Muckamore Abbey Hospital Inquiry

Module 5 – Regulation and other Agencies

MODULE 5 WITNESS STATEMENT
ON BEHALF OF BELFAST HEALTH AND SOCIAL CARE TRUST

I, Martin Dillon, formerly of the Belfast Health and Social Care Trust (the Belfast Trust), make the following statement for the purposes of the Muckamore Abbey Hospital Inquiry (the MAH Inquiry):

1. This statement is made on behalf of the Belfast Trust in response to a request for evidence from the MAH Inquiry Panel dated 9 December 2022. Module 5, addressing Regulation and other Agencies, identifies 4 specific topics. The Belfast Trust addresses those topics below from the perspective of the Belfast Trust. The statement is provided for the assistance of the MAH Inquiry.

2. This is my first witness statement to the MAH Inquiry.

3. While I am the witness statement maker on behalf of the Belfast Trust for the purposes of the MAH Inquiry Module 5, I make this statement having had the assistance of the following individuals:

    a. Marie Heaney, former Director of Adult Social Care, Belfast Trust
    b. June Champion, former Co-Director Risk & Governance, Belfast Trust

4. The documents that I refer to in this statement can be found in the exhibit bundle attached to this statement marked MD1. The MAH Inquiry request for evidence can be found at Tab 1 in the exhibit bundle.

Qualifications and Position of the statement maker, and those who have assisted with the Module 5 statement on behalf of the Belfast Trust

5. I am an Economics Graduate and Qualified Accountant by academic background.

6. I was Chief Executive of the Belfast Trust between February 2017 and my retirement in February 2020.

7. Prior to this I held the following roles within the Belfast Trust; Deputy Chief Executive and Executive Director of Finance (January 2015 - January 2017), Executive Director of Finance (October 2010 – June 2014) and Interim Chief Executive (June 2014 – December 2014).

8. Before joining the Belfast Trust, I held Executive Director of Finance roles in the Newry and Mourne HSC Trust, the Southern HSC Trust and the Northern HSC Trust.

Topic 1 – Mental Health Commission

9. The Mental Health Commission for Northern Ireland (the Commission) was established under Part VI of the Mental Health (Northern Ireland) Order 1986. As and from 1 April 2009 the functions of the Commission were transferred to the Regulation and Quality and Improvement Authority (RQIA), by section 25 of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

10. It was the statutory function of the Commission to keep under review the care and treatment of "patients" (within the meaning of that definition in section 2 of the

Mental Health (Northern Ireland) Order 1986). In the discharge of that statutory function the Commission was given various duties and powers as set out in Article 86(2) of the Mental Health (Northern Ireland) Order 1986.

11. This included the duty to make inquiry into any case of a patient where it appeared to the Commission, amongst other things, that there may be ill-treatment of a patient, deficiency in their care or treatment, improper detention in hospital or where their property may be exposed to loss or damage. The Commission had a duty to visit and interview detained patients, and a duty to report to those running a hospital (including the Department or Secretary of State as appropriate) in order to secure, amongst other things, the prevention of ill-treatment, the remedying of deficiencies in care and treatment, or the termination of improper detention. The Commission had other advisory and notification duties.

12. In order to discharge its functions, the Commission was given wide powers of visitation to conduct medical examinations, the ability to have records of a patient produced for inspection, and the ability to refer a case to what was originally the Mental Health Review Tribunal for Northern Ireland.

13. I have exhibited for the assistance of the MAH Inquiry, behind Tab 2 of the exhibit bundle, a Hansard report from 3 July 2008 when members of the Commission gave evidence to the Committee for Health, Social Services and Public Safety of the Northern Ireland Assembly, where they summarised the role of the Commission.

14. The Commission had a chair and commissioners drawn from a range of professions as well as lay people.

15. It is perhaps notable that whilst the Mental Health (Northern Ireland) Order 1986 specified a range of duties and powers for the Commission, it did not provide the Commission with the authority to impose any sanctions.

16. The Bamford Review commented on the effectiveness of the Commission in its August 2007 report "A Comprehensive Legislative Framework" (exhibited to the Module 1 statement) where it said:

> *"The discharge of that wide ranging responsibility has been constrained from the outset by the lack of resources and the lack of an agreed Operational Plan."*

17. Paragraph 3.25 of the same report from the Bamford Review made recommendations about the intended transfer of the Commission's functions to RQIA, announced in March 2006.

18. I am informed by Marie Heaney that at a meeting which occurred in and around the Summer of 2008, in advance of the transfer of functions to RQIA, the Commission advised that its role consisted of the following:

    a) Multi-Disciplinary team visits to hospitals and community facilities to check on services being provided, and to speak to patients and relatives;

    b) Preventing improper detentions by scrutinising legal documentation;

    c) Reviewing individual drug regimens for patients who had been detained for longer than three months;

    d) Examining serious incidents noted by the multi-disciplinary teams, to include serious incidents of abuse, violence, self-harm and suicide; and

    e) Monitoring the exercise of powers over the possessions and finances of patients pursuant to Article 116 of the Mental Health (Northern Ireland) Order 1986.

19. Ms Heaney recalls that it was stressed that the focus of the Commission was on experiences of the individual, rather than a review of the generalities of the service

as a whole. It was noted that the Commission could bring to the Department, relevant Trust, or any other body, important issues of concern.

20. It appears to be the case, from copies of Commission reports relating to visits to MAH when it was operated by the North and West Belfast Health and Social Services Trust, that the Commission conducted announced and unannounced visits.

21. By way of illustration, I exhibit behind Tab 2 a copy of two reports of the Commission's visits to MAH on 19 June 2001 and on 19 February 2002.

22. By way of example, I also exhibit behind Tab 2 a copy of the 'Response of North & West Belfast HSS Trust to the Report of the Mental Health Commission Visit to Muckamore Abbey Hospital on 19 June 2001". The response addresses the matters raised by the Commission in its 2001 report, and also corresponds with the Commission on issues such as staffing.

23. I am also aware that, following the circulation of the report from the Commission, there appeared to be memoranda sent to staff which asked for various questions to be addressed and comments given. A copy of one of these memoranda, related to the 19 February 2002 inspection, can be found behind Tab 2 in the exhibit bundle.

24. A formal announcement was made in March 2006 by the then Secretary of State for Northern Ireland that the functions of the Commission would transfer to the RQIA by 2008. As set out above, the functions were transferred from 1 April 2009 pursuant to the Health and Social Care Reform Act (Northern Ireland) 2009.

25. When, in July 2008, the Commission gave evidence to the then Health Committee it expressed concerns about the impending transfer of functions. The concerns were:

a) The Commission was a stand-alone, multi-disciplinary, independent body able to challenge the care and treatment being provided to patients. The RQIA did not enjoy the same set-up;

b) The functions of the Commission would only equate to a small part of the overall functions of the RQIA and there was a fear that these important Commission functions would become eclipsed;

c) The RQIA focus on measurable standards would not allow for the focus on individuals that the Commision had previously provided, removing emphasis from those vulnerable patients who have severe learning disabilities and mental illness, heightening concerns about the protection of vulnerable adults;

d) The Commission highlighted that lay involvement was lacking in RQIA and that the professional representation for the Mental Health (Northern Ireland) Order 1986 functions being transferred was not what it should be.

26. Various suggestions were made to combat the above concerns:

a) There should be full time staff working on the specific Mental Health (Northern Ireland) Order 1986 functions being transferred;

b) The budget should be protected;

c) The MHO should be included in the RQIA logo;

d) The RQIA Board should reflect the functions of the MHO;

e) An annual Mental Health/Learning Disability report should be provided;

f) There should be clarity on the model of delivery;

g) There should be carer representation at a senior level;

h) Service users and carers should be made aware of changes; and

i) The Commission suggested a stand-alone unit within RQIA to ensure visibility of the specific Mental Health (Northern Ireland) Order 1986 functions being transferred.

Topic 2- Regulation Quality and Improvement Authority

27. On 25 March 2009 RQIA provided the Belfast Trust with an information document for dissemination entitled "*Changes in the delivery of Mental Health and Learning Disability functions in Northern Ireland. Information for service users, their carers, and providers of mental health and learning disability services"*. I exhibit a copy of the document behind Tab 3 in the exhibit bundle. The RQIA advised that under the Mental Health (Northern Ireland) Order 1986, it now had:

"Specific responsibility for keeping under review the care and treatment of patients with a mental disorder. In taking on their responsibility, RQIA takes an approach that is independent, multidisciplinary, protective, and has investigative, inspectorial and advisory functions. In particular, it will:

- *Enquire into cases where there may have been ill-treatment or deficiency in care or treatment; improper detention in hospital; improper reception into guardianship of a patient; or where the property of a patient may have been exposed to loss or damage*
- *Visit and interview detained patients in private*
- *Advise the relevant authorities of steps to be taken to secure the welfare of a patient; or any matter concerning the welfare of a patient*

- *Inspect a patient's records and their movements within mental health and learning disability services"*

28. In the same communication, RQIA indicated:

"These new structures allow RQIA to build upon and extend the role of the Mental Health Commission:

- *A focus on the individual, on the rights of service users and carers, incorporating the powers of enforcement and improvement on organisations under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003*
- *Multi-professional and lay working through RQIA's programme of inspection and review*
- *Promotion and sharing of good practice across mental health and learning disability services*
- *Wider promotion of mental health, advocacy, service user and carer engagement."*

29. Further to the outline of their wider role, RQIA explained that their Mental Health and Learning Disability Review Team were tasked with the following:

"Under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, the RQIA has established a dedicated team responsible for inspecting and reviewing mental health and learning disability services across Northern Ireland. This includes:

- *Conducting reviews into the monitoring and improvement arrangements*
- *Carrying out investigations and inspections*
- *Recommending actions for improvement*
- *Reporting unacceptably poor quality or significant failings to the DHSSPS*

Our visiting programme includes annual announced and unannounced reviews and inspections of mental health and learning disability hospital, community care and treatment facilities."

30. RQIA advised that it had:

"A statutory duty to undertake inspections of a wide range of services, including care homes for adults and children, day care and domiciliary care. Many of these services provide care and treatment for people with mental health and learning disability. Carried out by a multidisciplinary team of inspection staff, our inspections focus on compliance with regulations and minimum care standards. In our inspections, we examine the quality of:

- *Care*
- *Life of the residents*
- *Management*
- *The environment"*

31. Further, the notification spoke of:

"The combined strengths of the Mental Health (Northern Ireland) Order 1986 and The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 which ensures that all reviews and inspections focus on:

- *The specific care and treatment of individuals under the Mental Health (Northern Ireland) Order 1986*
- *Engagement and consultation with service users, their carers and advocates*
- *The context and environment within which care is provided*
- *The quality and availability of care, and*

- *Appropriate enforcement action where RQIA identifies failures in service quality or non-compliance with regulations."*

32. I am not aware as to whether there has been any evaluation of the discharge by the RQIA of the Mental Health (Northern Ireland) Order 1986 functions that were transferred in 2009.

33. RQIA engaged with MAH through an inspection mechanism that led to recommendations for improvement at MAH. The precise nature of the RQIA inspection mechanism, and the form of its reports, did change over time. It did involve, in different ways, engaging with patients, families, staff and other professionals who operated on the MAH site. Below I utilise three randomly selected RQIA reports from across the period of the RQIA work to illustrate the nature of the inspections. In passing, I do draw attention to the fact that the reports, and potentially the important feedback material that underlies them, are a detailed record of the position on a particular ward, and the views of its patients and families, at particular points in time.

34. RQIA inspections at MAH, up until around 2019, were ward specific. They could be both announced and unannounced. They could be planned or occur as a result of some complaint or report made directly to RQIA.

35. I understand that the inspection process originally included three key parts: self-assessment, pre-inspection analysis and the inspection visit by the Inspector. I provide an early example of a November 2010 announced inspection of MAH Ennis Ward behind Tab 4 in the exhibit bundle. Page 3 of the exhibited "Announced Inspection Report" part of the material provides information about the development of the RQIA inspection methodology. It went on to explain:

"RQIA, with the support of a range of experts has taken the current legal obligations recognised by DHSSPS, such as the Mental Health (Northern Ireland) Order 1986 and

the Patient Client Experience Standards (DHSSPS, 2008) to create a range of expectation statements in the areas of:

- *Fairness*
- *Respect*
- *Autonomy*
- *Dignity*
- *Equality*
- *Protection*

It is expected that these expectation statements and their assessment will ensure the momentum towards the fulfilment of the Bamford principles and the achievement of the RQIA core activities of:

- *Improving care*
- *Informing the population*
- *Safeguarding rights and*
- *Influencing policy. "*

36. The 'focus' for the exhibited inspection from November 2010 was said to be 'fairness':

"The focus for this inspection is Fairness. RQIA looked at 13 expectation statements and assessed the ward's level of achievement in relation to each statement. The expectation statements were assessed against an achievement scale set out in table 1 of this report.

Where achievement is assessed as fully achieved and identified as an exemplar of best practice, permission will be sought to share the initiative(s) across other provider organisations.

Where compliance is assessed as partially or substantially achieved and is envisaged as being fulfilled within the year, relevant recommendations relating to the improvement areas will be made as part of the trust's report of the inspection.

Where achievement levels are found not to have been achieved at the time of inspection, or unlikely to be achieved, RQIA will issue a Quality Improvement Plan (QIP) outlining the recommendations being made. The Trust should complete this QIP (by indicating the proposed actions to be taken and timescales involved) and return to RQIA within 20 working days."

37. The November 2010 report also explained the then RQIA inspection methodology. It said:

"Committed to a culture of learning, the RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the expectation statements. The inspection process has three key parts; self-assessment, pre-inspection analysis and the inspection visit by the Inspector. Specific methods/processes used in this inspection include the following:

- *Analysis of pre-inspection information*
- *Discussion with the ward manager and staff*
- *Examination of records*
- *Consultation with stakeholders*
- *Evaluation and feedback"*

38. The November 2010 report went on to explain the consultation process engaged in as part of the inspection:

"During the course of the inspection, the inspectors spoke to the following users of the service, relatives/carers, health and social care professionals and staff:

- *Patients,*
- *staff,*
- *relatives/carers,*
- *visiting professionals,*

- *advocates*

Questionnaires were provided, prior to the inspection, for patients, relatives/carers, health and social care professionals and staff to find out their views regarding the service. Matters raised from the questionnaires were addressed by the Inspector in the course of the inspection."

39. Section 3.0 of the November 2010 report described the nature and layout of Ennis ward and the patient profile on the ward.

40. Then, in section 4.0, there is a summary of the inspection that was undertaken. It is noted that, as part of the inspection process, RQIA issued questionnaires to patients, staff, relatives/carers and visiting professionals. RQIA then commented on the content of the returned questionnaires. If the completed questionnaires were preserved by RQIA, then this is a potentially important source of contemporaneous evidence for the MAH Inquiry.

41. The section 4.0 summary goes on to explain that the inspection began with the ward manager completing the self-assessment document (this accompanies the inspection report behind Tab 4), followed by the inspectors spending two days on site, where they were given unrestricted access to all areas of the ward and to all of the patients.

42. The process involved the inspectors observing routines and practices within the ward.

43. The inspectors also spoke to nursing staff, with patients and with some relatives.

44. During the inspection recommendations were made and verbal feedback provided.

45. The inspectors then recorded their findings in the available report.

46. RQIA also conducted Unannounced inspections. I have exhibited a copy of a report from an unannounced inspection of MAH Cranfield Female Ward from February 2015 behind Tab 5 in the exhibit bundle.

47. On internal page 4 of the February 2015 report the purpose of the RQIA inspection of Cranfield Female was described:

> *"The aim of the inspection was to examine the policies, procedures, practices and monitoring arrangements for the provision of care and treatment, and to determine the ward's compliance with the following:*
>
> - *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.*
>
> *Other published standards which guide best practice may also be referenced during the inspection process."*

48. The report indicated that matters were being considered against the previous inspection in July 2013, but also against a patient experience interview inspection from June 2014. Such of the patient experience inspection material relating to MAH that has been preserved by RQIA is another potentially important source of contemporaneous evidence for the MAH Inquiry. There was also a finance inspection in December 2014. It appears that almost all recommendations from across the various inspections had been addressed at MAH.

49. Section 5.0 of the report (internal pages 6 to 9) provide considerable detail on the nature of the care and treatment being provided at the point in time of the inspection. It is recorded as demonstrating, amongst other things:

    a. Patients with behaviours that challenge being treated with dignity and respect;
    b. The quality of person-centred patient care plans;
    c. Care plans being reviewed at weekly multi-disciplinary meetings;
    d. The use of therapeutic communication;
    e. The use of patient forum meetings;
    f. The use of individualised restrictive practice and deprivation of liberty care plans.

50. There were also areas identified that required improvement.

51. The report also records, in its section 6.0 and 7.0, engagement with patients and the generally positive views they expressed about the quality of their care. Six questionnaires returned from relatives rated the care on the ward from good to excellent.

52. The report records engagement with various ward professionals, but also with one of the independent advocates. The MAH Inquiry may consider that such individuals are an important source of evidence in respect of the patient experience. The particular independent advocate spoken to during the subject inspection stated that the overall care on the ward was good, that staff made appropriate referrals, that concerns raised by patients were addressed. The advocate also said that patients who did not attend day care complained of "boredom".

53. Alterations made to how RQIA conducted its inspections at MAH are reflected in an example inspection report on MAH from July and August 2021. It can be found

behind Tab 6 in the exhibit bundle. The inspection covered all of the then 5 wards operating at MAH, in which there were a total of 41 patients.

54. Section 3.0 (internal page 2) recorded that RQIA had been conducting contemporaneous scrutiny of all safeguarding notifications involving staff as and from July 2019. It also explained:

> *"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."*

55. Section 4.0 of the report recorded the views of patients and relatives:

> *"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."

56. The report itself contains considerable detail, including about:

a. Progress on improvements from previous inspection recommendations;
b. Staffing difficulties;
c. Staff shortages;
d. Resettlement, including dealing with a small group of patients who did not wish to be resettled from MAH;
e. The management of restrictive practices;
f. The maintenance of risk assessments on ligatures, fire, mattresses and environmental cleanliness;
g. Incident reporting and subsequent action plans;
h. Finances;
i. Governance systems;
j. The development and introduction of a Muckamore Abbey Carers Questionnaire;
k. The 3 areas found for improvement that were then subject to a Quality Improvement Plan, which also recorded the intended response of the Belfast Trust.

57. Following receipt of RQIA reports, Belfast Trust staff responded through developing Action Plans. There were also responses provided to RQIA as to what was to be done to address recommendations, which would then be recorded in the likes of the RQIA Quality Improvement Plans.

58. The Level 3 SAI investigation "A Review of Safeguarding at Muckamore Abbey Hospital" that in November 2018 provided the "A Way to Go" report did address the role of RQIA inspections (see internal pages 28 and 29). In Appendix 5 to the "A Way to Go Report" (internal pages 65 to 73) the Level 3 SAI Review team summarised its position on RQIA inspection reports on MAH wards relating to the period 2012 to 2017 (the Level 3 SAI Review team also appear to have included RQIA inspections relating to the Iveagh Centre; this is not an MAH ward, is in a different location, and provides a service to children.) Consequently, some of the analysis and conclusions may be based on information that should not have been included. Appendix 6 (internal pages 74 to 77) contained the RQIA response to what was said by the Level 3 Review team in Appendix 5. It will be apparent that RQIA considered there was considerable difficulty with the approach that had been taken by the Level 3 SAI Review team, and with the analysis that had been set out.

59. The RQIA does have an enforcement process, which includes its "Serious Concerns" process, and, where necessary, the service of an "Improvement Notice". It is my understanding that, notwithstanding the volume of inspections, no RQIA "Improvement Notice" was issued in respect of MAH before 2019.

60. RQIA has also conducted reviews of safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland, which included MAH. There is an overview report from 2008. There is then a review report in 2013 with follow up reports in 2015. These reports will be addressed in the Module 6 statement from the Belfast Trust.

Topic 3 - Health and Safety Executive Northern Ireland (HSENI)

61. The Health and Safety Executive for Northern Ireland (HSENI) is an executive non-departmental public body sponsored by the Department for the Economy. It is the lead body responsible for the promotion and enforcement of health and safety at work standards in Northern Ireland.

62. The Belfast Trust, in certain circumstances related to particular deaths, major injuries, or dangerous occurrences, had reporting obligations to the HSENI pursuant to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997.

Topic 4 - Patient and Client Council (PCC)

63. The Patient and Client Council (PCC) is a body corporate health and social care body established by section 16 and schedule 4 of the Health and Social Care (Reform) Act (Northern Ireland) 2009. It came into being on 1 April 2009 pursuant to the Health and Social Care Reform (2009 Act) (Commencement) Order (Northern Ireland) 2009. The Patient and Client Council (Membership and Procedure) Regulations (Northern Ireland) 2009 also came into operation on 1 April 2009.

64. Section 17 of the Health and Social Care (Reform) Act (Northern Ireland) 2009 lists the functions of the PCC. They include, in respect of the provision of health and social care in Northern Ireland, amongst other things, representing the interests of the public and promoting the involvement of the public.

Conclusion

65. It is hoped that the provision of the above information will assist the MAH Inquiry. Should further information be of assistance as to how the Belfast Trust interacts with the various bodies addressed in this witness statement, then I will take steps to have this provided.

Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have either exhibited or referred to the documents which, collectively, the contributors to this statement believe are necessary to address the matters on which the MAHI Panel has requested the Belfast Trust to give evidence.

Signed: Martin Dillon

Dated: 28 March 2023

Belfast Trust Module 5 Statement Exhibit Bundle – "MD1"

Muckamore Abbey Hospital Inquiry

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09 December 2022

By Email Only
Ms Jane McManus
Solicitor Consultant
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Dear Ms McManus

Evidence Modules 2023

You will be aware from the Chair's statement of 20 October 2022 that, in the next phase of evidence, the Inquiry intends to hear evidence relating to the legal and regulatory framework, organisational structures, policies, methods and governance.

The purpose of this correspondence is to issue a request to the Belfast Health and Social Care Trust in the first instance for a statement or, if appropriate, statements that will assist the Inquiry in that phase of evidence. It should be regarded as a request for the purposes of Rule 9 of the Inquiry Rules 2006. It is anticipated that the maker(s) of the statement(s) will be called to give oral evidence in March – April 2023.

Please find enclosed the document "Evidence Modules March - April 2023", which provides an outline of the topics to be addressed. The Belfast Health and Social Care Trust is asked to provide a statement or statements for the purpose of addressing the topics highlighted in red text in the document.

Please note that the primary objective of this phase of the evidence is to ensure that the Panel is fully informed of the legal and regulatory framework, the organisational structures that are relevant to the Terms of Reference and the relevant policies, procedures and practices that were applicable during the timeframe with which the Inquiry is concerned. It is anticipated that the Inquiry will wish to hear further evidence at a later juncture to address the adequacy and effectiveness of the systems and processes in place at the relevant time.

The content of the modules is set out in some detail in the enclosed document, but the following may also assist with an understanding of some of the matters on which the Inquiry wishes to hear evidence:

Module 2: Health Care Structures and Governance

2e. The historical overview should include the history of placement of patients at MAH and the provision of alternative inpatient beds.

2f. The account of the management and governance structure should include an explanation of directorate, divisional and corporate structures and the flow of information between them.

2g. The account of the interrelationship between Trusts relating to patients admitted to Muckamore should include detail of contracting arrangements and accountability agreements that were in place at the relevant time.

2h. There may be some overlap between this and the preceding topics, as well as Modules 3 and 4. The Trust is asked to identify and explain the key mechanisms in place to promote quality of care at MAH.

2i. The account of provision for community based services should include information on the use of learning disability teams and their staffing and on any differences between community based support for children and for adults with learning disability.

Module 3: Policy and Procedure

The Trust may wish, if appropriate, to include reference to other policies and procedures that touch on the Terms of Reference.

Module 4: Staffing

Evidence relating to the issue of training should include the training of all staff in areas such as safeguarding, use of restraint, use of seclusion, use of medication and side effects of medication, choking risks, communication strategies for persons with learning disabilities, positive behavioural support in respect of learning disability, autism and challenging behaviour.

Module 6: MAH Reports and Responses

The Inquiry wishes to receive evidence at this stage detailing the formal responses by the Trust to the reports referenced in this module. It is anticipated that the Inquiry will wish to examine further in evidence at a later stage the adequacy and effectiveness of such responses.

The Inquiry also wishes to ensure that all higher level reports in relation to the hospital and of relevance to the Terms of Reference are identified at this stage (for example, the Report of the Independent Assurance Team 2018 and the Independent Review of the Learning Disability Resettlement Programme 2022). The Inquiry would welcome input from the Trust in respect of that exercise.

Please see enclosed Statement Format Guide. It is important that statements made for Inquiry purposes should be consistent in format. It is appreciated that the number of required sections will depend on the range and breadth of issues to be covered and that some flexibility will be needed to ensure the most effective presentation, but you are asked to adhere to the Guide to the extent that is possible.

For planning purposes, you are asked to inform the Inquiry of the identity and role of the person(s) who will be making the necessary statement(s) and a brief summary of their qualifications and experience by Friday 16 December 2022.

You are requested to furnish the Inquiry with the completed statement(s) by Friday 10 February 2023; if any statement is completed prior to that date, please do furnish it to the Inquiry as soon as possible following completion in order to assist with scheduling.

If you have any queries about this correspondence please contact the Solicitor to the Inquiry at solicitor@mahinquiry.org.uk.

Yours faithfully,

Lorraine Keown
Solicitor to the Inquiry

Enclosure:

1. Evidence Modules March – April 2023.
2. Statement Format Guide.

Muckamore Abbey Hospital Inquiry

EVIDENCE MODULES MARCH - APRIL 2023

The Inquiry intends to hear the following evidence modules in March – April 2023:

Module 1:	Bamford and Mental Health Law in Northern Ireland
Module 2:	Health Care Structures and Governance
Module 3:	Policy and Procedure
Module 4:	Staffing
Module 5:	Regulation and Other Agencies
Module 6:	MAH Reports and Responses

Module 1: Bamford and Mental Health Law in Northern Ireland

a. Overview of Bamford Review and subsequent developments.
b. Analysis of different models for learning disability services.
c. Focused Study of the “Equal Lives Learning Disability” Review (September 2005).
d. Focused Study of “A Comprehensive Legislative Framework” (August 2007).
e. Mental Health (Northern Ireland) Order 1986: key provisions.
f. The new legislative framework: Mental Capacity Act 2016.
g. Comparative analysis: law in UK (outside NI) and elsewhere.

Module 2: Health Care Structures and Governance

a. Budget for learning disability and mental health services:

- Northern Ireland and elsewhere in UK;
- children and adults;
- health care and social care;
- institutional and hospital provision and community support.

b. Department of Health: oversight of learning disability services.

c. Public Health Agency: role in organisation and commissioning services at MAH and quality improvement.

d. Health and Social Care Board/ Strategic Planning and Performance Group.

e. The Trusts and MAH: historical overview.

f. BHSCT and MAH management and governance structure.

g. Interrelationship between Trusts re patients admitted to Muckamore.

h. Explanation of structures in place to promote quality of care at MAH.

i. Outline of provision for community based services.

Module 3: Policy and Procedure

a. Policies for delivering health and social care to learning disability patients 1999 – 2021.

b. Nursing care delivery model.

c. Policies regarding restraint/ seclusion.

d. Safeguarding policies.

e. Policies and procedures re medication/ auditing of medication.

f. Policies and procedures concerning patients' property and finances.

g. Policies and procedures re psychological treatment, speech and language therapy, occupational therapy and physiotherapy.

h. Resettlement policies (and provision for monitoring of resettlement).

i. Complaints and whistleblowing: policies and procedures.

j. Overview of mechanisms for identifying and responding to concerns.

k. Risk assessments and planning regarding changes of policy.

l. Procedures to provide assurance regarding adherence to policies.

m. Policies and procedures for further training for staff/ continuing professional development.

Module 4: Staffing

a. Workforce plans for disability care 1999 – 2021 (Trust and Department of Health).
b. Training and recruitment of learning disability nurses.
c. Leadership education for ward managers and senior nurses/ key performance indicators.
d. Training, recruitment and deployment of learning disability psychiatrists, psychologists, speech and language therapists, occupational therapists and physiotherapists.
e. Measures relating to staff retention and support.
f. Induction programme for new unregistered staff and temporary workers.
g. Practice regarding supervision of unregistered staff.
h. Programme at MAH for clinical audits/ University placement audits/ NIMDTA placement audits.
i. Provision for trend analysis of Datix incident reporting and response.
j. Overview of turnover and vacancy rates on wards.
k. Exit interviews: management and analysis.
l. Impact of (and response to) suspensions and increased use of agency staff.

Module 5: Regulation and Other Agencies

a. Regulation and Quality Improvement Authority (and MHC):

- history, statutory remit, objectives, inspection procedures and methodology;
- procedures for ensuring improvement;
- roles and responsibilities re MAH.

b. Health and Safety Executive Northern Ireland (HSENI):

- history, statutory remit, objectives, procedures and methodology;
- roles and responsibilities re MAH.

c. Patient and Client Council (PCC):

- history, statutory remit, objectives and methodology;
- roles and responsibilities re MAH.

Module 6: MAH Reports and Responses

a. EHSSB/ NWBT Review (December 2005):

- overview;
- analysis of recommendations;
- examination of response.

b. Ennis Ward Adult Safeguarding Report (August 2013):

- overview;
- analysis of recommendations;
- examination of response.

c. Review of Safeguarding at MAH - A Way to Go (November 2018):

- overview;
- analysis of recommendations;
- examination of response.

d. Review of Leadership and Governance at MAH (July 2020):

- overview;
- analysis of recommendations;
- examination of response.

e. Identification of other key reports concerning MAH.

09 December 2022

Official Report (Hansard)

Session: 2007/2008
Date: 02 July 2008

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Health & Social Care Reform (Mental Health Commission)

3 July 2008

Members present for all or part of the proceedings:

Mrs Iris Robinson (Chairperson)
Mr Thomas Buchanan
Mr Alex Easton
Mrs Carmel Hanna
Mr John McCallister
Ms Sue Ramsey

Witnesses:

Mr Paul McBrearty)
Dr Brian Fleming) Mental Health Commission
Mr Noel McKenna)
Ms Clare Quigley)

The Chairperson (Mrs I Robinson):

I welcome Mr Paul McBrearty, chief executive, Mr Noel McKenna, chairperson, Ms Clare Quigley, social-work member, and Dr Brian Fleming, consultant psychiatrist and medical member, from the Mental Health Commission. I apologise that the Committee had to deal with other business before the evidence session could begin. I invite you to make a brief presentation, after which members will ask questions. When you have finished your presentation, I will allow up to one hour for the question-and-answer session. You are very welcome.

Mr Noel McKenna (Mental Health Commission):

As chairperson of the Mental Health Commission, I thank the Committee for receiving us. Paul McBrearty will deliver the substantive presentation. I want simply to record our thanks to the Committee before he starts. Clare, Brian and I — and, indeed, Paul — will answer any questions that arise from the presentation.

Mr Paul McBrearty (Mental Health Commission):

Thank you, Madam Chairperson. I understand that members have possession of our briefing paper. We will deal substantially with most of its points.

The Mental Health Commission is an independent, non-departmental public body — probably the smallest in Northern Ireland. Our budget is in the region of £600,000. We are comprised of a chairman and 16 sessional commissioners, who carry out a range of activities. Although those activities have been listed in our briefing paper, it is important that I highlight what they are and what they mean for the commission.

Commission members are drawn from a range of professions: psychiatrists, psychologists, nurses, social workers and other individuals — lay members — who bring their expertise to our work. We create teams that are required to visit any individual who is detained in hospital under the Mental Health (Northern Ireland) Order 1986. We also visit any individual who has a mental-health problem and is being treated under the legislation. That leads us to people who have difficulties that are associated with learning disability. Multi-disciplinary teams visit individuals in hospital and community facilities to check on the services that are being provided and, specifically, to meet and talk to those people and their relatives about their experiences while they are receiving treatment from health and personal social services.

That is a very important starting point because that means that we focus on the individual. We do not focus on the generalities of the service, but how the service has been delivered to specific individuals, how they are dealing with it and the sorts of issues that emerge. Within the statutory requirements, we can bring to the Department, the health trusts and any other body — this Committee included — any important issues that have arisen from the findings of our visits and discussions with those individuals. For example, we have expressed concern to the Minister in the past about under-18s being admitted to adult wards in mental-health facilities, and we are tracking progress on that regularly. We also have issues about the unavailability of acute psychiatric admission beds. Again, the commission has raised that issue in the past.

If we feel that it is necessary, we can refer a particular case to the Mental Health Review Tribunal so that it can review it with regard to, for example, issues of detention or guardianship. Very specifically, the commission has the power to gain access to any facilities, and, if required, it can medically examine an individual in private, whether it be in a hospital or a community facility. We have access to their medical notes to assure ourselves that the treatment that they are receiving is appropriate to their illness and that it is required. Last week, two of our commissioners travelled to Enniskillen to visit a learning-disabled individual in his own home to check that the guardianship was appropriate to his circumstances, as an issue had been raised with the commission about whether it was appropriate. We had to assure ourselves that that arrangement was appropriate for this individual. Again, I must emphasis that we focus on the individual, not on general services, although those general services are important to us.

The commission will appoint doctors who, at the end of the Mental Health (Northern Ireland) Order 1986 assessment process, can detain an individual — that is the "part II" appointment, as we call it. We also appoint doctors under part IV of the Order, which enables a doctor to get a second opinion if a patient has to undergo, for example, electroconvulsive therapy (ECT).

We review all legal documentation in relation to any formal detention, which is a very important function. The removal of anyone’s liberty is an extremely serious issue. The commission has to ensure that trusts that apply the legislation do so correctly. Not only do we check that the legislation is being applied appropriately, but we consider whether the clinical reasons for the detention are appropriate. That is an important function of the commission.

If an individual has been detained for more than three months, we are required to see the drug-treatment plan for that individual, and I know that the Committee is interested in drug-treatment regimes. Our medical panel, which is made up of the medical members of the commission, will review each and every drug-treatment plan for that individual and assure itself that the treatment plan is appropriate to the patient’s needs. We will obviously appoint individuals to give second opinions.

On 23 June, the Minister announced that, as part of the Health and Social Care (Reform) Bill, he intended to transfer the Mental Health Order functions from the commission to the Regulation and Quality Improvement Authority (RQIA). The commission welcomed the opportunity to make its views on that proposal known in the consultation process. In essence, the commission believes that it should be retained and its members made a submission to the Minister to indicate why it believes that that should happen. The commission felt that the fact that it is an independent body is important — that is especially important for those who access mental-health and learning-disability services. As we are a stand-alone body that is separate from the health and social services bodies, we are able to question the care and treatment that is being provided. We have indicated that we believe that that facility will be lost with the transfer of functions to RQIA because those functions will be only a small part of that overall body’s work. We are concerned about that, and I will address that issue in more detail shortly.

People with learning disabilities and mental-health needs are vulnerable and require an element of independence. As I said, we focus on the individual. The body that will take responsibility for that field is, in the main, focused on measurable standards, such as the regulation of various organisations and quality improvement. Although that is an important issue, the focus is different from that of the commission — we focus on the individual, rather than the wider body.

As I said, the commission is made up of professionals and lay members, which has been very important. The lay members challenge the professionals, and many have experience as either a service user or a carer for someone with mental-health requirements or a learning disability. That challenge is an important element of the discussion in the commission and is important to the way in

which we carry out our visits. We are concerned that that level of service and client-user involvement would be lost if the commissions functions were transferred.

In recognition of the Minister's indication that there will be a transfer of functions, the commission considered how to respond. We said that if our functions transfer to the RQIA, we would prefer a stand-alone unit in the RQIA to maintain the pseudo independence of the commission and to ensure that the mental-health and learning-disability element of the Mental Health Order is visible to anyone who wants to access our services. Part of our argument against the transfer is that the title "RQIA" does not reflect any aspect of the Mental Health (Northern Ireland) Order 1986. In contrast, the title "Mental Health Commission" conveys a clear message — if someone is unsure about who to contact for help, he or she will find the Mental Health Commission in the phone book or on the Internet and, if we cannot help that person, we will send him or her to the correct organisation. That is an important element that should not be lost if there is a transfer of functions. We are not sure whether a stand-alone unit can be established under the RQIA's constitution, but we want it to be considered.

The functions of the commission include visiting patients and scrutinising legal documentation. Another important element of our work is the examination of serious incidents by the commission's multi-disciplinary teams — those teams that are notified of any serious incidents that happen to people involved with mental-health services. Such incidents include suicide, other serious self-harm and violent incidents in hospitals or in the community, such as abuse from staff — which, sadly, sometimes happens — or abuse from another patient. The commission is notified of all serious incidents and intensely scrutinises the issues that arise from them. We talk to the trusts about their responses after their investigations and refer any issues that arise to our visiting panel so that, when they visit the facilities in question, they can ask what has been done to address the problems. We document the issues that are raised and how they are addressed.

Lay involvement is not as significant in RQIA's format as it should be. Also, some of the professional representation for the Mental Health Order is not what it should be. Those are issues of concern, and we raise them as such with the Committee.

The commission made several recommendations to the Minister in the event of the functions being transferred, which is why we have come to give evidence to the Committee. Certain actions will reassure the commission about the future delivery of the Mental Health Order functions and that the interests of the vulnerable groups that I have mentioned — those who have a mental illness or a learning disability — will be protected.

Therefore, we made a number of suggestions. Firstly, the commission has a small budget, which it believes should be given to RQIA in its entirety. Given that that funding is a small proportion of the overall budget of RQIA, the commission feels that it should be protected for a period of years, enabling the functions to become embedded in the organisation. If efficiencies are produced as a result of economies of scale, the commission wants those additional moneys reinvested in the operations of the Order. That would allow the development of, for example, links with user-care organisations, enabling RQIA to become more familiar with the general public. The commission wants the Committee to be particularly aware of that issue.

The commission has suggested that the RQIA organisation should have full-time staff. That departs from the commission's current practice of part-time sessional commissioners, but there was always an aspiration to bring in full-time professionals at some point. The commission believes that that approach is essential in delivering the function and in ensuring that it is delivered in a proper manner.

I have already referenced the name and logo of the RQIA. However, the commission would again ask that consideration is given to the inclusion of a reference to the Mental Health Order somewhere within that name or logo. It is not about the commission, but the Order, and it is important that it is reflected in some way so that users of the service and carers can find their way to that particular service.

The commission also suggests that the board of the RQIA should reflect the functions that it delivers, particularly in relation to the Mental Health (Northern Ireland) Order 1986. The commission may be being a little cheeky in that respect, but we have raised and discussed that with RQIA, and I know that it is giving it due consideration. It is fundamental that whoever is involved in the strategic direction-setting of the organisation running the Mental Health Order, has knowledge of the Order, mental-health and disability services. Furthermore, the commission feels that there should be someone with that knowledge at a very senior level in the new organisation. The commission has suggested

appointing a new deputy or vice-chairperson, but that would be very aspirational in relation to what it wants to see.

As referenced at point 4·7, the commission is working with RQIA on a model of delivery. If a clearly identifiable and visual stand-alone unit cannot be created, the commission will work closely with RQIA between now and March 2009 to develop that model. That will satisfy the commission that delivery through RQIA will be appropriate to our beliefs and ethos, with respect to focusing on the individual. It is fundamental that a clear model of delivery is determined prior to the transfer.

It is also important that service users and the client groups are made fully aware of RQIA. The commission feels that that is important and that it should be actioned through the external-relations function. Preferably, there should be user or carer representation at a significant level within the RQIA organisation to represent mental-health and any disability functions.

The Chairperson:

Thank you, Paul, for that interesting presentation. I would also like to congratulate you all for the sterling work that you have done up to now. I hope that the Minister will listen to those calls for the commission to have representation on RQIA, so that that sterling work does not get lost in the ether.

Mr Easton:

I am a great believer that if something is working, it should remain the way that it is. In my opinion, the commission does not need fixed or changed.

Has the commission had direct meetings with the Minister about RQIA and is the Minister sympathetic to the commission? Furthermore, what can the Committee do to influence the Minister in the right direction?

Finally, how many people in Northern Ireland are held under the Mental Health Order?

Mr McKenna:

I will answer some of those questions, and, perhaps, Paul will provide the statistical information. The commission did not have a personal, direct engagement with the Minister, but during a consultation meeting in a local hotel, I, along with Paul and some other colleagues, did have an opportunity to make a verbal representation to him, which we followed up with a substantive letter. He was well-disposed to listening to what we had to say. He told us that the purpose of transferring the functions of the commission to RQIA was to strengthen the work that will be done on mental-health and learning-disability services. If that materialises, I would be truly delighted.

I accept that there were deficiencies in the commission. Given its size, being a small organisation, the commission is vulnerable when it loses one or two key members of staff. There are certain benefits in economies of scale and a larger resource. If money was not a major factor, I could prescribe exactly what is needed for an independent commission. However, we live in the real world and acknowledge that money is a factor. We in the commission would be very concerned if the budget allocation for mental-health and learning-disability services was cut, and there were moves to economise, because those affected by such issues are a vulnerable section of the community.

I have a son with Asperger’s syndrome, and, when I meet psychiatrists and mental-health professionals, they tell me that they do not have the resources to do much for him. I will stay at the Committee meeting after this session to hear Lord Maginnis’s presentation on autism.

The commission would love to continue to carry out its functions, but we are not reactionary; if the democratic decision is to transfer those functions to RQIA, we are merely keen to ensure that the baby is not thrown out with the bath water. The challenge is there for RQIA, and we will do our level best to ensure that, when the functions of the commission are transferred, RQIA will deliver those functions in a competent and, indeed, an enhanced manner. We are confident that that will be the case

Had the commission remained in being, there were plans to appoint two or three full-time commissioners; to create a more expansive role for users and carers; to establish strong external communication links; and to provide some mental-health education. Hopefully, those things can still be done when RQIA assumes control of the functions. I was reassured when you told me on Monday,

Madam Chairperson, that, as a watchdog body, the Committee will be monitoring very closely what happens when the functions transfer.

We accept that the decision has been made, but welcome the fact that the Committee will be monitoring the transfer of functions very closely. If the Committee can use its good offices to influence the Minister and the Department, perhaps some of the recommendations that have been suggested — which I think are valid recommendations — can be implemented under the governance of RQIA. The transfer of functions is going to happen, whether I like it or not — we are democrats, and accept the decision of the Government. All we are keen to do — and this is our bottom line — is to ensure that a good service is provided to our stakeholders; primarily, users and carers.

The Chairperson:

Thank you. Will you provide statistics on the number of people who have been sectioned under the Mental Health Order?

Dr Brian Fleming (Mental Health Commission):

On average, around 1,500 people per annum are compulsorily admitted to hospital by their general practitioners, and usually an approved social worker or member of the family. That period of admission is for, in the first instance, a week, then two weeks, and, thereafter, they may be detained for treatment for up to six months. Of the 1,500 people admitted per year, just over half of those remain detained for treatment. In others words, half are regraded as voluntary admissions or they are discharged from hospital before they require that detention.

Ms Clare Quigley (Mental Health Commission):

To clarify, the role of the Mental Health Commission is also to monitor the care and treatment of the great number of voluntary patients in hospitals, in the community and with learning disabilities. Primarily, the voluntary patients with whom we deal have mental-health problems, but others may have learning disabilities.

Mr McKenna:

Clare made an important point to which I want to add. As more and more vulnerable people with learning disabilities or mental-health problems are being decanted out of hospitals and into the community, they will need a watchdog body to represent and speak up for them. At least when those patients were in hospital they were sure of a visit from the commission, when it was in existence. My son lives in the community, so I am involved in the care movement. Community groups, with which I am in contact, are crying out for a watchdog body to represent them.

I want the programme for mental-health and learning-disability services to offer more user and care representation, which can deliver improvements to the service

The Chairperson:

Thank you for your input.

Ms Hanna:

Thank you, Chairperson. Good afternoon. Thank you for your presentation; it was very good. I do not have a specific question, but I understand where you are coming from.

I share your concerns about the role of an independent watchdog following the transfer. It is important that an additional mental-health role is clearly defined; at times, it is inclined to be an add-on. The presence of user groups is essential. As the Chairperson said, we will continue to monitor what happens following the transfer, because it is vital that there continues to be a specific role for the inclusion of your recommendations.

Mr McKenna:

Thank you.

Ms Quigley:

In future, there may be an opportunity for that when the new mental-health legislation is considered. It may be that, in the course of your monitoring, you are not satisfied with the level of specific individual attention that can be paid to mental-health issues within the transferred functions. You may want to look for a body under the proposed future legislation. That is worth keeping in mind, because we, as a commission, will not be around to make that plea.

Mr McCallister:

We are keen that the good work undertaken by the commission is not lost or swallowed up in RQIA and forgotten about. Will you develop your point about the external-relations function; do you see some of that feeding into this Committee? How is that function being progressed? Is it effective? Where must we direct our focus to ensure that that continues to work?

Everyone in the room agrees that we must do more for the groups that you identified and with which you have been working. They are some of the most vulnerable people in society, so we want to be rock solid that we do everything that we can. Will the external-relations function help to build on that by not only promoting your work in the community, but by assisting all elected office bearers to communicate any problems arising from your duties back to the Committee and Assembly?

Mr McBrearty:

It is fair to say that the commission expects a much broader discussion to take place with a wide range of groups about the operation of the Mental Health (Northern Ireland) Order 1986.

The commission has a limited life-span. We have only nine months left in which to work closely with RQIA on those issues. I hope that two developments take place before 1 April 2009.

First, the Committee will be keeping a close watching brief on the application of the Mental Health (Northern Ireland) Order 1986. However, RQIA, with its own statutory responsibilities, will be in a position to address the Committee or make reports to it, through whatever mechanisms are in place.

Secondly, we want RQIA to become actively involved with voluntary organisations and other user and care organisations. Without fear of contradiction, I can state that we have a good relationship with RQIA. We work very closely with it in order to develop everything that we have flagged up.

We cannot make RQIA do what we want, but we can try to influence its approach — in the same manner that, through talking with members, we hope that the Committee will seek to exert its influence to secure reassurance on issues that it regards as important.

RQIA seeks to develop external communications and to actively involve users and carers as part of a total remit, not just in regard to areas such as mental health and learning disability. RQIA must address the Committee about its plans on those issues. However, I would be remiss if failed to state that we are working closely with RQIA in order to share what we do and how we do it.

RQIA may have a better way of doing things — we will be happy if that is the case — but we have told it to heed our concerns. We would like to walk away on 31 March 2009, content that we had shared all our functional knowledge, and that RQIA had satisfactory plans in place for delivering services. However, we will not know whether that is the case, because we will no longer exist. RQIA's preparedness might not be formally assessed until a year later.

Mr McAllister:

In light of the relationship that has grown up, are you hoping for as seamless a transfer of functions as possible from RQIA?

Mr McKenna:

Absolutely, we are anxious to ensure that a good, smooth transfer takes place. That is our responsibility and that is what we are charged to do. We have a good working relationship. We do not agree on everything, but dialogue is about negotiating.

We are here to make representations to the Committee, Madam Chairperson, because we will be gone in fewer than nine months, whereas the Committee will still have influence and be able to continue to monitor developments.

On Monday, I was reassured by your undertaking, in a personal capacity, to meet with us again formally or — time permitting — informally, if we have concerns that things are not progressing as well as we would like them to. I am confident that progress will be made.

Madam Chairperson, the Committee's support, if it were possible, would be a confidence boost that we could convey to the Department, with which we share a steering group. We are also represented on a project group with RQIA. Committee support will add weight to our recommendations and ensure that both groups pay serious attention to your views.

Finally — and our psychiatrist, Brian, is very keen on this issue: we must have a separate annual report on mental health and learning disabilities.

RQIA must have some form of mechanism to convey to the population of Northern Ireland exactly what is happening in the fields of mental health and learning disability. The incidence of mental-health illness is increasing, instead of decreasing. We must take every step that is possible to reassure our population that the Government are doing everything that they can through both good health education and services. The Bamford Review has been endorsed, and the Government's response to it, which looks positive, is available.

I am grateful that the Committee has listened to us today. With its support, the minds of senior civil servants and the RQIA will be more concentrated, and they may take the view that the recommendations have a lot of validity. Although they may not necessarily agree with everything that has been said, they will try to thrash out the recommendations and see whether some consensus can be reached.

Mr Buchanan:

I commend the work that the commission has carried out already. I share its concerns about the transfer and hope that, during the transfer, none of that good work will be lost. We must keep a close eye on matters and scrutinise events. We do not want mental-health services to take a step backwards; we want to keep it moving forward.

I am disappointed that the Minister refused to meet with the commission during the consultation period. He should have met with it and listened to the concerns that you are now expressing to the Committee. The Minister will want to streamline services to provide a more efficient, effective service. I note that in your presentation, you said that the commission is already providing such a service.

What financial savings does the commission envisage the transfer will make, while maintaining the current level of service and building on it? We cannot stand still; we must build on the services that are provided already. If the services are being streamlined to make them more efficient financially, what will the savings be?

Mr McBrearty:

The question of how the RQIA was dealing with the situation was put to it in discussion with the commission a year ago. At that time, the RQIA — perhaps not having an understanding of the full remit of the functions being transferred to it — indicated that there could be savings of about £250,000 to £300,000 from the commission's existing budget. That is a considerable sum. However, that took into account the fact that the commission has a secretariat, a building and offices that represent expenditure that would be subsumed in a much larger organisation. At that time, and as the RQIA was considering addressing the transfer of functions, that was probably a reasonable place to be initially. However, following from our more detailed discussions about what will be required, the RQIA has shifted considerably from that position. Although I am not in a position to give an exact figure, I think that the potential cash saving that would come about from a transfer of functions would be less than £100,000.

The Chairperson:

I reassure the commission that, following today's meeting, the Committee will be making general comments to the Minister. I also reassure you that we will be scrutinising any legislation on the matter at Committee Stage, and we will ensure that the points on which you have major concerns are addressed in that legislation. However, if, before decisions are made, there is disparity between that and what the Committee sees as the continuation of effective good mental-health services, it will be mindful to ask the commission to come back and highlight those issues.

We thank you for coming before the Committee and making your presentation. I endorse what you said. It is important that we hear the voice of the user and the carer in any set-up; they represent the coalface. It is also important that that mechanism for representation is afforded to the carer or the user. It has been an interesting session; thank you very much.

Mr McKenna:

On behalf of my accompanying colleagues from the Mental Health Commission — and, indeed, all commission staff and members — I thank the Chairperson and Committee members for receiving us today.

The Chairperson:

Thank you.

Mental Health Commission
for NORTHERN IRELAND

IN CONFIDENCE

REPORT OF THE MENTAL HEALTH COMMISSION VISIT TO MUCKAMORE ABBEY HOSPITAL ON 19 JUNE 2001

INTRODUCTION

The Mental Health Commission visited Muckamore Abbey Hospital on 19 June 2001. The purpose of the visit was to give a private interview to patients or their relatives who requested it, to see patients detained for 3 months or more and to speak to professionals involved in the care of such patients. The Commission wished to speak to senior personnel having key responsibility for the clinical care and treatment of patients about current issues. A Feedback Meeting was held; the names of those who attended are shown in Appendix I.

Catchment Area

The hospital provides in-patient and out-patient specialist treatment services for people with a learning disability from the Eastern and Northern Health & Social Services Board areas. In addition it provides semi-secure and other core treatment services on a regional basis. There are also a small number of patients admitted from the Republic of Ireland. The population of the Eastern and Northern Board areas is approximately 1.1 million.

There are currently 381 beds in use, located in 17 wards.
Three children have had 8 admissions to adult wards in the relevant period. In addition, three more children previously admitted were in-patients during that time.

PLANS FOR THE FUTURE

A programme of ward closure has now been agreed. Seven wards in total are to close, the first being Moyola. Treatment beds are to be reduced to 115.

A project board and a team have been established to take forward a resettlement programme and a business case is being prepared at present. Those responsible will try to find alternatives within the community which will meet with the patients', and the patients' families, approval. There is an acknowledgement however of the difficulties of planning resettlement such as this considering the lack of resources for the professional infrastructure in the community.

At present there is lack of clarity as to the future provision for children and adolescent services.

In terms of the hospital's financial base, the £750,000 reinstated by the Eastern Health and Social Services Board following the withdrawal of over £1 million previously, will be recurrent.

Mental Health Commission
for NORTHERN IRELAND

IN CONFIDENCE

In addition, £500,000, part of which is recurrent has been provided by the Northern and Eastern Board aimed at targeting the shortage of nurses.

STAFF PROFILE

There are 4.5 Consultant Psychiatry Posts. There is no change in the nursing complement since last year and the hospital remains 42.21 nurses short. £500,000 provided by the Northern and Eastern boards, part of which is recurrent, has been specifically directed to address budgetary overspend which is in part due to so many patients requiring constant supervision in the hospital and in accompanying patients when they are in-patients in the general hospitals.

There is a full range of specialist professional support services including psychology, behaviour nurse therapy, physiotherapy, speech & language therapy, dietetics, pharmacy, music therapy, aromatherapy, orthotics & dental services.

The nursing skill mix is now 48% trained and 52% untrained.

EXAMPLES OF INNOVATION OR GOOD PRACTICE

A Muckamore Abbey nurse has won an award for her work in the field of epilepsy. Another nurse was a finalist in the Nurse of the Year competition – Learning Disability Category.

Specialist staff within the hospital have had a range of articles published and the hospital, in conjunction with the National Association for the Treatment of Abusers, hosted a major conference on the topic of offender patients.

Within the childrens ward – Conicar – a user group has been set up. The group consists of users, social workers, nursing & medical staff. The focus of the group is on supporting the family of the patient by opening channels of communication between them and other families.

There is an Advocacy Service commissioned by the Eastern Health and Social Services Board. It originally targeted patients who are to be resettled. The Advocate has been in the post for some time and his role is now to recruit and train citizen advocates.

The citizens' advocates are volunteers. Their job is to articulate the patients' views. It is not clear in the event of a conflict between the wishes and views of the patient and those of the primary carer, which is to take precedence. The issue of competence also arises. The issues will of course crystallise and will need to be resolved now that the order of ward closure has been agreed.

Mental Health Commission
for NORTHERN IRELAND

IN CONFIDENCE

ACTIVITIES

Many of the patients attend Day Care,Contracts or Work Skills programmes during the day. In the evenings and at weekends a variety of activities are organised. The hospital has a full time entertainments officer who organises discos, dances, films, bowling and other events. Rehearsals are underway within the hospital at present for a production of the musical "Grease". This is the first time that such a project has been undertaken. The Commissioners spoke to several patients who were involved in the show and all spoke with great enthusiasm about it.

INTERVIEWS

Twenty seven patients attended in person for interview. The relatives of a further six patients attended. In addition, the commissioners spoke to several detained and voluntary patients who had not requested interviews.. Discussions were also held with several members of staff at ward level. Specific issues in relation to patients were dealt with at ward level and general and common issues were raised at the feedback meeting. Several sets of case notes were examined by the medical member and found to be well written, complete, up to date and comprehensive.

POLICIES

Final drafts of the following have been approved:

- Seclusion Policy – October 2000
- Policy for the Management of Aggressive and Violent Patients – October 2000
- Policy on the Levels of Supervision and Observation – October 2000

The hospital will furnish copies of the final policies to the Commission.

FEEDBACK MEETING

- Consultation Process

  The consultation process leading to the agreed programme of ward closures was discussed. During the patient interviews several of the relatives had complained about an alleged lack of information and lack of consultation in relation to same. It was explained that all relatives had been provided with a letter and with a copy of the consultation document. There were 87 responses all of which got an individual reply and all of the responses were shared with the DHSS&PS and the commissioning boards.

  The hospital felt that the concerns articulated by the relatives related to concerns about alternative care. The difficulties for the hospital in dealing with queries of that nature were acknowledged. The duty to make alternative arrangements lies

with the Trust which has responsibility for the area where the patient resided prior to admission.

- SWIMMING POOL

  The closure of the on site swimming pool was discussed. Several of the staff to whom the Commissioners spoke felt that the closure was having a huge impact on the patients' quality of life especially as staff shortages meant that access to the swimming pool at the Antrim Forum was restricted. Several patients also complained about the closure of the swimming pool, as did one of the relatives who felt that his sister had become obese as a result of a lack of exercise.

  The hospital team explained that as the swimming pool was some forty years old there were significant issues relating to Health and Safety and to disabled access which left the hospital with no alternative but to close it.

  It seems that a full refurbishment of the pool would cost £500,000 with a partial refurbishment costing £250,000. The hospital together with the Patients and Friends Association were looking at alternative ways to secure funding for refurbishment. In the longer term the issue arose as to whether a swimming pool would be necessary or feasible given the planned reduction in numbers within the hospital.

- Policies

  The Commissioners brought it to the hospital's attention that even though up to date policies were on file in the wards visited, several of the wards had also retained corresponding draft policies and some previous policies on file.

- Safety Action Notice – SAN(NI) 9853

  A risk assessment had been carried out, and, in terms of replacement of curtain rails, wards had been graded as high, medium or low risk. In Fintona North, which is regarded as high risk, curtain rails had been replaced but an old type solid beam had been left in situ in the ante room to the bathroom. The Commission would like the hospital to confirm that curtain rails in all wards categorised as being in the high or medium risk bracket are in compliance with the Safety Action Notice.

Fintona North

The Commissioners were concerned at the lack of bathing and showering facilities within this unit and at the lack of privacy within that facility. There are twenty three patients and only two baths and one shower; all located in one bathroom. Otherwise the ward is in excellent decorative order and has a homely and an inviting atmosphere.

Several of the patients within Fintona North complained about the quality of the food and one patient complained that the portions were small.

Mental Health Commission
for NORTHERN IRELAND

IN CONFIDENCE

The Commissioners were impressed that all of the patients interviewed were able to name their consultant and their named nurse. Without exception, they spoke in very positive terms about the care afforded them by the staff.

Movilla A

The Commissioners who visited this ward found it to be singularly uninviting. It was overcrowded and the environment was unpleasant. It was explained that this was due in part to the nature of the user group. Movilla A is a semi secure unit for male patients. It admits patients with severe problems including offender patients from all over Northern Ireland, with some admissions from the Republic.

Fintona South/Movilla A

During interview, a patient from each of these wards alleged that they had been restrained by having their thumbs and their arms twisted. The hospital are to investigate the allegations. It was indicated that staff receive St Edward's Hospital training in the management of aggression. This type of training is endorsed by The Beeches Training Unit.

The names of these patients are recorded in Appendix 2.

Admission to General Hospitals.

The admission of patients to general hospitals continues to be a problem. The hospital continues to send their staff to the general hospitals to stay with patients. They feel that there is a lack of understanding and a lack of training as to the needs of the learning disabled within the general hospitals. This has placed an enormous strain on their already stretched resources.

The Commissioners thanked the staff of Muckamore Abbey Hospital for their courtesy and helpfulness throughout the visit.

Mental Health Commission
for NORTHERN IRELAND

IN CONFIDENCE

MENTAL HEALTH COMMISSION VISIT TO MUCKAMORE ABBEY HOSPITAL ON JUNE 19 2001

APPENDIX I

FEEDBACK MEETING

Name	Designation
Mrs. M. Keenan	Team Leader, Mental Health Commission
Ms. M. McHugh	Reporter, Mental Health Commission
Mr. M. Dixon	Member, Mental Health Commission
Dr. R. Galloway	Member, Mental Health Commission
Mr. B. Mullen	Member, Mental Health Commission
Mrs. J. Jefferson	Member, Mental Health Commission
Dr. C. Marriott	Consultant Psychiatrist Director, Medical Services
Ms. N. Evans	Director, Hospital Services
Ms. A. Campbell	Acting Nursing Services Manager
Mr. O. Donnelly	Business Manager
Dr. C. Milliken	Consultant Psychiatrist
Dr. J. MacPherson	Consultant Psychiatrist

Mental Health Commission
for NORTHERN IRELAND

IN CONFIDENCE

Appendix II

The patients mentioned at page 6 are:-

.; Fintona South
; Movilla A

Report\Hospital\MuckamoreJune2001

3

Mental Health Commission
for NORTHERN IRELAND

Date: 19 March 2002

Our Ref: H2/2002

Your Ref:

Mr R Black
Chief Executive
North & West Belfast Health & Social Services Trust
Glendinning House
6 Murray Street
BELFAST
BT1 6DP

Dear Mr Black

The Mental Health Commission visited Muckamore Abbey Hospital on 19 February 2002 and I enclose a copy of the Report of that visit.

The Commissioners who visited the hospital wish to convey their thanks to all concerned for the assistance and hospitality extended to them.

Yours sincerely

F WALSH
Chief Executive

Encs.

North and West Belfast
Health and Social Services Trust
RECEIVED: 21/03/02
CHIEF EXECUTIVE'S OFFICE

	AR	C	I
CHAIRMAN			
CHIEF EXECUTIVE	✓		
DIRECTOR OF PLANNING			
DIRECTOR OF OPERATIONS			
DIRECTOR OF FINANCE			
DIRECTOR OF NURSING			
DIRECTOR OF MEDICAL SERVICES (Health)			
DIRECTOR OF MEDICAL SERVICES (Community)			
DIRECTOR OF HOSPITAL SERVICES	✓		✓
DIRECTOR OF HUMAN RESOURCES			
DIRECTOR OF SUPPORT SERVICES			
AGENDA			
OTHERS			

AR - ACTION REQUIRED

T2\PostU84

Textphone (028) 9065 1319

Elizabeth House, 118 Holywood Road, Belfast BT4 1NY.
Tel: 028 9065 1157 Fax: 028 9047 1180 Email: mhc@dhsspsni.gov.uk

Mental Health Commission
for NORTHERN IRELAND

IN CONFIDENCE

REPORT OF THE MENTAL HEALTH COMMISSION VISIT TO MUCKAMORE ABBEY HOSPITAL ON THE 19th FEBRUARY 2002

The Mental Health Commission made an unannounced visit to Muckamore Abbey Hospital on February 19th 2002. The Hospital provides inpatient care and treatment to people with a learning disability to a local population of 1.1 million in the Eastern and Northern Board areas.

The Commissioners arrived at the Hospital at approximately 7pm and first visited the Oldstone project and interviewed the senior Nurse on duty within Oldstone. If in the event of an emergency this Nurse informed the Commissioners that she would contact the Duty Doctor or Consultant Psychiatrist on duty through the telephone switchboard and would also inform the Nursing Manager as to the nature of the emergency. The Commissioners asked the Senior Nurse if she knew the name of the Duty Doctor. The Commissioners were informed that the Hospital Duty Doctor was unavailable after 5pm Mondays to Fridays and 12 Noon Saturdays and Sundays. In the event of an emergency where a Doctor was required then the Hospital accessed the local GPs Service. The Commissioners then asked if the Senior Nurse knew the name of the Duty Consultant Psychiatrist. The Commissioners were informed that if the Senior Nurse required to contact the Duty Psychiatrist then she would do so through the telephone switchboard but was unaware of the name of the Duty Consultant Psychiatrist.

Oldstone has accommodation for 16 patients. There were currently 14 patients at Oldstone. There is a staff mixture of full time, part time and job share in both Nursing and Ward Manager levels. There is no agency staff employed within the Hospital and they utilise the hospital's own bank staff.

The Commissioners visited a double bungalow that accommodated a total of 5 patients each with their own bedrooms and with communal living room, kitchen and bathroom.

We spoke with a patient who informed the Commissioners that he was happy with his accommodation and had no issues to raise with the Commissioners. Overall Oldstone provided a user-friendly environment.

The Commissioners then visited the Finglass Unit, which is for female patients' adult to elderly with high dependency, a number of whom have an additional physical disability. There are currently 30 beds available in Finglass and 28 patients. The Commissioners viewed a large communal area with patients and staff mixing well and watching television. The Commissioners asked the Senior Staff Nurse if she was aware of the Safety Action Notice regarding curtain rails; their knowledge was vague in relation to Safety Action Notice (SAN) NI 98/53. However, it would appear that the patients in the Unit are

[redacted]

Mental Health Commission
for NORTHERN IRELAND

deemed 'low risk' due to their particular health needs and this may have a bearing on their knowledge of the Safety Action Notice (SAN) NI 98/53 in relation to curtain rails.

The Senior Nurse informed the Commissioners of the procedures she would activate if there were an emergency; this was similar to that in Oldstone. The Commissioners were also informed that this ward was on the list for future closure.

The Commissioners then visited Fintina North, which is a female semi-secure Unit with 19 available beds and which has currently 18 patients. The Commissioners spoke with the Senior Nurse present with regard to the procedures in the case of an emergency and these were similar to Oldstone. In this Unit the Senior Nurse did know the name of the Duty Consultant Psychiatrist, who was at home; he was contacted by telephone by the visiting Team Leader. The Commissioners asked the Senior Nurse the distance between the Duty Consultant's home and the Hospital to ascertain the length of time it would require the Duty Consultant Psychiatrist to get to the Hospital in the event of an emergency. The Commissioners requested information and a case history of the Unit's seclusion room. The seclusion room is situated beside the Nurse's station and there is a policy of observation every fifteen minutes when patients are placed within the Unit. The Commissioners further interviewed the Senior Nurse on the procedures when the seclusion room is used and the most recent dates of when patients were secluded.

? MOYOLA

The Commissioners then visited Moyola A which is a male semi-secure unit with currently 17 patients. The Commissioners interviewed the Senior Nurse present and were given access to the communal area were the patients were watching television.

The Senior Nurse informed the Commissioners that patients who required constant observation affected the availability of nursing staff within the unit. The Senior Nurse also informed the Commissioners that having a unit that included patients with both high and low mental ability was demanding on the Nursing staff. The Commissioners requested information on the closure of Moyola Unit, they were informed that the resettlement process has commenced and that the Unit would remain open for several months.

The Commissioners were shown the refurbishment work being undertaken in the Unit's kitchen, which was to be welcomed by staff, patients and the patients' families. During the refurbishment work there was a level of disruption to the visiting area and the Nursing Staff had made alternative arrangements for visits to patients.

During the unannounced visit to Muckamore Abbey Hospital the Commissioners sought information on the following,

- Availability of the Duty Doctor.
- The availability of the Duty Consultant Psychiatrist
- Nurses on duty – i.e. permanent, bank or agency (the Hospital does not use agency nursing staff)

[redacted]

Mental Health Commission
for NORTHERN IRELAND

- Management back up for Nursing staff (there was a Nursing Manager on site during the Commissioners visit)
- Nurse – patient ratio and arrangements for dealing with emergency situations and for special observations.
- Beds for emergency admissions
- General geography and ward lay out.
- Privacy for visitors including children.
- Issues from previous report (with reference to the closure of the swimming pool the Commissioners were informed that funding had been secured to meet the costs of the refurbishment to the swimming pool though there was no information as to an opening date or who had provided the funding)
- The closure of Moyola

The unannounced visit lasted approximately two hours.

The Commissioners would like to thank all the staff at Muckamore Hospital for the assistance afforded to them during their visit.

Visiting Commissioners: Marjorie Keenan
Gerard Finnegan

Reports/hospital/MuckamoreFeb02

[redacted]

644/1-M

NORTH & WEST BELFAST HEALTH AND SOCIAL SERVICES TRUST

PAPER OMG 65/01
FOR CONSIDERATION

TITLE: **Response of North and West Belfast HSS Trust to the Report of the Mental Health Commission Visit to Muckamore Abbey Hospital on 19th June 2001**

CONTENT: **This paper contains the report of the Mental Health Commission's Visit to Muckamore Abbey Hospital and the Trust response**

PREPARED BY: **Ms N Evans, Director of Hospital Services**

DATE PRESENTED: **15th October 2001**

Approved

RESPONSE OF NORTH & WEST BELFAST HEALTH & SOCIAL SERVICES TRUST

REPORT TO THE MENTAL HEALTH COMMISSION

VISIT TO MUCKAMORE ABBEY HOSPITAL ON 19TH JUNE 2001

1.0 INTRODUCTION

1.1 The Mental Health Commission visited Muckamore Abbey Hospital on 19th June 2001. The purpose of the visit was to interview patients and relatives who had requested an interview and to see all patients detained for three months or over. Initial and feedback meetings with Hospital Management were also held.

2.0 INITIAL MEETING

2.1 Plans for the Future

The Project Board and Project Team referred to during the visit is bringing forward an Outline Business Case for a 115 bed Core Treatment Service. The Project Board is chaired by the Chief Executive, Mr R B Black. The Project Team is chaired by Ms N Evans, Director of Hospital Services.

The resettlement process is co-ordinated by a Resettlement Strategy Group chaired by Ms N Evans, Director of Hospital Services with membership from the EHSSB, NHSSB, six Trusts in EHSSB and NHSSB and a range of clinical and managerial staff from Muckamore Abbey Hospital.

The need for the development of services for children, adolescents and a rehabilitation service in the community has been highlighted through the Regional Project Steering Group chaired by Mr L Frew, DHSS&PS. These services continue to be provided at Muckamore Abbey Hospital but do not form part of the service specified for the 115 bed Core Treatment Service. It is now generally acknowledged that the target of a 115 bed core treatment service will require until 2005-07 to be achieved.

3.0 STAFF PROFILE

3.1 Medical Complement

Dr Colin Milliken was appointed to a Consultant post with effect from 4 June 2001. Negotiations with Commissioners are ongoing to secure funding to make up the 0.4 WTE vacant post to a full time post. There is agreement in principle to the need but no funds have been identified at this point in time.

3.2 Nursing Complement

The recurrent funding secured from Commissioning Boards during 2000/01 has helped to stabilise the nursing establishment. The levels of constant supervision and the overcrowding resulting from difficulties over prompt discharge on completion of treatment are exacerbating the pressure on the nursing establishment. The Trust has requested Commissioner agreement to open an additional house providing 3-4 beds in Oldstone Rehabilitation Unit to ease this pressure on a temporary basis. Negotiations are ongoing in relation to additional nursing resource which would be required. The Trust has secured funding for two nursing assistant Grade A posts to facilitate the ongoing resettlement process. Staff have been appointed and will be deployed to Moyola, the first ward to close, in mid October 2001 when they complete induction training.

The Trust continues to work with Commissioning Boards to address pressures on nursing budgets and to achieve a smooth transition to the required workforce for a core treatment service.

3.3 Professional Support Services

The Trust are currently trying to recruit three chartered clinical psychologists to fill two vacant posts and to augment the department and provide a service into the community of N&WBH&SST. There is a national shortage of clinical psychologists and given their importance to the Trust's capacity to provide a full multi-disciplinary service to its patients the hospital has completed a review of psychology services. Dr Pat Frankish, Consultant Clinical Psychologist, Rampton Special Hospital has provided external advice to the Review.

4.0 EXAMPLES OF INNOVATION AND GOOD PRACTICE.

4.1 The Trust welcome the recognition of the Commission of examples of good practice at Muckamore Abbey Hospital. Professional staff continue to pursue research and to promote a learning culture for staff. The User Group referred to in relation to Conicar Children's ward is in fact a Parent and Carers group.

5.0 INTERVIEWS

5.1 L W - Fintona South

During the interview with visiting Commissioners Mrs W alleged she was inappropriately restrained by having her thumbs and arms twisted. After the Commission's visit Mrs W repeated the allegation to staff and was assisted to make a formal complaint. This allegation was investigated by a senior nurse at the hospital who interviewed Mrs W, another patient and 3 members of staff. The investigation confirmed that an incident occurred between Mrs W and another patient resulting in a decision to transfer Mrs W to the seclusion room in Fintona North. Physical intervention holds were used to safely escort Mrs W. A witness to the transfer and the staff involved indicate that correct intervention holds were used. Mrs W was examined by the ward Doctor who felt it was highly unlikely the bruise on Mrs W's arm was caused by having her arm pushed up her back as she alleged.

A full response was forwarded to Mrs W on 19 July 2001.

5.2 J W - Movilla A

The concerns expressed by Mr W were of a more general nature and were not the subject of a formal investigation under the Trusts complaints procedures as in the other case named. On investigation it was confirmed that physical intervention had not been used with Mr W since April 2001. Frequently when distressed and under escort to the seclusion room Mr W makes allegations against staff which are always investigated. His allegations have been referred to the police who have cautioned Mr W about making unfounded allegations. Notwithstanding this any allegations he makes are addressed by staff and he is afforded the opportunity to make a formal complaint which would be thoroughly investigated under the Trusts complaints procedure.

6.0 FEEDBACK MEETING

6.1 Consultation

The comments contained in the Commissioners report accurately reflect the discussion about parental perception of lack of communication. In addition to the general letters and visits discussed, the Trust has included information on the consultation process and available information on the future resettlement process in a Muckamore Abbey Hospital supplement in the Trust Magazine All Points North and West which was sent to all families in September 2001 and is widely available within the Trust facilities including Muckamore Abbey Hospital.

6.2 Swimming Pool

The Trust has submitted a bid to the Sports Lottery Fund for a grant to refurbish the swimming pool. There are also a number of fundraising efforts by the Parents and Friends group and other groups to raise funds. The Trust has committed to the necessary match funding for the Sports Lottery bid. If the requisite funds can be raised by a combination of sport lottery money, match funding from the Trust and voluntary donations, the Trust is committed to such refurbishment as will permit the ongoing use of the swimming pool as the hospital retracts to 115 beds. The long term provision of the swimming pool will be fully explored as part of the outline business case for the 115 bed core treatment service.

6.3 Policies

The Nursing Services Manager has instructed all wards to remove draft policies from files at ward level. Senior Nurse Managers will check that this has been done during monitoring visits.

6.4 Safety Action Notice: SAN (NI) 9853

Following a risk assessment all curtain rails in wards categorised high or medium risk have been replaced. Colleagues in estates services have sourced a supplier of curtain rails which may provide additional safety features. It is proposed to trial the product in some areas to assess its suitability throughout the hospital. With reference to the solid beam in Fintona North – as advised at the feedback meeting patients do not have unsupervised access to this area. However, given the concerns expressed by visiting Commissioners the Trust has removed the beam. Risk assessments in relation to other potential hazards e.g. coat hooks and towel rails are ongoing.

6.5 Fintona North

The Trust is aware of the inadequacy of the bathing facilities in Fintona North. The overcrowding exacerbates the problems which are created by lack of privacy and very close contact by patients attending to personal hygiene. The building, however, does not lend itself to easy alteration to address the shortcomings in provision.

With reference to the quality and quantity of food. The patients forum in the ward now provide feedback on food on a monthly basis to hotel services staff. This process seems to have improved their overall satisfaction with the food.

7.0 The Trust note the comments on the "singularly uninviting" environment in Movilla A. The concerns about the environment are shared by the Trust. A major aspect of the problem stems from the continuing high levels of admission and inability to effect discharges when treatment is complete. This issue has, is and will continue to be raised with Commissioners of services at Muckamore Abbey Hospital.

8.0 The Trust welcome the Commissioners positive comments about patient awareness of their responsible consultant and named nurse. Equally we welcome the reference to positive comments made by all patients on the quality of care they receive from staff.

9.0 ADMISSION TO GENERAL HOSPITALS

The Trust continue to support patients in general hospitals by the provision of nurses from Muckamore Abbey Hospital where it is assessed as an essential requirement by senior nursing or medical staff who know the patient. We have recently been asked by the Northern Health & Social Services Board to participate in a review of the experiences of patients with a mental disorder when admitted to general hospitals. Dr C Marriott Medical Director (Hospital)/Consultant Psychiatrist and Mrs E Steele, Nursing Services Manager will represent the Trust.

10.0 CONCLUSION

The Trust value the comments of the visiting Commissioners and have sought to address any issues raised.

641M

NORTH AND WEST BELFAST
HEALTH AND SOCIAL SERVICES TRUST

MUCKAMORE ABBEY HOSPITAL

M E M O R A N D U M

From: Ms N Evans
Director of Hospital Services

To: Core Group ES ✓ NM ✓
Dr M McGinnity (Re: Moyola, ✓
Oldstone, Finglass)
Dr C Milliken (Re: Movilla) ✓

Ref: NE/ba

27.3.02

Re: Mental Health Commission Unannounced Visit

Attached please find the report of the above visit.

I have been asked to forward views and comments to the Chief Executive.

I would be grateful for your comments generally and specifically in relation to wards for which you have responsibility, to incorporate into the response.

A response by Monday 9th April 02 would be helpful.

Thank You

Norma Evans.

NORMA EVANS
DIRECTOR OF HOSPITAL SERVICES

NORTH AND WEST BELFAST
HEALTH AND SOCIAL SERVICES TRUST

MUCKAMORE ABBEY HOSPITAL

M E M O R A N D U M

From: Mrs E Steele
Nursing Services Manager

To: Norma Evans
Director of Hospital Services

Ref: ES/ba

4.4.02

Re: Mental Health Commission Unannounced Visit

In response to your request for comments I write on two issues that were raised.

1. No nurse on duty or senior nurse manager would be aware of who the duty consultant is on evening or night unless they had occasion to speak with them during a shift.

   i.e. there is no list circulated nor would I expect all staff to know how far away the duty consultant lives.

2. All health & safety notices are circulated and held on each ward. I know that it is hard to ensure that all staff keep up to date reading them but that the particular notice on curtain rails should have been known as there was an extensive risk assessment carried out.

I will write out to ward managers and staff to urge the importance of all staff keeping up to date with these notices.

E Steele

Eilish Steele

File with Draft response

NORTH & WEST BELFAST
HEALTH & SOCIAL SERVICES TRUST

MUCKAMORE ABBEY HOSPITAL

MEMORANDUM

From : Dr C M Marriott
Medical Director (Hosp)

To : Ms N Evans
Dir. Of Hospital Services

Ref : CMM/wb

Date : 3 April, 2002

Re : **Mental Health Commission Unannounced Visit**

I would like to make the following observations :

1. We might wish to remind the Commission of our regional remit (para 1).

2. The hospital medical staff are not available on site on Sundays (para 2).

3. I do not think it is necessary for the senior nurse on duty in each ward to know the name of the Duty Consultant – so long as the switchboard do !

4. Curtain rails – perhaps we should advise the Commission of the risk assessment we did ? I expect Mrs Steele has observations re this. I assume that SAN NI 98/53 is available and formed part of the risk assessment.

5. I am surprised to note that we had an empty bed in Fintona North !

6. There seems to be confusion about Movilla and Moyola – did the Commissioners visit both units ?

7. Should we provide information on all the "bullet points" to ensure that Mental Health Commission has correct information ?

Medical Director (Hosp)

NORTH AND WEST BELFAST
HEALTH AND SOCIAL SERVICES TRUST

MUCKAMORE ABBEY HOSPITAL

M E M O R A N D U M

From: Dr C R Milliken
Consultant Psychiatrist

To: Ms N Evans
Director of Hospital Services

CRM/dmcf

03 April 2002

Re: Mental Health Commission's Unannounced Visit

Thank you for asking me to comment on the Mental Health Commission's recent unannounced visit to Muckamore Abbey Hospital.

It may be useful to clarify two points. Firstly, in paragraph two, the Commission note that 'in the event of an emergency where a doctor was required then the hospital accessed the local G.P. service'.

It may be useful to point out to the Commission the specific arrangement the hospital has for nighttime cover from a named G.P./G.P. practice – the report may give the impression that we contact an 'on call' G.P. in the same way as a member of the public might when they require a G.P. out of hours.

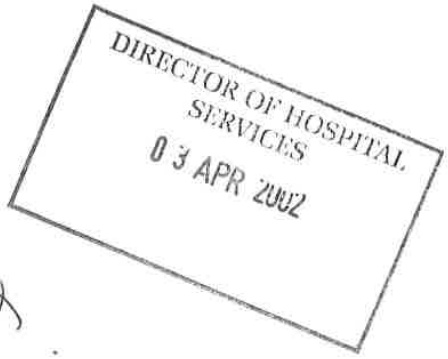
Paragraph 9 presumably refers to Movilla 'A', rather than Moyola 'A'.

The next paragraph refers to 'information on the closure of the Moyola unit. They were informed that the resettlement process has commenced and the unit would remain open for several months'. This is obviously a little confusing as Movilla 'A' and Moyola seem to be confused.

I am grateful for the opportunity to comment.

Kind regards.

Consultant Psychiatrist



NORTH AND WEST BELFAST
HEALTH & SOCIAL SERVICES TRUST

MUCKAMORE ABBEY HOSPITAL

M E M O R A N D U M

From: Dr M McGinnity
Consultant Psychiatrist

To: Ms Norma Evans
Director of Hospital Services

Ref: Dr MMcG/mc

Date: 5 April, 2002

Mental Health Commission Unannounced Visit

Thank you for forwarding me the report of the Unannounced Visit on February 19 2002.

With respect to contacting medical staff in the event of emergency, I am satisfied that all of the nursing staff in all of the wards visited are confident of the procedure involved, and I personally would not expect them to know the name of either the duty doctor or the duty consultant unless they had previously cause to contact them that same evening.

Finglass

Patients in Finglass have high nursing dependency needs and would be considered very low risk for suicide. However, the hospital may wish to make a comment on the implementation of safety action notice NI98/53 with respect to which wards the Safety Action notice has been considered relevant for implementation.

Moyola

There seems to be some confusion on the second page about the name of the Unit which was visited. Clearly the male semi-secure unit with 17 patients is Movilla. However, it appears that staff in Movilla were asked for information on the closure of Moyola.

2/5 April, 2002/ Mental Health Commission Unannounced Visit

I note that the Commissioners also sought information on other matters listed at the end of their report. One of is these beds for emergency admissions and since there is no comment about this in the report, I wonder if you intend to forward any information regarding the extreme pressure which the admission wards have suffered leading to the patients sleeping out.

Dr M McGinnity
Consultant Psychiatrist

P.S. I understand that a query Health & Safety Team carried out an assessment of Finglass ward with respect to the Safety Action Notice mentioned above just a few weeks before the visit, but the Staff Nurse who was on duty at the time had not been aware of this.

cc. Dr Monnelt

The Regulation and Quality Improvement Authority

Changes in the delivery of Mental Health & Learning Disability functions in Northern Ireland

Information for service users, their carers, and providers of mental health and learning disability services

1. Introduction

The framework for the delivery of health and social care services in Northern Ireland is changing. This leaflet provides useful information for users, their carers and for providers of Mental Health and Learning Disability Services in Northern Ireland.

Under the *Health and Social Care Reform (Northern Ireland) Act 2008* the functions of the Mental Health Commission (MHC) as prescribed in the *Mental Health (Northern Ireland) Order 1986* transfer to the Regulation and Quality Improvement Authority (RQIA), with effect from 1 April 2009.

RQIA has worked in partnership with the Mental Health Commission to ensure a seamless transition that will have no adverse impact on service users, their carers and providers.

2. What is the RQIA?

RQIA is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and we encourage improvements in the quality of those services.

RQIA's main functions are:

- to inspect the quality of services provided by health and social care (HSC) bodies in Northern Ireland through reviews of clinical and social care governance arrangements within these bodies
- to regulate (register and inspect) a wide range of services delivered by HSC bodies and by the independent sector. The regulation of services is based on legislative requirements and minimum care standards to ensure that service users know what quality of services they can expect to receive, and service providers have a benchmark against which to measure their quality
- responsibilities for people with a mental illness and those with a learning disability. These include: preventing ill treatment; remedying any deficiency in care or treatment; terminating improper detention in a hospital or guardianship; and preventing or redressing loss or damage to a patient's property

3. RQIA's responsibilities under the *Mental Health (Northern Ireland) Order 1986*

Under the *Mental Health (NI) Order 1986*, RQIA has specific responsibility for keeping under review the care and treatment of patients with a mental disorder. In taking on this responsibility RQIA takes an approach that is independent, multidisciplinary, protective, and has investigative, inspectorial and advisory functions. In particular, we will:

- enquire into cases where there may have been ill-treatment or deficiency in care and treatment; improper detention in hospital; improper reception into guardianship of a patient; or where the property of a patient may have been exposed to loss or damage
- visit and interview detained patients in private
- advise the relevant authorities of steps to be taken to secure the welfare of a patient; or any matter concerning the welfare of a patient
- inspect a patient's records and their movements within mental health and learning disability services

These new structures also allow RQIA to build upon and extend the role of the Mental Health Commission. These include:

- a focus on the individual, on the rights of service users and carers, incorporating the powers of enforcement and improvement on organisations under *The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003*
- multi-professional and lay working through RQIA's programme of inspection and review
- promotion and sharing of good practice across mental health and learning disability services
- wider promotion of mental health, advocacy, service user and carer engagement

4. RQIA's Mental Health and Learning Disability Review Team

Under *The Health and Personal Social Services (Quality, Improvement and Regulation)(Northern Ireland) Order 2003*, the RQIA has established a dedicated team responsible for inspecting and reviewing mental health and learning disability services across Northern Ireland. This includes:

- conducting reviews into the monitoring and improvement arrangements
- carrying out investigations and inspections
- recommending actions for improvement
- reporting unacceptably poor quality or significant failings to the DHSSPS

Our visiting programme includes annual announced and unannounced reviews and inspections of mental health and learning disability hospital, community care and treatment facilities.

In addition, following a transfer of responsibility for the health and social care of people detained in prison, in partnership with Criminal Justice Inspectorate Northern Ireland (CJINI) and Her Majesty's Inspectorate of Prisons (HMIP), we monitor this area, including for those with a mental disorder and/or learning disability.

RQIA has a statutory duty to undertake inspections of a wide range of services, including care homes for adults and children, day care and domiciliary care. Many of these services provide care and treatment for people with mental health and learning disability. Carried out by a multidisciplinary team of inspection staff, our inspections focus on compliance with regulations and minimum care standards. In our inspections we examine the quality of:

- care
- life of the residents
- management
- the environment

The combined strengths of the *Mental Health (Northern Ireland) Order 1986* and *The Health and Personal Social Services (Quality, Improvement and Regulation)(Northern Ireland) Order 2003* ensure that all review and inspection focuses on:

- the specific care and treatment of individuals under the *Mental Health (Northern Ireland) Order 1986*
- engagement and consultation with service users, their carers and advocates
- the context and environment within which care is provided
- the quality and availability of care
- appropriate enforcement action where RQIA identifies failures in service quality or non-compliance with regulations

5. Involving Service Users, Carers and Advocates

Public participation plays an important role in the work of RQIA. By listening to and acting on the views and opinions of the public, we ensure that we respond to existing and emerging issues within health and social care. We aim to be more accessible, responsive and targeted in how we monitor the quality of health and social care by engaging more effectively with the public. We ensure that participation is at the centre of our work by engaging with the public in a meaningful way. RQIA's Public Participation Strategy builds upon the existing participation, engagement and partnership approaches used throughout RQIA, and provides a coordinated approach to future public participation.

We are committed to further developing this approach in informing, planning, implementing and evaluating our mental health and learning disability functions within RQIA.

To ensure a clear user and carer voice, two external reference groups will be established that will include service users, carers and advocates representing the respective interests of mental health and learning disability. These will provide a platform for users and carers to play an active part in the work of RQIA, from policy-making to providing practical advice on matters relating to inspections and reviews.

January 2009

The Regulation and Quality Improvement Authority

25 March 2009 Ref: GH/JON/PC

Mr William McKee CBE
Chief Executive
Belfast Health and Social Care Trust
Trust Headquarters
Roe Villa
Knockbracken Healthcare Park
Saintfield Road
Belfast BT8 8BH

Dear ~~Mr McKee~~ William,

Re: Update on transfer of functions from the Mental Health Commission to the RQIA

You will be aware that with effect from 1 April 2009, RQIA will assume responsibility for the functions of the Mental Health Commission as set out within Part VI of The Mental Health (Northern Ireland) Order 1986.

In facilitating the discharge of these functions, Trusts should report to RQIA all untoward events, as set out in the revised guidance on the monitoring of untoward events issued by the Mental Health Commission (August 2007) and attached for reference. I am aware that the reporting of untoward events is to be reviewed following the establishment of the HSC Board but, in the interim, Trusts should continue to adhere to this guidance.

The Mental Health & Learning Disability Team at the RQIA may be contacted directly at the address and telephone number below:

The Mental Health & Learning Disability Team
RQIA
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Tel: 028 9051 7530
Fax: 028 9051 7531
email: mhld@rqia.org.uk

As part of the ongoing communication around the transfer, I would be grateful if the attached information leaflet and factsheet could be shared with service users,

carers and staff as appropriate. It would also be appreciated if the attached poster could be displayed on relevant notice boards across trust facilities.

If your require further information in relation to the work ongoing in this area, please contact Jude O'Neill, Head of Mental Health & Learning Disability Review, RQIA on 02890 517538 or email jude.oneill@rqia.org.uk

Yours sincerely

GLENN HOUSTON
Chief Executive

Enc

QUALITY IMPROVEMENT PLAN

ANNOUNCED INSPECTION

Ennis Ward, Muckamore Abbey Hospital

10 and 11 November 2010

The issue(s) identified during this inspection are detailed in the Quality Improvement Plan.

The details of the Quality Improvement Plan were discussed with Service Manager, Senior Nurse Manager, Ward Manager Ennis ward, two staff nurses for the ward and the Ward Consultant.

RECOMMENDATIONS

Recommendations when implemented may enhance service, quality and delivery.

NO.	EXPECTATION STATEMENT	RECOMMENDATIONS	NUMBER OF TIMES PREVIOUSLY STATED	DETAILS OF ACTION TO BE TAKEN	INDICATIVE TIMESCALES
1	Advocacy services are available to all patients.	It is recommended that the Trust is proactive in the delivery of an independent advocate service to the ward.		• Approach the advocacy service in order that a proactive service may be offered to the patients in Ennis ward • Awaiting outcome of advocacy referral for one patient • Mencap approached families of a further 4 patients offering this service to them and are awaiting a response	2 months 2 months 2 months
2	All patients have been advised of their rights and what they can expect in terms of care and treatment, in a manner appropriate to their understanding.	It is recommended that the outcomes of patient's' meetings are clearly recorded and monitored and that rights and routines are on a standing agenda.		• The minutes will have the outcomes clearly defined and evidence of carrying out these forwarded to the next meeting	Ongoing

RECOMMENDATIONS

Recommendations when implemented may enhance service, quality and delivery.

NO.	EXPECTATION STATEMENT	RECOMMENDATIONS	NUMBER OF TIMES PREVIOUSLY STATED	DETAILS OF ACTION TO BE TAKEN	INDICATIVE TIMESCALES
6	All patients are informed of and involved in a person centred assessment and care planning process.	It is recommended that patients are asked to sign their care plans to evidence consent to change. It is recommended that there is a record to evidence patients being asked for their views for multi-disciplinary meetings and reviews and to evidence informing them of outcomes.		• Care plans will be discussed with the patient when reviewed and evidenced by patients signature • Review of the nursing review proforma with updated evidence of discussion and patients signature • Changes made to the monthly MDT book to reflect this	Ongoing 4 months Complete
7	There will be weekly multi-disciplinary team review with patient involvement and appropriate	It is recommended that the format for recording reviews includes: • Tasks identified. • Who has responsibility for tasks.		• The MDT book has been modified to include this information • Will be actioned through EQC audit tool	Complete 4 months

RECOMMENDATIONS

Recommendations when implemented may enhance service, quality and delivery.

NO.	EXPECTATION STATEMENT	RECOMMENDATIONS	NUMBER OF TIMES PREVIOUSLY STATED	DETAILS OF ACTION TO BE TAKEN	INDICATIVE TIMESCALES
	representation from advocates and other relevant agencies involved in the patient's care.	• Who attends, including designation. • Capturing patient views prior to the meeting. • How the patient is informed.			
9	Patients will be given the opportunity to meet and discuss in private any issues with their primary nurse or in their absence an allocated nurse on a daily basis.	It is recommended that 1:1 meaningful engagement with the named or allocated nurse is recorded as such to evidence this expectation statement.		• On a daily basis the named nurse will record in the care plan all engagement with the patient	Ongoing
11	The discharge plan should be initiated at the earlier opportunity following admission.	The method of recording must include monitoring of outcomes.		• This will be evaluated at a minimum 6 monthly (more often if actively being prepared for discharge) and signed by the patient when applicable	Ongoing

RECOMMENDATIONS

Recommendations when implemented may enhance service, quality and delivery.

NO.	EXPECTATION STATEMENT	RECOMMENDATIONS	NUMBER OF TIMES PREVIOUSLY STATED	DETAILS OF ACTION TO BE TAKEN	INDICATIVE TIMESCALES
13	Clear documented systems are in place for the management and filing of records in accordance with professional and legislative requirements	It is recommended that entry of all records consistently comply with professional guidance and include signature, date, time and designation. It is recommended that the ward is provided with clerical support to relieve nurses to care for patients.		• Inform staff via staff meetings and the communication book • Highlighted through EQC yearly • Staff have been reissued with the trust policy on record keeping, admin staff are available to support ward manager in records management	Ongoing Ongoing Completed

RECOMMENDATIONS

Recommendations when implemented may enhance service, quality and delivery.

NO.	EXPECTATION STATEMENT	RECOMMENDATIONS	NUMBER OF TIMES PREVIOUSLY STATED	DETAILS OF ACTION TO BE TAKEN	INDICATIVE TIMESCALES

ADDITIONAL RECOMMENDATIONS:

AREA OF CONCERN/ ISSUES	RECOMMENDATIONS	NUMBER OF TIMES PREVIOUSLY STATED	DETAILS OF ACTION TO BE TAKEN	INDICATIVE TIMESCALES
Environmental	It is recommended that all environmental recommendations in this report are resolved.		• Requests for repainting re-submitted • Requests for new flooring submitted • Referral made to Hotel Services re lack of cleaning provision • New bedroom furniture requested	**Ongoing**
Staffing	It is recommended that the process of taking staff from the ward to relieve other ward is reviewed and monitored as it impinges on patient care.		• Senior Nurse Management to monitor and review	**Ongoing**
Patient transfers	It is recommended that there is a transfer policy for patients to and from the ward which incorporates a phased person centred approach.		• Will be referred to policy group for inclusion in the admission discharge protocol • Review transfer checklist	**4 months**

Social activity	It is recommended that onsite social activity is monitored for all patients.		• Continue to record all social activities for patients including those taking place on site	**Ongoing**

The Quality Improvement Plan is to be signed by the Chief Executive and returned to:

Mental Health and Learning Disability Team
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

SIGNED: _____

NAME: _____

DATE: _____

FOR OFFICE USE ONLY:

QIP viewed by inspector on:

DATE: _____

SIGNED: _____

NAME: _____

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

MENTAL HEALTH INSPECTION - SELF ASSESSMENT

Name of Facility/Ward: **Ennis Ward, Muckamore Abbey Hospital**

Date of Inspection: **10 and 11 November 2010**

Lead Inspector: **Margaret Cullen**

Introduction

The Regulation and Quality Improvement Authority (RQIA) is a non departmental public body responsible for the monitoring and inspecting the quality, safety and availability of health and social care services across Northern Ireland. It also has the responsibility of encouraging improvements in those services.

From the 1 April 2009 RQIA also assumed responsibility for a range of functions under the Mental Health (Northern Ireland) Order 1986, these include making an inquiry into a case where it appears to the Commission that there may be ill-treatment, deficiency in care or treatment, or improper detention in hospital or reception into guardianship of any patient, or where the property of any patient may, by reason of his mental disorder, be exposed to loss or damage.

The agreement for the transfer stressed the importance of applying a Human Rights Based approach and made reference to the principles agreed in the conclusion of the Bamford review of justice, benefit, least harm and autonomy.

In line with the duties under legislation and Human Rights approach RQIA developed a programme of patient experience review in 2009. This commenced the programme of inspection with the service user. RQIA have used the experience of the patient experience reviews in 2009 and 2010 to aid the development of this inspection methodology.

RQIA with the support of a range of experts, has taken the current legal obligations recognised by DHSSPS, such as the Mental Health (Northern Ireland) Order and the Patient Experience Standards to create a range of expectation statements in the areas of:

- fairness
- respect
- autonomy
- dignity
- equality
- protection

It is anticipated that these expectation statements and their assessment will ensure the momentum towards the fulfilment of the Bamford principles and the achievement of the RQIA core activities[1] of:

- improving care
- informing the population
- safeguarding rights and
- influencing policy

The expectation statements being used will be assessed against an achievement scale set out in table 1 of this self assessment workbook.

[1] RQIA Corporate Strategy 2009-2012

In order to affect a continuum for improvement RQIA will apply a range of interventions.

Where achievement is assessed as fully achieved and identified as an exemplar of best practice, permission will be sought to share the initiative(s) across other provider organisations.

Where compliance is assessed as partially or substantially achieved and is envisaged as being fulfilled within the year, relevant recommendations relating to the improvement areas will be made as part of the trust's report of the inspection.

Where achievement levels are found not to have been achieved at the time of inspection or unlikely to be achieved, the RQIA will issue a requirement to comply (with department standards and legislation) in this instance an action plan will be forwarded by the Trust. This action plan will outline timescales against the actions required.

Section 2 - Guidance on completion of the self assessment document

Please read the description for each of the 13 Expectation Statements and the associated criterion for assessment (the latter as contained within Appendix 1). You are then asked to provide some brief narrative regarding each Expectation Statement to describe how the unit is meeting the Expectation Statement (and associated Indicators as contained within Appendix 1) in the grey text box in the Provider's self assessment section beneath the Expectation Statement. Please use 'plain English' and note that **the response is limited to 200 words for each criterion**

As well as narrative for each Expectation Statement, the provider should also complete the Level of Achievement box choosing from the available drop down options. The definitions for Levels of Achievement are listed below to assist the Provider in completing the document:

TABLE 1: LEVELS OF ACHIEVEMENT

Level of Achievement	Definition
Not applicable	The criterion is not applicable to this service setting. (A reason must be clearly stated in the service response.)
Unlikely to be Achieved	The criterion is unlikely to ever be achieved. (A reason must be stated clearly in the service response).
Not Achieved	The criterion is unlikely to be achieved in full before end of March 2011. For example, the service has only started to develop a policy and implementation will not take place until after March 2011.
Partially Achieved	Work has been progressing satisfactorily and the service is likely to have achieved the criterion prior to end of March 2011. For example, the service has developed a policy and will have

Level of Achievement	Definition
	completed implementation by end of March 2011.
Substantially Achieved	A significant proportion of action has been completed to ensure the service performance is in line with the criterion. For example, a policy has been developed and implemented but a plan to ensure practice is fully embedded has not yet been put in place.
Fully Achieved	Action has been completed that ensures the service performance is fully in line with the criterion. For example, a policy has been developed, implemented, monitored and an ongoing programme is in place to review its effectiveness.

Following completion of the 13 Expectation Statements, please email the self assessment document to mhld@rqia.org.uk no later than 13 October 2010.

Section 3 Declaration Page

Please complete the Declaration Page to be found at the end of the Self Assessment document and return a hard copy of the page to Patrick Convery (Head of Programme) Mental Health and Learning Disability Team, RQIA, 9th Floor Riverside Tower, 5 Lanyon Place, Belfast BT1 3BT, once signed by the Chief Executive.

INSPECTION STANDARDS - FAIRNESS

PROVIDER'S SELF-ASSESSMENT
Please outline (in no more than 200 words) how you are meeting this standard

Expectation Statement 1: Advocacy services are available to all patients. *For associated indicators please refer to Appendix 1.*	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
The patient's family (N.O.K) advocates on behalf of the patient. In this ward (Long-Stay) the Named Nurse advocates for the patient in the absence of family or alongside family. Contact with Named Nurses are ongoing for all patients. A large number of our patients have communication problems, Autism and challenging behaviour. **The Multidisciplinary Team will refer the patient to the Advocacy Service if it is deemed to be in the best interests of the patient e.g. during Resettlement or if the patient requests it. There is access to the Independent Advocacy Groups such as Mencap and Bryson - they visit the hospital weekly although this is a limited resource.** **The Tilli Self-Advocacy Group is supported by the Arc Association and meets regularly within the hospital. The ward has posters which display information relating to where and how advocates can be contacted. This has been discussed via the Patients Forum and patients are made aware of the right to an advocate in the Welcome to Ennis Booklet for Patients and their Families.** **Advocates are welcome to attend Multidisciplinary Reviews/other patient meetings and to have regular contact in private with the patient. They are directly contactable by the patients or the nurse will assist with this if it is required or requested by the patient.** **Staff in Ennis have had training relating to Advocacy groups ie The Tilli Group.**	Not Applicable **Fully Achieved**
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
	Not Applicable

INSPECTION STANDARDS - FAIRNESS

PROVIDER'S SELF-ASSESSMENT
Please outline (in no more than 200 words) how you are meeting this standard

Expectation Statement 2: All patients have been advised of their rights, and what they can expect in terms of care and treatment, in a manner appropriate to their understanding. *For associated indicators please refer to Appendix 1.*	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
On transfer the patients' Named Nurse will explain Ennis Ward's Philosophy and Aims and Objectives. The Named Nurse will read the Welcome to Ennis for Patients and their Families booklet with the patient and if present their family. The patient is encouraged to share this with their family. This booklet is user friendly and has additional Makaton symbols if required. A high percentage of patients in Ennis would not have any understanding of symbols or simple language. **The booklet states that the patients have the same rights as others in society, the right to make a complaint and so on. It promotes discussion i.e. How bodies such as RQIA can help you and others.** **Patients are encouraged to attend regular Patient Forums. The Trusts Complaints Procedure, the work of the RQIA, the Tilli Group and Advocacy groups have been discussed at these.** **Nursing Staff provide a 24 hour service offering support to patients and their families.** **In the event of a transfer of a detained patient there is a workbook available to explain a Patients Rights whilst in Hospital. Staff have training in Human Rights in Learning Disability.**	Not Applicable **Fully Achieved**
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
	Not Applicable

INSPECTION STANDARDS - FAIRNESS PROVIDER'S SELF-ASSESSMENT Please outline (in no more than 200 words) how you are meeting this standard	
Expectation Statement 3: Each patient who is detained is informed of the process and the implications for them. *For associated indicators please refer to Appendix 1.*	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
THERE ARE NO DETAINED PATIENTS WITHIN THIS SETTING.	Not Applicable
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
	Not Applicable

INSPECTION STANDARDS - FAIRNESS PROVIDER'S SELF-ASSESSMENT Please outline (in no more than 200 words) how you are meeting this standard	
Expectation Statement 4: Patients are informed and familiarised with the comments and complaints process. *For associated indicators please refer to Appendix 1.*	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
Patients are advised of their right to complain by nursing staff. The Welcome to Ennis Booklet which is shared with patients and their families on transfer explains the right to complain and that staff will explain how to do this. It encourages participation at Patient Forums and states that they have a right to an advocate or contact with other protective bodies or Support Agencies e.g. RQIA, Tilli group. A high percentage of our patients have communication difficulties. Families are invited to patient multidisciplinary reviews and are encouraged to discuss the patients care and treatment at these and at any time.	Not Applicable **Fully Achieved**

There are regular Ward Meetings in Ennis and one objective of these is to identify ways in which we can continue to improve our service. **The current Trust Management Policy regarding complaints is followed by staff.** **Complaints Awareness Training is available for staff within the trust.** **There are Trust information leaflets available for patients and their families "How to make a comment or Complaint on our Service".** **There is a complaints register available in the ward but there have been no complaints recorded since the year 2000.**	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
	Not Applicable

INSPECTION STANDARDS - FAIRNESS **PROVIDER'S SELF-ASSESSMENT** **Please outline (in no more than 200 words) how you are meeting this standard**	
Expectation Statement 5: Patients are informed and familiarised with the ward environment and routines in an ongoing patient focused manner. *For associated indicators please refer to Appendix 1.*	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
Ennis amalgamated with Fairview ward in January 2010. There have been no transfers to Ennis during this time. Current patients have been made aware of the Welcome booklet for Patients and their families. This will be read to newly transferred patients when a transfer occurs. There is a high proportion of our patients who would not be able to read and/or understand symbols. **Staff on duty will orientate the patient to the ward by showing them around the facility and introducing them to all staff within the ward ie Nursing, Medical, Domestic etc.**	Not Applicable **Fully Achieved**

On the day they will explain the Ward Philosophy, Aims and Objectives, Rights etc. using the Welcome Booklet. **The patients' Named Nurse and Associate Nurses are allocated on that day. The importance of a good relationship with patients and their families is highlighted in our ward Aims and Objectives.** **Patient Forums are ongoing and the Advocacy Service is explained.**	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
	Not Applicable

INSPECTION STANDARDS - FAIRNESS **PROVIDER'S SELF-ASSESSMENT** **Please outline (in no more than 200 words) how you are meeting this standard**	
Expectation Statement 6: All patients are informed of and involved in a person centred assessment and care planning process. *For associated indicators please refer to Appendix 1.*	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
Patient Centred Care Plans have been devised by Named Nurses and are reviewed by the Multidisciplinary team. **All care-plans were recently audited by the EQC team within the trust.** **Care-plan entries are signed, dated and now timed where applicable.** **Care-plans are responsive to change and do reflect changes in patient care and treatment, behaviour etc.** **Any points of disagreement in relation to care would be identified and recorded.** **Ongoing assessments are up to date and regularly reviewed and with the patient where possible** **Many of patients in Ennis have problems with communication and or understanding. An unmet need for some of the ladies in Ennis could be the fact that they await a place in the Community.** **Where capacity is available that patient has participated in and signed her care-plan. There is evidence of consent being sought and given orally or non-verbally on a variety of issues. Consent and best interests**	Not Applicable **Fully Achieved**

are discussed by the Multidisciplinary team.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
	Not Applicable

INSPECTION STANDARDS - FAIRNESS **PROVIDER'S SELF-ASSESSMENT** **Please outline (in no more than 200 words) how you are meeting this standard**	
Expectation Statement 7: There will be a weekly multidisciplinary team review with patient involvement and appropriate representation from advocates and other relevant agencies involved in the patient's care. *For associated indicators please refer to Appendix 1.*	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
Ennis is long stay ward and Multi-disciplinary Team Reviews are held at least monthly. **Patients have an Annual Review and for this reports are prepared from Nursing, Medical, Daycare etc and are discussed at this.** **The Careplan is reviewed and aims and objectives are set accordingly. The Named Nurse is responsible for the follow up and to coordinate any planned action. The patient attends if they wish to and their N.O.K are invited to attend. Other professions ie daycare, speech and language etc may attend or provide reports for this also. The outcome is forwarded to the patient's family unless this is against the wishes of the patient.** **There are also Doctors rounds held 2-4 weekly whereby the Ward Consultant and Ward Doctor review any changes with the Nurse in Charge. Any changes to be made will be documented in the care plan and action taken again coordinated by the nurse in charge. Careplans reflect changes in patients care and treatment.** **Both of these meetings reflect a multidisciplinary approach. Referrals to various services can be made at any time during that year i.e. Adult Behaviour Services. Reports can be requested at any time and are provided at any time during the year i.e. Speech and Language.**	Not Applicable **Fully Achieved**

The Ward Doctor visits regularly during the week. The Ward Consultant is available during any given week. **The Daily care given to patients in Ennis is based upon a Multidisciplinary Approach. It reflects individual care based upon individual needs.**	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
	Not Applicable

INSPECTION STANDARDS - FAIRNESS **STANDARD 1 - FAIRNESS** **PROVIDER'S SELF-ASSESSMENT** **Please outline (in no more than 200 words) how you are meeting this standard**	
Expectation Statement 8: Patients have the opportunity to meet and discuss their care and treatment in private with their consultant. *For associated indicators please refer to Appendix 1.*	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
The Ward Consultant is available for patient appointments on a Monday to Friday Basis. **Patients can be helped to make an appointment, relatives are advised how to and on occasions the Nurse will make the appointment for the patient or their family. This is done by a telephone call to the Consultant's secretary to arrange an appointment.** **There is a poster to explain this and the opportunity to do this is explained in the Welcome Booklet for Patients and their families.** **The Ward Consultant will record any meetings in the patient's Medical File and sign it. The Ward is advised of any changes to be made as a result of this.** **Nurses can be present at any such meetings if the Patient requests it.** **Patients and their families can meet in private with the Consultant at this office or in the ward. Speech and Language Services are available to assist with the interview.**	Not Applicable **Fully Achieved**

Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
	Not Applicable

INSPECTION STANDARDS - FAIRNESS

PROVIDER'S SELF-ASSESSMENT
Please outline (in no more than 200 words) how you are meeting this standard

Expectation Statement 9: Patients will be given the opportunity to discuss in private any issues with their primary nurse, associated nurse or in their absence an allocated nurse, on a daily basis. *For associated indicators please refer to Appendix 1.*	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
Named Nurses record issues brought to them by patients in their Nursing Care Plan, action to be taken and resulting changes are reflected. **This is often following discussion with members of the Multidisciplinary Team. There are 6 monthly reviews of care-plans including progress/changes etc.** **If a Named Nurse is unavailable the patient will be aware who the Associate Nurse or Allocated Nurse is in her place. A friendly approach is taken by staff whilst engaging with patients.** **There are rooms available to allow privacy for meetings. The services of Speech and Language can be employed where there are Communication problems.**	Not Applicable **Fully Achieved**
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
	Not Applicable

INSPECTION STANDARDS - FAIRNESS

PROVIDER'S SELF-ASSESSMENT
Please outline (in no more than 200 words) how you are meeting this standard

Expectation Statement 10: Patients have the opportunity to meet and discuss in private their care and treatment, with any health or social care professional involved in their care. *For associated indicators please refer to Appendix 1.*	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
Patients are made aware of their right to meet with all professionals who are involved in their care. This is explained to them by their Named Nurse and using the Welcome to Ennis for Patients and Families booklet. Many of our patients have difficulty with communication and may need the assistant of other agencies i.e. Speech and Language. **Appointments can be made by the Nurse to facilitate this or by the patient themselves or their families. The Nursing staff can advise how to do this.** **Records are made of issues discussed, actions to be taken resulting changes and follow up. Patients notes evidence discussion of overall progress and changes. Nursing staff can be present at meetings if the patient requests it.** **There are rooms which can be provided for private discussion.**	Not Applicable
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
	Not Applicable

INSPECTION STANDARDS - FAIRNESS

PROVIDER'S SELF-ASSESSMENT
Please outline (in no more than 200 words) how you are meeting this standard

Expectation Statement 11: The discharge plan should be initiated at the earliest opportunity following admission. *For associated indicators please refer to Appendix 1.*	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
All patients in Ennis are awaiting discharge. There is no funding available for any of the current population in Ennis. **Should a bed become available it would be discussed immediately with the multidisciplinary team. When this is confirmed the patient is fully involved. All relevant persons will be invited to MDT meetings i.e. Advocates. Assistance can be given from the Speech and Language Service to aid communication if applicable.** **There is a Discharge Plan included in the care-plans. This is reviewed at least 6 monthly and is ready for planned action when a bed becomes available.** **There is information available in Ennis regarding Resettlement procedure.**	Not Applicable **Fully Achieved**
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
	Not Applicable

INSPECTION STANDARDS - FAIRNESS PROVIDER'S SELF-ASSESSMENT Please outline (in no more than 200 words) how you are meeting this standard	
Expectation Statement 12: The discharge interview with the patient should review the discharge plan, progress to date and include confirmation of the indicators in Appendix 1, Expectation Statement 12. *For associated indicators please refer to Appendix 1.*	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
The Trust's Protocol and Procedures are followed upon discharge. **Hospital Resettlement Guidelines are fully applied.** **There is a format to provide leave medications and this is the same for discharge.** **Medication is issued to families with clear guidance and instruction.** **Personal possessions and monies are returned to the patient.** **If communication is a problem the Speech and Language Service will provide assistance.** **The Discharge Checklist (Hospital and Trust) are completed by Named nurse or Allocated Nurse.**	Not Applicable **Fully Achieved**
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
	Not Applicable

INSPECTION STANDARDS - FAIRNESS

PROVIDER'S SELF-ASSESSMENT
Please outline (in no more than 200 words) how you are meeting this standard

Expectation Statement 13: Clear documented systems are in place for the management and filing of records in accordance with professional and legislative requirements. *For associated indicators and please refer to Appendix 1.*	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
Following the policy for the Management of Records Ennis has implemented the system for all staff to use. **Information held on record is accurate, up to date and readily accessible. Staff are trained how to manage records. Files are organised in a practical manner, communication is clear between Multidisciplinary Staff. All old records are available on the ward.** **Notes are current, dated, timed and signed. Treatment given and recommendations are written into case notes.** **There are records kept of patients possessions.**	Not Applicable **Fully achieved**
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
	Not Applicable

CEO Declaration

Regulation and Quality Improvement Authority

MENTAL HEALTH AND LEARNING DISABILITY TEAM INSPECTION PROGRAMME

PRINT AND RETURN A HARD COPY OF SECTION I : DECLARATION BY POST TO:
Patrick Convery, (Head of Programme) Mental Health and Learning Disability Team
RQIA, 9th Floor Riverside Tower, 5 Lanyon Place, BELFAST, BT1 3BT

Organisation's self assessment declaration			
Name of organisation: -	**Ennis Ward, Muckamore Abbey Hospital Belfast Health and Social Care Trust**		
Address: -	**1 Abbey Road, Antrim, BT41 4SH**		
Chief Executive's name: -	**Mr Colm Donaghy**		
Contact details: -	**Email**		
	Telephone		
Date self-assessment form was completed:-			
In accordance with Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, I confirm that the information provided in this pro-forma and the accompanying evidence is a true reflection of the Clinical and Social Care Governance arrangements in this organisation.			
Signature of Chief Executive: -		**Date: -**	

FAIRNESS

Expectation Statement 1: Advocacy services are available to all patients.

Indicators:

- on admission or as soon thereafter as patients mental state is amenable to receive and discuss information patients are informed on of the name and role of their personal advocate.
- patients are informed of the date and time of MDT meetings and afforded the opportunity to meet with their advocate for the purpose of feeding their views and concerns into the multidisciplinary meeting.
- meetings with advocates shall be arranged on an ongoing basis for those patients without capacity and advocates will manage same in accordance with perceived needs and wishes of the patient.
- advocates are present on the wards on at least a weekly basis.
- ward managers will advise advocates as appropriate of matters on the ward which would necessitate their attendance.
- advocates are contactable directly by the patient.
- patients are able to speak privately with advocates in a timely manner.
- advocates are involved in the facilitation of patient meetings and can attend the same.

Expectation Statement 2: All patients have been advised of their rights, and what they can expect in terms of care and treatment, in a manner appropriate to their understanding**.**

Indicators:

- patient's rights are explained to them on arrival or as soon thereafter a patient's mental state is amenable to receive and discuss information which connects the standard to the setting.
- personal applicability of the role and work of RQIA is explained to patients.
- carers are advised of the right to be protected for all patients to include information on RQIA and any relevant support agencies.

Expectation Statement 3: Each patient who is detained is informed of the process and the implications for them.

Indicators:

- the detention process is explained to them on arrival or as soon thereafter as a patient's mental state is amenable to receive and discuss information and this will include the provision of written information appropriate to their understanding.
- a further opportunity should be provided when a patient's mental state is more amenable to receive and discuss information.
- the specific role of the RMO in relation to detention is explained to the patient.
- patients are informed on arrival or as soon thereafter as a patient's mental state is amenable to receive and discuss information of the Mental Health Review Tribunal, its role and how to access it.
- specific information is shared and explanation is give at each and every point of or alteration of detention i.e. following the completion of each and every detention form.
- patients are supported in relation to making application to the Mental Health Review Tribunal. The Ward Manager will ensure that a record will be maintained of eligible patients who do not make application, for the purposes of improving support to the individual and patients overall.
- patients are informed of any impediments or delays in their access to the Mental Health Review Tribunal.
- the Trust monitors all MHRT to include those whose detention ended prior to hearing. This information should include details on dates of hearings, adjournments, legal representation of the patient, decisions, subsequent actions, any implementation issues and patients comments.
- patients are provided with support following notification of extended detention.
- the specific rights of patients who are detained will be explained to them in a manner appropriate to their understanding and this will include the provision of written information and an understanding of the application of this information to the patient be confirmed thereafter.

Expectation Statement 4: Patient's are informed and familiarised with the comments and complaints process.

Indicators:

- patients are provided with appropriate information around what they can expect in their care and treatment and how to comment or complain.
- the ward promotes information on how to comment or complain to all visitors to the site.
- the Trust ensures that responses to comments and complaints are recorded and communicated to relevant persons.
- the ward manager gives timely dissemination of details of comments, complaints and actions to be taken in meetings with staff.
- the Trust has governance arrangements in place to audit comments and complaints and disseminate the analysis amongst staff.
- the ward manager documents all complaints, responses by staff and the reaction of the complainant to the response.

Expectation Statement 5: Patients are informed and familiarised with ward environment and routines in an ongoing patient focused manner.

Indicators:

- patient's are given a physical tour of the ward and are guided through a welcome pack appropriate to their understanding.

- on the day of their admission or as soon as they are well enough, the patient is given a “welcome pack” or introductory booklet that contains the following.
    - a clear description of the aims of the acute ward.
    - the current programme and modes of treatment.
    - a clear description of what is expected and rights and responsibilities.
    - a simple description of the ward’s philosophy, principles and their rationales, and the ward team membership, including the name of the patient’s Consultant Psychiatrist and Key Worker/Primary Nurse.
    - visiting arrangements.
    - personal safety on the ward.

- an opportunity is provided for questions and answers in relation to the ward and welcome pack with an indication of when there will be further discussions for questions and answers.

- explanation will be provided to each patient of the implications of Trust and ward policies for them.

Expectation Statement 6: All patients are informed of, and involved in a person centred assessment and care planning process.

Indicators:

- the admission assessment and initiated care plan for all patients should be in accordance with relative guidance and standards and should include the following:
    - communication needs.
    - preferred name.
    - domestic arrangements to include where relevant:
        - caring responsibilities.
        - animal welfare issues.
        - security of property.
        - nearest relative contact.
    - identification of points of disagreement in relation to assessment, care and or treatment.
    - identification of unmet need.

- the care plan and all subsequent entries is agreed, signed, dated and timed as an accurate reflection of the individual assessment by patient and staff member (and nearest relative as appropriate).

- the ongoing assessment and care plan should also include the following:
    - dietary requirements.
    - smoking.
    - ethnicity.
    - employment status.
    - gender needs.
    - spiritual needs.
    - continuing consent or refusal of consent to treatment.
    - interests.
    - personal preferences.
    - financial circumstances.
    - needs for intimacy/sexual expression.

- care plans evidence consideration of consent requirements for interventions on every occasion and consent being given or withheld on every occasion.

- care plans are responsive to change and are regularly reviewed with the multidisciplinary team and patient.

Expectation Statement 7: There will be weekly multidisciplinary team review with patient involvement and appropriate representation from advocates and other relevant agencies involved in the patient's care.

- there should be a written record of the MDT meeting to include:
    - persons present.
    - presentation of patient's views.
    - written record of inputs from relevant agencies.
    - review of care plan.
    - indication of, in the absence of the patient, what is to be communicated for further consideration by the patient.
    - written evidence of patient involvement in decision making process with regard to care and treatment.
    - evidence of resulting changes in care plans.
    - evidence of changes resulting from input of patients views and concerns.
    - there is written evaluation of progress of patient in respect of optimising independence and promoting positive outcomes.
    - be able to demonstrate that MDT's operate in a person centred, user friendly manner.
    - be able to demonstrate co ordination of all disciplines.
    - decisions and reasons for decisions from MDT are discussed with the patient by allocated nurse in a timely manner.
    - patients wishes in relation to communication of decisions from MDT being shared with carer and/or advocate upon request are noted and complied with.

Expectation Statement 8: Patients have the opportunity to meet and discuss their care and treatment in private with their consultant.

Indicators:

- a record should be made of overall progress, issues discussed and any actions to be taken.
- a record should be made of all patient requests to meet in private with their consultant.
- a record should be made of actual changes resulting, communication of same with patient and follow up evaluation.
- there should be a user friendly, person centred style of engagement.
- in an acute admission unit this opportunity should be at least weekly.

Expectation Statement 9: Patients will be given the opportunity to meet and discuss in private any issues with their primary nurse, associated nurse or in their absence an allocated nurse on a daily basis.

Evidence Type

Indicators:

- a record should be made of issues discussed, actions to be taken, resulting changes and follow up evaluation.
- patient's notes record discussion of overall progress.
- there should be a user friendly, person centred style of engagement.
- in advance of the MDT, meetings shall be arranged with the named or allocated nurse and also with the patients advocate.

Expectation Statement 10: Patients have the opportunity to meet and discuss in private their care and treatment, with any health or social care professional involved in their care.

Indicators:

- a record should be made of issues discussed, actions to be taken, resulting changes and follow up evaluation.
- patient's notes record discussion of overall progress.
- there should be a user friendly, person centred style of engagement.
- in advance of the MDT, meetings shall be arranged with the named or allocated nurse and also with the patients advocate.

Expectation Statement 11: The discharge plan should be initiated at the earliest opportunity following admission.

Indicators:

- estimated date of discharge is recorded in the patient's notes and signed by the patient.
- discharge discussed at first multidisciplinary team meeting.
- there is a record of liaison in relation to discharge with appropriate health and social care statutory and voluntary agencies e.g. GP and Community Teams.
- evidence of involvement with the patient from the point of admission around discharge, to include discussion of:
    - progress towards recovery.
    - positive risk management.
    - personal circumstances and concerns.
    - identification of persons to be notified.
    - identification of health and social care package and/or placement.
    - summary of treatment benefits e.g. therapeutic interventions and outcomes.
    - family support.
    - continuing treatment.

- the patient is made aware of progress towards expected discharge and any obstacles to or changes in expectation of discharge with reasons.
- with consent from the patient, carers and advocates are informed as above.
- the carer or agency to whose address the patient is being discharged are notified of the discharge plan in a timely manner and their preparedness to receive the patient considered prior to actual discharge.
- on the morning of discharge the patient will be again advised of time of discharge interview, and transport arrangements confirmed.
- the decision to discharge is made by the multidisciplinary team with patient involvement.
- delay in discharge must be documented, evaluated, subject to audit and discussed with the patient.

Expectation Statement 12: The discharge interview with the patient and carer of appropriate, will review the discharge plan, progress to date and include confirmation of the following.

Indicators:

- provided with adequate supply of all medication unless contraindicated.
- medication is issued with clear directions.
- information of emergency contact.
- next review/appointment date/s(CMHT).
- discussion around care plan and discharge plan.
- discussion with carer if appropriate.
- arrangements at discharge address.
- return of personal possessions.
- clarification of any financial arrangements.
- sickness certification.

Expectation Statement 13: Clear documented systems are in place for the management and filing of records in accordance with professional and legislative requirements.

Indicators:

- the policies and procedures for the management of records detail the arrangements for the creation, use, retention, storage, transfer, disposal of and access to those records.
- information held on record is accurate, up to date, readily accessible and staff are trained to manage records.
- the practical organisation of files should support the patients care and treatment and communication between multidisciplinary staff.
- all previous records in relation to the patients care should be available on the ward.
- patients' case notes and kardex are accurate and up to date:
    - all entries on patients' notes are contemporaneous, dated, timed, signed and name and designation of signatory made clear.
    - any alterations are dated, timed and signed.
    - all notes are legible and in accordance with guidelines from professional bodies.
    - all treatment given and recommendations made are recorded in case notes.
    - records are kept of patients' possessions.

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY
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Tel: 028 9051 7530 Fax: 028 9051 7531

ANNOUNCED INSPECTION REPORT

Name of Facility/Ward:	**Ennis Ward, Muckamore Abbey Hospital**
Date of Inspection:	**10 and 11 November 2010**
Lead Inspector:	**Margaret Cullen**

1.0 General Information

Name of hospital/facility	Ennis Ward, Muckamore Abbey Hospital
Address	1 Abbey Road, Antrim, BT 41 4SH
Telephone number	028 94463333
Person in charge on day of inspection	Sr. Linda Mc Cartney
Email address	linda.mccartney@belfasttrust.hscni.net
Trust	Belfast Health and Social Care Trust
Chief Executive	Mr Colm Donaghy
Director of Mental Health and Learning Disability service	Ms Bernie McNally
Email address	Bernie.mcnally@belfasttrust.hscni.net
Nature of service - MH/LD	Learning Disability
Name of ward/s and category of care	Female, Continuing Care
Number of patients and occupancy level	17 beds / full occupancy
Number of detained patients	0
Details of last inspection	None

INSPECTION DETAILS	
Type of current inspection	Announced inspection
List of inspectors	Margaret Cullen Gerry Colgan
Date and time of inspection	10 November 2010 9.00am-5.00pm 11 November 2010 9.00 am-4.00pm

2.0 INTRODUCTION

The Regulation and Quality Improvement Authority (RQIA) is a non departmental public body responsible for monitoring and inspecting the quality, safety and availability of health and social care services across Northern Ireland. It also has the responsibility of encouraging improvements in those services.

From the 1 April 2009 RQIA also assumed responsibility for the range of functions under the Mental Health (Northern Ireland) Order 1986, this includes making an inquiry into a case where it appears that there may be ill-treatment, deficiency in care or treatment, or improper detention in hospital or reception into guardianship of any patient, or where the property of any patient may, by reason of his mental disorder, be exposed to loss or damage.

The agreement for the transfer stressed the importance of applying a Human Rights Based approach and made reference to the principles agreed in the conclusion of the Bamford Review, of justice, benefit, least harm and autonomy.

In line with the duties under legislation and Human Rights approach, RQIA developed a programme of patient experience reviews in 2009. RQIA have used the findings of the patient experience reviews in 2009 and 2010 to aid the development of this inspection methodology.

RQIA, with the support of a range of experts has taken the current legal obligations recognised by DHSSPS, such as the Mental Health (Northern Ireland) Order 1986 and the Patient Client Experience Standards (DHSSPS, 2008) to create a range of expectation statements in the areas of:

- fairness
- respect
- autonomy
- dignity
- equality
- protection

It is anticipated that these expectation statements and their assessment will ensure the momentum towards the fulfilment of the Bamford principles and the achievement of the RQIA core activities[1] of:

- improving care
- informing the population
- safeguarding rights and
- influencing policy

The focus for this inspection is Fairness. RQIA looked at 13 expectation statements and assessed the ward's level of achievement in relation to each statement.

[1] RQIA Corporate Strategy 2009-2012

The expectation statements were assessed against an achievement scale set out in table 1 of this report.

Where achievement is assessed as fully achieved and identified as an exemplar of best practice, permission will be sought to share the initiative(s) across other provider organisations.

Where compliance is assessed as partially or substantially achieved and is envisaged as being fulfilled within the year, relevant recommendations relating to the improvement areas will be made as part of the trust's report of the inspection.

Where achievement levels are found not to have been achieved at the time of inspection or unlikely to be achieved, RQIA will issue a Quality Improvement Plan (QIP) outlining the recommendations being made. The trust should complete this QIP (by indicating the proposed actions to be taken and timescales involved) and return to RQIA within 20 working days.

METHODS / PROCESS

Committed to a culture of learning, the RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the expectation statements.

The inspection process has three key parts; self-assessment, pre-inspection analysis and the inspection visit by the Inspector.

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

- Analysis of pre-inspection information
- Discussion with the Ward Manager and staff
- Examination of records
- Consultation with stakeholders
- Evaluation and feedback

Any other information received by RQIA about this facility has also been considered by the Inspector in preparing for this inspection.

CONSULTATION PROCESS

During the course of the inspection, the Inspectors spoke to the following users of the service, relatives/carers, health and social care professionals and staff:

Patients	**4**
Staff	**4**
Relatives/Carers	**2**
Visiting Professionals	**0**
Advocates	**0**

Questionnaires were provided, prior to the inspection, for patients, relatives/carers, health and social care professionals and staff to find out their views regarding the service. Matters raised from the questionnaires were addressed by the Inspector in the course of this inspection. Some of the information was not returned prior to the inspection.

Issued To	Number issued	Number returned
Staff	**5**	**4**
Relatives/Carers	**16**	**5**
Visiting Professional	**5**	**4**
Patients	**17**	**15**

The definitions for Levels of Achievement are below:

TABLE 1: LEVELS OF ACHIEVEMENT

Level of Achievement	Definition
Not applicable	The criterion is not applicable to this service setting. (A reason must be clearly stated in the service response.)
Unlikely to be Achieved	The criterion is unlikely to ever be achieved. (A reason must be stated clearly in the service response).
Not Achieved	The criterion is unlikely to be achieved in full before end of March 2011. For example, the service has only started to develop a policy and implementation will not take place until after March 2011.
Partially Achieved	Work has been progressing satisfactorily and the service is likely to have achieved the criterion prior to end of March 2011. For example, the service has developed a policy and will have completed implementation by end of March 2011.
Substantially Achieved	A significant proportion of action has been completed to ensure the service performance is in line with the criterion. For example, a policy has been developed and implemented but a plan to ensure practice is fully embedded has not yet been put in place.
Fully Achieved	Action has been completed that ensures the service performance is fully in line with the criterion. For example, a policy has been developed, implemented, monitored and an ongoing programme is in place to review its effectiveness.

3.0 PROFILE OF SERVICE

Ennis Ward is a 17 bed female continuing care ward for adults with a learning disability. The ward is on the Muckamore Abbey Hospital site and is managed by the Belfast Health and Social Care Trust. The ward consists of three areas. To the right of the main entrance there are facilities for five patients; a bright and homely furnished living and dining room, a well maintained toilet and bathroom and three single and one double bedroom, all of which are personalised by the patients. The patients in this part of the ward are more independent than other patients on the ward and this is reflected in the range and choice of furniture. All rooms have televisions and music equipment.

The entrance to the ward is welcoming with flowers and plants outside the door. A car which is used by patients to facilitate socialisation and integration was parked at the entrance to the ward. There is homely furniture in the entrance hall with a large digital photo frame on the wall which rotates photographs of interest to the patients.

To the left of the entrance there are facilities for 12 other patients. There are two bright day rooms and each day room is appropriately furnished to reflect the needs of patients who are less able and less independent. One of the rooms has a range of furnishings and a television with DVDs and Wii for patient's use, while the other has more protective furnishings and is used by patients with more challenging behaviour. The television in this room is in a cabinet for patient's safety. There is a mixture of bedrooms from single, two bedded and four bed dormitories. They are all cabled for televisions which have been ordered and all beds have homely quilts. One patient has been involved in individualising her room but overall there are less personal items in this section of the ward and staff explained that this is due to the high level of challenging behaviour. The kitchen and kitchen store are on this side of the ward and there is a dining area between both day rooms. This area is not as well furnished or maintained as the other dining area and needs redecorated. The flooring in this area of the ward is quite worn and redecorating is required. There is a sensory room in this part of the ward and inspectors observed patients enjoying it.

The ward has a spacious well maintained garden with swings and a barbeque area. One of the patients was a smoker and there is a smoking shed and chair outside the door to accommodate this. It was noted that storage facilities on the ward are limited.

4.0 SUMMARY

A number of questionnaires were sent out in advance of the inspection to patients, staff, relatives/carers and visiting professionals. The returned questionnaires indicated an appropriate standard of care provided in relation to the expectation statements.

The inspection process began with the Ward Manager completing the self assessment document. Inspectors spent two days on site and had unrestricted access to all areas of the ward and to all of the patients.

A tour of the ward was undertaken on the first day of the inspection and a number of areas for improvement were identified.

Throughout the two days, inspectors observed routines and practices within the ward and took the opportunity to speak with a number of nursing staff. Inspectors also spoke with patients and two relatives. Inspectors recorded and highlighted issues raised at these meetings and made recommendations for improvement where appropriate.

Inspectors also commended good practice which was identified.

The standard of fairness was assessed by inspectors and included the examination of a number of care records, policies and procedures and other documentation maintained by the ward.

The provision of an independent advocacy service to the ward is very limited at present and this was acknowledged by the Trust who are endeavouring to resolve this issue. A recommendation was made to develop the service as a matter of urgency.

There were no detained patients on the ward at the time of the inspection. Only four patients were deemed to have capacity during the inspection and these patients gave consent to access their case notes. Inspectors did not access the records of the more dependent patients as these patients were deemed to lack the capacity to consent to this.

In relation to patients' rights, the questionnaires submitted by patients and those patients interviewed indicated that they are fully considered. This included their right to make comments or complaints. However, as most patients on the ward would not have the ability or capacity to do so, the need for an independent advocate was reinforced.

Inspectors noted efforts to inform and familiarise patients with the environment and routines of the ward. However it was recommended that patients meetings continue on a regular basis to enhance informing patients and that any changes or outcomes agreed at these meetings are recorded and monitored.

A person centred approach to assessment and care planning was evidenced in the

nursing notes and there was also evidence of nurses advocating on behalf of patients and appropriate and regular access to medical personnel. Each patient is discussed at the monthly multi-disciplinary ward meeting and patients have a comprehensive review annually. Inspectors recommended that a more robust method of recording reviews is developed to include an account of the patient's views and informing them of outcomes where appropriate. It was also recommended that one to one therapeutic engagement with the named or allocated nurse is recorded consistently. All patients on the ward are awaiting discharge and the Trust have processes in place to record and monitor this. Discharge planning was included in the care plans of all patients. Inspectors were advised of the process should a patient be identified for discharge and were satisfied that appropriate measures were considered. Inspectors examined the Trust policies for record keeping and records management and monitored compliance with professional standards. There were some inconsistencies in compliance noted and therefore it was recommended that all records consistently adhere to the standards. One of the nurses on the ward had done considerable work to ensure records adhere to the Trust policy on management of records. It was recommended that clerical support is provided to undertake this role and relieve nursing staff for patient care.

At the end of the inspection, inspectors provided verbal feedback to:

- Service Manager
- Senior Nurse Manager
- Ward Manager, Ennis ward
- Two staff nurses for the ward
- Ward Consultant

The inspectors were Mrs Margaret Cullen, RQIA Mental Health Officer, Lead Inspector and Mr Gerry Colgan, RQIA Sessional Mental Health Officer. The inspectors would like to extend thanks to the staff and patients on Ennis Ward for their warm welcome and cooperation throughout the inspection.

5.0 ISSUES FROM PREVIOUS INSPECTION

There is no record of previous inspection by the Mental Health Commission (MHC) to this ward.

As there have been no detained patients on this ward for some time there has been no patient experience reviews carried out in this ward.

6.0

INSPECTION STANDARDS - FAIRNESS	
Expectation Statement 1: Advocacy services are available to all patients.	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
The patient's family (N.O.K) advocates on behalf of the patient. In this ward (Long-Stay) the Named Nurse advocates for the patient in the absence of family or alongside family. Contact with Named Nurses is ongoing for all patients. A large number of our patients have Communication problems, Autism and Challenging behaviour. **The Multidisciplinary Team will refer the patient to the Advocacy Service if it is deemed to be in the Best Interests of the patient eg during Resettlement or if the patient requests it. There is Access to the Independent Advocacy Groups such as Mencap and Bryson, they visit the hospital weekly although this is a limited resource.** **The Tilli Self-Advocacy Group is supported by the Arc association and meets regularly within the hospital. The ward has Posters which display information relating to where and how advocates can be contacted. This has been discussed via the Patients Forum and Patients are made aware of the right to an Advocate in the Welcome to Ennis Booklet for Patients and their Families.** **Advocates are welcome to attend Multidisciplinary Reviews/other patient meetings and to have regular contact in private with the patient. They are directly contactable by the patients or the nurse will assist with this if it is required or requested by the patient.** **Staff in Ennis have had training relating to Advocacy groups ie The Tilli Group.**	**Fully Achieved**
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors found evidence in patient's notes, from relative's questionnaires, a letter from a relative and interview with two relatives that relatives are involved in patient care and can advocate on their behalf. Observation on the ward and interviews with nursing staff confirmed how well staff are tuned into patients' needs and the need for consistency of staff working with this patient group was emphasised.	Substantially Achieved

Only one patient interviewed confirmed that they attended the 'Tell It Like It Is' (TILII) self advocacy group. There were numerous leaflets around the ward and information in the ward booklet informing patients about advocacy; while these were in a user friendly format, most patients did not have the ability to understand or access services. In view of the nature of the patient group on the ward, it would be good practice to be more proactive in the delivery of an independent advocacy service to the ward. The advocacy service would also need to be proactive in its engagement with the patients on the ward due to the patient's level of understanding of their rights.	

INSPECTION STANDARDS - FAIRNESS	
Expectation Statement 2: All patients have been advised of their rights, and what they can expect in terms of care and treatment, in a manner appropriate to their understanding.	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
On transfer the patients Named Nurse will explain Ennis wards Philosophy and Aims and Objectives. She will read the Welcome to Ennis for Patients and their Families booklet with the patient and if present their family. The patient is encouraged to share this with their family. This is user friendly and has additional Makaton symbols if required. A High percentage of patient's in Ennis would not have any understanding of Symbols or Simple Language. **It states that the patients have the same rights as others in society, the right to make a complaint and so on. It promotes discussion ie How bodies such as RQIA can help you and others.** **Patients are encouraged to attend regular Patient Forums. The Trusts Complaints Procedure, the work of the RQIA, the Tilli Group and Advocacy groups have been discussed at these.** **Nursing Staff provide 24hour service offering support to patients and their families.** **In the event of a transfer of a Detained patient there is a workbook available to explain a Patients Rights whilst in Hospital. Staff have training in Human Rights in Learning Disability.**	**Fully Achieved**
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The ward booklet covers all aspects of patient care. There are leaflets and notices all around the ward for patients and relatives with relevant information. There was evidence that efforts were made to provide information in a style that was appropriate to the needs of the patient group. Patient's routines were on the notice boards and those patients interviewed evidenced that these had been discussed with them and that staff read these documents to them.	Substantially Achieved

Inspectors examined detailed minutes of patients' meetings. These provided evidence that all aspects of care are discussed with patients, for example, use of the car, patient's rights, menus etc but outcomes are not clearly recorded. Inspectors recommend that this continues on a regular basis but that the outcomes of the meetings are clearly recorded and monitored. Inspectors also examined a user friendly leaflet and booklet on the Mental Health Order and patient's rights which the Trust had commissioned. This was specifically for patients with a learning disability. Inspectors observed an easy read leaflet displayed on the ward regarding the role of RQIA and patients confirmed this was discussed with them. Patient and staff questionnaires further confirmed that reasonable efforts are made to keep patients informed of their rights and what to expect in terms of their care and treatment.	

INSPECTION STANDARDS - FAIRNESS	
Expectation Statement 3: Each patient who is detained is informed of the process and the implications for them.	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
THERE ARE NO DETAINED PATIENTS WITHIN THIS SETTING	Not Applicable
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
This expectation statement could not be fully validated as there were no detained patients on the ward. However, inspectors observed a user friendly booklet about the Mental Health Oder which informs patients of their rights and staff indicated knowledge of the process of informing detained patients.	Not Applicable

INSPECTION STANDARDS - FAIRNESS	
Expectation Statement 4: Patients are informed and familiarised with the comments and complaints process.	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
Patients are advised of their right to Complain by Nursing Staff. The Welcome to Ennis Booklet which is shared with patients and their families on transfer explains the right to Complain and that staff will explain how to do this. It encourages participation at Patient Forums and states that they have a right to an advocate or contact with other protective bodies or Support Agencies eg. RQIA, Tilli group. A high percentage of our patients have Communication difficulties. Families are invited to patient multidisciplinary reviews and are encouraged to discuss the patients care and treatment at these and at any time. **There are regular Ward Meetings in Ennis and one objective of these is to identify ways in which we can continue to improve our service.** **The current Trust Management policy regarding complaints is followed by staff.** **Complaints Awareness Training is available for staff within the trust.** **There are Trust information leaflets available for patients and their families "How to make a comment or Complaint on our Service".** **There is a complaints register available in the ward but there have been no complaints recorded since the year 2000.**	**Fully Achieved**
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The patients who were interviewed indicated that they could talk to staff if they had issues or concerns. The minutes of the patients' meetings also confirmed that patients are informed of their right to complain. The ward booklet also explains this right and there were numerous leaflets on notice boards around the ward to inform patients and relatives. Inspectors viewed the complaints log on the ward and confirmed that the last complaint recorded was in 2000. As most patients on the ward would neither have the understanding or ability to make comments or complaints, the presence of an independent advocate on the ward would provide enhanced protection for patients and staff. Questionnaires received from relatives and discussion with relatives during the	Fully Achieved

inspection provided further evidence that they are informed how to process complaints and comments. Interviews with staff confirmed that they understood the complaints process and endeavoured to inform patients who could understand. Inspectors viewed the Trusts current complaints policy and this is due for review in April 2013.	

INSPECTION STANDARDS - FAIRNESS	
Expectation Statement 5: Patients are informed and familiarised with the ward environment and routines in an ongoing patient focused manner.	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
Ennis amalgamated with Fairview ward in January 2010. There have been no transfers to Ennis during this time. Current patients have been made aware of the Welcome booklet for Patients and their families. This will be read to newly transferred patients when a transfer occurs. There is a high proportion of our patients who would not be able to read and/or understand symbols. **Staff on duty will orientate the patient to the ward by showing them around the facility and introducing them to all staff within the ward ie Nursing, Medical, Domestic etc.** **On the day they will explain the Ward Philosophy, Aims and Objectives, Rights etc. using the Welcome Booklet.** **The patients Named Nurse and Associate nurses are allocated on that day. The importance of a good relationship with patients and their families is highlighted in our ward Aims and Objectives.** **Patient Forums are ongoing and the Advocacy Service is explained.**	**Fully Achieved**
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Relatives of a patient who had been recently transferred to the ward stated that patients were transferred on a phased basis and were so pleased with the outcome that they felt "it should be policy for any other transfers". Three of the patients interviewed could confirm that staff read information out to them. These patients demonstrated a clear understanding of the routine, times and choices offered on the ward. Two patients could point to appropriate information sheets which evidenced clearly, as they could not read that this information had been shared with them. They also stated it had been shared with their relatives. The ward booklet and leaflet clearly explained relevant aspects of care. The minutes of patients' meetings provided strong evidence that efforts are made to keep patients informed and to discuss ongoing issues with them.	Fully Achieved

INSPECTION STANDARDS - FAIRNESS	
Expectation Statement 6: All patients are informed of and involved in a person centred assessment and care planning process.	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
Patient Centred Care Plans have been devised by Named Nurses and are reviewed by the Multidisciplinary team. **All care-plans were recently audited by the EQC team within the trust.** **Care-plan entries are signed, dated and now timed where applicable.** **Care-plans are responsive to change and do reflect changes in patient care and treatment, behaviour etc.** **Any points of disagreement in relation to care would be identified and recorded.** **Ongoing assessments are up to date and regularly reviewed and with the patient where possible** **Many of patients in Ennis have problems with Communication and or Understanding. An unmet need for some of the ladies in Ennis could be the fact that they await a place in the Community.** **Where capacity is available that patient has participated in and signed her care-plan. There is evidence of Consent being sought and given orally or non-verbally on a variety of issues. Consent and Best Interests are discussed by the Multidisciplinary team.**	**Fully Achieved**
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors examined the nursing records and they were noted to include a person centred method for assessment and care plans which met the indicators of this expectation statement. Documentation regarding patient consent had recently been added to each treatment change recorded. Three patients interviewed indicated that medical and nursing staff endeavour to explain things to them and nursing staff interviewed confirmed this. The patients who have capacity sign the initial assessment document which incorporates agreement to their care plan. There was no evidence however in the notes of patients being involved in an ongoing manner as there were no other signatures where changes to care have been documented. There was no evidence to confirm that patients with capacity were informed of the outcome of their review or consistent documentation that they had been asked to attend. Staff showed inspectors one file which confirmed that the patient had attended her last review but	Substantially Achieved

inspectors had difficulty confirming this consistently. There was little evidence of the outcomes of reviews being discussed with patients though inspectors observed that copies were sent to relatives. The format of recording reviews formally is undertaken by nursing staff and the detail was of a high standard, however it is recommended that staff document who attended and who takes responsibility for tasks identified including informing patients appropriately and asking for their views.	

INSPECTION STANDARDS - FAIRNESS	
Expectation Statement 7: There will be a weekly multidisciplinary team review with patient involvement and appropriate representation from advocates and other relevant agencies involved in the patient's care.	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
Ennis is long stay ward and Multi-disciplinary Team Reviews are held at least monthly. **Patients have an Annual Review and for this reports are prepared from Nursing, Medical, Daycare etc and are discussed at this.** **The Careplan is reviewed and aims and objectives are set accordingly. The named nurse is responsible for the follow up and to coordinate any planned action. The patient attends if they wish to and their N.O.K are invited to attend. Other professions ie daycare, speech and language etc may attend or provide reports for this also. The Outcome is forwarded to the patients family unless this is against the wishes of the patient.** **There are also Doctors rounds held 2-4 weekly whereby the Ward Consultant and Ward Doctor review any changes with the Nurse in Charge. Any changes to be made will be documented in the care plan and action taken again coordinated by the nurse in charge. Careplans reflect changes in patients care and treatment.** **Both of these meetings reflect a Multidisciplinary approach. Referrals to various services can be made at any time during that year ie Adult behaviour Services. Reports can be requested at any time and are provided at any time during the year ie Speech and Language.** **The Ward Doctor visits regularly during the week. The Ward Consultant is available during any given week.** **The Daily care given to patients in Ennis is based upon a Multidisciplinary Approach. It reflects individual care based upon individual needs.**	**Fully Achieved**
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Multi-disciplinary team reviews are held monthly on the ward and all patients are discussed; this was evidenced in the book which records multi-disciplinary meetings. Nursing progress notes also refer to the multi-disciplinary discussion of patients and medical notes provide further evidence, however, this was not consistently referenced. Annual reviews were evidenced in all of the case notes that were examined. The named nurse completes a typed comprehensive report of the review and a copy is sent to the next of kin. The reports examined did not record who	Partially Achieved

attended the review and they were not signed. The medical and progress notes confirmed attendance but they did not include the full names or designations of attendees. There was not consistent evidence of patients being asked to attend or of them having attended the review or having outcomes explained to them. Inspectors found that the method of recording monthly multi-disciplinary meetings was not consistent and recommended that a template is devised to record consistently the following:

- Tasks identified
- Responsible officers
- Attendees, including designation
- Patient's views discussed prior to the meeting
- How information will be shared with the patient.

Patient's notes indicated that patients are seen very regularly by medical staff and there were clear entries regarding the care and treatment. There was evidence of nursing staff advocating on patients behalf in the notes and ward diary. There was also evidence of appropriate multi-disciplinary input throughout the notes, for example, dietician, podiatry, tissue viability nurse, dentistry and behavioural team.

INSPECTION STANDARDS - FAIRNESS	
Expectation Statement 8: Patients have the opportunity to meet and discuss their care and treatment in private with their consultant. *For associated indicators please refer to Appendix 1.*	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
The Ward Consultant is available for patient appointments on a Monday to Friday Basis. **Patients can be helped to make and appointment, Relatives are advised how to and on occasions the Nurse will make the appointment for the patient or their family. This is done by a telephone call to the Consultants secretary to arrange an appointment.** **There is a poster to explain this and the opportunity to do this is explained in the Welcome booklet for Patients and their families.** **The Ward Consultant will record any meetings in the patients Medical File and sign it. The Ward is advised of any changes to be made as a result of this.** **Nurses can be present at any such meetings if the Patient requests it.** **Patients and their families can meet in Private with the Consultant at this office or in the ward. Speech and language services are available to assist with the interview.**	**Fully Achieved**
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The patients interviewed confirmed that they knew the Consultant and Ward Doctor and they had regular access to both. They were unable to give exact details of when the consultant was available but explained that they did see him and he spoke to them in a person centred manner. Patients' medical notes indicated that they are seen regularly and appropriately by medical staff. The ward booklet informs patients and relatives that they can access the consultant privately and there were a number of easy read notices on the ward informing patients and relatives of this, however due to the nature of the patient group, very few patients would have capacity to request a private meeting with the consultant. Despite evidence of staff endeavouring to inform patients of this opportunity, inspectors were unable to confirm this happens. However, patient and relative questionnaires indicated satisfaction with the level of contact provided.	Fully Achieved

INSPECTION STANDARDS - FAIRNESS	
Expectation Statement 9: Patients will be given the opportunity to discuss in private any issues with their primary nurse, associated nurse or in their absence an allocated nurse, on a daily basis.	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
Named Nurses record issues brought to them by Patients in their Nursing Care Plan, action to be taken and resulting changes are reflected. **This is often following discussion with members of the Multidisciplinary Team. There are 6 monthly reviews of care-plans including progress/changes etc.** **If a Named Nurse is unavailable the patient will be aware who the associate nurse or allocated nurse is in her place. A friendly approach is taken by staff whilst engaging with patients.** **There are rooms available to allow privacy for meetings. The services of Speech and Language can be employed where there are Communication problems.**	**Fully Achieved**
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors were informed that a named nurse system is used on the ward. Patients interviewed could inform inspectors of their named nurse and suggested that the level of contact was variable. The role of the named nurse is outlined in the ward booklet. Inspectors observed a user friendly style of engagement with patients and staff appeared to be responsive to patient needs. The notes indicated that staff advocate on behalf of patients and access relevant personnel / professionals where appropriate. However one to one meaningful engagement by the named or allocated nurse was not evidenced in the notes as there was little evidence that patient's views were sought for relevant meetings. Information obtained from patient and relative questionnaires and interviews confirmed satisfaction with the overall level of care provided by the nursing staff on the ward however patients were unable to confirm the frequency of contact.	Substantially Achieved

INSPECTION STANDARDS - FAIRNESS

Expectation Statement 10: Patients have the opportunity to meet and discuss in private their care and treatment, with any health or social care professional involved in their care.	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
Patients are made aware of their right to meet with all professionals who are involved in their care. This is explained to them by their Named Nurse and using the Welcome to Ennis for Patients and Families booklet. Many of our patients have difficulty with communication and may need the assistant of other agencies ie Speech and Language. **Appointments can be made by the Nurse to facilitate this or by the patient themselves or their families. The Nursing staff can advise how to do this.** **Records are made of issues discussed, actions to be taken resulting changes and follow up. Patients notes evidence discussion of overall progress and changes. Nursing Staff can be present at meetings if the patient requests it.** **There are rooms which can be provided for Private discussion.**	**Fully Achieved**
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors were satisfied that there was sufficient evidence from discussion with staff and patients, responses from all sets of questionnaires and examination of the ward booklet, that efforts are made to inform patients of their right to discuss their care and treatment in private with any relevant health or social care professional. Patients' notes indicated that all relevant professionals are involved in their care. It was apparent that many patients on the ward are unable to communicate verbally and will require the assistance of nursing staff to advocate on their behalf at meetings with visiting professionals to the ward.	Fully Achieved

INSPECTION STANDARDS - FAIRNESS	
Expectation Statement 11: The discharge plan should be initiated at the earliest opportunity following admission.	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
All patients in Ennis are awaiting discharge. There is no funding available for any of the current population in Ennis. **Should a bed become available it would be discussed immediately with the Multidisciplinary team. When this is confirmed the patient is fully involved. All relevant persons will be invited to MDT meetings ie.Advocates. Assist can be given from the Speech and Language Service to aid Communication if applicable.** **There is a Discharge Plan included in the care-plans. This is reviewed at least 6 monthly and is ready for planned action when a bed becomes available.** **There is information available in Ennis regarding Resettlement procedure.**	**Fully Achieved**
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors verified that patient's notes indicated that discharge is considered in their care plans. Discussion with relatives at interview highlighted their concerns as they reported that they felt that the level of care received on this ward could not be achieved in a community setting. Inspectors were advised that all of these patients are awaiting placements as there are no appropriate community facilities available. Inspectors were informed that monthly returns are sent to the Department in relation to its requirement concerning patients awaiting discharge, which indicates resettlement options. The Ward Consultant chairs the Resettlement Strategy Group and is immediately aware of potential options. Therefore, efforts are ongoing to regularly monitor the discharge potential on the ward and ensure that the consultant is informed of impending options for patients. Inspectors examined the discharge policy and the Ward Manager explained the discharge plan in the event of an appropriate facility becoming available for any patient. It was noted in a patient's records that one patient had previously written to the Trust requesting a community placement. As a consequence one action agreed at their review in 2009 was that the medical staff would initiate	Substantially Achieved

contact with the Care Manager on their behalf. There was no evidence that this was processed however and this highlighted to inspectors the deficits in the ward's procedures for recording reviews and a recommendation has been made accordingly.	

INSPECTION STANDARDS - FAIRNESS	
Expectation Statement 12: The discharge interview with the patient should review the discharge plan, progress to date and include confirmation of the indicators in Appendix 1, Expectation Statement 12.	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
The Trust's Protocol and Procedures are followed upon discharge. **Hospital Resettlement Guidelines are fully applied.** **There is a format to provide leave medications and this is the same for discharge.** **Medication is issued to families with clear guidance and instruction.** **Personal possessions and monies are returned to the patient.** **If communication is a problem the Speech and Language Service will provide assistance.** **The Discharge Checklist (Hospital and Trust) are completed by Named nurse or Allocated Nurse.**	**Fully Achieved**
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors were unable to fully evidence this expectation statement, however, the Ward Manager did explain fully the discharge process to inspectors in the event of an appropriate place being made available to a patient. This process involved a patient centre inclusive approach to discharge. Inspectors were satisfied that appropriate procedures would be followed in the event of a patient being discharged.	Not Applicable

INSPECTION STANDARDS - FAIRNESS	
Expectation Statement 13: Clear documented systems are in place for the management and filing of records in accordance with professional and legislative requirements.	**ACHIEVEMENT LEVEL**
Provider's Self Assessment:	
Following the policy for the Management of Records Ennis has implemented the system for all staff to use. **Information held on record is accurate, up to date and readily accessible. Staff are trained how to manage records. Files are organised in a practical manner, communication is clear between Multidisciplinary Staff. All old records are available on the ward.** **Notes are current, dated, timed and signed. Treatment given and recommendations are written into case notes.** **There are records kept of patients possessions.**	**Fully achieved**
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors evidenced from the staff meeting minutes that records management was discussed following a notification from the Trusts Governance Department; this verified learning from incidents was shared. Records management polices and procedures were examined and were accessible to staff and current. Inspector's examination of patients' notes confirmed that all notes and Kardexes were up to date. Entries in nursing notes were all dated and signed but the time was not consistently recorded. The medical notes did not consistently contain records of the designation of all medical staff making entries, therefore they did not fully reflect compliance with professional guidance. The notes clearly indicated involvement of relevant professionals. The Ward Manager demonstrated how records on the ward have been archived and explained that one of the nursing staff had undertaken this task to ensure compliance with the Trust policy. While this reflected good practice, inspectors felt that this is not a nursing role and took nursing staff away from patient care and therefore inspectors recommend clerical support for the ward for the maintenance of records. Inspectors examined the patients' property policy which was due for review in 2009. The Ward Manager has	Substantially Achieved

summarised this policy in the ward booklet for staff and patient information. This demonstrated effective practice which was further evidenced in the practical processes devised for safeguarding patient's property and money which were explained and demonstrated to inspectors.	

7.0 ADDITIONAL INFORMATION

7.1 Environment

The ward was noted to be warm, bright and homely. There were a number of areas identified during the inspection that needed attention, these included:

- The dining room needed to be redecorated.
- The floor covering in areas of the ward, particularly left of the entrance, needed to be renewed as there are areas which are badly scored and patched.
- There was paint peeling on a section of wall in the clinical room.
- The dormitories and two bedded room needed to be repainted.
- There were no curtains or screens to provide privacy in the dormitories; these are recommended to enhance patient privacy and dignity.
- Inspectors noted that one of the dormitories was used to sort clothes that had arrived from the laundry and staff reported there is a shortage of storage space on the ward. It was recommended that appropriate storage room is sought.
- The floors in the section of the ward for patients with more intensive support needs needed to be cleaned. The Ward Manager explained that the current domestic cover on the ward was relief cover as the regular domestic was of for some time. It was recommended that domestic cover for the ward and regular cleaning is monitored.
- The section of the ward for patients with more intensive support needs was sparse in comparison to the other side of the ward. The Ward Manager explained the efforts being made to make the area more homely while prioritising safety and personal televisions for each bed area have been ordered.

All these issues were addressed with the Ward Manager.

7.2

There were a number of positives identified:

- The efforts made to provide a homely, bright, person centred environment..
- The efforts made to normalise the environment, for example, the use of Denby crockery for all but two patients on the ward who need alternative crockery due to safety reasons.
- The provision of a car for the ward was greatly praised by both staff and patients and patients reported and indicated that it was used on a frequent basis.
- The notice boards in all parts of the ward provided a range of appropriate information, much of which was in a user friendly format for patients.
- The individual storage area in bathrooms for personal toiletries which demonstrated an individualised, person centred approach.
- The water cooler in the main entrance.
- The digital photo frames for which patients indicated enjoyment and pleasure.
- The file for policies and procedures and process which included a template for monitoring staff reading the policies and procedures.
- The garden, swings and smoking area.
- The level of nursing knowledge of the patients' needs likes and dislikes.

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8.0 QUALITY IMPROVEMENT PLAN

The details of the Quality Improvement Plan appended to this report were discussed with the Ward Manager, as part of the inspection process.

Comments on any proposed actions as a result of recommendations should be recorded on Quality Improvement Plan with an indicative timescale.

Indicative timescales commence from last day of inspection.

Enquiries relating to this report should be addressed to:

Margaret Cullen
Mental Health and Learning Disability Team
The Regulation and Quality Improvement Authority
9th Floor Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

8 December 2010

_____ _____

MARGARET CULLEN **DATE**
Lead Inspector

The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Cranfield Female

Muckamore Abbey Hospital

Belfast Health & Social Care Trust

2 & 3 February 2015

npm national preventive mechanism

informing and improving health and social care
www.rqia.org.uk

Contents

1.0 General Information

Ward Name	Cranfield Female
Trust	Belfast Health & Social Care Trust
Hospital Address	Muckamore Abbey Hospital 1 Abbey Road Muckamore BT41 4SH
Ward Telephone number	028 94 662299
Ward Manager	Adrienne Creane
Email address	Adrienne.creane@belfasttrust.hscni.net
Person in charge on day of inspection	Adrienne Creane
Category of Care	Mental Health
Date of last inspection and inspection type	11 June 2014, Patient Experience Interviews
Name of inspector Name of Lay assessor	Wendy McGregor Alex Parkinson

2.0 Ward profile

Cranfield Women's is a fifteen bedded female admission ward on the Muckamore Abbey Hospital site. The purpose of the ward is to provide assessment and treatment to female patients with a learning disability who need to be supported in an acute psychiatric care environment.

The ward is connected to Cranfield Men's ward which is the male acute admission ward and Cranfield ICU, which is the intensive care unit. All three wards can be gained via a corridor linking all three Cranfield wards.

Patients within Cranfield Women's have access to a multi-disciplinary team which incorporates psychiatry, nursing, psychology, occupational therapy, behavioural support, speech and language therapy, and social work professionals. Patient advocacy services were also available.

The ward had an open planned structure which created space for patients who had mobility issues to move freely and safely around the ward. Patients had their own bedroom with en-suite facilities. Bedrooms were noted to be personalised. Patients had access to a garden.

Several visitor rooms were available. Signage to the ward was clear and there were written and pictorial/photographic signs on the internal doors which supported patients with orientation.

On the days of the inspection were thirteen patients on the ward and two patients on leave. Of these there were eight patients detained in accordance with the Mental Health (Northern Ireland) Order 1986.

3.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Northern Ireland's health and social care services. RQIA was established under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to drive improvements for everyone using health and social care services. Additionally, RQIA is designated as one of the four Northern Ireland bodies that form part of the UK's National Preventive Mechanism (NPM). RQIA undertake a programme of regular visits to places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment, upholding the organisation's commitment to the United Nations Optional Protocol to the Convention Against Torture (OPCAT).

3.1 Purpose and Aim of the Inspection

The purpose of the inspection was to ensure that the service was compliant with relevant legislation, minimum standards and good practice indicators and to consider whether the service provided was in accordance with the patients' assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

The aim of the inspection was to examine the policies, procedures, practices and monitoring arrangements for the provision of care and treatment, and to determine the ward's compliance with the following:

- 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.

Other published standards which guide best practice may also be referenced during the inspection process.

3.2 Methodology

RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the inspection standards.

Prior to the inspection RQIA forwarded the associated inspection documentation to the Trust, which allowed the ward the opportunity to demonstrate its ability to deliver a service against best practice indicators. This included the assessment of the Trust's performance against an RQIA Compliance Scale, as outlined in Section 6.

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.
Specific methods/processes used in this inspection include the following:

- analysis of pre-inspection information;
- discussion with patients and/or representatives;
- discussion with multi-disciplinary staff and managers;
- examination of records;
- consultation with stakeholders;
- file audit; and
- evaluation and feedback.

Any other information received by RQIA about this service and the service delivery has also been considered by the inspector in preparing for this inspection.

The recommendations made during previous inspections were also assessed during this inspection to determine the Trust's progress towards compliance. A summary of these findings are included in section 4.0, and full details of these findings are included in Appendix 1.

An overall summary of the ward's performance against the human rights theme of Autonomy is in Section 5.0 and full details of the inspection findings are included in Appendix 2.

The inspector would like to thank the patients, staff and relatives for their cooperation throughout the inspection process.

4.0 Review of action plans/progress

An unannounced inspection of Cranfield Female was undertaken on 2 and 3 February 2015.

4.1 Review of action plans/progress to address outcomes from the previous announced inspection

The recommendations made following the last announced inspection on 9 July 2013 were evaluated. The inspector was pleased to note that 20 recommendations had been fully met.

However, despite assurances for the Trust, one recommendation had been partially met and one recommendation had not been met.
Two recommendations will require to be restated for a second time.in the Quality Improvement Plan (QIP) accompanying this report.

4.2 Review of action plans/progress to address outcomes from the patient experience interview inspection

There were no recommendations made following the patient experience interview inspection on 11 June 2014.

4.3 Review of action plans/progress to address outcomes from the previous finance inspection

The recommendations made following the finance inspection on 31 December 2014 were evaluated. The inspector was pleased to note the recommendations had been fully met.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection it was good to note that progress had been made in meeting recommendations made following the previous announced inspection. There was evidence of patient and relative involvement in decisions in relation to their care and treatment plans. It was noted that improvements have been made in relation to safeguarding vulnerable adults as policies and procedures in safeguarding vulnerable adults was included in the induction programme for new staff, protection plans were in place and there was a formalised mechanism to alert the safeguarding officer to multiple referrals. It was good to note that all staff had received up to date training in safeguarding vulnerable adults and physical interventions. The inspector was informed by behaviour support staff that there are plans to increase the number of behaviour support staff in the hospital.

The inspector observed staff providing care and support to patients with a range of different needs, abilities, levels of understanding and communication

needs. Patients on the ward also presented with a number of behaviours that challenge. Staff were observed treating patients with dignity and respect.

The following is a summary of the inspection findings in relation to the Human Rights indicator of Autonomy and represents the position on the ward on the days of the inspection.

Information in relation to Department of Health Guidance on Capacity and Consent was available for staff. Patients or where appropriate their relatives were involved in decisions in relation to capacity to consent. Patients had been given time to understand their care and treatment plans. Staff sought consent prior to care delivery. Staff demonstrated their knowledge of capacity and consent and when to use the best interest check list and decision making tool. Information on patients' capacity to manage and control their finances was included in the two sets of care documentation reviewed. Where appropriate, financial control forms had been completed and signed by the consultant psychiatrist.

Patients had holistic needs assessments and individualised, person centred care plans completed with patient and, where appropriate, relative involvement. Care plans addressed each identified assessed need. Promoting Quality Care risk screening tool and subsequent comprehensive risk assessments had been completed where required. However, patient and or relative involvement was inconsistent. A relevant recommendation has been made. Care plans were reviewed at the weekly multi-disciplinary meetings and changes made when necessary. Patients and / or their relatives were offered the opportunity to attend their weekly multi-disciplinary meetings. Care plans and risk management plans reviewed in relation to responding to patients who present with behaviours that challenge detailed proactive strategies as well as reactive strategies.

Patients had a communication assessment completed and were referred to speech and language therapy services were assessed as needing support with communication. Patients were provided with alternative means to support them with communication. Staff were observed to engage with patients using therapeutic communication. Staff had knowledge of how to best support patients with their communication needs.

Patients had therapeutic and recreational activity assessments completed with individual activity plans with patient and relative involvement. Patients had access to Moyola day care facility. Ward based activities that were available were on display in the patient communal area. Patient participation in activities was monitored and recorded daily. During the inspection some patients were participating in activities, however the inspector noted that activity based proactive strategies as detailed in one patients care documentation were not being implemented. A recommendation has been made.

Patients and the advocate stated that there wasn't enough ward based activities provided. This was also raised at patient forum meetings. Staff

indicated that it was difficult to provide activities when the ward was busy. A recommendation has been made.

The inspector and lay assessor observed that information on who was on duty, ward based activities, independent advocacy services and how to make a complaint was displayed in the patient communal areas. A ward information booklet was available in an easy to read format. Patients could raise areas of concern at patient forum meetings convened every two months. Patients who were detained in accordance with the mental health (Northern Ireland) Order 1986 had been informed of their rights to appeal to the Mental Health Review Tribunal.

Patients had been informed of their rights in relation to their detention, how to make a complaint, and how to access advocacy services. Staff were aware how to effectively utilise advocacy services and automatically referred patients to independent advocacy services on admission. Independent advocates were invited to attend patients' progress meetings. Relatives had been informed of advocacy services.

Patients had individualised restrictive practice and deprivation liberty care plans completed with patients and relative involvement. Each restriction had a clear rationale recorded that was proportionate to the risk. Restrictive practices were reviewed regularly and changes made where appropriate. The inspector reviewed documentation in relation to the use physical interventions for one patient and staff had not completed a body map and not accurately completed the physical intervention form. This has been addressed separately with the trust and assurances given that any gaps identified will be addressed through an action plan. Physical intervention forms are audited by the physical intervention team.

Incidents resulting in the use of restrictive practices are reviewed by senior management at the monthly core meetings and at the monthly unit meetings. Patients and relatives had been informed of restrictive practices on the ward. Staff demonstrated their knowledge and understanding of the Deprivation of Liberty Safeguards – Interim Guidance DHSSPS 2010.

Staff had knowledge of patients Human Rights Article 3; the right to be free from torture, inhuman or degrading treatment or punishment, Article 5; the right to liberty and security of person Article 8; the right to respect to private and family life and Article 14; the right to be free from discrimination.

Consideration of patients Human Rights Article 3; the right to be free from torture, inhuman or degrading treatment or punishment, Article 5; the right to liberty and security of person Article 8; the right to respect to private and family life and Article 14; the right to be free from discrimination was recorded in the patients care documentation.

Details of the above findings are included in Appendix 2.

On this occasion Cranfield Women's ward has achieved an overall compliance level of substantially compliant in relation to the Human Rights inspection theme of "Autonomy".

6.0 Consultation processes

During the course of the inspection, the inspector was able to meet with:

Patients	**Four**
Ward Staff	**Two**
Relatives	**None**
Other Ward Professionals	**Five**
Advocates	**One**

Patients

The inspector was joined by a lay assessor on the inspection. Three patients met with the inspector and one patient met with the lay assessor.

The three patients that met with the inspector indicated they knew why they were in hospital. Patients also stated they had been involved in their care and treatment plans. Patients all commented that they had a good relationship with their named nurse and had the opportunity to spend time with them. Patients knew what an advocate was and had used this service. Patients stated they felt safe on the ward. Patients stated they got time off the ward and attended both day care and activities in the community. Although patients stated there wasn't enough activities happening as they "often felt bored". All patients stated they were overall satisfied with the quality of care and treatment.

One patient met with the lay assessor. The patient informed the lay assessor that;

- They felt safe
- They could talk to staff if they were unhappy
- They knew who their doctor was
- They knew who their named nurse was
- They were well cared for
- Being in hospital has helped them
- They did not receive an update all the time
- There took part in activities
- They felt like they were getting better
- Staff had time to talk to them about how they were being cared for
- They got time off the ward

- It was easy for them to see their friends and family
- They can use the phone on the ward
- Exit from the ward was locked but the door was opened if they needed to go out
- The garden is open
- They had a key for their bedroom door

Relatives/Carers

The inspection was unannounced. There were no relatives available during the inspection.

Ward Staff

Two ward staff met with the inspector. Staff demonstrated their knowledge and understanding of individual patients needs on the ward and demonstrated how they adjust their communication to support patients who require support with communication. Staff indicated that although caring for the patients was rewarding, working on the ward can be challenging at times due to the different range of patient needs, level of understanding and the number of patients who present with behaviours that challenge. However staff stated they felt well supported by the ward sister.

Other Ward Professionals

The inspector met with an occupational therapist, designated officer, physical interventions co-ordinator and behaviour support staff. Staff indicated that team work was good and staff make appropriate referrals.

Advocates

The inspector met with one independent advocate. The advocate stated overall the care on the ward was good. Staff made appropriate referrals. Concerns raised by patients were addressed. The advocate stated that patients who do not attend day care complained of “boredom”.

Lay assessor feedback

The lay assessor informed the ward sister of the outcomes from speaking with the patient. The inspector reviewed the patients documentation and noted the patient was involved with their care and treatment plans and had been kept up to date in relation to any proposed changes to their care plans.

Questionnaires were issued to staff, relatives/carers and other ward professionals in advance of the inspection. The responses from the questionnaires were used to inform the inspection process, and are included in inspection findings.

Questionnaires issued to	Number issued	Number returned
Ward Staff	20	7
Other Ward Professionals	6	2
Relatives/carers	14	6

Ward Staff

Seven questionnaires were returned from staff nurses and health care assistants. Six out of seven staff had not received training in capacity and consent. The ward sister informed the inspector that dates have been arranged for staff to attend this training and information in relation to capacity and consent is shared at team meetings. All staff stated they had received training in Human Rights and were aware Deprivation of Liberty Safeguard (DOLS) – Interim Guidance (2010). All staff were aware of the restrictive practices on the ward. All staff stated patients communication needs were recorded in their assessment and care plans and the ward had processes in place to meet patients' individual communication needs. All staff stated the ward has information in a format to meet individual needs in relation to patients' rights. All staff stated that patients had individualised activity programmes in plans and patients had access to therapeutic and recreational activities.

Other Ward Professionals

Two questionnaires were returned by the hospital aroma therapist and behaviour specialist. The aroma therapist visited the ward to provide treatment to patients when referred. The behaviour specialist had received training in capacity and consent and Human Rights and was aware of Deprivation of Liberty Safeguard (DOLS) – Interim Guidance (2010). The behaviour specialist had received training in relation to restrictive practices. The behaviour specialist had received training on meeting the needs of patients who require support with communication and confirmed that patients communication needs were recorded on their assessment and care plan. The behaviour specialist stated that patients on the ward had access to recreational and therapeutic activities.

Relatives/carers

Six questionnaires were returned by relatives. Relatives rated the care on the ward from good to excellent. Relatives indicated, where appropriate, they were involved in their family members care and treatment plans. Where relatives stated a formal assessment had been completed where there were concerns in relation to their family members ability to consent. Relatives stated their family member took part in recreational and therapeutic activities. Where appropriate relatives stated their family member had been informed of their rights in relation to their detention. All relatives stated they had been informed of advocacy services. Relatives stated they had been involved in a person centred discharge plan where appropriate.

Relatives quoted;

"The care and service provided on the ward to my relative is very good. The consultant, nursing, auxiliary / medical team staff and all other staff in the unit are helpful, friendly, approachable and keep me informed of all aspects of my relatives treatment."
"Pleased with the care my relative is receiving."

"We are quite happy with the care our relative receives in hospital."

7.0 Additional matters examined/additional concerns noted

Complaints

The ward was asked to complete a record of any complaints received between 1 April 2013 and 31 March 2014. The inspector confirmed that there have been no formal or informal complaints received on the ward.

Summary of Lay assessor observations.

The lay assessor completed a direct observation of the ward.

The lay assessor observed the following;

- Staff talked to the patients
- The ward was clean, tidy warm and had a nice smell
- The ward was not noisy
- Patients knew where to go on the ward
- Staff helped patients when they needed it
- Patients were not doing activities
- Staff were nice to patients
- Names of staff were on display; however this was not in a format that meet all the communication needs of the patients on the ward. A recommendation has been made
- Staff explained what they were doing with the patients before they started
- There was information displayed about advocacy services
- There was information about the ward for patients
- The lay assessor stated the ward was good.

The lay assessor informed the ward sister of their findings and the recommendation that will be made.

8.0 RQIA Compliance Scale Guidance

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable	Compliance with this criterion does not apply to this ward.	A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant	Compliance will not be demonstrated by the date of the inspection.	A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the inspection year.	In most situations this will result in a recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a recommendation, being made within the Inspection Report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and being made within the inspection report.

Appendix 1 – Follow up on Previous Recommendations

The details of follow up on previously made recommendations contained within this report are an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Appendix 2 – Inspection Findings

The Inspection Findings contained within this report is an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Contact Details
Telephone: 028 90517500
Email: Team.MentalHealth@rqia.org.uk

Appendix 1

Follow-up on recommendations made following the announced inspection on 9 July 2013

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	17 section 5.3.3(a)	It is recommended that patients' involvement in the assessment and care planning process is consistently documented. (2)	The inspector reviewed care documentation in relation to two patients and spoke with three patients on the ward. There was evidence that patients were involved in their assessments and the care planning process.	Fully met
2	18 Section 3	It is recommended that the ward sister ensures that policies, procedures, guidance and training in safeguarding vulnerable adults is included and recorded in the induction programme for new staff.	The Inspector reviewed the wards induction procedures and noted that guidance on safeguarding vulnerable adults and child protection was included.	Fully met
3	18 Section 5	It is recommended that the trust ensures that details of protection plans developed in response to adult safeguarding referrals are documented clearly on the safeguarding documentation.	The inspector reviewed documentation in relation to safeguarding vulnerable adult referrals for one patient and noted that the details of protection plans were clearly included in the documentation. Timely review of the protection plan was also noted. The inspector met with the hospital safeguarding vulnerable adult officer designated officer (DO) who confirmed that protection plans are completed promptly when a referral is completed.	Fully met
4	18 Section	It is recommended that the trust	The inspector met with the hospital	Fully met

Appendix 1

	1	ensures that a formal mechanism to alert the safeguarding officers to multiple referrals due to the same alleged perpetrator is developed, implemented and included in the Trust Vulnerable Adult Safeguarding Procedures.	safeguarding vulnerable adult officer designated officer (DO). All referrals are forwarded to the DO and a formal mechanism is now in place to alert when there are multiple referrals due to the same perpetrator. This is included in the Trust Vulnerable Adult Safeguarding Procedures.	
5	12 Statements 3;8;11	It is recommended that the ward sister ensures that risk assessments and care plans are discussed with the patient and their carer. This should be evidenced within the care documentation.	The inspector reviewed risk assessments and care plans in relation to two patients. There was evidence that care plans had been discussed with both patients. However there was no evidence the risk assessment had been discussed with one patient or a rationale recorded why this had not occurred. This recommendation will be restated for a second time.	Partially met
6	12 Statements 3;8	It is recommended that the ward sister ensures that the template for recording the multi-disciplinary team meetings includes domains to record patient/relative views/involvement, names of those present, agreed actions and outcomes including responsibility for completion, agreed timescales for completion, and review of risks.	The inspector reviewed the template for recording multi-disciplinary team meetings. The template included patients/ relative views / involvement, the names of those present, agreed actions and outcomes including responsibility for completion, agreed timescales for completion and review of risks.	Fully met

Appendix 1

7	17 Section 5.3	It is recommended that the ward sister introduces a system of auditing of records and record keeping to ensure defined processes are followed by relevant staff.	The inspector noted a system for auditing records and record keeping had been introduced and ensured defined processes were followed by relevant staff. The last audit was completed on 27 January 2015. The audit tool used was in keeping with NMC standards for record keeping and NIPEC guidance for record keeping. The audit was also noted to consider recommendations made by RQIA inspections on other wards in Muckamore.	Fully met
8	6	It is recommended that the trust ensures that staff within Cranfield Women's receive awareness training on their role in relation to Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010.	The inspector reviewed the training records for staff working on the ward and noted that 15 out of 30 staff had received awareness training in relation to Deprivation of Liberty Safeguards (DOLS) – interim guidance as outlined by DHSSPSNI (2010). The inspector noted that the 15 staff who had attended were staff nurses. Dates have been arranged for the remaining staff to attend awareness training.	Fully met
9	6	It is recommended that the ward sister ensures that the Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010, is implemented within Cranfield Women's ward.	The inspector reviewed care documentation in relation to two patients and noted that individualised care plans in relation to DHSSPSNI Deprivation of Liberty Safeguards (DOLS) - interim guidance (2010) had been completed. All staff spoken to during the inspection	Fully met

Appendix 1

			demonstrated their knowledge of the DOLS guidance.	
10	6	It is recommended that the ward sister ensures that care plans in relation to actual or perceived deprivation of liberty are reviewed to ensure that an explanation of deprivation of liberty is included and relevant to the plan of care.	Since the last inspection, new care documentation has been introduced. The inspector reviewed care plans in relation to actual or perceived deprivation of liberty completed for two patients. The inspector noted that an explanation for the deprivation of liberty was recorded in the care plan	Fully met
11	6	It is recommended that the trust ensures that the 'restriction checklist' currently in use on the ward is reviewed to ensure that the implementation of this tool is appropriate to the care environment.	The "restriction check list" is no longer used on the ward. Patients who present with risks that require restrictions were individually assessed and recorded in patients care documentation. This was evidenced in the two sets of care documentation reviewed during the inspection.	Fully met
12	12 Standard 13	It is recommended that the ward sister ensures that a timetable of ward based activities is developed, implemented and shared with patients.	The inspector observed a list of ward based activities on offer was displayed in the ward communal area. Activities on offer for the days during the inspection were recorded on the ward staffing notice board. A timetable had not been completed as this would not meet the individual needs of the patients. However patients and the ward advocate stated there was not enough activities occurring. Patients stated they were often	Fully met

Appendix 1

			bored when they did not attend day care. A new recommendation will made in relation to ward based activities.	
13	17 Section 4.3	It is recommended that the trust ensures that a needs/capacity analysis is undertaken to establish need for and availability of clinical therapeutic inputs to include psychiatric, psychological, behavioural, social work and occupational therapy specialties.	The trust had undertaken a needs/capacity analysis and the inspector noted patients on the ward had access to the following; One full time hospital occupational therapist One part time hospital based psychologist Three full time behaviour therapists with a plan this will increase by three in April 2015. Two full time hospital social workers One full time consultant psychiatrist One special registrar One ward doctor.	Fully Met
14	16	It is recommended that the trust ensures that a new policy for mobile phone use is developed and implemented.	The inspector was informed that a policy for mobile phone use was not developed and there are no plans to develop one in the future. Risks on mobile phone use will assessed on an individual basis and patients will retain their mobile phones unless risks were identified.	Fully met
15	17 Section 4.3	It is recommended that the trust ensures that the supervision needs for all staff working on the ward is examined and that a timetable of supervision for all staff working on the ward is developed and	The inspector noted a timetable for supervision for all staff working on the ward was displayed in the ward office and indicated when supervision had been completed and the date staff were due their supervision.	Fully met

Appendix 1

		implemented so that staff receive regular supervision appropriate to their needs and role.		
16	18 Section 2	It is recommended that the trust put a system in place so that the ward sister/nurse in charge can ensure that bank staff have the appropriate training skills and knowledge to work on the ward.	The inspector was informed by the senior manager that all bank staff had received up to date mandatory training and have the appropriate training skills and knowledge to work on the ward.	Fully met
17	17 Section 4.3	It is recommended that the ward manager ensures that a training needs analysis is undertaken and that a training plan is developed from the findings of this analysis.	The ward sister informed the inspector that staff training needs are identified through staff appraisals and supervision. The inspector reviewed training records and noted that all staff had received up to date mandatory training. Dates for positive behaviour support training have been arranged and confirmed.	Fully met
18	20 Standard 8	It is recommended that to promote optimum levels of care and treatment, the trust put a mechanism in place to ensure that staff at all levels working with patient's on Cranfield Women's Ward are fully supported in their role.	The inspector reviewed records in relation to staff supervision and noted that all staff had received up to date supervision. The inspector noted that staff meetings had been convened two monthly. Staff interviewed during the inspection stated they felt fully supported in their role.	Fully met
19	12	It is recommended that the ward sister ensures that information	The inspector noted that information relating to staff on duty was displayed in the patient	Fully met

Appendix 1

		relating to staff on duty is displayed in patient areas.	area. A new recommendation will be made following observation by the lay assessor.	
20	17 Section 8.1	It is recommended that the trust ensures that the local complaints resolution form is completed as necessary.	The inspector reviewed information to guide staff on how to support patients to make either a formal or informal complaint was held on the ward. Local resolution forms were available. Information on how to make a complaint was displayed in the patients' communal areas. Patients interviewed during the inspection knew who to speak to if they were unhappy. The ward sister stated there have been no formal or local complaints on the ward.	Fully met
21	17 Section 5.3	It is recommended that the trust ensures that all care documentation is accurate, current, personalised and in keeping with relevant published professional guidance documents including NMC Record keeping guidance and DHSSPSNI 2010 Deprivation of Liberty Safeguards (DOLS) – Interim Guidance.	The inspector reviewed care documentation in relation to three patients. It was noted that records completed following the use of a physical intervention with one patient had not been completed accurately and did not reflect the information written in the daily progress notes. This recommendation will be restated for a second time.	Not met
22	18 Section 5	It is recommended that the trust ensures that a system to provide the ward sister with information in	The inspector noted the minutes of monthly senior management core meetings were shared at the unit meetings attended by the	Fully met

Appendix 1

		relation to review and outcomes of accidents, incidents and near misses that may influence ward practices is implemented.	senior nurse manager and Cranfield ward managers. Accidents, incidents and near misses were reviewed at the unit meetings.	

Appendix 1

Follow-up on recommendations made following the patient experience interview inspection on 11 June 2014

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1		N/A		

Follow-up on recommendations made at the finance inspection on 31 December 2013

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensures that a record of all staff who obtain the key to the drawers where patient's money is stored is kept, including the reason for access.	The inspector reviewed records in relation to patients' finances. There was a record of all staff who obtain the key to the drawers where patients money is stored and this included the reason for access.	Fully met

Follow up on the implementation of any recommendations made following the investigation of a Serious Adverse Incident

No.	SAI No	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1		N/A		

Quality Improvement Plan

Unannounced Inspection

Cranfield Female, Muckamore Abbey Hospital

2 & 3 February 2015

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with the ward sister, hospital staff, senior management and other trust personnel on the day of the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the senior manager.

It is the responsibility of the Trust to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	5.3.3 (b)	It is recommended that the ward sister ensures that risk assessments and care plans are discussed with the patient and / or their carers where appropriate. This should be evidenced within the care documentation.	2	Immediate and on-going	In response to this recommendation, the Ward Sister carries out monthly internal audits within the ward to monitor care documentation. Evidence of the patient and /or their carers involvement in risk assessments and care plans is monitored as part of this audit.
2	5.3 (f)	It is recommended that the trust ensures that all care documentation is accurate, current, personalised and in keeping with relevant published professional guidance documents including NMC Record keeping guidance and DHSSPSNI 2010 Deprivation of Liberty Safeguards (DOLS) – Interim Guidance.	2	Immediate and on-going	In response to this recommendation, the trust ensures all care documentation is accurate, current, personalised and in keeping with relevant published professional guidance documents including NMC Record keeping guidance and DHSSPSNI 2010 Deprivation of Liberty Safeguards (DOLS) – Interim Guidance through the monitoring of care documentation by monthly internal audits within the ward.
3	5.3.3 (b)	It is recommended that the ward sister ensures that a rationale is recorded where patients and or their representatives are not involved in their risk assessments. This rationale should reflect the patients' level	1	Immediate and on-going	In response to this recommendation, the Ward Sister carries out monthly internal audits within the ward to monitor care documentation. Evidence of the patient and /or their carers involvement in risk assessments is monitored as part of this audit. Where the patient or their representatives are not

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		of understanding and demonstrate that all reasonable adjustments have been made to support the patient to understand their care and treatment plans.			involved in their risk assessments, a rationale is detailed to reflect the reasons. The rationale reflects the patients' level of understanding and demonstrates that all reasonable adjustments have been made to support the patient
4	5.3.1 (a)	It is recommended that the ward sister ensures that activities that are used as proactive strategies as documented in patients behaviour support plans are implemented.	1	Immediate and on-going	In response to this recommendation, the ward Sister has reinforced with staff the need to implement activities used as proactive strategies as detailed in individual behaviour support plans. This is evidenced through the patients progress notes.
5	5.3.3 (b)	It is recommended that the ward sister ensures that patients who are not attending Moyola day care have access to a range of individualised and group therapeutic and recreational activities. A reason should be documented when these are unavailable or patients do not participate.	1	Immediate and on-going	In response to this recommendation the Ward Sister and ward staff have updated the patients assessment to reflect preferred activites. An activity schedule, detailing available activities has been drawn up and is displayed on the ward. Each patient also has an individualised activity schedule based on their assessed need and available activities. Staff document patients participation in the progress notes. Patients non participation is also documented, detailing the reasons for non

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					participation. This includes the reason why activities may not be available.
6	6.3.2 (c)	It is recommended that the ward sister ensures that all information displayed in the ward meets the communication needs of all the patients. (Lay assessor recommendation)	1	3 July 2015	In response to this recommendation the Ward Sister has liaised with the patients forum and the patients council to ascertain what information patients want and how patients need information displayed. The ward Sister is also liaising with Speech & Language Therapy to assist in producing information for display.

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

NAME OF WARD MANAGER COMPLETING QIP	Adrienne Creane
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Martin Dllon

Inspector assessment of returned QIP		**Yes**	**No**	**Inspector**	**Date**
A.	Quality Improvement Plan response assessed by inspector as acceptable	✓		Wendy McGregor	**26 March 2015**
B.	Further information requested from provider				

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,
BT41 2RJ
Tel No: 028 9446 3333

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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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.	
	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.	**Met**
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.	
	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.	**Met**

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.

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

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