: Behavioural support staff. Students are placed in all clinical areas supported by their mentors and sign off mentors. We have implemented the Future Nurse Future Midwife standards. The Practice education facilitator is regularly on site and we have completed in the early part of 2020 our educational audits. Feedback from students is largely positive. We are active members of the QUB partnership chaired by Head of School Prof L Marsh. The Joint appointment for LD nursing has been appointed. We are also supporting a total of 14 OU nurse students from our own Band 3 workforce. **Future workforce planning** Communication from the current Health Minister has determined that MAH will not be closing. However there still needs to be clear direction about what the future plan is for MAH/LD services. Senior team involved in strategic meetings			

Belfast Health and Social Care Trust

Local Ref No: _____

work related adjustment, which has a direct impact on how a clinical care can be managed. **ON CALL** The senior manager on call has been a 1 in 7 oncall. Recently this has dropped to a 1 in 6 and will drop to a 1 in 4-5 by end of March due to staff leaving. **Requests for admission** Since September 2021 there have been multiple requests for admission. There have been 2 patients admitted due to a detention order. One of those patients still remains in hospital. New admissions to MAH are in risk of having their discharge delayed. **Currently there is a further request for an admission of a patient who will require 2:1 care.** **(2:1 care equates to an additional 11-12 wte staff)** **If this Patient is admitted this will elevate the risk from 4x4 high immediately to 5 x 4 extreme** **Patients on Article 15 leave**		Workshop planned by BHSCT senior management team to determine vision and direction for the service. Work underway to review the remaining patients care needs are and whether or not we are working with the appropriate correct model of care. Senior nursing team involved in phase 9A of Delivering care. **Staff Morale & Culture & Team work** Listening exercises are planned with staff over Autumn/Winter 2021. Formal staff meetings held in partnership with trade union colleagues. Staff report that they are concerned about the ongoing safeguarding investigation and impact on the site, the future of the site, the management of challenging behaviour from patients, how incidents are followed up, the impact of COVID, the use of CCTV, some interpersonal issues between teams and perceptions as to how agency staff work. Support mechanisms for staff who are either directly or indirectly involved in the CCTV investigation are being reviewed formally with Management/TU/Central Nursing and HR. We are working closely with HR to plan some sessions around values, team work, resilience and interpersonal working relationships on site We promote good new stories on social media. Also we have linked in with our corporate comms team to make sure that good news stories are “pushed” out by the Belfast trust accounts (Facebook/twitter) in the main. We report false/inaccurate stories on twitter. Clinical Improvement groups continue Some areas have formal reflective practice sessions.			

Belfast Health and Social Care Trust

Local Ref No: _____

There are patients who are granted article 15 leave by the DOJ. This means that they can be recalled to the hospital by the DoJ. Late November one patient had their article 15 leave rescinded. This person required 2:1 care which equates to 11-12 wte staff required for that one person. This individual can be particularly challenging to manage and has injured staff contributing to increased levels of sickness absence There are a further 2 patients who remain on Article 15 leave. **Regional Bed capacity** The other trusts do not have capacity to admit LD patients to their in-patient facilities. **This situation has been escalated to Service Director, Director of Nursing and Director of Social work and wider Executive team.**					

NOTE: There are also specific risk assessment forms for specific Health & Safety issues such as Substances Hazardous to Health (COSHH), Display Screen Equipment Self Assessment Form, Manual Handling Risk Assessment Form (which includes Patient & Load Handling) for particular clients or clinical issues.

Belfast Health and Social Care Trust

Local Ref No: _____

Action Plan

Sources of Information / Persons Consulted	Further Action if necessary to control the Risk	Person/s responsible for Co-Ordinating implementation of the Action.	Recommended Timescales	Date completed	Revised Risk Rating
Brenda Creaney Moira Kearney Paula Forrest Francis Rice (Report on Professional Nursing assurance 2019/20) Emma Pringle Rhonda Scott Paul Magowan	1. Admitting any additional patients will elevate the risk rating from 20 to 25 extreme risk. 2. This requires urgent escalation to HSCB in respect of the regional contingency plan. 3. Nurse bank to be contacted to identify if there are any additional staff who can be sourced via agencies. 4. All trial leave/extended home leave patients to be reviewed with a view to a formal discharge. 5. Expedite the discharge of newly patient to Cranfield 1. 6. Expedite the discharge of patient in Cranfield 2 who has advanced resettlement plans. 7. Explore the urgent resettlement of other patients to alternative areas. 8. Explore possibility of agency staff “following” the patients into their resettlement plan. This will require a conversation with NHSCT and SET. 9. Negotiation of leaving dates of experienced staff to other trusts. going to other trusts. **Staff morale**	Senior Team HSCB Other trusts	Immediate Review Monthly		

Belfast Health and Social Care Trust

Local Ref No: _____

	1. Listening exercises for staff with senior team and external facilitators. 2. Support mechanisms for staff who are either directly or indirectly involved in the CCTV investigation are being reviewed formally with Management/TU/Central Nursing and HR. 3. All areas to have formal reflective practice sessions. 4. Continue to promote good news stories on social media and with Corporate Comms teams. 5. Raise the issue of additional incentives with senior teams/DoH.	1. Senior MAH management team 2. Collective leadership team, Service Manager/ Management/TU/Central Nursing and HR. 3. Senior MAH management team 4. Senior MAH management team 5. Collective leadership team/Senior MAH management team			
	<u>Staffing levels & stabilising the workforce & recruitment</u> 1. Continue all efforts to recruit registrants and SNAs. 2. Recruit remaining Ward manager post on a permanent basis 3. Recruit remaining band 6 Deputy ward sister posts *(also referenced in Rice report 2019/20)* 4. Work in partnership with Nurse bank to ensure sustainable levels of block booked bank and agency	Senior management team MAH	Review quarterly March-April 2022		

Belfast Health and Social Care Trust

Local Ref No: _____

	staff. Review SLA with Direct Health care. 5. Work continues with e roster team to review all rosters to ensure safe rostering of staff. 6. Continue to promote visibility and accessibility of senior team. 7. Fully recruit to the OoH co-ordinators posts to cover weekends on a permanent basis *(also referenced in Rice report 2019/20)* 8. Ensure the agency nurses continue to be fully integrated into ward teams *(also referenced in Rice report 2019/20)*				
	Managerial/Leadership Support & Communication 1. Interim Director position to be permanently recruited 2. Interim Divisional Nurse position to be permanently recruited. 3. Continue planned Leadership walksrounds/team meetings. *(also referenced in Rice report 2019/20)* 4. Re-instate staff briefings & communication *(also referenced in Rice report 2019/20)* 5. Re-instate Newsletter.	Executive Team Collective Leadership team Senior management team MAH	1.Recruitment process to be determined by CEx 2. recruitment process to be complete by End march 2022 3. Ongoing 4. Ongoing 5. Ongoing		

Belfast Health and Social Care Trust

Local Ref No: _____

	Future Workforce planning 1. Senior team involved in strategic meetings. Clear direction about what the future plan is for MAH/LD services. 2. Plan for 3 admission beds to open. 3. Workshop planned by BHSCT senior management team to determine vision and direction for the service. 4. Work planned to review the remaining patients care needs are and whether or not we are working with the appropriate correct model of care. 5. Senior nursing team involved in phase 9 of Delivering care *(also referenced in Rice report 2019/20)*	Senior management team MAH and Central nursing team	Review March 2022		

Please ensure that you:

1. Communicate this risk assessment with the staff and others affected by the work assessed.
2. Monitor the implementation of any further action identified.
3. Monitor the continued implementation of existing controls.
4. Revise the Risk Rating when additional actions have been implemented.
5. Retain this Risk Assessment in your Health & Safety Policy & Documentation folders.
6. When further action has been identified it is good practice to set a
7. Review your risk assessment at least every two years or more frequently if required.

date shortly after measures are likely to be implemented. This will enable you to assess their effectiveness in reducing risk.

In certain circumstances it will be necessary to undertake a new assessment eg. following an Accident/Incident, new legislation/guidance/best practice, changes in work activities/location, new hazards/activities identified.

KEY TO RISK RATING: Likelihood x Severity/Consequence = Risk Rating

MAHI - STM - 102 - 11802

Belfast Health and Social Care Trust

Local Ref No: _____

Likelihood	Severity / Consequence
1 Rare	1 Insignificant
2 Unlikely	2 Minor
3 Possible	3 Moderate
4 Likely	4 Major
5 Almost Certain	5 Catastrophic

Risk Rating
Low Risk (Green)
Medium Risk (Yellow)
High Risk (Amber)
Extreme Risk (Red)

(See Risk Management Strategy on Belfast Trust Intranet for Risk Rating Tables)

Line Manager Signature _____ **Date** _____

Initial Review Date: _____

Risk Matrix **Stabilisation of the MAH workforce** as of 12.01.22

BHSCT Impact Table

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Minimal injury requiring no/ minimal intervention. • Non-permanent harm lasting less than one month (1-4 day extended stay). • Emotional distress (recovery expected within days or weeks). • Increased patient monitoring	• Medium-term harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Increase in length of hospital stay/care provision by 5-14 days.	• Long-term / permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (e.g., Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.

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Local Ref No: _____

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Table 2

Risk Likelihood Scoring Table				
Likelihood Scoring Descriptors	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed Descriptions of Frequency**	**Probability**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily	75%+ More likely to occur than not
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly	50-74% Likely to occur
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly	25-49% Reasonable chance of occurring
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually	10-24% Unlikely to occur
Rare	1	This will probably never happen/recur	Not expected to occur for years	<10% Will only occur in exceptional circumstances

Local Ref No: _____

Belfast Health and Social Care Trust

BHSCT RISK MATRIX

Table 3

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High ***	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Current Risk Matrix Rating is **"HIGH"**

Belfast Health and Social Care Trust

Local Ref No: _____

Risk Matrix **Stabilisation of the MAH workforce** with an additional detained forensic patient (12.01.22)

BHSCT Impact Table

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Minimal injury requiring no/ minimal intervention. • Non-permanent harm lasting less than one month (1-4 day extended stay). • Emotional distress (recovery expected within days or weeks). • Increased patient monitoring	• Medium-term harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Increase in length of hospital stay/care provision by 5-14 days.	• Long-term / permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
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Local Ref No: _____

BHSCT RISK MATRIX

Table 3

Likelihood Scoring Descriptors	Impact (Consequence) Levels				
	Insignificant(1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost Certain (5)	Medium	Medium	High	Extreme *	Extreme
Likely (4)	Low	Medium	Medium	High	Extreme
Possible (3)	Low	Low	Medium	High	Extreme
Unlikely (2)	Low	Low	Medium	High	High
Rare (1)	Low	Low	Medium	High	High

Re-Assessed Risk Matrix Rating is **"Extreme"**

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20 June 2019

Professor Charlotte McArdle
Chief Nursing Officer
Department of Health
Room C5.4
Castle Buildings
Stormont
Belfast
BT4 3SQ

Dear Charlotte

Thank you for your letter dated 31 May 2019 in which you asked for information on the following:

Current staffing ratio and skill mix available to patients, taking account of differing levels of observations:

The staff ratio in Muckamore Abbey Hospital is funded at 113.9 WTE Registrant staff and 117.23 WTE Non Registrant Nursing Support staff. Additional funding was provided by Commissioners in recognition of delayed discharges of complex patients approximately four years ago to provide a total of 158.05 WTE Registrant staff and 180.4 WTE Non Registrant Nursing Support staff. This ratio is further augmented by bank and agency staff dependent on assessed patient need by the Ward Sisters and Lead Nurses.

Below is listed real-time staffing per ward dependent on assessed patient need by the ward sisters and lead nurses.

Table 1: Care delivered Period 29th April - 26th May

Skill Mix for Roster	
Ward	Skill Mix
Ardmore	35/65
Cranfield 1	38/62
Cranfield 2	33/67
Sixmile	46/54
Erne	30/70
Site	**36.4/63.6**

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Table 2: Planned staffing before all available resources allocated.

Skill Mix for Roster Period 27th May - 23rd June	
Ward	Skill Mix %
Ardmore	32/68
Cranfield 1	40/60
Cranfield 2	29/71
Sixmile	46/54
Erne 1	39/61
Site	**37.2/62.8**

Presence of a senior clinical decision maker (ie Band 6 or above) on each ward 24 hours per day, 7 days per week:

The presence of a senior clinical decision maker (i.e. Band 6 or above) on each ward 24-hours a day, 7 days per week is not presently included in the FSL. In line with the delivering care methodology, we are planning to uplift Band 5 to Band 6 to provide senior clinical decision-making and aim to achieve a minimum of three per ward. (6 more)

Presently, there are 4 x Band 7 Night Coordinators (senior nurses out of hours), 6 x Sisters/Charge Nurses on daytime roster with a minimum of 1 x Ward Sister/Charge Nurse on at the weekend. There are 13 x Deputy Ward Sisters/Charge Nurses; 1.00 WTE vacancy with a recruitment plan in place. They are rostered across 24x7 days per week across the five wards providing senior decision-making skills including leadership across the wards/site.

Current number of nurse vacancies and actions taken to fill same:

There is a FSL of 115 Band 5 staff and FSL of 160 Senior Nursing Assistants; there are 180 Senior Nursing Assistants in post (additional recurrent funding by the PHA to address levels of observations required by patient need).

Registered Nurses

Funded Staff	Staff in Post
115	71

Maternity	Sickness	Suspensions	Vacancy Post	Backfill
7	9	11	44	45

Non-Registrants

Funded Staff	Staff in Post
160	180

Maternity	Sickness	Suspensions	Vacancy	Backfill
2	33	9	0	43

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There is also the following:
1 x Nurse Development Lead Band 7
1 x MAPA Coordinator Band 7
1 x Governance Lead Band 6

Action Taken:
Recruitment activity
To provide stability to the workforce and to reduce backfill, we continue to recruit to Band 3 Senior Nursing Assistants and anticipate a number of new starts over the summer months. This will also provide service continuity for those who are unavailable to work.

A Recruitment Fair took place in March 2018 with 28 final year students from Queens University been offered a post, 7 staff took up their posts between October 2018 until present, explanations by those that didn't take up the job offer were positions closer to home, several job offers therefore change of mind with choice. Attendance at Job Fairs in QUB, UUJ, Dublin, Dundee, RCN Congress Liverpool and Belfast Open Day on the 11 May 2019. We have offered 8 Final Year Student Nurses from QUB, 3 of who want to work in Iveagh with 5 choosing to work in Muckamore.

We continue to hold an open file on HSC recruit for recruitment purposes; we are presently planning a further recruit event for Learning Disability nurses in the summer months.

We have requested staff to consider been redeployed from other host HSC Trusts to work within Muckamore which resulted in one individual. The reason for this is that other Trusts have challenges in this area and the lack of staff in this field.

We have recruited registrants N=35 both Learning Disability, Mental Health and Nurses with Forensic external off contracted agencies, initially for six to eight months with monitoring and review processes. This is in addition resource available through the Trust Nurse Bank. The organisations meet the Trust's contracts specifications. The staff are fully prepared with MAPA training and induction to policies and practice expectations prior to commencing within the wards. They have local induction to the ward environment and the population so patients they will be contributing to their care.

As stated above we are recruiting additional senior decision makers per ward to stabilise the workforce and provide visible clinical leadership.

The substantive Service Manager Nursing post has been approved for permanent recruitment alongside 2 x Band 7 Practice Development nursing posts to progress the creating caring cultures agenda. The development of the Home Treatment model will progress a minimum of 3 x Band 6/7 nursing positions.

We are also supporting a secondment to the regional work-stream for the development of Regional Learning Disability Pathway Band 8A of 1.00 WTE nurse.

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Number of new permanent WTE that have commenced employment in Muckamore Abbey Hospital since 1 March 2019:

The Trust has ongoing recruitment activities outlined above and commencement dates are anticipated from 1st July onwards in line with the Trusts Strategy of Corporate Welcome and Induction. There will be 2 x Band 3 and 1 x Band 6 coming into the Trust within the next 2 months.

Number of new permanent WTE nurses that have left employment in Muckamore Abbey Hospital since 1 March 2019

January –April 2019, 8 x registered staff have left employment within the above period.

Number of anticipated WTE nursing appointments over the next two months

1 x Band 6 registrants
2 x Band 3 non-registrants

The steps taken to ensure that all current and former patients involved in the ongoing investigation have had their biopsychosocial needs assessed and reviewed in light of the allegations regarding their care and treatment while in Muckamore including the provision for addressing associated trauma.

Continuous review through each wards multidisciplinary team in collaboration with the patient and their Next of Kin, care plans have being updated on biopsychosocial model.

The expansion of Psychological Services across Muckamore site, in terms of an increased applied psychology workforce and an increase in Behaviour Therapy workforce, will provide increased psychological attention towards the needs of the patients. This includes increased focus on formulation, cascading a positive behaviour support approach to delivering care and the provision of psychological therapies with an emphasis on impact of trauma and attachment issues. A pilot recruitment of adding Behavioural Assistant posts onto wards is commencing through Psychological Services towards end of June 2019. They will supplement the work of Behaviour Therapists.

We continue to explore additional resources to address the complex needs of the presenting patient population and are engaged in regional work to identify other therapeutic interventions which could be of value.

The nursing care provided within all wards in Muckamore Abbey Hospital is conducive to the delivery of safe, effective, therapeutic and compassionate care:

We can confirm that a daily review of 'Is Care Safe Today' has been introduced including Safety Briefs and Safety Huddles with a weekly 'live' governance meeting. This important development included monthly, weekly and on-occasions daily review of staffing complement to meet the prescribed care needs of the patient population.

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The current nursing governance arrangements for staff working in Muckamore Abbey Hospital

The Ward Sister/Charge Nurse have a daily review of 'Is Care Safe Today' has been introduced. Daily Safety briefs and Safety Huddles which inform the weekly 'live' governance meeting.

Daily review of staffing across the wards is undertaken by the Service Manager and Senior Nurse Managers and they contribute to the nursing element of the weekly SITrep report submitted to the Director.

Senior Manager Leadership walk around daily and weekly.

- Director of AS&PC
- Executive Director of Nursing
- Deputy Director of Nursing
- Co- Director
- Divisional Medical Chair
- Divisional Social Worker
- Divisional Psychologist
- Clinical Medical Lead
- Carer Consultant
- Service Manager Daily
- Senior Nurse Manager Daily
- Nurse Development Lead Weekly
- Practice Education Facilitator – In-reach and Governance monitoring of NMC learning and assessment standards supporting mentors, sign off mentors and students.
- University Link Lecturers supporting students on placement
- Governance Lead Nurse weekly
- Business & Governance Manager weekly
- Safeguarding Lead for Learning Disability

Application of roster policy one month in advance. Regular communication with Bank Office and Roster team when required.

The arrangements to ensure that senior nurses are available to frontline staff 24 hours per day, 7 days per week, and confirmation that all frontline staff are aware of how to contact senior nurses to escalate concerns. BHSCT are supporting promoting staff wellbeing:

The Trust can confirm that senior nurses are available to frontline staff 24-hours per day 7-day per week. We can also confirm that it has been communicated to all staff the Internal Escalation Process for Raising Concerns.

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How BHSCT are supporting, promoting and monitoring nursing staff wellbeing and morale in Muckamore Abbey Hospital and the impact of this?

The following are actions to support staff to promote their wellbeing and to improve morale:

- Along with a Lead Nurse, Human Resources support staff who are absence to meet staff and understand 'What's to them" and to see how the Trust can support the individual to return to work. This is also done in collaboration with colleagues from Occupational Health. This approach has reduced staff absence.
- Massage Therapists have been commissioned to provide sessions for staff. Staff have engaged in this activity with very positive feedback.
- Counselling Services are on site each week. Staff are fully engaged in this service.
- There is also psychological support from the Occupational Health Department
- Head of Psychological services who is currently acting as Divisional Psychologist has made contact with a number of staff as requested.
- All information around staff care have being shared with staff
- Ward sisters have weekly meeting with Operational Manager
- Ward team meetings are held monthly
- Monthly feedback sessions on site for improved communication
- B-well Health Fair has taken place on the Muckamore site for all staff with the relaunch of Rehydrate, Refuel Stations.
- Stress assessment workshops to be facilitated by Health and Safety team in BHSCT
- Listening Sessions for staff.
- Engagement with Staff-side for information sessions, updates and facilitating staff support with their respective Staff side.
- The publication of first Care Consultant Newsletter for the site and Carers was published.
- Creating and Caring Cultures continues to be supported which focused on joy at work and delivering compassionate care. Creating Caring Culture an exciting nursing led development programme supported by FONS. The programme has a keen focus upon learning from within the organisation and from external sources.
- There are two Quality Improvement projects taken place in two of the ward environments.
- Day care services have extended their hours for patients with additional activities, i.e. Art therapy, music therapy and available Day Care staff on wards to facilitate patients to undertake meaningful activities.

The opportunities for nursing staff to deliver evidence based therapeutic interventions in line with NICE guidance:

All nursing staff are trained to manage and de-escalate behaviours that challenge and the model in use is accredited with British Institute of Learning Disability and this model is in use in all Trusts in Northern Ireland and UK. Training is available via the CEC and BHSCT Trust Trainers. (MAPA)

Evidence based Therapeutic Interventions are planned and delivered as part of an MDT assessment of need. There is close working between nursing, medical psychological, behavioural and AHP staff in developing and implementing care plans, positive behaviour

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support plans, including communication assessments and sensory assessments which may lead to development and delivery of interventions such as social stories, using talking mats, activity schedules.

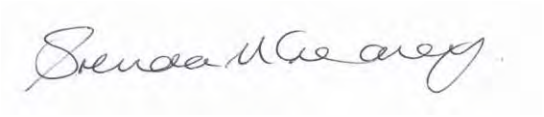
Dialectical Behaviour Therapy as a specific psychological intervention is delivered in groups and individually across the site by Psychological Services in partnership with the MDT. Where workforce issues allow this is supported by Nursing Staff – included in the support of a "DBT Skill for the week" on wards and with specific patients. Positive Behaviour Support (PBS) as a culture of care is being rolled out across the site, although this has been challenging due to workforce difficulties. Additional workshops are planned for PBS and also in Compassionate Care and leadership for the autumn and are led by Psychological services.

How nursing staff are being kept appraised and updated on service developments and actions including outcomes of RQIA recommendations and outcomes:

- Engagement with Staffside for information sessions, updates and facilitating staff support with their respective Trade Unions
- Ward Sister/Charge Nurses have weekly meeting with Operational Manager
- Ward team meetings held monthly
- Monthly feedback sessions on site for improved communication

Please do not hesitate to contact me should you require any further information.

Yours sincerely



Miss Brenda Creaney
Executive Director of Nursing and User Experience

Copy to: Mr M Dillon
Dr C Jack
Mrs M Heaney
Mrs M Mannion

Belfast Health and Social Care Trust, Trust Headquarters, A Floor, Belfast City Hospital, Lisburn Road, Belfast BT9 7AB Tel No [redacted]

Report on Professional Nursing Assurance

Muckamore Abbey Hospital

Findings, Recommendations and Action Plan

JANUARY 2020

Background

1. An adult safeguarding investigation was initiated in September 2017, following reports of inappropriate behaviour and alleged physical abuse of patients by staff in two wards in Muckamore Abbey Hospital. These ongoing investigations are being carried out between the PSNI and Belfast Health and Social Care Trust (the 'Trust').

2. During January 2018, the Trust set out Terms of Reference for a level 3 review of safeguarding activities at the Hospital under the Health and Social Care Board (2016) Procedure for the Reporting and Follow up of Serious Adverse Incidents, Version 1.1. The Trust asked the Review Team to identify the principal factors responsible for historic and recent safeguarding incidents at the Hospital. The review team appointed was independent of the Hospital.

3. A Review of Safeguarding at Muckamore Abbey Hospital 'A Way to Go' was published in November 2018

4. This review made a number of recommendations relating to the need for reform within the Hospital and the development of robust community based Health and Social Care services so that individuals with a learning disability are enabled to have full lives in their families and communities.

5. The Chief Executive of the Trust wrote to the Permanent Secretary on 8 March 2019 indicating that it fully accepted the complexity and gravity of the situation, and requested the Department's help and support in order to achieve the best possible outcome for patients at Muckamore Abbey Hospital.

6. The Department agreed to facilitate monthly update meetings with the Trust and Health and Social Care Board (HSCB) in relation to Muckamore Abbey Hospital. These meetings were set up at the request of the Trust to help support them in relation to improving services at Muckamore Abbey Hospital. Three meetings have taken place to date (10 April, 8 May and 5 June 2019). The Trust repeatedly

highlighted recruitment and retention of nursing staff as an ongoing and significant risk at these meetings.

7. The Regulation and Quality Improvement Authority (RQIA) carried out two unannounced inspections in Muckamore Abbey Hospital in 26–28 February 2019 and 15-17April 2019. The RQIA subsequently wrote to the Chief Medical Officer (CMO) on the 30th April 2019 advising of their 'serious concerns relating to care treatment and services as currently provided for patients in Muckamore Abbey Hospital' - the RQIA specifically highlighted their concerns in relation to availability and planning of nursing staff to meet assessed patient need; a 'disconnect between site managers and ward staff'; and expressed their concern for health and wellbeing of staff, particularly nursing staff, in the hospital. The RQIA recommended that the Department of Health implement a special measure and establish two taskforces.

8. The Department called a meeting in relation to the RQIA letter to CMO which was held on 14th May 2019. This meeting was convened in response to the 30th April 2019 RQIA Article 4 letter to the CMO.

9. The DOH agreed to establish the new Muckamore Departmental Assurance Group (MDAG) following the second RQIA unannounced inspections in April 2019 and the associated Article 4 letter to the Department. The objective of the group, to be jointly chaired the Chief Social Services Office/Chief Nursing Office was to provide the Permanent Secretary (and any incoming Minister) with assurance that the Permanent Secretary's commitments on resettlement and also the recommendations in the SAI report were being robustly and effectively addressed.

10. The Belfast Trust advised the DOH that as of 20 June 2019 there were 44 WTE Registered Nurse vacancies at the hospital currently being backfilled by use of agency and Bank Nursing staff. The number of staff suspensions to date is 44 (20 registered nurses and 24 healthcare assistants), though there remains the potential for this number to increase should further concerns emerge from the viewing of historical CCTV footage which is ongoing.

11. In light of this, and due to the fundamental role that nursing plays in care delivery on a day to basis to patients in the hospital, the Belfast Trust have commenced a contingency planning process to prepare options in the event of further deterioration in staffing levels at Muckamore.

Professional Assurance

12. The Chief Nursing Officer sent a letter to Executive Director of Nursing, Belfast Health and Social Care Trust on 31 May 2019 seeking assurances regarding patient care and treatment and professional nursing in Muckamore Abbey Hospital. The Executive Director of Nursing, Belfast Health and Social Care Trust responded to this on 20 June 2019. There remained some issues of assurance that needed to be taken forward and therefore, I as professional advisor, was asked to take these forward in conjunction with Senior Nursing and Management Staff in Belfast Health and Social Care Trust..

Professional Nursing Advisor

13. I was asked, having been, a former HSC Executive/Director of Nursing and Interim Chief Executive, to work as professional Nursing advisor alongside clinicians and management in the Belfast Trust to assist with stabilising the nursing workforce, providing expert advice, professional assurances and if appropriate, make recommendations to The Chief Nursing Officer and Department of Health regarding current services, care and treatment within Muckamore Abbey Hospital. This work commenced on 18 September 2019.

Terms of Reference for Professional Nursing Advisor

14.

- To work alongside clinicians and management in BHSCT with responsibility for services provided at Muckamore Abbey Hospital.
- To provide expert professional advice and guidance to colleagues in the BHSCT around all aspects of nursing care for individuals with a learning disability.

- To provide expert professional advice and guidance to colleagues in the BHSCT around all aspects of nursing governance, training and development for nurses and healthcare support workers working in Muckamore Abbey Hospital.
- To ensure that there is a clear and effective clinical, professional, and operational structures in place for all registrants and health care support workers and that staff are aware of these.
- To ensure that all registrants and health care support workers are aware of how to escalate or raise concerns and feel confident and supported in doing so.
- To establish if current nursing practice and care in Muckamore Abbey Hospital is safe, effective and compassionate.
- To review the quality and effectiveness of nursing care and practice currently being delivered in conjunction with ward sisters and ensure that it is in keeping with NICE and other relevant evidence based clinical guidelines and that progress is being monitored and evaluated.
- To identify and where appropriate introduce appropriate routine outcome measures to nursing care as delivered in Muckamore Abbey Hospital.
- To report on the above to CNO via the Muckamore Departmental Assurance Group and other mechanisms as appropriate.

Methodology

15. I officially commenced this work on the 18th September 2019 and prior to this date in preparation for starting, read the following reports:

    - "A Way to Go" A review of Safeguarding at Muckamore Abbey Hospital – November 2018.
    - Final Report of Independence Assurance Team – Muckamore Abbey Hospital – 19 September 2018.
    - Belfast Trust ASPC Directorate, Muckamore Abbey Hospital summary of staff exit interviews 16 August 2018

- CNO Professional Letter to Miss Brenda Creaney, Executive Director of Nursing and User Experience, Belfast Health and Social Care Trust – 31 May 2019
- Response to CNO Professional Letter from Miss Brenda Creaney, Director of Nursing, Belfast Health and Social Care Trust – 20 June 2019
- The Draft HSC Action Plan in relation to the review "A Way to Go"

- From 18th September 2019 I requested information in relation to Nursing Workforce, Professional Governance, Patient Safety, Performance against resettlement targets, Regulation and Quality Improvement Notices (RQIA) and communication mechanisms with Muckamore Abbey Hospital Staff, users, carers and advocates in Muckamore.
- I visited all the wards in Muckamore Abbey Hospital and spoke to the multi-disciplinary teams to include Nursing staff (registered and non registered)
- I met with Nursing students, Medical, Social Work, Psychology, Patient Client Support Services and Allied Health Professional staff.
- I met with Service Users, carers and advocates.
- I attended Charge Nurses meetings and purposeful Inpatient Admission (PIPA) Meetings
- I spoke to and attended Senior Management Meetings (Belfast Health and Social Care Trust)
- I met with the Nurse Development Lead for the Hospital, Day Services Staff, and Clinical Governance staff.
- I met with the Resettlement Lead for Muckamore Abbey Hospital.
- I met with staff from the Muckamore Abbey Review Team (DOH), The Chief and Deputy Chief Nursing Officers, The Nursing Advisor for Mental Health and Learning Disability, Chief Social Services Officer and staff from the Directorate of Mental Health, Disability and other people (DOH).
- I met with the leads responsible for taking forward the recommendations of the HSC Action Plan in response to the Review of Safeguarding "A Way to Go"
- I met with the Director of Nursing (PHA) and Director of Social Care (HSCB)

- I carried out a number of visits to wards observing Leadership and Professional Practice, to get a better understanding of challenges and determine the level and nature of assurance I would be able to provide to DOH.
- I attend the Muckamore Departmental Assurance Group (DOH)

Through this I believe I was able to gain a fuller understanding of the Professional Nursing issues and determine how the Trust was taking actions forward and addressing future professional issues in Muckamore Abbey Hospital. This in turn enabled me to ascertain the level of assurance I could provide for the Department of Health Chief Nursing Officer and make recommendations for improvement.

Preliminary Findings

16. I found all the staff, service users, carers and advocates in the Hospital to be very receptive to me being there to provide professional nursing advice and support. Through spending time individually with staff, with teams, service users, carers and advocates I was able to ascertain a significant level of commitment to ensure the complex needs of patients were met and that patients received the best care possible under very difficult circumstances, mainly negative media attention and significant workforce challenges.

    Staff were extremely honest and forthcoming in identifying and communicating issues what help they need and how the Belfast Trust could help and support them further. The staff were exhausted.

Workforce

17. There are a significant number of vacancies in the nursing workforce in Muckamore Abbey Hospital, which presents a daily challenge to the provision of safe staffing on wards with a disproportionate reliance on bank and agency staff. This is of significant concern in terms of the safe and effective care of patients and the future sustainability of the Hospital.

- There are 121.00 WTE vacancies in the Hospital of registered and non-registered nurses as a result of vacancies, sick leave, maternity leave and suspensions being covered by bank and agency staff (74.23 WTE). There are less agency nurses available due to Christmas and extended New Year Leave.
- A significant number of staff resignations 15 WTE (8 Band 5, 2 Band 6 and 5 Band 3) 6 WTE Retirements (Band 5) (December 2019)
- Agency and bank staff (registered) are not taking charge of work shifts in spite of some of them having been "block booked" for 18 months.
- There are on average 84 WTE nursing staff (non-registered) involved in the special observation of patients each week
- There are no Ward Support Officers in post in the Hospital.
- The Nurse Development Lead is working his resignation.
- Staff are exhausted.
- Behaviour Support training needs to be extended to include registered and non-registered staff and fully integrated into MDT Treatment Plans.
- An interim workforce plan is required to ensure safe staffing levels on each ward (RQIA Improvement Notice) (February 2019)

Governance and Safety

18.

a. Hospital Risk Register requires reviewing specifically in relation to nursing workforce
b. Observation and Seclusion policies require reviewing
c. Policy development process require reviewing
d. Weekly Ward safety report is required to keep staff abreast of patient safety issues and required action and improvement
e. Induction, MAPA and mandatory training is not 100% complete for all staff.
f. Staff care planning and "PARIS" Training requires updating
g. Charge Nurse/Senior Nurse meetings require reinstating
h. Patient inpatient admission (PIPA) meetings require to be implemented in all wards

i. Increased focus required on the implementation of NICE Guidelines/DOH Circulars/Professional Letters

j. Due to the significant challenges in relation to Workforce there requires to be renewed focus on:

- Staff appraisal and supervision
- Reflective practice
- The development of Key Performance Indicators for nursing
- The development of a professional nursing forum
- The development of Nursing Practice
- The implementation of research and development to inform Clinical Practice
- Professional training and development Plans require updating.

Communication

19.

a. Communication lines have become complicated and staff do not understand the professional or operational structures within the Hospital.

b. There is a feeling expressed by staff that they are not adequately communicated with or listened to in relation to the ongoing workforce and professional issues and the PSNI Investigation and hear most of the information on the news.

c. Staff report a “disconnect” between them and site managers.

Leadership

20.

a. Because of ongoing staff changes and the ongoing investigation in Muckamore Abbey Hospital, there is not clear evidence of effective leadership at ward or directorate level.

b. Clinical Leadership (all disciplines) is not as strong as it should or could be and staff feel vulnerable and disempowered due to recent events.

c. There is no divisional nurse in the current structure and professional governance lines of accountability are unclear.

Summary

21. In the course of my observation visits, most of which were unannounced, I found the care to be compassionate and effective and staffing levels were being monitored on a shift basis to ensure patient safety in spite of the issues I have outlined in my findings to date. I could not see evidence of true multi-disciplinary working on the hospital site which is a significant issue of concern as the nursing staff are carrying a bigger share of the workload.

    In the absence of a regional alternative the hospital is still receiving admission which is adding further pressure on the nursing staff.

The staff are fully aware that a number of professional and governance issues require revision, updating and renewed focus, however until the workforce is stabilised this will prove to be extremely difficult.

The staff's main concern is having sufficient nurses to look after the needs of patients and ensuring there is a truly multidisciplinary approach to the effective needs assessment, care planning and resettlement of patients. They were also very unnerved by the continued reading of the CCTV footage and feel that they could be in danger of being disciplined in spite of not, in their view, having done anything wrong

I spoke to and met Dr Cathy Jack, Deputy Chief Executive and Ms Brenda Creaney, Director of Nursing, Belfast Health and Social Care Trust on 23 September 2019 as the Chief Executive was on annual leave relayed my concerns and highlighted preliminary findings and recommendations.

On 8 October 2019 a new operational and professional nursing structure was put in place by the Belfast Health and Social Care Trust to include and a Director, Co-Director, Divisional Nurse, Interim Senior Manager, Senior Nurses and based on hospital wards and included revised arrangements for overseeing the Safeguarding

and Financial agendas. A diagrammatic version of the new professional and management structure was sent to all wards and departments in the Hospital.

I am fully included in the work of the Senior Management Team, Senior Nursing and ward teams and members of the Multi-Disciplinary Team. I am working with them to take forward actions in relation to, Professional Governance and Nursing issues based on my findings and can report progress to date against an action plan I have devised to address the Professional Nursing issues of concern. The implementation of this action plan will go a long way to ensure the safe staffing of wards in Muckamore Abbey Hospital, the provision of a competent, confident and supported workforce and ultimately the safe and effective care to patients enhanced by effective Clinical and Social Care Governance and Communication Mechanisms.

The Regulation and Quality Improvement Authority carried out a further inspection on the 10 – 12 December 2019 of all wards and services in Muckamore Abbey Hospital and were extremely complimentary of the progress made to date in relation to the areas of Governance, Staffing, Financial Governance, Physical Healthcare, Seclusion, Restrictive Practice and Safeguarding. The Improvement Notices around staffing have been lifted in full, Financial Governance lifted in full except for the requirement for “internal audit” to conduct their audit, which is due on February 2020.

With regard to the Safeguarding, Improvement Notice, when the Trust provides further evidence, in the form of audits, currently being carried out that new policies and procedures being implemented are effective, the improvement notice will be lifted in full.

RQIA report a totally different ‘feel’ about the site, the staff are more open, honest, feel totally supported and the patients receive safe and effective care.

The challenges with the Nursing Workforce still remain and RQIA recognise the need for the Trust to continue to receive help from the wider HSC to ensure patients continue to receive safe and effective care and that the care being delivered can be sustained.

Action Plan

I, in conjunction with the Senior Staff in Muckamore Abbey Hospital, have devised an action plan to address the professional nursing and governance issues I have identified to date. The implementation of the action plan will go a long way to ensure the safe staffing of wards in Muckamore Abbey Hospital, the provision of a competent, confident and fully supported workforce, enhanced by effective clinical, social care governance and communication mechanisms.

Future Challenges

There are a number of issues that remain to be addressed that will have a direct impact on the present and future sustainability of Muckamore Abbey Hospital in its current form, and indeed the efficiency and effectiveness of Learning Disability Services in the future. These, in my view are;

A. The inability to permanently recruit and retain the nursing workforce required to ensure the safe and effective nursing care of the current and future Learning Disability patient population.
B. The absence of a Comprehensive needs assessment of our Learning Disability population in Northern Ireland, to inform the development of a regional strategic approach to an integrated hospital and community service model, clinical practice, standards of service provision, and future accommodation needs.
C. The need for an increased focus on quality improvement, user, carer and advocacy involvement in Co. design and delivery of services.
D. The absence of suitable accommodation to facilitate the complete resettlement of the complex patients who are currently cared for in the Muckamore Abbey Hospital and the need for consideration of a regional approach to this.
E. The absence of an agreed modern care pathway and model of Acute Hospital Care Service provision for Learning Disability patients.
F. The absence of a modern Community Learning Disability Care and treatment model for Learning Disability patients to include forensic, home treatment, crisis response, assertive in and out reach multi-disciplinary teams.
G. The absence of a comprehensive and fully integrated training and development multi-disciplinary programme to equip staff with the skills, knowledge, and expertise to assess and care for all Learning Disability patients.
H. The lack of development of Clinical and Social Care ‘Leaders’ in the field of Learning Disability.

NURSING WORKFORCE

ACTION PLAN

Nursing Workforce			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
Agency nursing staff are fully integrated into ward teams and registered nursing staff are competent to take charge of shifts on wards in MAH.	Divisional Nurse Senior Nurses	To develop and implement a competency framework for registered agency nursing staff to assess and sign off competency to take charge of ward shifts. 75% complete	
To ensure all vacant Band 6 and 7 registered nursing staff posts are appointed to every ward in the hospital.	Divisional Nurse	No band 7 vacancies remain. All band 6 vacancies in process of recruitment.	
To ensure vacant Ward Sister Support Officer posts are recruited to hospital wards.	Divisional Nurse	To advertise, shortlist, interview and appoint Ward Sister Support Officer to hospital wards. No suitable applicants from Agency Workers.	
To appoint 30 WTE registered nurse from 5 HSC Trusts to work for a period of 3 months initially in MAH to stabilise the nursing workforce and ensure the delivery of safe staffing levels in MAH.	DOH Chief Nursing Officer Director of Nursing BHSCT Director	DOH to issue a letter to Trust to reflect that each Trust identify 6 WTE registered nurses who would benefit from a 15% increase in pay, terms and conditions.	
		To work with each of the 5 HSC Trusts to identify 6 WTE registered (RNMH/RMN) nurses to work in MAH. 5 Registered Nurses appointed to date.	

To develop an interim workforce plan for each ward to ensure safe staffing levels in all wards in MAH.	Divisional Nurse	To develop a nursing workforce plan on a spreadsheet with guidance for nursing staff to ensure adequate levels of registered and non-registered sisters staff on a daily basis ensure the safety and effective care of patients in MAH.	
		To work with Finance to build an appropriate budget to take forward the implementation of the workforce plan and identify cost pressures.	
		To review the night co-ordinator role to include twilight hours and weekends.	
To develop an agreed job description for the appointment of a Regional Bed Manager for Adult Learning Disability.	Co-Director	To advertise, shortlist, interview and appoint a Regional Bed Manager for Adult Learning Disability. In the process of recruiting. Interview second week in February 2020.	
To participate fully with the PHA in the development of the future nursing workforce plan (delivering care) for Adult Learning Disability Service.	Divisional Nurse	To identify senior nurses to join the regional (PHA) and 5 HSC Trust workforce planning group for Adult Learning Disability Service.	

To develop and make available a staff counselling service to be available for MAH staff.	Co-Director	To appoint a counsellor to be available on site for staff who wish to avail of confidential counselling service. Counsellor appointed three days per week and communicate to staff on the MAH site.	
To work closely with Trade Union colleagues to keep them abreast of issues on MAH site and ensure there are appropriate arrangements for them to support staff.	Divisional Nurse/Co-Director	Trade union colleagues to attend charge nurse meetings with senior nurses and meetings with staff on MAH site as appropriate.	

Governance, Safety and Professional Nursing			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
To review the policy on special observation of patients in MAH.	Divisional Nurse	To collate data which clearly identifies the number of patients on special observation, reason for, type of, and mechanisms for multi-disciplinary review of special observations.	
		To review the policy in line with findings in connection with members of the multi-disciplinary forum.	
To review the risk register in MAH to ensure all risks have been identified and escalated as appropriate.	Co-Director	Senior leadership and clinical team to review risk reports in line with Trust policy and current event in MAH.	
To work with senior and governance team to ensure the policy development process is reviewed and that there is a plan to review all hospital policies.	Co-Director	Governance lead with senior management and senior clinical team to review the policy development process to ensure it is in line with the Trust policy review process.	
		To develop a plan to review all existing hospital policies.	
		To draft and implement a restrictive practice policy.	
To work with clinical and governance teams to ensure that each ward receives information pertaining to patient safety and actions to address areas of concern.	Co-Director	Governance lead to collate all information in relation to safety reported by each ward and prepare a safety report for each ward, which also feeds into the Trust Safety reports to Trust board.	
		MAH site safety brief to be circulated every morning at 7am	

		MAH site safety brief to be circulated every night at 8pm with senior nursing staff.	
		Weekly Live Governance to be implemented on the hospital site.	
		Weekly MAH Safety Reports are now provided for each ward on the hospital site.	
To ensure all staff including agency staff attend induction	Divisional Nurse	Senior Nurses, Ward Sisters and Charge Nurses to ensure that staff attend induction.	
All elements of Mandatory training will be up to date and recorded for all staff on MAH site.		WSSOs to assist Ward Sisters/Charge Nurses with organising and recording of training when appointed.	
To ensure care planning and 'PARIS' training is up to date for all staff on MAH site.	Divisional Nurse	Senior Nurse managers to work with Human Resources and charge nurses to identify training needs of staff and ensure all training and records are up to date. Care Planning 90%/Paris 100% (Registered Staff)	
To develop a training needs analysis and training matrix for all staff by ward.	Divisional Nurse	Senior nurses, charge nurses, and care support officers to work together to identify training needs of staff, a training matrix and work with the education provider (CEC) to provide same.	
To introduce multi-disciplinary Patient Inpatient Admission (PIPA) review meetings on each ward.	Divisional Nurse	Senior nurse manager to work with charge nurse and ward MDT teams to develop and implement PIPA meetings by November 2019 and review effectiveness.	

To appoint a Nurse Development Lead in MAH.	Divisional Nurse	To devise job description, advertise, shortlist, interview and appoint to these positions.	
		The NDL post will focus on: - The development of key performance indicators for hospital learning (i.e. circular observation, seclusion, rapid tranquilisation). - The development of professional nurse forum. - The development and implementation of appraisal, clinical supervision and reflective practice for all nursing staff. - The development and implementation of professional standards and practices in all wards in MAH. - The promotion of Research and Development in the nursing workforce to guide clinical practice. - To provide assurance to the Trust in relation to the implementation of NICE Guidelines/DOH Circulars/Professional Letters. Nurse Development Lead Post appointed December 2019 (waiting on pre-employment checks)	

		Service Improvement Coordinator appointed November 2019. Learning Disability Governance Manager appointed December 2019.	

Communication			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
Senior Management to establish meetings with all staff in the hospital, users, carers and advocates to listen to and communicate with them. To keep them abreast of all issues in the hospital and take their issues on board and ensure they are addressed.	Director	To establish two weekly senior management forum meeting during which strategic, operational, clinical, finance, and Human Resource issues are tabled and discussed.	
	Co-Director/Divisional Nurse	To establish bi-monthly meetings with users and carers and advocacy workers on site to promote open communication. To establish weekly meetings between senior nurses and charge nurses on site to discuss operational issues. Charge nurses to have monthly update meetings in their respective wards for all staff minuted and sent to all staff.	

Leadership			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
To put in place an effective leadership team to ensure that the operational, strategic and professional issues are taken forward on the MAH site and in particular those issues raised in the Adult Safeguarding investigation and subsequent report 'A way to go'.	Director	To appoint an interim leadership team to include divisional nurse to ensure the efficient and effective management and leadership of the MAH site.	
		Put in place plans to appoint a permanent Leadership team and communicate the same to staff, users, carers and advocates.	
		To consider the commissioning of a leadership programme for senior clinical staff at MAH through the "HSC Leadership Centre".	
		To implement Patient Inpatient Admission (PIPA) meetings at clinical level with senior nursing leadership.	
		To implement multi-disciplinary clinical improvement meeting on each ward monthly.	
		To implement Leadership "walk about" on a weekly basis.	
		Trust to appoint a service improvement co-ordinator MH and LD services. Post appointed January 2020.	
		To Review the model of Multi-Disciplinary working on the Muckamore Abbey Hospital site to include staff working in Community Services.	

Regulation Quality and Improvement Authority			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
To address the recommendations raised by RQIA in their improvement notices – to finance, staffing, -- and safeguarding.	Co-Director	To review patient finances in MAH, develop guidance for nursing and finance staff. Work with "Department of Communities" to ascertain the accuracy of benefits currently received by patients to ensure appropriate financial systems and processes are in place to protect patients and staff and refer to the "Office of Care and Protection" where appropriate.	
		To conduct unannounced inspections of the revised finance procedures.	
		To review the Trust seclusion policy and provide training to staff as appropriate	
		To work with the RHSCB to access the Trust compliance with safeguarding policies and procedures on the MAH site, review and train staff as appropriate.	
	Divisional Nurse	To develop an interactive interim workforce plan for each ward to ensure the safe and effective care and staffing levels until the regional 'Delivering Care' workforce plan is complete and train staff in its use.	

Resettlement			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
To resettle the Adult Learning Disability population (52 of MAH patients into suitable community facilities with appropriate support and input from facilities staff and Health and Social Care teams.	Director	All care and treatment plans to be fully updated by the multidisciplinary team for all patients in each HSC Trust to ascertain the level of need for each patient, where their need can best be met alongside assessing the level and nature of unmet needs (52 patients remaining)	
		To inform the commissioner and DOH of current and future needs of the Muckamore Abbey Hospital patient population to ensure adequate commissioning and provision of safe and effective care now and in the future.	
		To work with the commissioner and HSC Trusts to review the “admission policy” and current agreement for Muckamore Abbey Hospital to continue to receive admissions from other Trusts with a view to finding alternative arrangements within the region in order to expedite the resettlement process.	

RAG Rating	
Completed	
Work in progress	
Progress required/Risk of not meeting target	

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NURSING WORKFORCE STAFFING MODEL

Inpatient Learning Disability Service

March 2019

1.0 Background and Current Service Provision

Muckamore Abbey Hospital is currently commissioned to provide acute care to those individuals with an intellectual disability with behavioural or mental ill health needs who require acute inpatient care and treatment. The hospital is commissioned to deliver a total of 62 beds for acute assessment and treatment, 6 psychiatric intensive care beds for the Northern, South Eastern and Belfast Health & Social Care Trusts and 19 regional forensic low secure beds, totalling 87 beds. This bed total was agreed in 2005 however with decreasing inpatient numbers and admission trends a future plan will be forthcoming.

The hospital currently provides care to four groups of patients:

- assessment and treatment in-patient population
- regional low secure forensic patient population
- complex delayed discharge patient population
- resettlement patient population

Additionally there is an 8-bedded children's acute inpatient ward for assessment and treatment which is located in central Belfast and one remaining resettlement ward (Erne) which is still operational for 9 patients.

A regional workshop, facilitated by the HSCB was held on 27/01/16 at which the issues associated with hospital modernisation and community infrastructure developments were discussed. The model agreed following this consultation requires active treatment services for men and women who require acute admission for the least possible length of time and in the least restrictive environment possible. A small number of psychiatric intensive care beds and a specialist inpatient service for men with intellectual disability and forensic histories will continue to be provided. The potential to provide low secure treatment services for males and females is being considered to future proof the service and provide for the continuum of care. All these services will require a full range of multi-professional input, including psychiatry, psychology, nursing, social work, occupational therapy, speech and language therapy and other specialist inputs.

The proposed draft paper outlines a proposed workforce model based on a reduced bed compliment once the complex delayed discharge patient population has been re-settled. It also proposes an interim staffing model which will be adopted with immediate effect. There will be a gradual increase in staffing numbers over a 24-month period as additional staff are recruited.

Table 1: Inpatient Services Profile

Table 1: Commissioned Bed Numbers (1st April 2018) and Current Bed Numbers

Ward	Function	Commissioned Bed Numbers	Current Bed Numbers
Cranfield 1	Acute Admissions male	14	12
Cranfield 2	Treatment male (Future Low Secure male)	16	16
Donegore	Treatment female (Future low secure female)	9	17 (Ardmore)
Killead	Acute admissions female	24	0
Erne	Resettlement (closure planned)	9	9
PICU	Intensive care M / F	6	0
Sixmile Assessment & Treatment	Regional Acute Low secure Forensic Male	19	15
Total		**97**	**69**
Iveagh centre	Regional Acute Admissions M/F	8	8
Total		**105**	**77**

2.0 Driver for Change

Over recent years, as the retraction process of the hospital and ward closures has progressed, patient acuity levels have increased alongside the number of patients in active assessment and treatment. The staffing model and profile for the hospital was completed in 2005 with the building of the new assessment and treatment core wards. The increase of patients in active treatment has impacted on skill mix requiring more registrants to support the complexity of the patient profile however it has also resulted in higher levels of special observations required for patient safety. This is partly due to the high number of complex individual patients in wards designed to accommodate 14 to 24 patients. The HSCB has funded the cost pressures (total £3.3m) each year on both a recurrent £2m and £1.2 m non-recurrent basis for the past 6 years for additional one-to-one care for patients. In 2016 following a management review it was agreed to appoint substantive staff to stabilise the nursing workforce. The number of hours of one-to-one care for patients has not declined.

BHSCT aims to strengthen capacity and capability within its LD nursing workforce through the development of expertise to enable LD Nurses to provide specialised assessment and treatment inpatient services. The skill mix ratio for learning disability inpatient services within BHSCT to deliver acute assessment and treatment requires a skill mix ratio of 70% registrant / 30% non-registrant if compared with comparable mental health wards**.**

The Trust as part of the modernisation and transformation of the service is introducing a Positive Behaviour Support (PBS) model within adult services with extensive training following successful implementation in the children's inpatient service at Iveagh centre. The aim of this approach is to implement a treatment and intervention approach that builds on the patients' capacity to engage positively in their care and treatment and reduces reliance on restrictive practices. The hospital has invested in a number of specialist practitioners and BILD-accredited PBS coaches to support the rollout of awareness training to all staff and PBS plans to all patients.

The Executive Director of Nursing must provide assurance about the capacity of the workforce to provide quality nursing care to patients, and efficient use of resources through internal and external professional and other assurance frameworks. In line with this, she requested that a nursing workforce review be undertaken and a nurse staffing model developed that would ensure safe and effective nurse staffing levels with a grade mix that would provide appropriate cover for senior clinical decision-making.

3.0 Methodology and Review Process

Within inpatient settings in NI, the methodology used to calculate staff requirements is the Telford method. This approach is underpinned by the clinical judgement and experience of registrants and is often used with other methods of workforce calculation in order to provide a degree of triangulation. In completing this workforce review the Telford method was used

in conjunction with an acuity dependency tool (an adapted version of the Safer Nursing Care Tool (2013).

At a workshop in January 2018 this approach was agreed with the senior nursing team within Learning Disability Inpatient Services and all Ward Sisters and Charge Nurses engaged in this process over a period of 12 weeks.

Principles of the policy framework 'Delivering Care' were followed in reviewing the staffing profiles, specifically as follows:

Skill mix should take account of an allocation of 100% of a Ward Sister's/Charge Nurse's time to fulfil their ward leadership responsibilities; supervise clinical care; oversee and maintain nursing care standards; teach clinical practice and procedures; be a role model for good professional practice and behaviours; oversee the ward environment and assume high visibility as nurse leader for the ward. An appropriate number of Agenda for Change Bands 6 – 7 within a ward setting is also required to have sufficient grade mix to ensure availability of senior decision makers over the seven day week.

4.0 Findings

At the end of the audit period there remained some variances between the results of the two workforce tools and this was believed to be due to the lack of experience of some staff in completing the scores. The staffing requirements from the acuity dependency exercise were then used along with professional judgement to inform a final Telford exercise for each of the ward areas. The Delivering Care standards of 100% Ward Sister/Charge Nurse supervisory role and an appropriate number of senior clinical decisionmakers were incorporated as was the requirement to have a response team to diffuse and de-escalate episodes of challenging behaviour and support others in managing these incidents.

The skillmix and NTB ratio from the Telfords for each of the inpatient learning disability wards are tabulated below. The full Telford, detailing the staffing levels for each of the wards, follows the table.

	CF1	CF2	PICU	Sixmile	Ardmore	Iveagh	Erne
Bed Compliment	14	16	4	15	17	8	9
Skillmix	69:31	69:31	77:23	61:39	72:28	73:27	64:36
NTB Ratio	3.77	3.29	6.45	2.94	3.10	6.41	6.10

4.1 Iveagh – Regional Acute Admissions (Children).

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1			5	0	0	0				
Band 6	1	1	1	1	1	1	1	7	7.5	52.5		52.5			
Band 5	7	7	7	7	7	7	7	49	7.5	277.5			277.5		
Band 3	3	3	3	3	3	3	3	21	7.5	157.5				157.5	
Band 2								0		0					0
Evening															
Band 7								0	0	0	0				
Band 6	1	1	1	1	1	1	1	7	5	35		35			
Band 5	7	7	7	7	7	7	7	49	5	245			245		
Band 3	3	3	3	3	3	3	3	21	5	105				105	
Band 2								0	5	0					0
Night Duty															
Twilight Band 5	3	3	3	3	3	3	3	21	5	105			105		
Band 6	1	1	1	1	1	1	1	7	11.5	80.5		80.5			
Band 5	3	3	3	3	3	3	3	21	11.5	241.5			241.5		
Band 3	2	2	2	2	2	2	2	14	11.5	161				161	
									Sub total	1550.5	0	168	959	423.5	0
									add 24%	377.12	0	40.32	230.16	101.64	0
									Total	1922.62	0	208.32	1189.16	525.14	0
									WTE	51.27	0	5.56	31.71	14.00	0.00
									NTB	6.41	Total Reg			37.27	Total Unreg	14.00
									Beds	8					
									Skill Mix %		73				27

This Telford provides for the Ward Sister/Charge Nurse to be supervisory and ensures there is a Senior Clinical Decisionmaker (Band 6) on duty at all times. It provides for additional staff to be allocated to respond to alarms for management of crisis behaviour and 1:1 care or 2:1 care.

4.2 Erne - This is the last remaining resettlement ward with nine patients still residing on site (6 PTL patients and 3 complex delayed discharge patients).

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1			5	7.5	0	0				
Band 6	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 5	7	7	7	7	7	7	7	49	5.75	281.75			281.75		
Band 3	3	3	3	3	3	3	3	21	5.75	120.75				120.75	
Band 2								0	5.75	0					0
Evening															
Band 7								0	0	0	0				
Band 6	1	1	1	1	1	1	1	7	7.75	54.25		54.25			
Band 5	7	7	7	7	7	7	7	49	7.75	379.75			379.75		
Band 3	3	3	3	3	3	3	3	21	7.75	162.75				162.75	
Band 2								0	7.75	0					0
Night Duty															
										0	0				
Twilight band 5	2	2	2	2	2	2	2	14	6	84		84			
Band 5	3	3	3	3	3	3	3	21	10.75	225.75			225.75		
Band 3	3	3	3	3	3	3	3	21	10.75	225.75				225.75	
Band 3	2	2	2	2	2	2	2	14	6	84				84	
									Sub total	1659	0	178.5	887.25	593.25	0
									add 24%	398.16	0	42.84	212.94	142.38	0
									Total	2057.16	0	221.34	1100.19	735.63	0
									WTE	54.86	0	5.90	29.34	19.62	0.00
									NTB	6.10	Total Reg		35.24	Total Unreg	19.62
									Beds	9					
									Skill Mix %	64					36

This Telford provides for the Ward Sister/Charge Nurse to be supervisory and ensures there is a Senior Clinical Decisionmaker (Band 6) on duty from 0800 until 2000 7 days per week. It provides for additional staff to be allocated to respond to alarms for management of crisis behaviour and 1:1 care or 2:1 care.

The unit operates with a higher level of Senior Nursing Assistants ratio to manage the 1:1 and 2:1 care that all patients in this area are prescribed.

4.3.1 Sixmile Ward – Regional Male Low Secure Forensic Wards

Sixmile is a 19 bedded low secure regional forensic unit comprising of two wards one 6-bedded assessment and one 14-bedded treatment ward. There are a further 4 non-commissioned beds on the treatment ward.

The commissioned purpose of Sixmile is to provide a service for males only with an intellectual disability who come into contact with the criminal justice system due to their offending behaviour, be it challenging and / or aggressive in nature. It accepts referrals from prison services and community teams. The service operates two wards under one staffing team. The overarching purpose of care is to facilitate rehabilitation and re-integration within the community for individuals who have offended or who are at risk of offending.

The service recognises that the two wards have a different profile and acuity levels as patients in treatment ward are usually at a more advanced stage of their treatment as well as a number of those delayed in their discharge. As these patients can present as high risk to the public and to the other patients on site a high level of supervision and monitoring is required both in and out of the ward.

4.3.2 Sixmile In-Patient Unit (14 Beds - Treatment)

		Tues	Wed	Thurs	Fri	Sat		Mon	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1			5	7.5	0	0				
Band 6	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 5	4	4	4	4	4	4	4	28	5.75	161			161		
Band 3	1	1	1	1	1	1	1	7	5.75	40.25				40.25	
Evening															
Band 7	1	1	1	1	1			5	0	0	0				
Band 6	1	1	1	1	1	1	1	7	7.75	54.25		54.25			
Band 5	4	4	4	4	4	4	4	28	7.75	217			217		
Band 3	1	1	1	1	1	1	1	7	7.75	54.25				54.25	
Night Duty															
										0	0				
Twilight Band 6	1	1	1	1	1	1	1	7	6	42		42			
Band 5	2	2	2	2	2	2	2	14	10.75	150.5			150.5		
Band 3	1	1	1	1	1	1	1	7	10.75	75.25				75.25	
									Sub total	834.75	0	136.5	528.5	169.75	0
									add 24%	200.34	0	32.76	126.84	40.74	0
									Total	1035.09	0	169.26	655.34	210.49	0
									WTE	27.60	0	4.51	17.48	5.61	0.00
									NTB	2.12	Total Reg		21.99	Total Unreg	5.61
									Beds	13					
									Skill Mix %	80					20

The above Telford provides for the Ward Sister/Charge Nurse to be supervisory and ensures there is a Senior Clinical Decisionmaker (Band 6) on duty from 0800 until 0200 seven days per week. It provides for additional staff to be allocated to respond to alarms for management of crisis behaviour and 1:1 care or 2:1 care.

4.3.3 Sixmile In-Patient Unit (6 Beds - Assessment)

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1			5	7.5	0	0				
Band 6	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 5	3	3	3	3	3	3	3	21	5.75	120.75			120.75		
Band 3	1	1	1	1	1	1	1	7	5.75	40.25				40.25	
Evening															
Band 7	1	1	1	1	1			5	7.5	0	0				
Band 6	1	1	1	1	1	1	1	7	7.75	54.25		54.25			
Band 5	2	2	2	2	2	2	2	14	7.75	108.5			108.5		
Band 3	1	1	1	1	1	1	1	7	7.75	54.25				54.25	
Night Duty															
Twilight Band 6	1	1	1	1	1	1	1	7	6.0	42.0		42			
Band 5	1	1	1	1	1	1	1	14	10.75	150.5			150.5		
Band 3	1	1	1	1	1	1	1	7	10.75	75.25				75.25	
									Sub total	686	0	136.5	379.75	169.75	0
									add 24%	164.64	0	32.76	91.14	40.74	0
									Total	850.64	0	169.26	470.89	210.49	0
									WTE	22.68	0	5.61	12.56	5.61	0.00
									NTB	3.78	Total Reg		17.07	Total Unreg	5.61
									Beds	6					
									Skill Mix %	75					25

This Telford provides for the Ward Sister/Charge Nurse to be supervisory and ensures there is a Senior Clinical Decisionmaker (Band 6) on duty from 0800 until 0200 seven days per week.

The two units have now been amalgamated and operate at 15 beds. The revised Telford is tabulated below. This Telford provides for the Ward Sister/Charge Nurse to be supervisory and ensures there is a Senior Clinical Decisionmaker (Band 6) on duty at all times

4.3.5 Sixmile 15 beds

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1				7		0				
Band 6	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 5	4	4	4	4	4	4	4	28	5.75	161			161		
Band 3	3	3	3	3	3	3	3	21	5.75	120.75				120.75	
Band 2								0	5.75	0					0
Evening															
Band 7	0	0	0	0	0			0		0	0				
Band 6	1	1	1	1	1	1	1	7	7.75	54.25		54.25			
Band 5	4	4	4	4	4	4	4	28	7.75	217			217		
Band 3	3	3	3	3	3	3	3	21	7.75	162.75				162.75	
Band 2								0	7.75	0					0
Night Duty															
Twilight Band 5	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 6	1	1	1	1	1	1	1	7	11	77					77
Band 5	4	4	4	4	4	4	4	28	11	308			308		
Band 3	2	2	2	2	2	2	2	14	11	154				154	
Band 2								0	11	0					0
									Sub total	1335.25	0	134.75	686	437.5	77
									add 24%	320.46	0	32.34	164.64	105	18.48
									Total	1655.71	0	167.09	850.64	542.5	95.48
									WTE	44.15	0	4.46	22.68	14.47	2.55
									NTB	2.94	Total Reg		27.14	Total Unreg	17.01
									Beds	15					
									Skill Mix %	61					39

4.4 Donegore Ward – Female Assessment and Treatment Ward – 9 Beds

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1			5	7.5	37.5	37.5				
Band 6	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 5	5	5	5	5	5	5	5	35	5.75	201.25			201.25		
Band 3	2	2	2	2	2	2	2	14	5.75	80.5				80.5	
Evening															
Band 7	1	1	1	1	1			5	0	0	0				
Band 6	1	1	1	1	1	1	1	7	7.75	54.25		54.25			
Band 5	5	5	5	5	5	5	5	35	7.75	271.25			271.25		
Band 3	2	2	2	2	2	2	2	14	7.75	108.5				108.5	
Night Duty															
										0	0				
Twilight band 3	1	1	1	1	1	1	1	7	4	28				28	
Band 6	1	1	1	1	1	1	1	7	10.75	75.25		75.25			
Band 5	2	2	2	2	2	2	2	7	10.75	75.25			75.25		
Band 3	1	1	1	1	1	1	1	7	10.75	75.25				75.25	
									Sub total	1047.25	37.5	169.75	547.75	292.25	0
									add 24%	251.34	9	40.74	131.46	70.14	0
									Total	1298.59	46.5	210.49	679.21	362.39	0
									WTE	34.63	1.24	5.61	18.11	9.66	0.00
									NTB	3.85	Total Reg		24.97	Total Unreg	9.66
								Beds		9					
								Skill Mix %		72					28

This Telford provides for the Ward Sister/Charge Nurse to be supervisory and ensures there is a Senior Clinical Decisionmaker (Band 6) on duty at all times.

4.5 Killead Ward – Female Acute Admissions – 24 Beds

Killead is a 24 bedded ward for female patients requiring acute assessment and treatment.

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1			5	0	0	0				
Band 6	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 5	7	7	7	7	7	7	7	49	5.75	281.75			281.75		
Band 3	4	4	4	4	4	4	4	28	5.75	161				161	
Evening															
Band 7								0	0	0	0				
Band 6	1	1	1	1	1	1	1	7	7.75	54.25		54.25			
Band 5	7	7	7	7	7	7	7	49	7.75	379.75			379.75		
Band 3	4	4	4	4	4	4	4	28	7.75	217				217	
Night Duty															
										0	0				
Band 6 Twilight	1	1	1	1	1	1	1	7	5	35		35			
Band 5 Twilight	2	2	2	2	2	2	2	14	5	70			70		
Band 3 Twilight	2	2	2	2	2	2	2	14	5	70				70	
Band 5	4	4	4	4	4	4	4	28	10.75	301			301		
Band 3	2	2	2	2	2	2	2	14	10.75	150.5				150.5	
									Sub total	1760.5	0	129.5	1032.5	598.5	0
									add 24%	422.52	0	31.08	247.8	143.64	0
									Total	2183.02	0	160.58	1280.3	742.14	0
									WTE	58.21	0	4.28	34.14	19.79	0.00
									NTB	3.06	Total Reg		38.42	Total Unreg	19.79
									Beds	19					
									Skill Mix%	66					34

This Telford provides for the Ward Sister/Charge Nurse to be supervisory and ensures there is a Senior Clinical Decisionmaker (Band 6) on duty from 0800 until 0100 each day.

4.6 Killead and Donegore wards have now amalgamated and the new ward, Ardmore, comprises 17 beds. The Telford for Ardmore is tabulated below.

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1			5	7.5	0	0				
Band 6	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 5	7	7	7	7	7	7	7	49	5.75	281.75			281.75		
Band 3	3	3	3	3	3	3	3	21	5.75	120.75				120.75	
Evening															
Band 7								5	0	0	0				
Band 6	1	1	1	1	1	1	1	7	7.75	54.25		54.25			
Band 5	6	6	6	6	6	6	6	42	7.75	325.5			325.5		
Band 3	3	3	3	3	3	3	3	21	7.75	162.75				162.75	
Night Duty															
Twilight (B6)	1	1	1	1	1	1	1	7	5	35			35		
Twilight (B5)	2	2	2	2	2	2	2	14	5	70			70		
Band 5	4	4	4	4	4	4	4	28	10.75	301			301		
Band 3	2	2	2	2	2	2	2	14	10.75	150.5				150.5	
Twilight (B3)	1	1	1	1	1	1	1	7	7.5	52.5				52.5	
									Sub total	1594.25	0	171.5	950.25	437.5	0
									add 24%	382.62	0	41.16	228.06	105	0
									Total	1976.87	0	212.66	1178.31	542.5	0
									WTE	52.72	0	5.67	31.42	14.47	0.00
									NTB	3.10	Total Reg		37.09	Total Unreg	14.47
									Beds	17					
									Skill Mix %		72				28

This Telford provides for the Ward Sister/Charge Nurse to be supervisory and ensures there is a Senior Clinical Decisionmaker (Band 6) from 0800 until 0100 each day.

4.7 Cranfield 1 - Acute Admission Male – 14 beds

Cranfield 1 is a male admissions ward and provides acute assessment and treatment to patients admitted form Belfast, South Eastern and Northern Trust locations. There is on average 50 admissions per year to this ward. A number of these admissions are patients with complex autism and require 1:1 or 2:1 care to support their structure intensive daily routines and minimise the impact of their presentation on the other patients on the ward.

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1			5	7.5	0	0				
Band 6	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 5	7	7	7	7	7	7	7	49	5.75	281.75			281.75		
Band 3	3	3	3	3	3	3	3	21	5.75	120.75				120.75	
Evening															
Band 7	1	1	1	1	1			5	0	0	0				
Band 6	1	1	1	1	1	1	1	7	7.75	54.25		54.25			
Band 5	6	6	6	6	6	6	6	42	7.75	325.5			325.5		
Band 3	3	3	3	3	3	3	3	21	7.75	162.75				162.75	
Night Duty															
Twilight (B6)	1	1	1	1	1	1	1	7	5	35			35		
Twilight (B5)	2	2	2	2	2	2	2	14	5	70			70		
Band 5	4	4	4	4	4	4	4	28	10.75	301			301		
Band 3	2	2	2	2	2	2	2	14	10.75	150.5				150.5	
Twilight (B3)	1	1	1	1	1	1	1	7	7.5	52.5				52.5	
									Sub total	1594.25	0	129.5	978.25	486.5	0
									add 24%	382.62	0	31.08	234.78	116.76	0
									Total	1976.87	0	160.58	1213.03	603.26	0
									WTE	52.72	0	4.28	32.36	16.09	0.00
									NTB	3.77	Total Reg		36.63	Total Unreg	16.09
									Beds	14					
									Skill Mix %	69					31

This Telford provides for the Ward Sister/Charge Nurse to be supervisory and ensures there is a Senior Clinical Decisionmaker (Band 6) on duty from 0800 until 0100 each day.

4.8 Cranfield 2 – Ongoing Treatment Ward Male – 16 beds

Cranfield 2 is for patients for whom ongoing treatment in hospital is required and / or they have completed their treatment but a placement is no readily available for the patient to be discharged to.

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1			5	7.5	0	0				
Band 6	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 5	7	7	7	7	7	7	7	49	5.75	281.75			281.75		
Band 3	3	3	3	3	3	3	3	21	5.75	120.75				120.75	
Evening															
Band 7	1	1	1	1	1			5	0	0	0				
Band 6	1	1	1	1	1	1	1	7	7.75	54.25		54.25			
Band 5	6	6	6	6	6	6	6	42	7.75	325.5			325.5		
Band 3	3	3	3	3	3	3	3	21	7.75	162.75				162.75	
Night Duty															
Twilight (B6)	1	1	1	1	1	1	1	7	5	35			35		
Twilight (B5)	2	2	2	2	2	2	2	14	5	70			70		
Band 5	4	4	4	4	4	4	4	28	10.75	301			301		
Band 3	2	2	2	2	2	2	2	14	10.75	150.5				150.5	
Twilight (B3)	1	1	1	1	1	1	1	7	7.5	52.5				52.5	
									Sub total	1594.25	0	129.5	1013.25	486.5	0
									add 24%	382.62	0	31.08	243.18	116.76	0
									Total	1976.87	0	160.58	1256.43	603.26	0
									WTE	52.72	0	4.28	33.50	16.09	0.00
									NTB	3.29	Total Reg		36.63	Total Unreg	16.09
									Beds	16					
									Skill Mix %		69				31

This Telford provides for the Ward Sister/Charge Nurse to be supervisory and ensures there is a Senior Clinical Decisionmaker (Band 6) from 0800 until 0100 each day.

4.9 PICU – Intensive Care Unit male / Female – 6 beds

PICU supports the other wards on site by providing care and treatment for patients in the acute phase of their illness or acute behaviour management. All patients in PICU are detained and has a seclusion suite for extreme behaviour support.

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1	0	0	5	7.5	0	0				
Band 6	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 5	4	4	4	4	4	4	4	28	5.75	161			161		
Band 3	1	1	1	1	1	1	1	7	5.75	40.25				40.25	
Evening															
Band 7	0	0	0	0	0	0	0	0	0	0	0				
Band 6	1	1	1	1	1	1	1	7	7.75	54.25		54.25			
Band 5	4	4	4	4	4	4	4	28	7.75	217			217		
Band 3	1	1	1	1	1	1	1	7	7.75	54.25				54.25	
Night Duty															
Band 6	1	1	1	1	1	1	1	7	11	42		42			
Band 5	2	2	2	2	2	2	2	14	10.75	150.5			150.5		
Band 3	1	1	1	1	1	1	1	7	10.75	75.25				75.25	
									Sub total	834.75	0	136.5	528.5	169.75	0
									add 24%	200.34	0	32.76	126.84	40.74	0
									Total	1035.09	0	169.26	655.34	210.49	0
									WTE	27.60	0	4.51	17.48	5.61	0.00
									NTB	4.60	Total Reg		21.99	Total Unreg	5.61

This Telford provides for the Ward Sister/Charge Nurse to be supervisory and ensures there is a Senior Clinical Decisionmaker (Band 6) on duty at all times.

It is anticipated that the future requirement will be for a 4-bedded PICU. The Telford for this is tabulated below.

4.9.1 4 Bedded PICU

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1						0				
Band 6	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 5	3	3	3	3	3	3	3	21	5.75	120.75			120.75		
Band 3	1	1	1	1	1	1	1	7	5.75	40.25				40.25	
Band 2								0	5.75	0					0
Evening															
Band 7	0	0	0	0	0			0		0	0				
Band 6	1	1	1	1	1	1	1	7	7.75	54.25		54.25			
Band 5	3	3	3	3	3	3	3	21	7.75	162.75			162.75		
Band 3	1	1	1	1	1	1	1	7	7.75	54.25				54.25	
Band 2								0	7.75	0					0
Night Duty															
Twilight Band 6	1	1	1	1	1	1	1	7	11	77		77			
Band 5	2	2	2	2	2	2	2	14	11	154			154		
Band 3	1	1	1	1	1	1	1	7	11	77				77	
Band 2								0	11	0					0
									Sub total	780.5	0	171.5	437.5	171.5	0
									add 24%	187.32	0	41.16	105	41.16	0
									Total	967.82	0	212.66	542.5	212.66	0
									WTE	25.81	0	5.67	14.47	5.67	0.00
									NTB	6.45	Total Reg		20.14	Total Unreg	5.67
									Beds	4					
									Skill Mix %	77					23

This Telford provides for the Ward Sister/Charge Nurse to be supervisory and ensures there is a Senior Clinical Decisionmaker (Band 6) on duty at all times. It is comparable to the PICU normative ranges for mental Health (Phase 5B Delivering Care), with a NTB ratio of 6.66 and a skillmix of 79/21.

5.0 Current Staffing

The current staffing is detailed in the table below:

Ward	Band	FSL	Staff in post
CF1 12 beds	7	1	1
	6	2	1
	5	17.7	10.17
	3	20.4	19.27
CF2 16 beds	7	1	1
	6	2	2
	5	17	9.12
	3	32	30.95
PICU 6 beds but termporarily closed	7	1	1
	6	2	2.8
	5	14.75	9.53
	3	11	11.32
Sixmile 15 beds	7	1	1
	6	2	3
	5	20	9.9
	3	20	14.23
Ardmore 17 beds	7	1	1
	6	3	3
	5	33.2	19.36
	3	48	45.13
Iveagh 8 beds	7	1	1
	6	2	2.9
	5	21	11.8
	3	20	18.97
Erne 9 beds	7	1	1
	6	2	1
	5	12.4	9.4
	3	29	24.41
Total registrant		158.05	101.98
Total Non-Registrants		180.4	164.28
Total staff		338.45	266.26

6.0 Option Appraisal

A number of options have been considered in relation to strengthening capacity and capability within the LD nursing workforce to enable LD Nurses to provide specialised assessment and treatment inpatient services. The skill mix ratio for learning disability inpatient services within BHSCT to deliver acute assessment and treatment requires a skill mix ratio of 70% registrant / 30% non-registrant if compared with comparable mental health wards and the options below describe a number of phased approaches to achieving this.

Option 1:

Increase Registrants and Senior Decision Makers 12 hrs per day Interim with 50/50 skill mix and Supervisory Ward Sister/Charge Nurse:

This would provide for an interim staffing skill mix of 50/50 taking into account the substantive staffing required to deliver on the 3000 hours of constant supervision per week and includes the headroom in the whole time equivalent.
This interim solution incrementally increases the number of registrants per ward returning each ward to circa 50 /50 skill mix with increasing the senior decision-making on the ward to include a Band 6 on every shift from 0800 until 2000 each day. The Ward Sister/Charge Nurse will be supervisory.

Option 2:

Increase Registrants and Senior Decision Makers 24 hrs per day Interim with 50/50 skill mix and Supervisory Ward Sister/Charge Nurse:

This would provide for an interim staffing skill mix of 50/50 taking into account the substantive staffing required to deliver on the 3000 hours of constant supervision per week and includes the headroom in the whole time equivalent.
This interim solution incrementally increases the number of registrants per ward returning each ward to circa 50 /50 skill mix with increasing the senior decision-making on the ward to include a Band 6 on every shift. The Ward Sister/Charge Nurse will be supervisory.

Option 3:

Full implementation of the workforce assessment to implement the staffing numbers and ratios and the skill mix outlined in the preceding Telfords. This will include supervisory Ward Sister/Charge Nurse on all wards and enhance senior clinical decision making:

This will not be immediately deliverable or realised due to the limited numbers of available registrants trained per year. QUB has increased their training capacity for pre-registration students by 25% to 40. The OU programme is designing a LD pre-registration programme for 2019 with a potential 18 per year.

Review of Options:

It is proposed to implement interim staffing ratios (based on current availability of staff) as detailed by ward in the appendices. It is proposed to progress to full implementation of Option 3 within a 2-3 year timeframe. The 4-bedded PICU which is currently closed should be staffed on opening with a skillmix of 80:20. The Telfords for each area have been reviewed in line with this and incorporating current bed numbers and the summary of this is tabulated below. In summary an additional 27.57 Registrants are required to implement the interim proposed staffing model. There will be a surplus of 16.47 non-registrant staff. The resultant average skillmix will be 47:53 registrant to non-registrant.

Ward	Band	FSL	Current Staff in post	Proposed Interim SIP	Proposed Interim Skillmix	Proposed Interim NTB ratio
CF1	**7**	1	1	**1**	43/57	2.83
12 beds	**6**	2	1	**3.12**		
	5	17.7	10.17	**11.34**		
	3	20.4	19.27	**19.49**		
CF2	**7**	1	1	**1**	36/64	2.96
16 beds	**6**	2	2	**3.12**		
	5	17	9.12	**13.89**		
	3	32	30.95	**27.79**		
PICU 6 beds but termporarily closed	**7**	1	1	**1**	77/23	6.1
	6	2	2.8	**4.28**		
	5	14.75	9.53	**14.47**		
	3	11	11.32	**5.67**		
Sixmile	**7**	1	1	**1**	44/56	2.38
15 beds	**6**	2	3	**5.67**		
	5	20	9.9	**9.95**		
	3	20	14.23	**20.14**		
Ardmore	**7**	1	1	**1**	41/59	2.59
17 beds	**6**	3	3	**5.67**		
	5	33.2	19.36	**12.5**		
	3	48	45.13	**25.81**		
Iveagh	**7**	1	1	**1**	46/54	5.8
8 beds	**6**	2	2.9	**5.44**		
	5	21	11.8	**16.09**		
	3	20	18.97	**24.9**		
Erne	**7**	1	1	**1**	41/59	5.13
9 beds	**6**	2	1	**5.67**		
	5	12.4	9.4	**11.34**		
	3	29	24.41	**24.01**		
Total registrant		158.05	101.98	**129.55**	47/53	
Total Non-Registrants		180.4	164.28	**147.81**		
Total staff		338.45	266.26	**277.36**		

7.0 Recommendations

It is proposed the revised Safer Acuity Dependency tool is fully implemented within the Inpatient Learning Disability wards and it is expected that increased user confidence and improved compliance with all aspects of the tool will provide more robust data.

Following the review of the ward rosters, full and robust compliance with electronic rostering must continue to ensure effective resource utilisation.

It is recognised that remodelling the service to these levels will require significant investment and it is suggested that Learning Disability will be considered in the next phase of the Delivering Care (Normative Staffing) Programme. Mental Health services have been undertaken in Phase 5 and the Learning Disability model should be based on this.

The potential for recruitment of Adult Nurses/ Children's Nurses/Mental Health Nurses to relevant areas must be further explored. BHSCT is not currently experiencing difficulties in recruiting mental health registrants at Band 5 and this therefore would be the initial field to target, with a focus on recruiting from universities in Scotland/Northern England who have a large N Ireland undergraduate population.

The potential for a social care model for Erne Ward should be fully explored. This work is being undertaken by a senior nurse within Muckamore.

Full engagement in the development framework for Nursing Assistants/Senior Nursing Assistants is required to ensure a healthy, robust non-registrant workforce.

A nursing recruitment and retention strategy incorporating the identification of service-critical posts is required.

Appendices: Telfords for Interim Proposed Staffing Levels

Iveagh:

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1				0		0				
Band 6	1	1	1	1	1	1	1	7	7.5	52.5		52.5			
Band 5	3	3	3	3	3	3	3	21	7.5	157.5			157.5		
Band 3	6	6	6	6	6	6	6	36	7.5	270				270	
Band 2								0		0					0
Evening															
Band 7	0	0	0	0	0			0		0	0				
Band 6	1	1	1	1	1	1	1	7	5	35		35			
Band 5	4	4	4	4	4	4	4	28	5	140			140		
Band 3	5	5	5	5	5	5	5	35	5	175				175	
Band 2								0	5	0					0
Night Duty															
Night Band 6	1	1	1	1	1	1	1	7	11	77		77			
Twilight Band 5	1	1	1	1	1	1	1	7	5	35			35		
Band 5	2	2	2	2	2	2	2	14	11	154			154		
Band 3	4	4	4	4	4	4	4	28	11	308				308	
Band 2								0	11	0					0
									Sub total	1404	0	164.5	486.5	753	0
									add 24%	336.96	0	39.48	116.76	180.72	0
									Total	1740.96	0	203.98	603.26	933.72	0
									WTE	46.43	0	5.44	16.09	24.90	0.00
									NTB	5.8	Total Reg		21.53	Total Unreg	24.90
									Beds	8					
									Skill Mix %		46				54

Erne:

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1				7		0				
Band 6	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 5	2	2	2	2	2	2	2	14	5.75	80.5			80.5		
Band 3	5	5	5	5	5	5	5	35	5.75	201.25				201.25	
Band 2								0	5.75	0					0
Evening															
Band 7	0	0	0	0	0			0		0	0				
Band 6	1	1	1	1	1	1	1	7	7.75	54.25		54.25			
Band 5	2	2	2	2	2	2	2	14	7.75	108.5			108.5		
Band 3	4	4	4	4	4	4	4	28	7.75	217				217	
Band 2								0	7.75	0					0
Night Duty															
Night Band 6	1	1	1	1	1	1	1	7	11	77		77			
Band 5	2	2	2	2	2	2	2	14	11	154			154		
Band 3	4	4	4	4	4	4	4	28	11	308				308	
Band 2								0	11	0					0
									Sub total	1240.75	0	171.5	343	726.25	0
									add 24%	297.78	0	41.16	82.32	174.3	0
									Total	1538.53	0	212.66	425.32	900.55	0
									WTE	41.03	0	5.67	11.34	24.01	0
									NTB	5.13	Total Reg		17.01	Total Unreg	24.01
									Beds	9					
									Skill Mix %	41					59

Sixmile:

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1				7		0				
Band 6	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 5	2	2	2	2	2	2	2	14	5.75	80.5			80.5		
Band 3	4	4	4	4	4	4	4	28	5.75	161				161	
Band 2								0	5.75	0					0
Evening															
Band 7	0	0	0	0	0			0		0	0				
Band 6	1	1	1	1	1	1	1	7	7.75	54.25		54.25			
Band 5	2	2	2	2	2	2	2	14	7.75	108.5			108.5		
Band 3	4	4	4	4	4	4	4	28	7.75	217				217	
Band 2								0	7.75	0					0
Night Duty															
Night Band 6	1	1	1	1	1	1	1	7	11	77		77			
Twilight Band 5	1	1	1	1	1	1	1	7	5	35			35		0
Band 5	1	1	1	1	1	1	1	7	11	77			77		
Band 3	3	3	3	3	3	3	3	21	11	231				231	
Band 2								0	11	0					0
									Sub total	1081.5	0	171.5	301	609	0
									add 24%	259.56	0	41.16	72.24	146.16	0
									Total	1341.06	0	212.66	373.24	755.16	0
									WTE	35.76	0	5.67	9.95	20.14	0
									NTB	2.38	Total Reg		15.62	Total Unreg	20.14
									Beds	15					
									Skill Mix %		44				56

Ardmore:

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1				7		0				
Band 6	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 5	2	2	2	2	2	2	2	14	5.75	80.5			80.5		
Band 3	5	5	5	5	5	5	5	35	5.75	201.25				201.25	
Band 2								0	5.75	0					0
Evening															
Band 7	0	0	0	0	0			0		0	0				
Band 6	1	1	1	1	1	1	1	7	7.75	54.25		54.25			
Band 5	2	2	2	2	2	2	2	14	7.75	108.5			108.5		
Band 3	5	5	5	5	5	5	5	35	7.75	271.25				271.25	
Band 2								0	7.75	0					0
Night Duty															
Night Band 6	1	1	1	1	1	1	1	7	11	77					77
Twilight Band 5	1	1	1	1	1	1	1	7	5	35			35		0
Band 5	2	2	2	2	2	2	2	14	11	154			154		
Band 3	4	4	4	4	4	4	4	28	11	308				308	
Band 2								0	11	0					0
									Sub total	1330	0	171.5	378	780.5	
									add 24%	319.2	0	41.16	90.72	187.32	
									Total	1649.2	0	212.66	468.72	967.82	
									WTE	43.98	0	5.67	12.50	25.81	
									NTB	2.59	Total Reg		18.17	Total Unreg	25.81
									Beds	17					
									Skill Mix %	41					59

Cranfield 1:

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1				7		0				
Band 6	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 5	2	2	2	2	2	2	2	14	5.75	80.5			80.5		
Band 3	4	4	4	4	4	4	4	64	4	16				64	
Band 2								0	5.75	0					0
Evening															
Band 7	0	0	0	0	0			0		0	0				
Band 6	1	1	1	1	1	1	1	7	7.75	54.25		54.25			
Band 5	2	2	2	2	2	2	2	14	7.75	108.5			108.5		
Band 3	4	4	4	4	4	4	4	28	7.75	217				217	
Band 2								0	7.75	0					0
Night Duty															
Band 5	2	2	2	2	2	2	2	14	11	154			154		
Band 3	4	4	4	4	4	4	4	28	11	308				308	
Band 2								0	11	0					0
									Sub total	1026.5	0	94.5	343	589	0
									add 24%	246.36	0	22.68	82.32	141.36	0
									Total	272.86	0	117.18	425.32	730.36	0
									WTE	33.94	0	3.12	11.34	19.49	0.00
									NTB	2.83	Total Reg		14.47	Total Unreg	19.48
									Beds	12					
									Skill Mix %		43				57

Cranfield 2:

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1				7		0				
Band 6	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 5	2	2	2	2	2	2	2	14	5.75	80.5			80.5		
Band 3	6	6	6	6	6	6	6	36	5.75	207				207	
Band 2								0	5.75	0					0
Evening															
Band 7	0	0	0	0	0			0		0	0				
Band 6	1	1	1	1	1	1	1	7	7.75	54.25		54.25			
Band 5	2	2	2	2	2	2	2	14	7.75	108.5			108.5		
Band 3	6	6	6	6	6	6	6	42	7.75	325.5				325.5	
Band 2								0	7.75	0					0
Night Duty															
Night Band 6	1	1	1	1	1	1	1	7	11	77					77
Band 5	3	3	3	3	3	3	3	21	11	231			231		
Band 3	4	4	4	4	4	4	4	28	11	308				308	
Band 2								0	11	0					0
									Sub total	1432	0	94.5	420	840.5	77
									add 24%	343.68	0	22.68	100.8	201.72	18.48
									Total	1775.68	0	117.18	520.8	1042.22	95.48
									WTE	47.35	0	3.12	13.89	27.79	2.55
									NTB	2.96	Total Reg			Total Unreg	30.34
									Beds	16					
									Skill Mix %		36				64

4 Bedded PICU:

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1						0				
Band 6	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 5	3	3	3	3	3	3	3	21	5.75	120.75			120.75		
Band 3	1	1	1	1	1	1	1	7	5.75	40.25				40.25	
Band 2								0	5.75	0					0
Evening															
Band 7	0	0	0	0	0			0		0	0				
Band 6	1	1	1	1	1	1	1	7	7.75	54.25		54.25			
Band 5	3	3	3	3	3	3	3	21	7.75	162.75			162.75		
Band 3	1	1	1	1	1	1	1	7	7.75	54.25				54.25	
Band 2								0	7.75	0					0
Night Duty															
Twilight Band 6	1	1	1	1	1	1	1	7	5	35		35			
Band 5	2	2	2	2	2	2	2	14	11	154			154		
Band 3	1	1	1	1	1	1	1	7	11	77				77	
Band 2								0	11	0					0
									Sub total	738.5	0	129.5	437.5	171.5	0
									add 24%	177.24	0	31.08	105	41.16	0
									Total	915.74	0	160.58	542.5	212.66	0
									WTE	24.42	0	4.28	14.47	5.67	0.00
									NTB	6.10	Total Reg		18.75	Total Unreg	5.67
									Beds	4					
									Skill Mix %		77				23

Belfast Health and Social Care Trust

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NURSING WORKFORCE STAFFING MODEL

Inpatient Learning Disability Service

Feb 2022

V 1.1 01/06/18

Table of Contents **Page**

1.0 Background and Current Service Provision

Muckamore Abbey Hospital is currently commissioned to provide acute care to those individuals with an intellectual disability with behavioural or mental ill health needs who require acute inpatient care and treatment. The hospital is commissioned to deliver a total of 62 beds for acute assessment and treatment, 6 psychiatric intensive care beds for the Northern, South Eastern and Belfast Health & Social Care Trusts and 19 regional forensic low secure beds, totalling 87 beds.

The hospital provides care to four groups of patients:

- **resettlement patient population**
- **a small number of patients who require assessment and treatment**
- **complex delayed discharge patient population**
- **regional low secure forensic patient population**

The Bamford Review (2007) concluded that hospital settings are no longer considered appropriate long-term domicile settings for individuals and this has provided the strategic direction of travel for BHSCT within the last decade. There has been a process of retraction of hospital based care for those patients residing in continuing care wards within Muckamore.

In early 2019, the Permanent Secretary gave a commitment to service users, families, carers and the public that no person should call a hospital their home and resolved to have current residents resettled to their forever homes by December of that year. At that time there were more than 55 people living on site. As of 3rd February 2022, 38 people are living at MAH, these service users have been assessed as no longer requiring active hospital treatment and are awaiting resettlement to their forever homes. Many of these people have lived in MAH for more than 5 years, with some living on site for decades.

Despite active recruitment over the past 2-3 years there has been a reduction in the numbers of Registered Learning Disability Nurses (RNLDs) in MAH. Currently, there are 24 whole time equivalent (wte) RNLDs working on site. The BHSCT RNLD workforce is spread across the five clinical areas in an effort to maintain safe staffing levels while providing the essential clinical expertise and support to patients. In order to meet the current needs of the service a high number of block booked agency staff supplement the BHSCT nursing teams (circa 50 wte) , the majority of whom are Registered Mental Health Nurses (RNMH). Although many of the agency staff have been working on site for more than 1 year and are familiar with the care needs of the service users, they do not hold an RNLD qualification, which is an inherent risk the Trust is currently carrying. Ultimately, the workforce vacancies have had a direct and negative impact on the ability of the clinical teams to admit new patients for assessment and treatment.

Until October 2021, the last admission to MAH was in December 2019. The most recent admissions have been for detained patients with moderate intellectual disability for which all alternatives to detention and admission, i.e. Therapeutic Support Services, Multi-Disciplinary approaches, had failed.

These recent admissions have required wider discussion with the Health and Social Care Board (HSCB), Department of Health (DoH), Police Service of Northern Ireland (PSNI) and the Regulation and Quality Improvement Authority (RQIA) with an acceptance within the system that the pathway into MAH has been the least worst option for these individuals at the time, but is not without risk to care the provision to the existing population on site.

2.0 Budgetary Issues

Over the past number of years BHSCT has submitted cost pressures to the HSCB on a monthly and yearly basis to meet the nursing supervision and observation and treatment needs of the patient population within inpatient learning disability services and these have been funded each year on a non-recurrent basis. This budget (£2.8m, which equates 98 WTE Band 3 staff) continues to be provided on a non recurrent basis as a number of those on supervision are delayed discharge patients.

Table 2: Forecast End of Year position for Muckamore Abbey Hospital (excluding Iveagh Unit) for Financial Year 2021 / 2022

	Budget (£'000)	Actuals (£'000)	Variance (£'000)
Staff Costs	14,269	19,550	5,280
Goods and Services	605	735	130
Forecast Total on CP	14,874	20,285	5,411
Trust Board Adjustments	5,000	-	(5,000)
Revised Forecast Position	**19,874**	**20,285**	**411**

3.0 Drivers for Change/ Current position

3.1 Environment

The hospital has, over the past 10 years, undergone a significant retraction in the number of wards and bed numbers on site with the most recent ward closing being Erne ward. The total number of physical bedrooms available in the hospital is detailed below.

Table 1: Current Inpatient bed Profile

Ward	Function	Bed rooms	In patient numbers/open beds
Cranfield 1	Admission and long term care	14	8
Cranfield 2	Long terms care	16	7
PICU	Intensive Care	6 (closed as a PICU)	1
Killead	Male long term care	24	8
Donegore	Female long term care	9	5
Sixmile	Low Secure Forensic Unit	19	9
Total		88	38

3.2 Patients who require resettlement

MAH continues to provide care for 35 long stay patients across site. These patients in the main havetheir assessments completed and no longer require hospital inpatient care, however, their community placement is not yet available or they require bespoke intensive support models of community support and infrastructure due to complexity of their individual needs.
These patients are inappropriately residing in hospital and there is an on-going need for the three Trusts, the HSCB and other stakeholders / agencies to continue to plan, develop and deliver community based accommodation and support services to meet their needs.

Recently there has been agreement to explore and “on site option” for a very small number of patients (n=4) who have lived most of their adult lives in MAH. There is a business case in development with the HSCB to work through the requirements for this option.

The model of care for the service users who live on site and who require ongoing care whilst they wait on their forever home requires attention. Current wards would change from an illness to a functional social model of care.

A significant cohort of these service users require high levels of support and observation. Levels of support can vary based on the individual needs of each resident, but may take the form of at least

one member of staff with the service user during waking hours (that is they are on a 1:1 or a 2:1 level of support & observation).

The reasons for the high levels of support and observation are multi-factorial and based on risk assessments including:

a) Acute risk of deliberate/accidental self-harm/self-injury.
b) Acute risk of harm to others.
c) Acute risk of damage to property.
d) Risk of leaving the ward unattended.
e) Management of physical health risks (e.g., falls, seizures, etc.).
f) Immediate/short-term risk from common dangers ('continuing care need').
g) Prevention of safeguarding incidents (protection plan).
h) Implementation of care plan/communication plan/Positive Behaviour Support Plan (PBSP).
i) Implementation of structured daily activity schedule.
j) Engage in social and therapeutic interaction as far as the patient is willing and able.
k) Appropriate socialisation (especially for segregated patients).
l) Emotional/therapeutic support (for internal conflict/distress).
m) Support with functional needs/rehabilitation (building up life skills).
n) More in-depth assessment of mental/behavioural state/presentation (for feedback to MDT).
o) Assessment/outcome monitoring of care plan.
p) Staff need to be able to respond quickly if any immediate care needs arise.

3.3 Current assessment and Treatment

The hospital is commissioned to provide a total of 62 beds for acute assessment and ongoing treatment for the Northern, South Eastern and Belfast Health & Social Care Trusts across several ward areas.

In the past 2-3 years the ability to safely admit patients to Muckamore Abbey hospital has been negatively impacted by the reducing numbers of RNLDs available to work and the inability to recruit to those vacant RNLD posts.

There is an urgent requirement to rebuild the assessment and treatment service on site. An active assessment and treatment service focuses on the needs of the patients aimed at high quality and safe services with timely discharge. The service needs to provide this service for people who require acute admission for the least possible length of time and in the least restrictive environment possible. As well as assessment and treatment services there is a requirement to include capacity for a small number of intensive treatment beds for those who need a This cannot be managed

without the input and skills of the existing RNLD workforce and an intensive recruitment of RNLDs to supplement the wte numbers.

To create a modern assessment and treatment facility is entirely contingent upon patients with delayed discharges leaving hospital accommodation. In managing the admission beds there needs to be a recognition that there is a is a severe shortage of appropriate accommodation and support options for patients and their families to consider when they are deemed medically fit for discharge. This shortage has the negative impact of increasing the patient's length of stay in hospital whilst community placement options are explored. Also whilst awaiting placement some patients can experience deterioration in their mental health or behaviours and as a result need to move in and out of active treatment.

3.4 Current Regional Low Secure Forensic Services

The commissioned purpose of Sixmile is to provide a service for males only with an intellectual disability who come into contact with the criminal justice system due to their offending behaviour, be it challenging and / or aggressive in nature. Sixmile seeks to provide the most effective care and support within a low secure unit, which is a safe environment for both patients and staff. The overarching purpose of care is to facilitate rehabilitation and re-integration within the community for individuals who have offended or who are at risk of offending.

There is currently **no female low secure forensic provision** commissioned in N. Ireland for those with an intellectual disability.

In the past 2-3 years the ability to safely admit patients to the low secure forensic unit at Muckamore Abbey hospital has been negatively impacted by the reducing numbers of RNLDs available to work and the inability to recruit to those vacant RNLD posts.

3.5 Current Workforce

MAH retains its hospital registration; therefore, the therapeutic support and observation required by the people living in MAH is undertaken by nurses and SNAs as part of a wider multi-disciplinary team. However if these individuals lived in a social care setting outside of a hospital environment, both support and observation is provided by registered social care staff with input from a multi-disciplinary team including Allied Health Professionals, Social Work, Psychology, Behaviour Therapy, RNLDs and Medical Staff.

The hospital model of care that people currently receive does not reflect their individual needs and is disproportionate to how those needs are met once resettled in the community; leading to

disempowerment of patients and complicating the resettlement process as an extended period of transition maybe required.

4.0 Proposal

BHSCT aims to manage and balance the ongoing care needs of the existing patient population whilst strengthening the capacity and capability within its LD nursing workforce through the development of expertise to enable LD Nurses to provide specialised assessment and treatment inpatient & forensic services.

4.1 Care needs for those patients who await resettlement

This will require identification of a ward(s) which could become a step down/transitional unit and manage a bed configuration across site. Current wards would change from an illness to a functional social model of care with a re-configured workforce that takes full account of the staffing skill mix and multi-professional team that is required to manage the ongoing care needs people who are awaiting their forever homes.

This identified need, acknowledges that there are a number of unknowns at this point for example, Muckamore Abbey is registered as a hospital. There would need to be a rethink and review in respect of the registration of part of the site to facilitate a social care model on the site. As the result of this review as at this point unknown it may require adjustment to modernisation plans when impact is known.

4.2 Re-development of assessment and treatment beds (including capacity for forensic admissions)

There is a requirement to have assessment and treatment capacity based on MAH focussed on the needs of the patient, aimed at high quality and safe services with timely discharge. This model needs to deliver these services for men and women who require acute admission for:

- The least possible length of time,
- In the least restrictive environment possible.

Included within the assessment and treatment capacity there is a need to give consideration to a small number of small number of intensive care beds for those who need to move to such an environment for a period of treatment before returning to a less restrictive option, and a specialist inpatient service for men with intellectual disability and forensic histories.

The needs of female forensic patients with intellectual disability is not considered within this paper and although it is a recognised gap and would require additional consideration with the HSCB.

All these services will require a full range of multi-professional input-including psychiatry, psychology, nursing, social work, occupational therapy, speech and language therapists and other specialist inputs as required to meet need.

In the modernisation of assessment and treatment care, processes will be reviewed and updated to ensure that discharge planning is strengthened. Planning for discharge from hospital is essential, from the time of admission for patients whose admission is unscheduled. For patients whose admission is planned, discharge planning should begin prior to their hospital treatment. Robust engagement and collaborative working with HSCTs community colleagues to plan and achieve early and timely discharge will need to be consolidated as part of a managed clinical network of services.

4.3 Proposed modernised Bed Profile

Please see table below

Table 2: Proposed modernised Bed Profile

Ward	Function	Bed Numbers
Cranfield 1	Male Admission and ongoing care (includes staffing for 1 intensive care bed)	10 Start with 5 and phase to 10
Cranfield 2	Female admission and ongoing care (includes staffing for 1 intensive care bed)	10 Start with 5 and phase to 10
PICU	Intensive Care	Patients requiring ICU would move into the environment but staffed by existing Cranfield staff. Their bed in Cranfield would be kept for them.
Killead	Male long term care	9
Donegore	Male long term care to move to female long term care as numbers retract across site.	9
Sixmile	Low Secure Forensic Unit	Start with 10 in total and then phase to 14 4 assessment 10 treatment

There would be capacity built into the assessment and treatment beds to allow a patient to move from that ward into a PICU bed and the staff would follow them. Their bed in assessment and

treatment would be kept for the patient so that they have an exit strategy out of PICU and back to the general ward at the most appropriate time.

The step down unit would be for males in the first instance because the majority of the existing population currently are males. However as the patient numbers retract, Donegore could be reconfigured in the future as a female step down unit.

5.0 Methodology and Review Process

Within inpatient settings in NI, the method that is used to calculate staff requirements is the Telford method. This approach is underpinned by the clinical judgement and experience of registrants and is often used with other methods of workforce calculation in order to provide a degree of triangulation.

In completing this workforce review the Telford method was used in conjunction with an assessment of the care need of the existing patient population and the levels of observation policy.

Telford exercises were undertaken with each of the Ward Sisters and Charge Nurse and the results for each can be found in Appendix 1. The Ward Sister/Charge Nurse role has been designated a supervisory role for each ward.

Historically the ratio of the registrant workforce to non-registrants was in the region of 50% to 50% respectively. In recent years, this ratio has been further reduced due to availability of RNLDs and the care needs of the existing patients who are delayed in their discharge and would be cared for in a social care setting with input from a wider MDT on a referral basis. The current skill mix ratio for inpatient learning disability in patient services within BHSCT falls short of the national standard to deliver acute assessment and treatment for which a skill mix ratio of 70% registrant / 30% non-registrant is required**.** Work is ongoing regionally to determine skill mix for Learning Disability Inpatient services under the strategic project Delivering care phase 9a. The skill mix issue has not yet been agreed**.**

The Executive Director of Nursing must provide assurance about the capacity of the workforce to provide quality nursing care to patients, and efficient use of resources through internal and external professional and other assurance frameworks.

In line with this, she requested that a nursing workforce review be undertaken and a nurse staffing model developed that would ensure safe and effective nurse staffing levels with a grade mix that would provide appropriate cover for senior clinical decision-making.

There is a need to review the wider workforce that takes full account of the staffing skill mix and multi-professional team that is required to assess and treat the needs of the ID population requiring acute hospital care. All these services will require a full range of multi-professional input, including psychiatry, psychology, nursing, social work, occupational therapy, speech and language therapy and other specialist inputs. These case for these staff groups are not included in this particular paper.

6.0 Findings

The results of the workforce review using the Telford method in conjunction with an assessment of the care need of the existing patient population and the levels of observation policy is displayed below. In recognition that there would need to be a phased approach to the uplift of assessment beds the proposal offers a 10 bed option (5 male and 5 female) and a 20 bed option (10 male and 10 female).

Table 3: Proposed Inpatient Services NTB Ratios

Ward	Bed numbers	Nurse to bed ratio	Skill mix
Cranfield 1	5 10	3.62 3.92	69/31 68/32
Cranfield 2	5 10	3.62 3.92	69/31 68/32
Sixmile	10 14	3.92 3.65	68/32 70/30

Table 4: Proposed Transitional/ step down staff to bed ratios

Transitional/ step down	Bed numbers	Staff to bed ratio (based on 1:1 care)	
Killead	9	**5.27**	**21/79**
Donegore	9	**5.27**	**21/79**

7.0 Recommendations

It is proposed that the workforce is remodelled based on the results of the Telfords for 10 assessment beds (5 male, 5 female), a 10 bed forensic unit and a 18 bedded transitional unit (split into two 9 bedded areas).

Table 5: Funded staff V workforce requirement

	Funded by banding across site	Proposal inc. 10 assessment and treatment (5 male and 5 female) 10 forensic beds and 18 transition beds	variance
Band 7	6	5	-1
Band 6	7	18.73	11.73
Band 5	80.89	46.75	-34.14
Band 3	104.1	98.48	-5.62

To do this it is proposed to undertake a reprofiling exercise of the existing budget to realign the registrant workforce. This will enhance the skill mix to approximately 70:30 in the acute wards in keeping with the regional standard. The skill mix for the transitional ward would be 20:80 in keeping with a care model aligned with a community care facility.

It is recognised that remodelling the service to any additional levels will require significant investment and would be required to be considered within the context of the Delivering Care (Normative Staffing) Programme.

Learning disability services remains a very hard to recruit to area for the Belfast Trust. There are a number of reasons for this but the main ones are that the service is suffering significant reputational damage as a result of an ongoing historical abuse inquiry led by the PSNI and an associated Public Inquiry which has just commenced.

In 2019 the DOH did offer a temporary uplift of 15% to all nursing staff working in Muckamore Abbey hospital. Unfortunately, this did not have the desired affect to recruit or indeed retain staff and this temporary uplift has since ceased.

It is proposed that work is undertaken on developing a career pathway from band 5 to band 6. This would involve recruiting staff at band 5 level but with the achievement of specific goals and milestones they would quickly progress from their band 5 to band 6 role.

Recruitment of mental health registrants would be another key area to develop. Although all recruitment efforts are offered to all registrants, these nurses have key transferrable skills required to care for people in a mental health setting.

This paper focuses on the requirement for the inpatient services but there is also need to review the nursing requirement in the community as well. Nurses in Intensive treatment teams and Forensic treatment teams play a very important role in admission avoidance and allowing for that intensive case to be delivered closer to the persons home. A rotational programme between hospital and community would assist in this.

There has been a focus on commissioning of additional pre-registration programmes. This continues to be required to secure sufficient Learning Disability nurses, as well as nurses from other fields, to meet the needs of the patients.

QUB have increased their number of pre-registration students by 25% raising the numbers to 40 for the intake in September 2018 and to 50 pre-registration students in 2020. Despite this increase in numbers, less than 6 new registrants have joined Adult Learning Disability services at the Belfast Trust. Students report having excellent experiences when they have placements in MAH but this does not translate into new registrants taking up positons in the hospital once they have completed their nurse degree. Targeted work is required with the Universities to understand why this is the case.

The development of a career pathway for Health Care Support Workers (HCSWs) in post has assisted 14 non- registrants to progress to pre-registration nursing via the Open University programme. 9 of these staff are currently on the Learning disability pre-registration programme. There is a commitment to support 5 senior nurse assistants or social care assistants to apply for this development opportunity on an ongoing basis. This medium term strategy will incrementally increase the number of registrants.

There also needs to be focused programme of leadership development and career progression and succession planning to ensure that nurses are adequately prepared to take on challenging clinical nursing leadership positions. This is of particular importance with the recent joint appointment of a clinical nurse lecturer within Learning Disability and a Nurse Consultant, Advanced Nurse practitioner and other specialist roles as a result of Delivering care funding.

It is proposed that the Divisional Nurse leads a nursing workforce task and finish group to review these issues. This group will report through to the Trust Nursing and Midwifery Workforce Steering Group and to relevant groups within the Directorate of Adult, Social and Primary Care.

Appendix 1: Ward Telford Reviews

Assessment and treatment Unit 10 beds (Cranfield 1 & 2)

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1			5	7.5	37.5	37.5				
Band 6	2	2	2	2	2	2	2	14	5.75	80.5		80.5			
Band 5	3	3	3	3	3	3	3	21	5.75	120.75			120.75		
Band 3	2	2	2	2	2	2	2	14	5.75	80.5				80.5	
Band 2								0		0					0
Evening															
Band 7								0		0	0				
Band 6	2	2	2	2	2	2	2	14	7.75	108.5		108.5			
Band 5	3	3	3	3	3	3	3	21	7.75	162.75			162.75		
Band 3	2	2	2	2	2	2	2	14	7.75	108.5				108.5	
Band 2								0		0					0
Twilight															
band 6								0	5	0		0			
Band 5								0	5	0			0		
band 3	1	1	1	1	1	1	1	7	5	35				35	
Night Duty 8.10-7.45															
Band 6	0	0	0	0	0	0	0	0	10.75	0		0			
Band 5	4	4	4	4	4	4	4	28	10.75	301			301		
Band 3	2	2	2	2	2	2	2	14	10.75	150.5				150.5	
								0		0					0
									Sub total	1185.5	37.5	189	584.5	374.5	0
									add 24%	284.52	9	45.36	140.28	89.88	0
									Total	1470.02	46.5	234.36	724.78	464.38	0
									WTE	39.20	1.24	6.25	19.33	12.38	0.00
									NTB	3.92	Total Reg			Total Unreg	
													26.82		12.38
									Beds	10					
									Skill Mix %		68				32

MAHI - STM - 102 - 11884

Assessment and treatment Unit 5 beds (Cranfield 1 & 2)

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1			5	7.5	37.5	37.5				
Band 6	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 5	1	1	1	1	1	1	1	7	5.75	40.25			40.25		
Band 3	1	1	1	1	1	1	1	7	5.75	40.25				40.25	
Band 2								0		0					0
Evening															
Band 7								0		0	0				
Band 6	1	1	1	1	1	1	1	7	7.75	54.25		54.25			
Band 5	1	1	1	1	1	1	1	7	7.75	54.25			54.25		
Band 3	1	1	1	1	1	1	1	7	7.75	54.25				54.25	
Band 2								0		0					0
Twilight															
band 6								0	5	0		0			
Band 5								0	5	0			0		
band 3	0	0	0	0	0	0	0	0	5	0				0	
Night Duty 8.10-7.45															
Band 6	0	0	0	0	0	0	0	0	10.75	0		0			
Band 5	2	2	2	2	2	2	2	14	10.75	150.5			150.5		
Band 3	1	1	1	1	1	1	1	7	10.75	75.25				75.25	
								0		0					0
									Sub total	546.75	37.5	94.5	245	169.75	0
									add 24%	131.22	9	22.68	58.8	40.74	0
									Total	677.97	46.5	117.18	303.8	210.49	0
									WTE	18.08	1.24	3.12	8.10	5.61	0.00
									NTB	3.62	Total Reg		12.47	Total Unreg	5.61
									Beds	5					
									Skill Mix %	69					31

MAHI - STM - 102 - 11885

Forensic Unit (14 beds 4 assessment and 10 Treatment) Sixmile Unit

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1			5	7.5	37.5	37.5				
Band 6	3	3	3	3	3	3	3	21	5.75	120.75		120.75			
Band 5	4	4	4	4	4	4	4	28	5.75	161			161		
Band 3	3	3	3	3	3	3	3	21	5.75	120.75				120.75	
Band 2								0		0					0
Evening															
Band 7								0		0	0				
Band 6	3	3	3	3	3	3	3	21	7.75	162.75		162.75			
Band 5	4	4	4	4	4	4	4	28	7.75	217			217		
Band 3	3	3	3	3	3	3	3	21	7.75	162.75				162.75	
Band 2								0		0					0
Twilight															
band 6								0	5	0		0			
Band 5								0	5	0			0		
band 3	1	1	1	1	1	1	1	7	5	35				35	
Night Duty 8.10-7.45															
Band 6	0	0	0	0	0	0	0	0	10.75	0		0			
Band 5	5	5	5	5	5	5	5	35	10.75	376.25			376.25		
Band 3	2	2	2	2	2	2	2	14	10.75	150.5				150.5	
								0		0					0
									Sub total	1544.25	37.5	283.5	754.25	469	0
									add 24%	370.62	9	68.04	181.02	112.56	0
									Total	1914.87	46.5	351.54	935.27	581.56	0
									WTE	51.06	1.24	9.37	24.94	15.51	0.00
									NTB	3.65	Total Reg		35.55	Total Unreg	15.51
									Beds	14					
									Skill Mix %		70				30

MAHI - STM - 102 - 11886

Forensic Unit (10 beds 4 assessment and 6 Treatment) Sixmile Unit

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1			5	7.5	37.5	37.5				
Band 6	2	2	2	2	2	2	2	14	5.75	80.5		80.5			
Band 5	3	3	3	3	3	3	3	21	5.75	120.75			120.75		
Band 3	2	2	2	2	2	2	2	14	5.75	80.5				80.5	
Band 2								0		0					0
Evening															
Band 7								0		0	0				
Band 6	2	2	2	2	2	2	2	14	7.75	108.5		108.5			
Band 5	3	3	3	3	3	3	3	21	7.75	162.75			162.75		
Band 3	2	2	2	2	2	2	2	14	7.75	108.5				108.5	
Band 2								0		0					0
Twilight															
band 6								0	5	0		0			
Band 5								0	5	0			0		
band 3	1	1	1	1	1	1	1	7	5	35				35	
Night Duty 8.10-7.45															
Band 6	0	0	0	0	0	0	0	0	10.75	0		0			
Band 5	4	4	4	4	4	4	4	28	10.75	301			301		
Band 3	2	2	2	2	2	2	2	14	10.75	150.5				150.5	
								0		0					0
									Sub total	1185.5	37.5	189	584.5	374.5	0
									add 24%	284.52	9	45.36	140.28	89.88	0
									Total	1470.02	46.5	234.36	724.78	464.38	0
									WTE	39.20	1.24	6.25	19.33	12.38	0.00
									NTB	3.92	Total Reg		26.82	Total Unreg	12.38
									Beds	10					
									Skill Mix %		68				32

MAHI - STM - 102 - 11887

Transitional unit (social/transitional care model) Killead 9 beds based on 1:1 care

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1			5	7.5	37.5	37.5				
Band 6	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 5	1	1	1	1	1	1	1	7	5.75	40.25			40.25		
Band 3	9	9	9	9	9	9	9	63	5.75	362.25				362.25	
Band 2								0		0					0
Evening															
Band 7								0		0	0				
Band 6	1	1	1	1	1	1	1	7	7.75	54.25		54.25			
Band 5	1	1	1	1	1	1	1	7	7.75	54.25			54.25		
Band 3	8	8	8	8	8	8	8	56	7.75	434				434	
Band 2								0		0					0
Twilight															
band 6								0	5	0		0			
Band 5								0	5	0			0		
band 3	1	1	1	1	1	1	1	7	5	35				35	
Night Duty 8.10-7.45															
Band 6	0	0	0	0	0	0	0	0	10.75	0		0			
Band 5	1	1	1	1	1	1	1	7	10.75	75.25			75.25		
Band 3	4	4	4	4	4	4	4	28	10.75	301				301	
								0		0					0
									Sub total	1434	37.5	94.5	169.75	1132.25	0
									add 24%	344.16	9	22.68	40.74	271.74	0
									Total	1778.16	46.5	117.18	210.49	1403.99	0
									WTE	47.42	1.24	3.12	5.61	37.44	0.00
									NTB	5.27	Total Reg		9.98	Total Unreg	37.44
									Beds	9					
									Skill Mix %		21				79

Transitional unit (social/transitional care model) **Donegore 9 beds based on 1:1 care**

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total for week	hours per shift	weekly hours per shift per level					
Am											Band 7	Band 6	Band 5	Band 3	Band 2
Band 7	1	1	1	1	1			5	7.5	37.5	37.5				
Band 6	1	1	1	1	1	1	1	7	5.75	40.25		40.25			
Band 5	1	1	1	1	1	1	1	7	5.75	40.25			40.25		
Band 3	9	9	9	9	9	9	9	63	5.75	362.25				362.25	
Band 2								0		0					0
Evening															
Band 7								0		0	0				
Band 6	1	1	1	1	1	1	1	7	7.75	54.25		54.25			
Band 5	1	1	1	1	1	1	1	7	7.75	54.25			54.25		
Band 3	8	8	8	8	8	8	8	56	7.75	434				434	
Band 2								0		0					0
Twilight															
band 6								0	5	0		0			
Band 5								0	5	0			0		
band 3	1	1	1	1	1	1	1	7	5	35				35	
Night Duty 8.10-7.45															
Band 6	0	0	0	0	0	0	0	0	10.75	0		0			
Band 5	1	1	1	1	1	1	1	7	10.75	75.25			75.25		
Band 3	4	4	4	4	4	4	4	28	10.75	301				301	
								0		0					0
									Sub total	1434	37.5	94.5	169.75	1132.25	0
									add 24%	344.16	9	22.68	40.74	271.74	0
									Total	1778.16	46.5	117.18	210.49	1403.99	0
									WTE	47.42	1.24	3.12	5.61	37.44	0.00
									NTB	5.27	Total Reg		9.98	Total Unreg	37.44
									Beds	9					
									Skill Mix %	21					79

Appendix 2: Workforce Update at end January 2022

Ward	Beds	Beds Open	Funded Establishment						Staff in post as of January 2022					Variance				
			non recurrent funding in place															
			Total funded establishment	Registered					Total RN in post Registered			Band 3	Band 2	Reg			Unreg	
				Band 7	Band 6	Band 5	Band 3	Band 2	Band 7	Band 6	Band 5	Band 3	Band 2	Band 7	Band 6	Band 5	Band 3	Band 2
Muckamore																		
Cranfield 1	14	8	26.44	1	1	13.19	11.25	0	1	1	5.8	24.55	0	0	0	7.39	-13.3	0
Cranfield 2	16	7	41.98	1	2	14	24.98	0	1	0	2.53	16.43	0	0	2	11.47	8.55	0
PICU	6	1	23	1	1	10.5	10.5	0	0	0	2	1.58	0	1	1	8.5	8.92	0
Killead	24	8	26.5	1	1	11	13.5	0	-1	1	-3.53	-4.86	0	2	0	14.53	18.36	0
Donegore	9	5	30	1	1	12	16	0	3	1	3.96	20.92	0	-2	0	8.04	-4.92	0
Sixmile	19	9	31.5	1	1	14.5	15	0	0	3	3.45	16.04	0	1	-2	11.05	-1.04	0
Erne (now closed)	0	0	18.57	0	0	5.7	12.87	0	1	0	2	25.72	0	-1	0	3.7	-12.85	0
								0										

Appendix 3: Comparison of Funded and Proposed FSL

	Band 7	Band 6	Band 5	Total Registrants	Band 3	Band 2	Total Non-Registrants	Proposed Skillmix
Cranfield 1 FSL	1	1	13.19	15.19	11.25	0	11.25	
Cranfield 1 (Proposed 5 beds)	1	3.12	8.1	12.22	5.61		5.61	69/31
Cranfield 1 (Proposed 10 beds)	1	6.25	19.33	26.58	12.38		12.38	68/32
Cranfield 2 FSL	1	2	14	17	24.98	0	24.98	
Cranfield 2 (Proposed 5 beds)	1	3.12	8.1	12.22	5.61	0	5.61	69/31
Cranfield 2 (Proposed 5 beds)	1	6.25	19.33	26.58	12.38	0	12.38	68/32
PICU FSL	1	1	10.5	12.5	10.5	0	10.5	
PICU (Proposed)	0	0	0	0	0	0	0	
Killead FSL	1	1	11	13	13.5	0	13.5	
Killead (Proposed 9 beds)	1	3.12	5.61	9.73	37.44	0	37.44	21/79
Donegore FSL	1	1	12	14	16	0	16	
Donegore (Proposed 9 beds)	1	3.12	5.61	9.73	37.44	0	37.44	21/79
Sixmile FSL	1	1	14.5	16.5	15	0	15	
Sixmile (Proposed 14 beds)	1	9.37	24.94	35.31	15.51	0	15.51	70/30
Sixmile (Proposed 10 beds)	1	6.25	19.33	26.58	12.38		12.38	68/32
Erne FSL	0	0	5.7	5.7	12.87	0	12.87	
Erne (Proposed) Closed				0			0	

Appendix 4 Variance between existing funding and proposed models

	Funded by banding across site	Proposal inc. 10 assessment and treatment (5 male and 5 female) 10 forensic beds and 18 transition beds	variance	Proposal inc. 20 assessment and treatment (10 male and 10 female), 14 forensic and 24 transition beds	variance
Band 7	6	5	-1	5	-1
Band 6	7	18.73	11.73	28.11	21.11
Band 5	80.89	46.75	-34.14	74.82	-6.07
Band 3	104.1	98.48	-5.62	115.15	11.05