The Regulation and Quality Improvement Authority

MENTAL HEALTH AND LEARNING DISABILITY

UNANNOUNCED INSPECTION

ENNIS WARD, MUCKAMORE ABBEY HOSPITAL

BELFAST HEALTH AND SOCIAL CARE TRUST

29 JANUARY 2013

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

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1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is a non-departmental public body established under the provision of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. RQIA is responsible for providing independent assurance concerning the quality, safety and availability of health and social care services in Northern Ireland. Moreover, RQIA endeavours to encourage improvements in the quality of services and to safeguard the rights of service users. RQIA undertakes a range of responsibilities for people with mental ill health and those with a learning disability, following the transfer of duties of the former Mental Health Commission to RQIA under the Health and Social Care (Reform) Act (NI) 2009.

Inspectors would like to thank the patients and staff for their cooperation throughout the inspection process

2.0 Ward Profile

Trust	Belfast Health and Social Care Trust
Name of hospital/facility	Muckamore Abbey Hospital
Address	1 Abbey Road Antrim BT 41 4SH
Telephone number	02894463333
Email address	Linda.mccartney@belfasttrust.hscni.net
Person in charge on day of inspection	Margaret O'Boyle, Acting Ward Manager
Nature of service - MH/LD	Learning Disability
Name of ward/s and category of care	Resettlement/ Challenging behaviour
Number of patients and occupancy level on days of inspection	17 beds 17 patients
Number of detained patients on day of inspection	0
Date and type of last inspection	Unannounced 20 December 2012
Name of Inspectors	Patrick Convery – Lead Inspector Margaret Cullen Siobhan Rogan Rosaline Kelly Brenda Gallagher

Ennis Ward is a 17 bed resettlement female ward for adults with a learning disability who present with challenging behaviour. The ward is located 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 six patients; a bright and homely furnished living and dining room, a well maintained toilet and bathroom and three single bedrooms and one bedroom accommodating three patients, 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.

To the left of the entrance there are facilities for 11 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 a Wii for patient's use, while the other has more protective furnishings and is used by patients with more challenging behaviour.
Inspectors commented on the narrow corridors and the locked doors within the ward which restricted patient’s movements.

3.0 Inspection Summary

An unannounced inspection of Ennis Ward was undertaken on 29 January 2013. The purpose of this inspection was to assess the ward's arrangements and procedures for safeguarding vulnerable adults, following serious allegations made on 8 November 2012. Despite requests for information from the trust RQIA still had not received assurances that the safeguarding of vulnerable adults was adequate, at the time of the inspection.

The purpose of the Mental Health and Learning Disability (MHLD) inspection was to focus on the governance arrangements including the reporting of incidents and support for staff and patients in relation to safeguarding issues. This involved inspectors talking to individual staff and patients, meeting senior management, the review of documentation including care plans and vulnerable adults reporting mechanisms. Further observation of the ward environment including staffing levels and a review of the role of monitoring officers was also undertaken during this inspection.

The following is a summary of the inspection findings regarding the arrangements for safeguarding vulnerable adults on this ward.

Environment

There are three distinct areas of this ward, and the layout is such that this must be considered when calculating the observation and supervision needs of patients. The noise levels on the ward can be disturbing for patients and staff, and there are limited opportunities for patients to avail of quiet areas. One inspector was informed that a patient chooses to isolate herself in a "back hall" for some peace and quiet. This was noted by inspectors and raised at the Safeguarding Strategy meetings, in terms of the impact which the narrow corridor to the dining areas presents in relation to patient safety, i.e. the patients congregate and push each other to gain access to the dining room. Furthermore, there are a significant number of locked doors on this ward, with the entry and exit doors controlled by staff. This means that patients are very restricted in the space available to them and their movements are continually monitored and controlled by staff. Patients did not have access to their bedrooms and personal belongings during the day. It would appear that all patients are subject to the same level of restriction, regardless of their individual needs and abilities. This should be considered by the trust in the context of safeguarding the human rights of patients.

Behavioural Support

RQIA sought assurance that these vulnerable patients had access to the full range of therapeutic and clinical interventions, targeted at specific behaviour management, to support and appropriately address their presenting needs.

The profile of patients on the ward is such that many display a range of behaviours that are difficult to manage. These behaviours impact on the safety, dignity and well- being of all patients on the ward. For instance, one patient removes their clothing repeatedly. A high level of unpredictable aggressive behaviour was noted across the ward. RQIA and the Belfast Health and Social Care Trust (BHSCT) Safeguarding Strategy Panel were assured by the Independent Monitor, and verbally by the service manager, that there were appropriate behavioural plans in place for these patients, particularly the patients identified regarding the alleged abusive practices. However, inspectors examined five relevant sets of patients' notes and found that there was no evidence of input from Behavioural Support Services before, or since, these allegations were made. This was also noted in the patients' notes examined on the unannounced inspection of 13 November 2012, and again on 20 December 2012. A recommendation was made in the quality improvement plan. While references to the management of behaviour were noted, within the care documentation reviewed, there was no evidence of care planning to adequately address patient's behavioural presentation.

Protection Plans

In view of the serious nature of the allegations made on 8 November 2012, RQIA would expect that clear protection plans have been devised and implemented, to safeguard and protect all patients on this ward. As previously stated, five sets of patients' notes were examined.

Inspectors were concerned that no clear protection plans were evident in any of the notes examined. Inspectors noted that there were references to protection plans and review of protection plans in the nursing and medical notes. The vulnerable adult referral forms included responses from the Designated Officer, often advising that patients be kept separated and advice was given that enhanced monitoring arrangements should be put in place. No guidance as to how this should be achieved was evident in the notes. This information had not been included in care plans

Patient Interviews

During the Inspection four patients were interviewed and asked a range of questions. The questions used were to gauge the patient's experience of their care and their understanding of their human rights. Due to the limited cognitive ability of the patients it was difficult to ascertain a definitive answer to some of the questions. However, the questions that the patients did answer highlighted that they were happy with the care they were receiving. Some of the patients were able to explain who to go to make a complaint. The patients who could communicate said the staff were kind to them and helped them a lot. One patient said they only got seven cigarettes per day and would like to look after her cigarettes herself. When the inspector spoke to the senior nurse and examined the patients notes it was very clear why this

action had been taken. Due to the complex needs of this patient it was found to be in their best interests. There was a care-plan in place and it was being reviewed regularly.
The inspector did not find any areas for concern during the patient interviews.

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4.0 Additional concerns noted by Inspectors

Following an escalation letter to the Trust Chief Executive and the most recent inspection on 29 January, RQIA requested the following information by 8 February 2013:

- Detailed chronology of the actions taken by BHSCT following the initial reporting of allegations regarding care and treatment of patients in Ennis ward, including minutes of all meetings in relation to this issue.
- A copy of individual protection plans for Ennis patients identified in relation to the allegations and clarity where these plans are stored, as these were not available to inspectors and ward staff were unaware of their location.
- Confirmation of ward manager responsibility for Ennis Ward in the absence of the substantive post holder.
- Copies of all independent monitoring reports, since the allegations of abuse emerged in November 2012, and a list of all independent monitors for Ennis Ward.
- A list of all referrals to the Adult Behaviour Services for patients from Ennis ward, from 1 January 2012 to present and the outcome of these referrals.

A meeting was arranged with senior management on Monday 11 February 2013 to follow up on the letter of escalation.

RQIA received the information requested on 14 February 2013 and this is summarised as below:

The detailed chronology of events appeared to be accurate and detailed and outlined the actions taken by BHSCT as well as evidence minutes of meetings in relation to the on-going monitoring and investigation.

RQIA received and reviewed five protection plans for patients in Ennis and although these appeared detailed, Inspectors were of the view that these should be included in the notes on the ward. There was little evidence of specific interventions being recorded for each individual to inform a specific care plan. The care plans were not available on the ward for staff reference and to facilitate development of individualised care plans to protect individuals. Staff were unaware of their existence

Confirmation of acting ward manager was confirmed as requested.

Independent monitoring reports

In total 233 independent monitoring reports were received from 17 November 2012 - 8 February 2013. However some of these were duplicates/triplicates and in total 223 were reviewed by RQIA. In one form the date/time was not specified.

The forms were reviewed and it was evident that there was significant gaps in information from specific dates. Some monitoring reports were missing from both day and night time. Areas of concerns were noted in 54 of the monitoring reports received which can be summarised as follows:

Staffing Issues

Insufficient staffing levels during the day and night-time shifts and difficulty facilitating staff breaks, due to levels of observation on the ward.

Overreliance on agency/bank staff; it was noted that on occasions there was only one substantive staff member on duty who regularly worked on the ward.

Concerns were noted regarding staff morale and pressure on staff as well as staff feeling vulnerable due to concerns and staffing levels.

Environmental Concerns

Issues regarding the environment not being suitable for the client group and that the environment is in need of upgrading. There were issues identified regarding overcrowding in some areas and challenges in observation levels particularly during tea time. Lunchtime was described as “very chaotic” in one monitoring report. There were also difficulties documented in facilitating staff teas due to levels of patient observation.

Lack of Privacy/Dignity for Patients

Privacy and dignity issues were identified particularly in relation to absence of curtains. There was issues raised regarding patients stripping off clothes and staff were unable to offer a reason for this behaviour. It was stated in one monitoring report that patient(s) were unsettled due to the presence of unfamiliar staff on the ward.

Absence of Therapeutic Activities

The lack of stimulation and absence of therapeutic activities was stated in monitoring reports and that the current staffing ratio does not facilitate therapeutic interventions.

Care Plans

During examination of one of the patient's care-plans on restrictive practices the inspector found a restrictive care-plan wrote for two restrictions on the patient. These restrictions were locked doors and covert medication. It is recommended that this should be two separate restrictive practice care-plans. These care-plans should be dated and reviewed regularly

Safety Issues

On several occasions in January it was noted that the lack of magnetic keys and alarms were giving some cause for concern and considering the environment RQIA would share these concerns and would contribute to safe and effective care.

Referrals to Adult Behavioural Service were noted in information returned which clarified that behavioural support referrals were made regarding eight patients. These were mostly in 2011 and 2012 and one assessment was noted to be on-going in January 2013. Although it was recorded on the return that advice was given to nurse regarding care planning there was no evidence of staff being aware of this and the outcome following referrals to behaviour service. This information could not be located in patients care plans on the ward and RQIA were of the view that for this to be effective it should be readily available in the patients' notes. [RK1] The expectation is that guidance by behaviour support /support plans form the basis of a care plan to manage behaviours

A returned quality improvement plan (QIP) signed by the chief executive was received on 4 March 2013. Inspectors had previously received an electronic version and concerns were expressed regarding the lack of clarity and response to the recommendations made following the unannounced inspection on 20 December 2012. These are reflected in the restated recommendations below.

Appendix 1 – Quality Improvement Plan

The Regulation and Quality Improvement Authority

QUALITY IMPROVEMENT PLAN

UNANNOUNCED INSPECTION

Ennis Ward, Muckamore Abbey Hospital

29 January 2013

The issue(s) identified during this inspection are detailed in the quality improvement plan.

1. RECOMMENDATIONS RESTATED FROM PREVIOUS QIP

RECOMMENDATIONS FROM INSPECTION	NUMBER OF TIMES STATED	DETAILS OF ACTION TO BE TAKEN	TIMESCALE
It is recommended that the total staffing complement for Ennis Ward be clearly defined and monitored to ensure that at all times suitably qualified, competent and experienced persons are working in such numbers as are appropriate for the health and welfare of patients. The monitoring reports indicate concerns regarding staffing levels and appropriately trained staff.	**3**	**Staffing levels are based on the outcomes of the Telford Reviews which were carried out for this ward. This includes the provision of suitably qualified, competent and experienced persons available in the ward. Management, ward manager and ward staff are aware of the agreed staffing levels.** **A record of staffing levels for day and night duty is maintained in the nursing administration office, all duty nursing officers have been informed of the need to notify the Senior Nurse Manager for Ennis in the event of any deficits. The**	**Immediate and ongoing**

		SNM in turn informs RQIA of any occasions when staffing levels drop below what has been agreed	
It is recommended that staffing requirements in relation to special observations are clearly defined, and that RQIA is advised in writing, if the Telford and /or the Trust Observation Policy, is being adhered to and a review of both is undertaken for consistency with each other.	**3**	**Staffing levels, are based on the outcomes of the Telford Review which was carried out for this ward. Enhanced observations are prescribed and staffing levels allocated based on the level determined. There is clear understanding that staff assigned to special observations are not included within the daily ward staff complement. The observation policy has been reviewed and signed off at governance level and is now operational hospital wide** **If for any reason agreed ward complement staffing levels cannot be met because of observation levels, RQIA are notified of this in writing.**	**Immediate and ongoing**

		In light of the reviewed observation policy issued in April 2013. The SNM for Ennis will carry out an ongoing review of the ward staff complement and observation levels for consistency with each other.	
It is recommended the staffing on Ennis ward is reviewed to ensure there is a core complement of staff to meet the needs of the patients. The monitoring reports indicate an overreliance on input from staff from bank and other wards.	**2**	**Action complete** **A core complement of staff is now in place for this ward.** **Bank staff may still be used on occasion to cover deficits due to staff's temporary absence.** **Any on-going absence management is monitored in accordance with the Trusts Absence Management Policy**	**Immediate and ongoing**
It is recommended that any agreed actions from safeguarding strategy meetings are processed accurately and in a timely	**2**	**Outcomes from safeguarding processes**	**Immediate and ongoing**

manner, to all relevant staff. The inspectors noted the absence of individual protection plans in patient's notes.		**are incorporated in the patients care plan. All patients have an individual protection plan**	
It is recommended that any learning from the induction of any internal / external staff, under the terms of the new resettlement strategy, is reviewed and any lessons learned, documented and shared with relevant staff. RQIA will continue to review the induction and training of staff and specifically in relation to monitoring within Ennis Ward.	**2**	**The internal and external induction process is now complete and is in operation. Lessons learned have been incorporated by measuring and evaluating the experience. This has been shared with all wards in the hospital.**	**Immediate and ongoing**

2. RECOMMENDATIONS

RECOMMENDATIONS FROM INSPECTION	DETAILS OF ACTION TO BE TAKEN	TIMESCALE
It is recommended that individual behaviour support plans are updated regularly and information readily available within patients' notes.	**Where there has been a referral to behaviour services, the behaviour support services staff meet with the patient and the named nurse and following an initial assessment, behavioural interventions are agreed, this is written up in the patients care plan. Individual Behaviour Support Plans are devised for patients who the clinical team feel are most likely to benefit. These result from an in-depth analysis of data and observations. Where these plans are in place they are updated as indicated.**	**Immediate and ongoing**

It is recommended that patients have the opportunity to engage in therapeutic activities while on the ward.	**Activity programmes have been developed for all patients. These include beauty therapy, walks, visits to the Cosy Corner, art, table top activities such as inset boards/jigsaws, multisensory activities, such as hand massage and foot spas, Participation/non participation in activities are recorded in the patients care plan. In conjunction with this the Ward Manager and Senior Management are pursuing other options to facilitate therapeutic activity in the ward, i.e.** **- providing an activity room on the ward** **- input to the ward from art and music therapy**	**Immediate and ongoing**

It is recommended that consideration be given to upgrading the ward or alternative accommodation sought.	**A capital bid has been secured to upgrade and improve the existing environment. A meeting has been scheduled with ward staff, Senior Management and Estates to agree the extent of work required. It is anticipated to have this completed within 6 months**	**Immediate and 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: ___mairead mitchell_____

NAME: _____ _____

DATE: _____
FOR OFFICE USE ONLY:

QIP viewed by Inspector on:

DATE: _____

SIGNED: _____

NAME: _____

MAHI - STM - 107 - 450

The **Regulation** and **Quality Improvement** Authority

1 February 2013

Our Ref: MC/PC/CH

Private and Confidential

Mr Colm Donaghy
Chief Executive
BHSCT
Trust Headquarters
A Floor
Belfast City Hospital
Lisburn Road
Belfast
BT9 7AB

Dear Mr Donaghy

Unannounced Inspection Ennis Ward, Muckamore Abbey Hospital

RQIA undertook an unannounced inspection of Ennis Ward, Muckamore Abbey Hospital on 29 January 2013.

The inspection focused on the safeguarding arrangements on the ward, following the allegations of abuse of patients made by a third party to RQIA on 8 November 2012. I am advised that the allegations are currently subject of a vulnerable adult investigation, which I understand is being led by the PSNI. The inspection of 29 January 2013 is part of the ongoing monitoring and scrutiny of Ennis Ward. This also included unannounced inspections on 13 November and 20 December 2012.

A number of concerns arose during this latest inspection, which I wish to bring to your attention under the RQIA Escalation Policy.

Staffing

The number of staff allocated to the ward, week beginning 27 January 2013 was in accordance with the pre-assessed numbers determined by BHSCT. The ward manager or nurse in charge is included in this total, therefore cannot be fully committed to the roles of both managing the ward and nursing patients. This raises concerns about the correct number of staff to holistically meet the complex needs of 17 patients on this ward.

Additionally, for significant periods during the night two staff are allocated to this ward, (e.g. 28 - 29 January 2013, 23.00 – 07.00, and 29 - 30 January 2013, 02.00- 07.00).

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At the time of the inspection, two patients required observation at 15 minute intervals, between 23.00 – 07.30. In considering the layout of the ward; the complex needs of patients; the possibility that one or more patients may require assistance during the night; and the required level of observations, RQIA is concerned that insufficient numbers of staff are available to holistically meet the complex needs of patients on this ward.

RQIA would request that the trust undertakes a risk assessment, to review the staffing arrangements, to ensure that sufficient numbers of staff are available to holistically meet the needs of patients across the 24 hour period.

Behavioural Support

The profile of patients on the ward is such that many display a range of behaviours that are difficult to manage. These behaviours impact on the safety, dignity and well-being of all patients on the ward. For instance, one patient removes their clothing repeatedly. A high level of unpredictable aggressive behaviour was noted across the ward. RQIA and the trust's Safeguarding Strategy Panel were assured by the independent monitor, and verbally by the service manager, that there were appropriate behavioural plans in place for these patients, particularly the patients identified regarding the alleged abusive practices. However, inspectors examined five relevant sets of patients' notes and found that there was no evidence of input from Behavioural Support Services before, or since, these allegations were made. This was also noted in the patients' notes examined during the unannounced inspection of 13 November 2012, and a recommendation was made in the quality improvement plan. No behavioural plans were evident within the notes.

RQIA requires assurance that these vulnerable patients have access to the full range of therapeutic and clinical interventions, targeted at specific behaviour management, to support and appropriately address their presenting needs.

Environment

There are three distinct areas of this ward, and the layout must be considered when assessing the observation and supervision needs of patients. The noise levels on the ward can be disturbing for patients and staff. There are limited opportunities for patients to avail of quiet areas. One inspector was informed that a patient chooses to isolate herself in a back hall. It has been noted by inspectors, and raised at the safeguarding strategy meetings, the impact that the narrow corridor to the dining areas has in relation to patient safety. Here, the patients congregate and jostle each other to gain access to the dining room.

Furthermore, there are a significant number of locked doors on this ward, with entry and exit controlled by staff. This means that patients are very restricted

in the space available to them, and their movements are continually monitored and controlled by staff. Patients did not have access to their bedrooms and personal belongings during the day. It would appear that all patients are subject to the same level of restriction, regardless of their individual needs and abilities. This should be considered by the trust in the context of safeguarding the human rights of patients.

RQIA concluded that the environment is not conducive to meeting the needs of the patients on this ward. RQIA would ask the trust to consider whether other more suitable accommodation could be provided within the Muckamore site, or that appropriate adaptations could be made to Ennis Ward to improve the environment for both patients and staff.

Protection Plans

In view of the serious nature of the allegations made on 8 November 2013, RQIA would have expected that clear protection plans were devised and implemented, to safeguard and protect all patients on this ward.

As previously stated, five sets of patients' notes were examined and whilst inspectors noted that there were references to protection plans and review of protection plans in the nursing and medical notes, no clear protection plans were evident in any of the notes examined.

The vulnerable adult referral forms included responses from the designated officer, often advising that patients be kept separated, or advice was given that enhanced monitoring should be put in place. No guidance as to how this should be achieved was evident in the notes. This information had not been included in care plans.

RQIA requires assurances that individual protection plans are clearly documented and reviewed to ensure their effectiveness for all patients on the ward with immediate effect.

In view of the concerns highlighted, I invite the trusts' designated responsible managers to meet with RQIA on 11 February 2013 at 09.00 at our offices, to discuss these issues and to receive adequate assurance in relation to patient care and safeguarding. Mrs Theresa Nixon, Director of Mental Health, Learning Disability and Social Work, Mr Patrick Convery, Head of Programme, and the relevant inspector will be present at this meeting.

I look forward to your continued cooperation in addressing these important matters.

Yours sincerely

Glenn Houston
Chief Executive

cc: Mr John Compton, Chief Executive, Health and Social Care Board
Dr Michael McBride, Chief Medical Officer, DHSSPS

RQIA Unannounced Inspection Ennis Ward, Muckamore Abbey Hospital

Report

In response to your correspondence under the RQIA Escalation Policy of 1st February 2013 following the unannounced inspection undertaken in Ennis Ward, the Trust would like to provide assurance that it continues to strive to deliver a safe and effective service to the patients in this ward whilst discharging its responsibilities in relation to the Vulnerable Adult investigation which is being led by the PSNI. The Trust continues to cooperate fully with the lead agency in this investigation and is continuing to support patients, families and staff during this period. The Trust continues to reflect on actions taken to date, information submitted daily through the reporting procedures put in place, leadership monitoring and reviews and feedback from the vulnerable adult process as well as RQIA inspections. In doing so we aim to ensure all appropriate steps continue to be taken to create the necessary impetus to achieve all the changes required to improve the service to the patients in this ward and ultimately in the hospital.

Staffing

The number of staff allocated to the ward is in accordance with the Telford Assessment undertaken by the senior nurse manager for the ward and the ward sister. This is reviewed at regular intervals and when changes in patient acuity is reported. The ward sister is included in the this total in line with Belfast Trust Policy for best and agreed practice in relation to the rostering of nursing and midwifery staff. The Telford Assessment agreed with the ward sister is in line with the policy and this has indicated an allocated 2 shifts per week to managerial, audit, appraisal tasks and supervisory time to support staff.

The allocation of night staff is in line with current level of assessed need, in the event if there is unpredictable patterns of activity during the night an additional resource is available through the on-site duty nurse co-ordinator and the on call senior nurse manager. The Trust has also reviewed the staffing assessment following a review of patients on special observation levels on this ward. Three staff are now allocated to night duty.

Patients also attend day support activities on site which provides individualised programmes of activities with a staff team which supplements the ward staffing compliment to enhance the patient experience.

The Trust acknowledges that there is ongoing active recruitment programme for the hospital. This is to fill a number of staffing vacancies on site. A number of new employees are now in post since Christmas however we still await completion of the new starts for registrant's posts. When the process is completed this will enhance the skill set and resource available to the ward to offset fluctuations in staff availability due to planned and unplanned staff absences.

Behavioural Support

The primary named nurse for the patient has care planning processes in place for the management of challenging behaviours. This is section 14 of the care plan. The multi-disciplinary team has referred those patients with the need for specialist behavioural assessment and intervention to the Specialist Behavioural Nurses on site. The assessments for the patients referred have been commenced which will result in behavioural plans formulated as required for these identified patients. It is recognised that a core skill for learning disability nursing staff is the assessment and care-planning of behaviours that challenge. Ward nursing staff have reviewed a number of care plans in consultation with behavioural team, the consultations with the specialist behavioural nurse is recorded in the daily nursing notes and the care plan updated by the primary nurse based on this advice. This peer support will continue to ensure appropriate support is available to nursing staff in Ennis as newly allocated staff become familiar with the patients' needs.

Environment

The ward environment has been reviewed by the senior nursing team in conjunction with estates department. Improvements to the environment have already been realised with some areas already refreshed. The Trust does acknowledge that these continuing care ward environments are not ideal but have been home to these patients for a number of years. As the patients are known to respond negatively to unplanned changes the multidisciplinary team are reviewing appropriate and measured responses to the concerns raised. The Trust is also aware that a recent resettlement of patient along with the planned resettlement of 4 further patients from this lower part of the ward will enhance the individual experience for patients of Ennis. The hospital management team have also as part of their considerations reviewed alternative options on the site but there is no other available ward environment that can safely meet the assessed needs of the current patient profile of Ennis ward.

The patients in the lower part of the ward have underwent previous assessments and their care-plans indicate their inability to keep themselves safe from normal day to day dangers of bathrooms, kitchens, or outdoor spaces; therefore areas are locked to prevent patients for example leaving the building unaccompanied. It is noted that whilst the patients lack capacity to choose their environment, ongoing contact with families indicate their support for continued use of Ennis as a ward. A number of relatives have voiced strong opposition to even internal transfers of their relatives to another ward on site even if available. A structured programme of activities off the ward is available to patients on site with a dedicated day support staff team. In spite of this the Trust does hold the view that we will continue to endeavour to provide betterment to this patient group through ongoing improvements where possible in the ward but ultimately appropriate community reintegration and resettlement from the hospital.

Protection plans

The Trust has an overall protection plan for Ennis ward which involves 24 hour monitoring of staff who were present during the period allegations of abuse are reported. This involves independent review of practices and nursing interventions as well as notification of areas of concern. These reports are reviewed by the service manager, designated officer for the vulnerable adult investigation and the external independent monitor and coordinator. Earlier review of these forms have highlighted areas for improvement which included environmental, privacy, staffing and patient profile and mix issues and concerns. Each of these issues have been subject to planned improvements and ongoing review and management.

The independent monitor lead and service manager have led the local team on environmental, fire safety, infection control and hygiene audits with subsequent action plans developed. The RQIA announced and unannounced inspections have also highlighted areas for improvement which the QIP's will address. The Trust is committed to delivering a safe and sustainable improvement in the ward for patients which will also support staff in the workplace.

The designated officers for vulnerable adult processes within the hospital are continuing to work with the multidisciplinary team in Ennis to monitor and review incidences of vulnerable adult concerns to minimise risks and provide external monitoring of patterns or incidents. This work remains ongoing. The Trust will ensure that all agreed actions from each report is care planned appropriately within the patient notes to ensure compliance with the protection plans.

The Regulation and Quality Improvement Authority

Our Ref: PC /CH

9 May 2013

Private and Confidential

Mr John Veitch
Co-Director for Children's Mental Health and
Learning Disability Services
Belfast Health and Social Care Trust
Adult Social and Primary Care Directorate
Fairview House
Mater Hospital
45-51 Crumlin Road
Belfast
BT14 6AB

Dear Mr Veitch

Police Investigation - Allegations of Abuse, Ennis ward, Muckamore Abbey Hospital

I refer to the recent Police Investigation Report regarding the allegations of abuse in Ennis Ward.

I note this investigation has been conducted as a Joint Protocol Investigation and poor care practices have been highlighted and incidents of a non-criminal nature identified involving some other staff members. I note through the investigation, the two suspects in this case, were repeatedly identified as being responsible for incidents of ill treatment and rough handling of the patients on the ward. The investigation report indicates that "the patients in this ward are some of the most vulnerable in the hospital, as they are not able to verbalise or communicate. Although there was only one witness to several of the incidents, the description of the actions, particularly that of H197 show consistent rough handling and aggression by a staff member who has worked at Muckamore Abbey Hospital for 32 years. The disregard for carrying out these actions in the presence of independent staff raises concern".

I wish to seek assurances that this report has been shared with key staff and that the "poor care practices highlighted and incidents of a non-criminal nature identified involving some other staff members" are being addressed by the Trust currently.

SOCIAL SERVICES
FAMILY & CHILD CARE
15 MAY 2013
FAIRVIEW 1
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RQIA would like to seek assurances from the trust in relation to the following

- That issues in relation to the care, treatment and culture both within Ennis and other wards have been addressed by the Trust.
- That the ongoing monitoring of Ennis ward continues in the light of this report.
- That RQIA will continue to be kept appraised of incidents involving patients and staff both in Ennis and in other wards within Muckamore Abbey hospital.

I would welcome your response to these matters by 17 May 2013.

Your co-operation is much appreciated.

Yours sincerely

Theresa Nixon
Director of Mental Health and Learning Disability
and Social Work

The Regulation and Quality Improvement Authority

RQIA

Mental Health

& Learning Disability

Unannounced Inspection

Muckamore Abbey Hospital

Ennis

Belfast Health and Social Care Trust

29 May 2013

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1.0 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).

1.1 Purpose of the Inspection

The trust provided RQIA with an action plan following the areas of concern identified during the previous inspection. The purpose of this inspection was to review progress towards completion of the action plan.

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

- The Mental Health (Northern Ireland) Order 1986;
- 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.

1.2 Methods/Process

During the inspection the inspectors focused on focused on recommendations made following the last inspection in January 2013, and the progress made in their implementation. The outcomes of the inspection findings can be viewed in detail in section 6.0.

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

- discussion with multi-disciplinary staff and managers;
- examination of records;
- file audit.

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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.

2.0 RQIA Compliance Scale Guidance

The inspector has rated the ward's Compliance Level against each recommendation made following the previous inspection.

The table below sets out the definitions that RQIA has used to categorise the ward's performance:

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.

3.0 Ward Profile

Trust	Belfast Health and Social Care Trust
Name of hospital/facility	Muckamore Abbey Hospital
Address	1 Abbey Road Muckamore BT41 4SH
Telephone number	028 94662234
Email address	Margaret.OBoyle@belfasttrust.hscni.net
Person in charge on day of inspection	Margaret O'Boyle
Nature of service - MH/LD	Learning Disability
Name of ward	Ennis Ward
Date and type of last inspection	29 January 2013 Unannounced Inspection
Date and time of inspection	29 May 2013 2pm – 5.30pm
Name of Inspectors	Rosaline Kelly & Patrick Convery

Ennis ward is a 17 bedded ward on the Muckamore Abbey site. The ward provides long term care and accommodation for female patients with a learning disability and overlapping challenging behaviours. Patients on this ward will be moving to long term community accommodation and care as part of the regional resettlement programme.

4.0 Inspection Summary

Summary of Findings

This is a summary of the unannounced inspection findings, undertaken by Rosaline Kelly and Patrick Convery on the 29 May 2013 and reflects the position in the ward on the day of inspection.

The Health and Social Care Trust (HSCT) submitted a Quality Improvement Plan (QIP) to RQIA following the unannounced inspection on 29 January 2013. Eight recommendations were made following the last inspection. It is good to note that four recommendations had been fully met.

4.1 Recommendations 1, 2 & 3 Staffing Levels

It was good to note that staffing levels had been reviewed regularly. Minimum staffing levels had been specified and evidence was available to confirm that staffing requirements and provision in relation to special observations had been considered in the formal review of staffing levels for the ward. Increased staffing had been provided in accordance with patient requirements and policies and procedures. The skill mix of registered nurses and healthcare assistants appeared to be satisfactory at 65%/35%. This required skill mix had been specified during the formal review of staffing levels for this ward. Staff who met with the inspectors stated that they believed staffing levels had improved over recent months. It was stated by a registered nurse on the day of the inspection that bank staff working on the ward are drawn for the permanent staffing establishment for the ward. This was confirmed by reviewing the staff rota.

4.2 Recommendation 6 Individual behaviour support plans

It was good to note that since the last inspection six patients had been referred to behaviour support services. Individual assessments had been undertaken for four patients by behaviour nurse specialists who discussed care plans in detail with the inspectors. Staff had been made aware of the specialist needs of patients in relation to management of behaviours. However, the confirmation from the behaviour nurse specialist that behaviour support specialist services are not routinely involved in assessing behaviours and devising and overseeing management plans for patients who may present with behaviours that challenge on resettlement wards is concerning. A new recommendation will be made.

One recommendation had been partially met.

4.3 Recommendation 8 Upgrading the ward environment or seeking alternative accommodation

It was good to note that plans to improve both the internal and external environment had been agreed. The timescale for completion of the works was not available at the time of the inspection. This recommendation will be restated and RQIA will seek details and reassurances from the trust in relation to expected timescales for completion of agreed works to upgrade both internal and external environments.

Two recommendations had not been met.

4.4 Recommendation 4 Accurate processing of agreed actions from safeguarding strategy meetings in a timely manner to all relevant staff.

Despite assurances given by the trust it is concerning to note that this recommendation had not been fully implemented, and additional concerns noted. Review of patients' notes on the day of the inspection demonstrated that although referrals had been made to the designated officer, documentation completed and strategy meetings held, individualised protection plans had not been clearly developed. Protection plans had not been included in care plans. It was concerning to note that the acting ward sister stated that when documentation is returned to the ward by the designated officer it is not reviewed by any member of staff to ensure that an appropriate protection plan has been developed, processes are not put in place to implement any protection plan, and there is no formal mechanism in place to ensure that staff are fully aware of the detail of the protection plan and their associated role and responsibilities. A total of 95 individual monitoring forms completed between February and April were evaluated. The main theme emerging from these was that it was difficult to carry out a monitoring role and be involved in nursing duties at the same time. There were other issues in relation to the noise levels on the ward and on occasions staffing levels particularly when patients required increased supervision. A new recommendation will be made.

4.5 Recommendation 8 Therapeutic activity

The acting ward sister confirmed that a programme of therapeutic and recreational activity had not been developed.

These recommendations will be restated as recommendations of this inspection and additional new recommendations will be made..

One recommendation could not be evaluated at this inspection as processes were not in operation. This recommendation will be carried forward for evaluation at the next inspection.

5.0 Conclusion

It was good to note the significant progress made in particular areas of patient care and treatment, particularly involvement of specialist behaviour support services, and continual review of staffing levels and skill mix. However, it was concerning to note that protection plans had not been developed following referral to the safeguarding team, and the lack of review of this documentation on return to the ward by the ward manager. The lack of progress in developing therapeutic and recreational activity programmes was also noted.

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

5.0 FOLLOW-UP ON PREVIOUS ISSUES

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the total staffing complement for Ennis Ward be clearly defined and monitored to ensure that at all times suitably qualified, competent and experienced persons are working in such numbers as are appropriate for the health and welfare of patients. The monitoring reports indicate concerns regarding staffing levels and appropriately trained staff.	This recommendation had been made on three previous occasions. On the day of the inspection evidence was available to confirm that staffing levels had been reviewed by senior hospital staff and the acting ward manager on 29 May 2013. Minimum required staffing levels had been specified with additional staffing included for any agreed increased levels of patient observations. Review of staff rotas for weeks beginning 20 May 2013 and 27 July 2013 demonstrated that agreed staffing levels had been consistently achieved. The skill mix of registered nurses and healthcare assistants appeared to be satisfactory at 65%/35%. This required skill mix had been specified during the formal review of staffing levels for this ward. Staff who met with the inspectors stated that they believed staffing levels had improved over recent months.	**Fully met**
2	It is recommended that staffing requirements in relation to special observations are clearly defined, and that RQIA is advised in writing, if the Telford and /or the Trust Observation Policy, is being adhered to and a review of both is undertaken for consistency with each other.	This recommendation had been made on three previous occasions. On the day of the inspection evidence was available to confirm that staffing requirements and provision in relation to special observations had been considered in the formal review of staffing levels for the ward. Increased staffing had been provided in accordance with patient requirements and policies and procedures.	**Fully met**

3	It is recommended the staffing on Ennis ward is reviewed to ensure there is a core complement of staff to meet the needs of the patients. The monitoring reports indicate an overreliance on input from staff from bank and other wards.	This recommendation had been made on two previous occasions. It was stated by a registered nurse on the day of the inspection that bank staff working on the ward are drawn for the permanent staffing establishment for the ward. This was confirmed by reviewing the staff rota.	**Fully met**
4	It is recommended that any agreed actions from safeguarding strategy meetings are processed accurately and in a timely manner, to all relevant staff. The inspectors noted the absence of individual protection plans in patient's notes.	This recommendation had been made on two previous occasions. Five sets of patients' notes were reviewed on the day of the inspection. Referrals had been made to the designated officer and documentation completed. Reference to strategy meetings had been included. Individualised protection plans had not been clearly developed. Protection plans had not been included in care plans. It was concerning to note that the acting ward sister stated that when documentation is returned to the ward by the designated officer it is not reviewed by any member of staff to ensure that an appropriate protection plan has been developed, processes are not put in place to implement any protection plan, and there is no formal mechanism in place to ensure that staff are fully aware of the detail of the protection plan and their associated role and responsibilities. This recommendation will be restated and a new recommendation made.	**Not met**
5	It is recommended that any learning from the induction of any internal / external staff, under the terms of the new resettlement strategy, is reviewed and any lessons learned, documented and shared with relevant staff. RQIA will continue to review the induction	This recommendation had been made on two previous occasions. The inspectors were informed that a new induction template and checklist had been developed. However, at the time of the inspection there were no external staff working on the ward and the new system had not been implemented. Inspectors could not fully evaluate this recommendation during this inspection.	**To be evaluated at the next inspection**

	and training of staff and specifically in relation to monitoring within Ennis Ward.		
6	It is recommended that individual behaviour support plans are updated regularly and information readily available within patients' notes.	It was good to note that since the last inspection six patients have been referred to behaviour support services. Individual assessments had been undertaken for four patients by behaviour nurse specialists who discussed care plans in detail with the inspectors. Staff had been made aware of the specialist needs of patients in relation to management of behaviours. The behaviour nurse specialist confirmed that she will continue to oversee the implementation of the behaviour support care plans. However, it was confirmed by the behaviour nurse specialist that behaviour support specialist services are not routinely involved in assessing behaviours and devising and overseeing management plans for patients who may present with behaviours that challenge on resettlement wards. A new recommendation will be made.	**Fully met**
7	It is recommended that patients have the opportunity to engage in therapeutic activities while on the ward.	The acting ward sister confirmed that a programme of therapeutic and recreational activity had not been developed. This recommendation will be restated.	**Not met**
8	It is recommended that consideration be given to upgrading the ward or alternative accommodation sought.	It was good to note that plans to improve both the internal and external environment had been agreed. The timescale for completion of the works was not available at the time of the inspection.	**Partially met**

Appendix 1 – Quality Improvement Plan

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Inspection

Ennis

Muckamore Abbey Hospital

29 May 2013

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

The timescales for completion commence from the date of the inspection

1. RECOMMENDATIONS

RECOMMENDATIONS	NUMBER OF TIMES STATED	DETAILS OF ACTION TO BE TAKEN	TIMESCALE
It is recommended that the ward manager ensures any agreed actions from safeguarding strategy meetings are processed accurately, appropriately and in a timely manner. All staff must be made aware of the detail of the agreed actions and their role and responsibility.	**Three**	A process is being devised that will link the VA process with the care plans - this process will incorporate agreed actions from safeguarding strategy meetings being processed accurately, appropriately and in a timely manner and the sharing of the detail of the agreed actions with all staff, including their role and responsibility.	**Immediate and on-going**
It is recommended that the trust ensures that the designated officer includes details of appropriate and agreed protection plans following screening of vulnerable adult referral forms and related strategy meetings.	**One**	A process is being devised that will link the VA process with the care plans - this process will incorporate the designated officer including details of appropriate and agreed protection plans following screening of vulnerable adult referral forms and related strategy meetings. In the interim the designated officer	**Immediate and on-going**

		will include details of the protection plan on the vulnerable adult referral forms	
It is recommended that the ward manager develops and implements a system for reviewing protection plans returned to the ward by the designated officer to ensure that they are appropriate to the situation and the individual patient. All staff must be made aware of the detail of the plan and their role and responsibility.	**One**	A process has been agreed that will link the VA process with the care plans - this process includes a system for reviewing the protection plans returned to the ward to ensure that they are appropriate to the situation and the individual patient.	**Immediate and on-going**
It is recommended that the monitoring role is reviewed and dedicated staff input afforded to ensure the role is effective, and does not impact on staffs' day to day responsibilities.	**One**	The monitoring role was reviewed at a meeting on 5th July. A decision was taken to stand down 24 hour monitoring of the ward. The ward is supported by twice weekly senior Nurse visits for 1 month to support staff and continue with ad hoc monitoring.	**Immediate and on-going**
It is recommended that the trust ensures that all patients who present with a behaviour that may challenge are referred to specialist behaviour support services for assessment and implementation of formal behaviour support plans.	**One**	All Staff within Ennis are trained in challenging behaviour. The behaviour services team are providing further training for Ennis staff specifically targeted at meeting the behavioural needs of	**Immediate and on-going**

		patients. Should the multi - disciplinary team feel that any further patients in Ennis require more specialist input then the option to refer to Behaviour Support Services is available.	
It is recommended that the trust ensures that any learning from the induction of any internal / external staff, under the terms of the new resettlement strategy, is reviewed and any lessons learned, documented and shared with relevant staff.	**Two**	The internal and external induction process is complete and is in operation. Lessons learned have been incorporated by measuring and evaluating the experience.	**Immediate and on-going**
It is recommended that the ward manager develops individual and group activity programmes and that patients have the opportunity to engage in therapeutic and recreational activities while on the ward.	**Two**	A template has been developed for individual and group activity programmes for patients to have the opportunity to engage in therapeutic and recreational activities while on the ward.	**29 July 2013**
It is recommended that the trust plans to upgrade the ward's internal and external environments according to a firm timetable for completion are finalised, agreed and expedited.	**Two**	Work to upgrade the ward's internal and external environments is currently underway by the contractor. All work will be completed by end September 2013	**30 November 2013**

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: _____

Emailed to TNixon on 6/6/13 @ 1607
Copy Esther/Marcel 6/6/13 @ 1607

Belfast Health and Social Care Trust

6th June 2013

Mrs T Nixon
Director of Mental Health and Learning Disability
RQIA
9th Floor, Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Dear Theresa

Re: Police Investigation – Allegations of Abuse, Ennis Ward, Muckamore Abbey Hospital

I refer to your correspondence of 9th May 2013 and wish to sincerely apologise for our delay in providing this response which was partly due my own absence on annual leave last week.

I can now confirm that the Trust immediately initiated a thorough investigation through the joint protocol arrangements into the allegations raised by the visiting Care Worker to Ennis ward on 8th November 2012. I can also assure you that the Trust acted swiftly and diligently in immediately sharing information with all appropriate staff and in addressing the immediate and ongoing protection needs of the patients within this ward. A total of four staff were initially placed on precautionary suspension as part of the protection plan and two staff remain on suspension from the workplace; namely a Healthcare Worker Band 3 and a member of Bank staff at Band 5.

As you should be aware a number of Strategy meetings have been held to progress the ongoing investigation into the allegations. This investigation has not only focused on specific allegations but has equally explored any potential of institutional abuse. Action included putting in place a protection plan which involved independent daily monitoring of staff interventions and the quality of care delivered on the ward. This protection plan continues to be reviewed at each Strategy meeting and currently remains in place. I can also confirm that these monitoring arrangements remain in place despite the continuing and unavoidable disruption it is recognised as having on the ward routine and initially to patients who did not respond well to unfamiliar faces within their environment.

Belfast Health & Social Care Trust, Social Services Family & Child Care, Fairview 1, Mater Hospital Site, Crumlin Road, Belfast BT14 6AB Tel 028 95046918 Fax 028 90802101 Email: john.veitch@belfasttrust.hscni.net

I am pleased to confirm that these measures have not provided any evidence of concern in relation to institutional abuse but in fact has provided evidence of positive practice and culture. Support from Behavioural Services has also been provided to assist staff in their ongoing care of the patients in this ward. Environmental challenges have also been identified and are now part of the improvement plan for the ward.

Feedback from the monitoring reports has also been fully discussed at the Strategy meetings held to date at which representatives of your agency have been present. These reports have been forwarded daily to the Vulnerable Adult Designated Officer for the case, a Co-Director of Nursing, and the Hospital Service Manager who is the professional nursing lead for the service. If a concern or issue is noted these are reviewed by the hospital operational team and all actions are agreed in conjunction with the staff team in the ward.

To date key personnel within the Trust have continued to work proactively to progress improvements for patients in this ward and for all patients on site. I can also assure you that the Trust regards with the utmost seriousness any reported concern regarding any member of staff failing to provide the expected level of care, inappropriate attitude or appropriate interventions to any of those patients entrusted to our care. As the PSNI investigation is now completed, we now await a decision from the Public Prosecution Service on the next steps. The Trust is also now completing its own Vulnerable Adult processes to fully address all concerns raised including those allegations or concerns of non-criminal nature. Throughout the PSNI investigation the Trust did also act on any concerns raised regarding staff and these were addressed immediately by the Investigation team, and I understand that no actions remain outstanding.

The Trust has also over this period improved the ward environment, invested in new fixture and fittings and continued to review staffing ratios within the ward. Further quality improvements are planned over the coming weeks as outlined in recent Quality Improvement Plans submitted.

I trust the above information fully addresses the issues raised and wish to apologise again for the delay in providing this response.

Yours sincerely

J Veitch (Mr)
Co-Director of Learning Disability Services

Minutes of Adult Safeguarding Case Conference held on 5/7/13 Re: Ennis Ward

Present:

Aine Morrison, (Chair) Service Manager; Community LD Treatment and Support Services, Belfast H&SC Trust

John Veitch, Co-Director; Learning Disability, Belfast H&SC Trust

David Nesbitt, Care Manager; Resettlement, South Eastern H&SC Trust

Esther Rafferty, Service Manager, Muckamore Abbey Hospital, Belfast H&SC Trust

Moira Mannion, Co-Director of Nursing: Education & Learning, Belfast H&SC Trust

Patrick Convery, RQIA; Mental Health & Learning Disability

Constable Tracey Hawthorne, PSNI, PPU Antrim

Sergeant Elaine McCormill, PSNI, PPU Antrim

Carmel Drysdale, Team Leader; North Belfast Community Learning Disability Team, Belfast H&SC Trust

Colette Ireland, Team Leader; East Belfast Community Learning Disability Team, Belfast H&SC Trust

Teresita Dorman, Co-ordinator for Resettlement, Northern H&SC Trust

Apologies:

Carol Veitch, Operations Manager, South Eastern H&SC Trust

Siobhan Rogan, RQIA

Copies of the draft final report were circulated. As not everyone was able to read the report in advance of the meeting, it was agreed that they would take this away for further consideration.

Mr Veitch emphasised the confidential information in the report which is extremely sensitive and should be held securely.

As police officers Elaine McCormill and Tracey Hawthorne were unable to stay for the full meeting, the following issues relating to police matters were discussed.

Tracey Hawthorne advised that the outcome of their investigation remains with the PPS. They have asked that the case is prioritised but by yesterday afternoon they were advised that no prosecutor had been assigned to the case. Tracey Hawthorne has kept the patients' relatives informed and they will be notified directly by PPS regarding outcomes. Mr Veitch asked that pressure is kept on this process as public money is being spent with staff members remaining on suspension. Mr Veitch raised the question whether the disciplinary process can start pending an outcome of police proceedings. Mr Veitch asked that Mrs Rafferty would convene a meeting with the Trust's Human Resources Department to discuss proceeding with the disciplinary process. Police representatives

left the meeting. They took away a copy of the report and agreed to come back to Ms Morrison if they have any issues.

Ms Morrison advised that the focus of the rest of the meeting would be the conclusions and recommendations section of the investigative report.

There was general agreement that there hasn't been enough time to go through the report in detail prior to the meeting. It was agreed that there would be the opportunity to do this following the meeting with the agreement that individuals would come back in two weeks with any questions or issues.

Ms Morrison advised that there is one investigative interview outstanding with P10 [redacted] a patient on Ennis Ward. One of the difficulties has been that the speech and language therapist is not available during July. This interview will be completed as soon as the speech and language therapist becomes available.

Issues arising from the report:

- Section 1- The date of the original report is wrong. Also Mr Convery queried what was meant by 'visiting staff'. This was defined by Ms Morrison as 'staff from other facilities involved in the resettlement of patients'
- Section 2-Interviews with patients and staff. One patient (referred to above) to be interviewed. Page 10 interview with [redacted] H197 was noted to be missing.
- Recommendations & Conclusions. The following issues were raised:

Mrs Rafferty asked why Bohill management had not passed on any concerns during meetings with the hospital resettlement team. Their reports to hospital management team were that the introductory process was going well. Ms Morrison advised that staff had not been feeding back their experiences on the ward to their management. Mr Convery reported that RQIA have also addressed the failure to report with Bohill management.

In relation to Point 2, last paragraph Ms Mannion advised that referrals about concerns had been made by ward staff during this time period which had been investigated. Ms Morrison noted that while monitoring staff had raised environmental concerns, she had no records of any care concerns being raised by staff prior to the allegations being made. The one report of a care concern made in May 2012 was made by daycare staff, not ward staff.

Mr Veitch raised a number of issues. This has been a comprehensive investigation which has dealt with a broad range of issues which were not part of the original allegations but arose during the interviews with Bohill staff. Mr Veitch sought clarification about the outcome of the investigation. While this is clear in relation to the two members of staff investigated by police, Mr Veitch asked about the outcome of the investigation in relation to the other allegations made. The report refers at various points to 'no conclusions drawn'. Mr Veitch queried if this meant that there was no evidence to substantiate the other allegations. Ms Morrison stated that while no new evidence had arisen during the investigation to substantiate the allegations any

further, the investigating team had felt that the Bohill staff statements had credibility. This was based on the number of accounts, the consistency of the allegations and the level of detail contained in the Bohill staff interviews. The investigating team felt that while they could not make a definitive judgement about many of the allegations, the evidence of the Bohill staff team was significant and carried weight.

In relation to the issue of ward staff stating that they were unaware of the allegations made by Bohill staff, Mrs Rafferty advised that these have been recorded on individual patient files on the ward which staff have access to. Mr Veitch advised that further consideration needs to be given to what information can be shared and what needs to remain confidential. The example given is information pertaining to the two staff members subject to police proceedings.

Mr Veitch raised a further issue in relation to the work which has been ongoing over the past eight months while the investigation has been ongoing. Hospital staff have been working closely with RQIA staff and senior nursing to implement an improvement plan. Mr Veitch felt that it was not clear from the report e.g. staff interviews what the situation was before November 2012 and since the improvement plan has been implemented. Ms Morrison said that these distinctions were made during the interviewing process and agreed to make sure any necessary distinctions were contained in the final report.

It was noted that ward staff have raised other issues which were not felt to fall into the remit of the safeguarding investigation. It was agreed that the report needs to identify these and indicate how they were dealt with.

There followed discussion about whether there was any evidence of a culture of bad practice. Ms Morrison advised that the conclusion reached by the investigation team was that there was enough to warrant a considerable level of suspicion although she did note that Bohill staff also identified good practice by ward staff which would suggest that any poor practice was not totally widespread. Ms Mannion advised that there were enough things needing to be corrected to suggest that there may have been cultural deficiencies. David Nesbitt advised that we need to acknowledge that there is a context within these wards which visiting staff need to be aware of. The example given was [redacted]ister reporting that she observed a patient in a state of undress. Some of the patients display this type of behaviour on a regular basis. Ms D concurred with the concerns raised. Ms Mannion stated that there is zero tolerance of ward conditions not being maintained. The example given is that if curtains are pulled down they should be fixed immediately. Mr Veitch advised that any concerns raised must be taken seriously and investigated.

Point 4-Environmental concerns. Ms Rafferty advised that there has been a review of the ward environment and RQIA have also carried out environmental checks.

Mr Veitch concluded the discussion. This has been an extensive and thorough investigation and the hospital team are indebted to the staff who carried out the investigation. It has been eight months since the investigation commenced and robust management action has been taken in response to any concerns.

The final report will need to take into account the improvements which have already been put in place.

It was agreed that advice would be taken from the PSNI and HR about what information arising from the investigation could be shared with staff.

Ms Mannion and Mrs Raffetry will also liaise with HR about commencing a disciplinary investigation.

RQIA inspectors have visited the ward on three occasions since November 2012, most recently at the end of May2012 and improvements were noted. Mr Convery queried a statement made on Page 16 which was a report by a staff member that RQIA had identified the ward as an example of good practice. Mr Convery did not feel that this had happened. Ms Morrison agreed to look at this issue further.

Ms Morrison advised that the investigation found no safeguarding concerns in relation to the ward manager.

Review of care and protection plan:

1. Staff suspensions will remain. Mrs Rafferty and Ms Mannion will follow up with Human Resources and Ms Morrison will check with police whether the internal investigation can proceed.
2. It was agreed that the 24 hour monitoring should be stepped down with immediate effect.
3. Ms Mannion advised that the senior nurse management team will continue with monitoring visits, a minimum of twice weekly to support staff and address ongoing improvements.
4. All parties were asked to come back within two weeks regarding any inaccuracies in the report.
5. This is the conclusion of the investigation. The investigation team will finalise the recommendations including improvements which are already in place and which need to happen.
6. A final report will be circulated with a final action plan. This will be reviewed under adult safeguarding procedures when closure of the investigation will be considered.
7. Feedback to ward staff will be given jointly by the hospital and investigation team. Ms Morrison and Mrs Rafferty will take this forward in August / September.
8. Feedback will be given to families when the report is finalised. Ms Morrison has been providing updates throughout the investigation. Police have also maintained contact with the families. Families are keen to know the conclusions.

Aine Morrison

Adult Safeguarding Case Conference held on 28th October 2013 Re: Ennis Ward

Present

Aine Morrison, (Chair) Service Manager, Community LD Treatment and Support Services, Belfast H&SC Trust

Teresita Dorman, Co-ordinator for Resettlement, Northern H&SC Trust NHSCT

Colette Ireland , Team Leader, Team Leader, East Belfast Community Learning Disability Team, Belfast H&SC Trust

John Veitch, Co-Director, Learning Disability, Belfast H&SC Trust

Moira Mannion , Co-Director of Nursing: Education & Learning Disability, Belfast H&SC Trust

Rosaline Kelly, RQIA, Mental Health & Learning Disability

Esther Rafferty , Service Manager, Muckamore Abbey hospital, Belfast H&SC Trust

Constable Tracey Hawthorne, PSNI, PPU Antrim

David Nesbitt, Care Manager, Resettlement, South Eastern H&SC Trust

Carmel Drysdale, Team Leader, North Belfast Community Learning Disability Team, Belfast H&SC Trust

Today's meeting was convened to discuss the conclusions and recommendations following the adult safeguarding investigation in Ennis Ward.

This meeting was chaired by Ms Morrison.

Ms Morrison invited introductions from the group and outlined the agenda for today's meeting:

- Review of recommendations and conclusions made by the investigation team
- Discussion regarding updates to families/relatives of service users named in the investigation
- Update on the police investigation

A written report was provided by the investigation team which should be read in conjunction with this minute.

Ms Morrison updated that since our previous meeting held on 5/7/2013, when a draft investigation report was shared, comments were received, amendments were made and the report was emailed to the meeting participants. No feedback/issues were received in relation to the amended report.

The group reviewed the conclusions/recommendations starting on page 65 of the investigation report:

1. Disciplinary Investigation

D/C Tracy Hawthorne updated that the PPS have recommended prosecution of two staff named in the investigation – H159 and H197 – on all counts apart from one of the incidents involving P2 [redacted] D/C Hawthorne noted that it could take up to several months before the case would be heard in court.

It was recommended by the investigating team that MAH pursue a disciplinary investigation in relation to the conduct of H197 and H159 Mrs Rafferty updated that a disciplinary investigation by MAH had commenced although it was at the early stages.

Mr Veitch expressed concern in relation to the commencement of a disciplinary investigation in light of the PPU decision to recommend prosecution. Mr Veitch suggested that advice be sought from Human Resources in relation to Trust actions in the first instance before MAH staff were spoken to.

2. Analysis of staff reports

Ms Morrison noted the difficulty for the investigating team in weighing up the very different evidence provided by two staff teams – the team from MAH and the team from Bohill. Mr Veitch acknowledged that whilst it is difficult for staff to come forward and raise concerns about their own practice, it is an expectation of the Trust for all staff no matter where they are working and when. Mrs Rafferty stated that MAH staff had the appropriate training to make them aware of their responsibilities in this regard(ASP/Induction Training/Child Protection/Whistle Blowing etc) Ms Kelly noted that RQIA would expect this training to be in place and that it was an important point to reinforce with staff. Mr Veitch concurred with this and advised that the Trust's view was not different from that of the regulator.

3. - Identification of Muckamore Staff

Ms Morrison noted that the investigating team had some success in identifying other un-named MAH staff from accounts provided by Bohill staff, descriptions of MAH staff from Bohill staff and cross-referencing with duty rotas at the time but it was not possible to identify all of the MAH staff whom Bohill staff alleged were involved in poor practice. Of those ~~unmanned~~ named staff who were subsequently identified, the investigating team believed that there was not enough evidence to warrant disciplinary action against these staff given the lack of other corroboration and their own differing accounts of events.

Mr Veitch raised a concern about the report's statement that there was not enough evidence in relation to these staff and sought clarification about what was meant by the term evidence. Ms Morrison said that the investigating team had considered Bohill staff reports as evidence. Mr Veitch said that he had some concerns about calling uncorroborated reports evidence. Ms Morrison said that investigations often had to consider uncorroborated reports and that in this particular instance, the investigating team had attached some credibility to the Bohill staff reports and felt they did carry

some weight as evidence. There was considerable discussion in relation to having sufficient evidence to support the allegations made.

4. - Environmental Concerns

It was noted by the investigating team that MAH management staff had made minor adjustments to ensure significant environmental improvements and that more major structural changes are planned to improve the layout of the Ennis ward. The investigating team recommended that all hospital wards are reviewed by staff external to the ward to see if any environmental changes were needed. This recommendation was accepted by hospital management.

Mr Veitch suggested that the Band 8A hospital staff could review wards other than their own. Mrs Rafferty also noted that RQIA and senior management staff regularly check wards and that this would be sustained.

5. - Staffing Concerns

The investigating team found that there were significant staffing problems on Ennis ward in the months prior to the allegations being made by Bohill staff. Whilst it was recognised that there was an action plan in relation to the overall staffing crisis throughout the hospital at that time the investigating team recommended that MAH senior management review their response to two specific incidents noted in the report. This recommendation was accepted by hospital management. Mrs Rafferty also added that there are processes in place to check staffing numbers on a daily basis throughout the hospital.

6.-Bohill Staff Induction

There were discrepancies noted in the accounts received from Bohill and MAH staff in relation to the level of induction Bohill staff received. The investigating team made a number of recommendations for the induction of visiting staff and it is understood that the hospital have reviewed their induction practice for visiting staff.

Mrs Rafferty updated that new processes for inducting visiting staff are in place and the investigation recommendations have all been included in the new process. The new induction process also includes an evaluation.

7. [redacted] PS

The investigating team recommended that clear guidance in relation to Ms [redacted] PS support needs be provided to and implemented by all staff who work with her. Mrs Rafferty agreed to check that Ms [redacted] PS care plan had been updated accordingly.

8. - [redacted] P1

The investigating team made a number of recommendations in relation to approved interventions in managing Ms [redacted] challenging behaviours and that all grades of staff are involved in discussions with behaviour support staff. Ennis ward staff have suggested that Ms [redacted] attend day-care on a fulltime basis as her behaviours are less evident in this environment. Mrs Rafferty updated that Ms [redacted] is not at day-care full-time at present but that there is currently work ongoing in relation to resettling Ms [redacted] and that it may not be wise to introduce any change to her routine at present.

The investigating team noted their concern about the support needs of staff who were managing Ms [redacted] challenging behaviours and their recommendation that these be reviewed. This recommendation was accepted by hospital management.

Hospital management accepted the recommendation that the hospital needs to review for any practice on Ennis Ward that could be deemed restrictive.

Mrs Rafferty noted that a successful bid had been made for the input of psychology services into the resettlement wards to look at the specific needs of patients.

9. - Ennis Staff Team Composition

It was noted by the group that the staff team working in Ennis has changed substantially since the investigation and that this was a potential protective factor.

10. – Impact of the investigation

The investigating team recognised the stress to staff caused by the investigation and recommended that further information could now be shared with staff subject to police and HR approval.

Mr Veitch agreed that the staff team were under a significant amount of monitoring/ scrutiny as the investigation was carried out and felt that staff should be provided with detail of the investigation process and outcomes when we had reached our conclusions in relation to the investigation. Mr Veitch also noted the need for staff to keep information shared with them confidential.

D/C Hawthorne highlighted the difficulty in sharing any information in relation to the information that the police are following up on but agreed that a more generic response could be given to the staff team. D/C Hawthorne had no objection to sharing any information that was not subject to police investigation.

Mr Veitch agreed that staff needed to know the nature of the allegations but not the detail and stressed again the need for confidentiality.

Ms Mannion suggested that the sharing of information with staff be discussed with HR in the first instance before the decision was made regarding what information to share with staff.

11. - Staff Skill and Experience

The investigating team recognised the positive comments made by the monitoring staff in relation to the care provided by ward staff since the allegations were made and concluded that the current ward staff have both the skill and experience needed to provide good quality care to service users.

No further concerns were noted

12. - Adult Safeguarding Training

Mrs Rafferty updated that all staff grades have been referred to complete this training.

13. - Management at Mealtimes

No further concerns/recommendations noted

14. - Access to a full range of services by re-settlement patients

Mrs Rafferty updated that the introduction of other professional services has commenced in Ennis Ward.

It was noted by Mr Veitch that the definition of re-settlement indicated that there was no further treatment required for patients. However time delays in finding suitable resettlement accommodation could not be overlooked and there may be times that resettlement patients require additional professional intervention.

Mr Veitch acknowledged the very thorough investigation carried out and highlighted the very intense monitoring process which showed no evidence of institutional abuse.

Ms Mannion noted that the monitoring process had been stepped down as there was no concern about institutional abuse.

Ms Morrison stated that while the monitoring reports confirmed no evidence of institutional abuse post the allegations being made, she did not feel that this could be necessarily generalised to the period before the allegations were made. Ms Morrison re-iterated the conclusions in point two of the recommendations and conclusions section of the report and felt that this summed up the best judgement that the investigating team could form. Ms Morrison did not feel that the investigation was conclusive enough to be able to state categorically that there had not been institutional abuse. Ms Kelly concurred with Ms Morrison's views that it had not been possible to reach a conclusion on

whether or not there had been institutional abuse. She also stated that RQIA felt there was enough evidence to justify at least some concern about wider practice on the ward.

Mr Veitch said that he felt that it was important that we did not speculate but only draw conclusions on evidence. Ms Morrison said that she felt the conclusions of the report were based on evidence and on the professional judgements made by the investigating team based on that evidence.

Mr Veitch asked to review minutes of previous discussions for any discussion on institutional abuse before the case conference would conclude on this issue.

Updates to relatives

The group agreed to discuss what information can be shared with relatives and disciplinary action when they meet with HR.

Tracy confirmed that the police will speak to the relatives of those service users where prosecution is being recommended

Outcomes

1. Meeting to be arranged with HR to discuss information sharing with staff/relatives of service users and disciplinary action by the hospital.

2. Police to provide updates to the relatives of service users where prosecution is being recommended in relation to allegations against their relatives.

3. Protection plan relating to staff suspension to continue.

4. Further meeting arranged for 20th January @ 3:00pm in MAH.

Aine Morrison

Minutes of Adult Safeguarding Case Conference held on 8/4/14 Re: Investigation into concerns arising in November 2012 regarding practice on Ennis Ward.

Present:

Aine Morrison, (chair) Service Manager Community Treatment and Support Services, Belfast H&SC Trust

John Veitch, Co-Director for Learning Disability, Belfast H&SC Trust

Ester Rafferty, Service Manager, Muckamore Abbey Hospital, Belfast H&SC Trust

Siobhan Rogan, Senior Inspector, RQIA

Constable Tracey Hawthorne, PSNI, PPU Antrim

Carmel Drysdale, Team Leader North Belfast Community Learning Disability Team, Belfast H&SC Trust

Colette Ireland, Operations Manager Community Treatment and Support Services, Belfast H&SC Trust

Teresita Dorman, Co-ordinator for resettlement, Northern H&SC Trust

Aine advised that the purpose of this discussion was to:

1. Obtain an update on the police investigation
2. Review the conclusions and recommendations from the investigative report
3. Discuss feedback to relatives.

Police Investigation:

Constable Hawthorne advised that the PPS were proceeding with a prosecution of two staff members. This was up in court for mention on 1/4/14 and adjourned. Aine advised that the legal representatives for the defence asked for an adjournment and are requesting a lot of information.

DLS intend inviting them in to identify what information they wanted and intend to advise them to seek a court order to obtain this.

Ester confirmed that the information requested from the hospital was being prepared and should be with Aine by Friday or Monday of next week.

Constable Hawthorne advised that there had been no date set for re-convening the hearing but it is usually a six week adjournment.

Constable Hawthorne stated that she has spoken to the relatives of patients and provided full details of the allegations made against the staff members as this information is now in the public domain and has been published in local newspapers. Constable Hawthorne will be keeping them informed of future court dates and will keep Aine informed about contact with nearest relatives.

Review the conclusions & recommendations:

Discussion followed on issues which were ongoing at the time of the last meeting

Point 1: Disciplinary Investigation:

Ester provided an update on the disciplinary investigation. Two senior managers Rhonda Scott, from Muckamore Abbey Hospital and Geraldine Hamilton from a mental health background have read all the information including staff rotas etc and will be starting to interview staff. Ester has received some communication from Trade Union representatives advising that they do not wish to participate until the court hearing is completed. It has been explained that this is a separate investigation system which is taking place under disciplinary procedures. Dates for interviews have been sent and staff are advised that they are attending to clarify issues arising from interview statements already made during the adult safeguarding investigation. Ester advised that the communication via Trade Unions has delayed the disciplinary investigation but this is proceeding and is well underway.

John asked if it was anticipated that all staff would be re-interviewed. Ester felt that only those witnesses would be interviewed where it was felt that clarification was required around what lead to particular situations. Ester advised that it has been made clear to staff that they have to participate. Some ward staff have been approached by legal representatives for the defence to attend court as witnesses.

Point 4: Environmental concerns:

Ester advised the senior management on the hospital site continue to do walks around and visit the wards. Operation Managers also do visits to other wards as well as the wards they have managerial responsibility for. Ester advised that for some wards which are due for closure the cost of a full refurbishment cannot be justified and they are prioritising these wards for closure through re-settlement.

Ester advised that the minimum standards for privacy and dignity are being met in all wards. Aine stated that there were concerns in Ennis Ward which couldn't wait. Ester advised that in all of the wards where there is a dormitory-like environment, privacy screens have been put in place. This has been a challenge but minimum standards for privacy and dignity has been achieved.

Siobhan advised that RQIA inspectors will be on all of these wards within the next two months a part of the quality improvement plan. Siobhan stated that the provision of single rooms and en suite facilities is not feasible for wards that are closing in six

months time. Patient experience interviews will be carried out by RQIA in the next two months.

John stated that environmental issues had been identified by RQIA in the Quality Improvement Plans and these have been responded to and largely completed to the acceptance of RQIA.

Point 5: Staffing concerns:

Aine stated that it had been agreed that senior management would review the response to the two untoward incident reports made in relation to staff shortages. Ester confirmed that this had been taken forward. An escalation of concern in September and October 2012 was noted and raised with Ester. Meetings took place and the action agreed was to move forward with ward closure. The closure of Finglass Ward took place.

Aine asked about the response to the two specific incidents reported by the ward manager. Ester stated that it was part of the escalation of concern about staffing levels as outlined above. There was a report made to RQIA at the time about what actions had been taken to ensure safe staffing levels.

John advised that there is a robust recording process to ensure concerns are addressed. Ester advised that she was able to highlight and identify the process used for addressing this. All incidents were taken seriously and formed part of the overall problems with staffing levels at the time. The duty system record has this information and has also recorded situations when they were unable to access additional staffing. Action: Ester can provide this information.

Point 6: Induction of external staff:

Ester advised that all recommendations have been implemented.

Point 7: P43

P43 has been resettled from the hospital to Armagh. Ester confirmed that her support needs in relation to going out and sitting outside on the grass were reviewed and clear guidance established and implemented by all staff.

Point 8: P39

P39 has been resettled from hospital to Armagh.

Ester confirmed that any practice which could be restrictive has been reviewed as part of care planning. Processes are more robust about documenting and recording restrictive practices. Ester was not able to say how many restrictive practices were in place as these are recorded on individual care plans. All care plans have been updated. All restrictive practice and deprivation of liberty are recorded on the care

plans. All staff have had training on deprivation of liberty and are advised of further training opportunities. Siobhan advised that RQIA will be reviewing these.

Point 10: Impact of the investigation:

Ester and Aine met with the staff group from Ennis. Information was shared, although in relation to particular staff members. Written information was to be provided for staff however Ester explained that this had been delayed as HR had advised not to share this until the internal investigation is complete. Staff were angry and upset during the meeting and Ester advised that they remain upset and angry.

Siobhan asked what the anger related to. Ester reported that staff felt they have not been made aware of all the allegations. Siobhan felt that it was important that staff are made aware of the allegations. There is court action and that these things happened.

Aine stated that she got the feeling that staff didn't believe. Ester felt that they disbelieved that Bohill staff couldn't identify staff when they had been working with them.

Tracy raised concern about the attitude of staff if actions reported by Bohill Staff were not deemed to be of concern.

Ester felt that this was not the case and that staff have reported concerns. Staff understand safeguarding and the requirement to report.

Aine did not agree and she stated that had concerns.

John felt this was open to debate and doesn't add to the investigation, opinions are not evidence.

Siobhan asked if there were any current concerns about practice. Ester stated no. Ennis has now officially closed and amalgamated with Erne.

John confirmed that the independent monitors were positive in their reports and had no concerns. Ester confirmed this. Aine felt that the monitoring did show that staff did know what good practice was. A protective factor was the mix up of the staff group with new staff coming on to the ward.

John advised that there has been no other evidence to inform current perceptions about the ward.

Point 12: Adult safeguarding training:

Ester confirmed that all adult safeguarding training has been updated.

Information to relatives:

There followed discussion about what further information needed to be shared with relatives at this stage. For the relatives of the four people where there were specific allegations, they are being kept informed by police and kept up to date about the court process. For the relatives of the other patients, they have been kept informed of the course of the investigation, when the police concluded and the Trust investigation commenced. It was agreed that a general update is required particularly as families will be very aware of the media coverage.

Action agreed: Aine will prepare the information and circulate for agreement. Further discussion will be required with the other Trusts involved about how this will be delivered.

Conclusions:

The adult safeguarding investigation is concluded.

There is an ongoing protection plan in place. The two staff members remain suspended.

Court proceedings are ongoing and the disciplinary investigation has commenced.

It was agreed that this meeting should be re-convened if there is any change in the protection plan.

Aine Morrison

Designated Officer

TERMS OF REFERENCE

In relation to

Allegations of abuse of 7th November 2012 within

Ennis Ward, Muckamore Abbey hospital of patients by Staff

•To investigate the following matters regarding the treatment of patients in Ennis ward following a complaint of alleged abuse of patients by staff received from a visiting staff member from Priory Group.

•To investigate that managerial processes, had been adequately managed in a safe manner concerning the day to day running of staff rosters, the daily activities of the ward and the environment requirements, prior to the Vulnerable Adults Investigation.

•To immediately report to the Trust any matter which may undermine the objectivity or robustness of the investigation. Referring any issue of concern, not directly relevant to the terms of reference, to the appropriate senior manager for action as appropriate.

•To make recommendations on what action if any should be taken in relation to the matters investigated. This should include a recommendation on whether the case should be referred to a disciplinary hearing.

Belfast Health and Social Care Trust

Ennis Report

Investigation into alleged incidents reported on 8th November 2012 In Relation to H159

CONTENTS

List of Appendices

1. INTRODUCTION

In July 2013 Esther Rafferty, Service Manager, Learning Disability commissioned Rhonda Scott, Senior Nurse Manager, Learning Disability Manager and Geraldine Hamilton, Service Improvement Manager, Mental Health and Learning Disability to undertake an investigation into incidents alleged to have taken place within Ennis Ward involving Belfast Trust employee H159 These allegations were reported to RQIA on 8th November 2012 by the manager of the Priory Group, Bohill Care Home who had staff working on the ward as part of the resettlement programme for patients who were moving to the Bohill.

A joint Adult Safeguarding Investigation started immediately between the PSNI and the Belfast Health and Social Care Trust. This report details an internal investigation which followed the Adult Safeguarding Investigation and draws on information from the subsequent report which was completed in October 2013.

2. TERMS OF REFERENCE

1. To investigate allegations of abuse of vulnerable adults reported as safeguarding concerns raised in relation to H159 Band 3 Health Care Worker whilst working in Ennis ward in October and November 2012.

In addition the investigation team must:

2. Consider any other issues of concern relevant to the investigation.
3. Report any other matter which may undermine the investigation or any issues of concern not relevant to the terms of reference to the appropriate senior manager for action.
4. To make recommendations including referral for disciplinary action.

To support the investigation process the investigators were provided with:

- Witness statements
- Adverse Incident/ Accident Reports
- Minutes of Ward Meetings and Resettlement Meetings
- Adult Safeguarding Report with related interviews and minutes of meetings
- Briefing Reports post allegations by Moira Mannion, Co-Director, Education & Learning
- Duty Rotas (including rosters for Bohill Staff (Appendix 21) who worked on Ennis Ward)
- Shift Planner
- Daily Ward Reports
- Vulnerable Adult Referrals

- Patients notes/Care Plans
- Medical Files
- Day Care Attendances
- Access to interview Ennis staff and Bohill staff who were still available

NB: B2 (Bohill) not available during entirety of investigation and declined to be interviewed when contacted via PSNI on 1st August 2014
B3 (Bohill) not available during entirety of investigation
B8 (Bohill) unable to contact
B9 (Bohill) unable to contact
B10 (Bohill) unable to contact
B1 (Bohill) did not attend for interview in spite of pro-active attempts to accommodate
H198 (Ennis) no longer a Trust employee, declined to be interviewed but provided written statement (Appendix 2)
H870 (staff on relief to Ennis on the 7th November 2012) no longer a Trust employee, declined to be interviewed but provided written statement (Appendix 3)

The following Bohill staff also worked on Ennis during this period. These staff made no allegations or raised any concerns during their time on Ennis but have since left the service and no contact details were available:

B11
B12
B13
B14

- Access to interview Ward Manager (Appendix 4) on Ennis during this period and Senior Nurse Manager responsible for Ennis Ward, Muckamore Abbey Hospital (Appendix 5)
- Access to interview Bohill staff, B4 (Appendix 6), B7 (Appendix 7), B5 (B5 (Appendix 8) and B6 (Appendix 9) who worked in Ennis at the time of the allegations.
- Access to interview H197 (Appendix 10), Bank Nurse and H159 (Appendix 11) Health Care Support Worker who were named in the allegations.
- Access to interview H205 (Appendix 12), H869 (Appendix 13), H203 (Appendix 14) and H206 (Appendix 15) Health Care Support Workers who worked in Ennis at the time of the allegations
- Access to interview H196 (Appendix 16) Student Nurse on placement in Ennis at the time of the allegations.
- Access to interview Moira Mannion, Co-Director, Education & Learning

- Access to interview Aine Morrison, Senior Officer, Adult Safeguarding Investigation Team and lead author of Adult Safeguarding Report

SCOPE OF INTERVIEWS

The interviews covered the themes below – with specific adaptation for those involved in the allegations:

- Induction processes
- Training
- Staffing (numbers, attitudes, team working, morale)
- Supervision
- The Environment (Physical and General Atmosphere)
- Resources
- Summary of allegations from Adult Safeguarding Investigation (Appendix 1)
- Reporting processes

1. ADDITIONAL EVIDENCES

- Duty Rota – confirmed all involved in investigation worked in Ennis (allegations as per Adult Safeguarding Report state the alleged incidences occurred between **9th October and 7th November 2012** – same information elicited and confirmed from interview with B4 (Bohill) 19th May 2014.

- Allocation Book – Inadequate skill mix on ward at time of allegations. Skill mix 60% unregistered: 40% registered staff; this was further reduced by registered nurse sick leave. No clear allocation of duties – this was corroborated in subsequent staff interviews. Clear evidence in Duty Allocation Book that the responsibility for the patients at the lower end of Ennis (where incidents were alleged to have taken place) was mostly with unregistered staff.

- Adverse Incidents/ Accident Reports – no evidence of under reporting; all correlated with entries documented in patient notes, daily ward reports and care plans. An increase in incidents was also noted from November 2012 until February 2013 – this correlates with a monitoring rota which was implemented post allegations (Appendix 17). Staff noted in interviews that the monitoring in itself was disruptive to the patients and this may have had a bearing on these statistics.

- Day Care Attendances from Ennis (Appendix 18). This information highlighted a significant number of cancelled Day Care places during the period the alleged incidents took place. These cancellations added additional pressure to a ward that was already short staffed. The attached attendance report also highlights staff shortages in Day Care Services around this time

- Minutes of Resettlement Meetings (Appendix 19)

FINDINGS

This was a complex and lengthy investigation. The Terms of Reference as noted above required the investigating team to look at the whole system i.e. the context of Ennis Ward within the wider Muckamore Abbey Hospital site, the managerial processes on the ward, staffing, practices and individual patient needs. All interviews are attached and conclusions/ findings are summarised under each term of reference as follows:

2. **To investigate allegations of abuse of vulnerable adults reported as safeguarding concerns raised in relation to H159 Band 3 Health Care Worker whilst working in Ennis ward in October and November 2012.**

The allegations listed below are from the Adult Safeguarding Report. For ease and consistency of reference the allegation numbers correspond to their chronological order in the Adult Safeguarding Report.

1. **H159 – MAH Staff – pulled P39 (patient) from the sofa P39 was sitting on, by the hem of her trousers, onto the floor and was verbally condescending (Source: B2, Bohill Staff)**

H159 interviewed re allegation. H159 stated that at no time did she or did she ever witness staff push or pull P39 by any item of clothing, she has denied this allegation. She confirmed that staff needed to be assertive and due to the noise levels in the environment you had to raise your voice to be heard, she said that at no time did she ever shout at patients.

H197 interviewed re the allegation. She confirmed that staff did not shout but would have used a firm tone with her (P39) when she was about to hit another patient to prevent her continuing with this behaviour, P39 responded to this firmer tone and it would have prevented her from hitting another patient. H197 stated that she had not witnessed staff push or pull P39 by any item of clothing. Staff would have turned P39 away from an area by putting their hands on her shoulders and turning her away.

B7, B5 and B6 (Bohill) all interviewed and stated that they had not witnessed staff pull P39 by items of clothing or use abusive language to the patients.

H206, H205, H869, H203 Band 3 Support Workers within Ennis, H491 H491 Ward Sister of Ennis and H196 Student Nurse on placement in Ennis at this time all interviewed. All staff stated that they had not raised any issues regarding any staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that they were not comfortable with.

Investigating team unable to interview B2 (Bohill staff), B1 (Bohill Manager) and H870 (Staff on relief to Ennis) however, H870 declared in her statement that she had not seen anything untoward during her time in Ennis.

The investigating team concluded that the allegation made by B2 could not be substantiated.

2. **H159 MAH Staff, spoke in an inappropriate manner such as, 'get out of my way'/you're doing my head in', to patients in general. (Source: B2 Bohill Staff)**

H159 interviewed re allegation. She confirmed that staff needed to be assertive and firm to be heard in the noisy and challenging environment but she denied shouting or speaking to any patients in an inappropriate manner.

Other relevant staff interviewed re: this allegation and responses as follows:

H869 interviewed, Question 6, response: *"I have never heard staff shout or use aggressive language. Staff would have lifted their voices because of the noise levels within that area. Patients P202 , P43 and P41 could be very vocal and it could be hard to be heard."*

H206 interviewed, Question 6, response: *No*

H203 interviewed, Question 6, response: *"Not shouting at her, staff may have used a firmer tone if P39 was displaying Challenging Behaviour."*

H196 interviewed, Question 10, response: *No*

H205 interviewed, Question 6, response: *"Not in a raised voice but in a firm voice when P39 was displaying her behaviours. This was not in an angry way."*

B7 B6 and B5 staff from the Bohill interviewed and all stated that they had not witnessed staff speak to patients inappropriately or use abusive language.

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) H198 (Ennis) and H870 (Staff on relief to Ennis) however H870 declared in her statement that she had not seen anything untoward during her time in Ennis.

The investigating team concluded that the allegation made by B2 could not be substantiated.

3. **H159 MAH Staff, hit P40 (patient). P40 observed coming from the bathroom naked screaming and shouting "I hate her. I hate her, I hate H159 H159 she hit me". P40 very distressed and blood was coming from her mouth. (Source: B2 Bohill Staff)**

H159 interviewed. Question 8, response: *"the ward was short staffed; I was there on my own. I decided to start self-care earlier than usual straight after tea. I did not change P40 P40 she was in the toilet having a bowel movement and was screaming and yelling. I heard her I did not see her. Student Nurse H196 came to help after 10 mins with the patients self care. I started changing the girls between 6.15pm and 6.30pm and bringing them to the dayroom. At 7pm I finished, locked the bathroom door and commenced the patient's suppers. Patient P43 was soiled so I took her to the bathroom. Student Nurse H196 brought patient P40 to the bathroom, she was naked. B2 came down to the bathroom when I was changing P43 I asked her to get fresh pyjamas for P40 P40 and then take her back to the dayroom. I did not see blood and I did not complete P40 P40 s oral hygiene that night. No staff had made me aware of anything P40 had said that evening."*

Other relevant staff interviewed re: this allegation and responses as follows:

H196 interviewed. Questions 4, 5 6, 7, and 8:

Question 4, response: *"I was in the front office of the ward reading care plans this was to help me do management plans, I worked a PM shift that day. I was asked to give a hand to put away laundry in the back of the ward. Later on I was at the front of the ward with a patient. I spent most of the shift in the office going over care plans. I was down back of ward putting away laundry I put slippers on one of the girls I cannot remember the patients name or time. I cannot remember anything else."*

Question 5, response: *"Can remember the staff from the Bohill but cannot recall her name. Conversation was that it was* B2 *s first day.* B2 *had stated that she had applied for nursing but did not get in. Cannot remember* B2 *asking for assistance."*

Question 6, response: "*No*"

Question 7 response: "*No I cannot remember*"

Question 8 response: "*No I cannot remember*"

H197 interviewed re: allegation. Question 8, response: *"I was in the day room and then went with the Student Nurse to administer an enema on patient* P41 *,* P40 *was in the day room Student Nurse went to get pyjamas for her. I did not change any patients that evening.* P40 *alleges these things all the time. I do not recall as she says these things all the time."*

H196 called to attend a second interview 2nd June 2014.

Question 1, response: *"I took laundry down to the back area of the ward. I put slippers on a patient."*

Question 2, response: *"I cannot remember the patients' names"*

Question 3, response: *"Yes I did help with bedtime changes but do not remember who"*

Question 4, response: *"Cannot remember"*

H869 interviewed, Question 6, response: *"No never."*

H206 interviewed. Question 5, response: *"Yes ,* P40 *would say this about other patients never heard her say this about a member of staff."*

How was this addressed? Response: *"If we had not witnessed anything we would have reported this to the Nurse in Charge."*

H203 interviewed. Question 5, response: *"Frequently alleged that other patients had hit her e.g.* P44 *or* P43 *If she said that* P43 *had hit her then this would be true".* H203 H203 did not think that P40 ever alleged that staff had hit her. When asked how her behaviours were addressed she responded: *'*P40 *would be comforted by staff a bit like when you sooth a toddler. We would have reported this to the Nurse in Charge or another trained staff member that day."*

H205 interviewed. Question 5, response: *"Yes, but about patients only not staff. Heard her say patient* P43 *had hit her but this patient was not in the area at the time she was in the garden area. Patient* P40 *was coming from the bathroom on that occasion.* P40 P40 *would have alleged this a lot." When asked how this behaviour was addressed she responded: "I asked patient were she had been hit and I identified that the patient was not on the ward at the time."*

Sr H491 interviewed. Question 10, response: *"Patients* P197 *and* P40 *make allegations, this should be in their care plan. Patients who strip should have this in their Care plans"*

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) and H870 (Staff on relief to Ennis). However, Mrs H870 declared in her statement that she had not seen anything untoward during her time in Ennis

H196 Student Nurse on Ennis ward at this time was unable to provide any further information regarding this allegation. Staff in Ennis gave varying perceptions as to whether P40 P40 would make allegations regarding staff; H205 H203 H206 and H869 stated they had not heard her say this about staff. Sr H491 stated that P40 would make allegations and that this should have been documented in her care plan. The investigation team examined P40 s care plan and there is reference that she does make allegations but does not state if this is against patients and/or staff.

P40 was referred to the Dentist immediately following this incident and it was noted that she had an abscess in her mouth at the time. It is probable that the alleged bleeding coming from P40 s mouth was caused by the abscess.

H159 has denied that she carried out personal hygiene with P40 on this evening and has stated that Student Nurse H196 worked with P40 H197 during interview stated that Student Nurse H196 went and got pyjama's for P40 Student Nurse H196 stated during second interview that she did assist with getting the patients ready for bed that evening but cannot state who she worked with.

In relation to the allegation made by B2 above, the investigation team were unable to substantiate the allegation.

11. H159 MAH staff, entered the day room where there were two patients, shouting something like 'would you behave, that's enough'. (Source: B2 Bohill Staff)

Refer to allegation 2.

The investigating team concluded that the allegation made by B2 could not be substantiated.

17. H159 MAH Staff, told Bohill Staff they could not bring P43 (patient) in from where she was sitting outside on the wet grass or get her something to sit on. (Source: B3 or B4 Bohill Staff)

B4 s confirmed in her interview that this incident had occurred. When asked who the staff was she responded: 'H159 *I think was her name."*

When asked who the patient was she stated: P39 "

She was asked to describe the clothing the patients had on and responded: P39 *was wearing a hoodie and Jeans."*

When asked if she made any attempt to bring the patient back in she responded: *"No* B3 B3 *brough her back in immediately I did not say anything."*

B7 B5 and B6 (Bohill) interviewed. Responses: No issues/ concerns raised by any of these staff.

H159 interviewed re: allegation. Question 13, Response: *"No, P43 likes to be on her own and loves the garden she sits in the same area all the time. P43 was able to get back into the ward by the door but generally staff had to go and get her to bring her back in. P43 would have become agitated or self-injurious if she wanted out to the garden. P43 P43 was only out in the garden if the weather permitted this and was observed by staff. P39 P39 did not go out unless staff were with her she was never put out."*

H197 interviewed re: allegation. Question 18, Response: *"P43 loved out in the garden. All the patients liked this area and used it in the summer. P39 was never outside unless staff was with her. The door was always open. If there was no staff outside patients would have come inside, only out there when staff was out there. There are tables and a swing out there."*

H205 and H869 from Ennis were asked if there was scope for patient engagement in activities apart from day-care. Both staff stated that the garden was used.

Anomalies identified by Investigating Team in relation to the above allegation as follows:

1. Timeline discrepancy to be accounted for as this allegation is similar to allegation 45 dated the 9th October 2012; however issues/concerns were not reported until the 8th November 2012. The investigation team have checked duty rotas and it was on the 9th October that B4 and B3 worked in Ennis, both of these staff were not on the duty rota for the 7th November 2012. B15 Bohill Manager has clearly stated that she was made aware of concerns/issues on the 8th November 2012 and in resettlement minutes dated 21st October 2012 it states clearly that B1 (Bohill Manager) was in attendance and highlighted no concerns.

2. Weather report checked with the Met Office for the 8th and 9th October 2012. records show that it did not rain on these two days and the moisture content was low.

3. Different patient identified during interview

Investigating team unable to interview B3 (Bohill) or B1 (Bohill Manager).

The investigating team were unable to substantiate this allegation and found some evidence to undermine its validity.

32. Unnamed Staff (described as usually long standing staff) pulling/ dragging unnamed patients off sofa. Example given – female patient had just laid down on sofa when a staff member reached for her feet, swung her legs around and reached for her wrist and elbow and pulled her out of the chair with force. (Source: B10 Bohill Staff)

The interviews conducted questioned staff generally on moving interventions employed and observed.

Refer allegation 1.

H197 (Ennis) interviewed. Question 23, Response: *"P39 - we would place our hands on her two shoulders and turn her around, this was used when we wanted to redirect her and would have been employed daily this was also used with P41 ."*

H159 (Ennis) interviewed. Question 22, Response: *"Covering a patient's elbow or putting your hands on a patients shoulder to redirect them or turn them away. This was used with patients* P39 *and* P41 *"*

The following is an abstract taken from the 2nd Briefing Paper prepared by M Mannion 9th January 2013 (Appendix 22)

"Ergonomics trainer advised that a patient who has their legs in under their body on a chair to manoeuvre their legs to the floor as a first step prior to expecting them to stand or be assisted to stand."

Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigation team were unable to substantiate the allegation however they noted that the description given is in keeping with Manual Handling.

34. Unnamed staff (but including H159) – would reach for P39 (patient) by the shoulders from behind and pull her backwards into a chair, then staff would sit in front of her to stop her moving. (Source: B10 Bohill Staff)

Refer to allegation 1 & 32

Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigation team were unable to substantiate the allegation.

35. Unnamed staff (but described as H159 usually) – would stretch P39 P39 s (patient) T-shirt between her legs and tie it in place. (Source: B10 Bohill Staff)

H159 (Ennis) interviewed. Question 17, Response: Never

H197 (Ennis) interviewed: Question 17, Response: No

H206 H205 and H203 (Ennis) interviewed. Question 9, Response: No

H869 (Ennis) interviewed. Question 9, Response: *"No some of the patients wore vests with poppers at the bottom."*

Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigating team were unable to substantiate the allegation

36. Unnamed Staff (but again described as usually H159) would put P39 P39 's belt on over her clothes, just under her breasts and tie it tight to stop her stripping. B10 Bohill Staff, said to MAH staff that it looked tight but staff said that P39 would be fine. When B10 took P39 to be changed, she would loosen the belt but again when she came back from her tea break, the belt would be tightened again. (Source: B10 Bohill Staff)

H159 (Ennis) interviewed. Question 10, Response: **P39** *can display very challenging behaviours. She is obsessed with food, strips off her clothing, masturbates, will PR herself and smear faeces or attempt to eat this and can be wilfully incontinent throughout the day. These behaviours increase when there are strangers in the ward. She would throw things out the window such as her clothes and toys and pull down curtains.* **P39** *knew that she had to have her clothes on at meal times so would attempt to dress herself if she had striped at these times."*

How were these behaviours managed at ward level? Response: *"Staff tried to amuse* **P39** **P39** *with soft balls, toys that sang or played music, this helped her to behave. Staff constantly redressed her.* **P39** *s behaviours usually got worse between lunch and tea time. New or strange staff was informed not to let* **P39** *grab your hand as she would nip you or pull you around you had to set boundaries with* **P39** **P39** *wore a crop top or swimsuit to prevent her putting her hands down her trousers to prevent her masturbating in the day room. She also wore high waist trousers with a belt to maintain her dignity."*

H197 (Ennis) interviewed. Question 19, Response: *"Environment was restrictive. The space was small for the type of patients in the area. Doors were locked for patient's safety and to prevent accidents. Some patients have distasteful habits and this was to prevent this. Belt was used but this was not used as a restrictive practice it was used to hold up the patients trousers to maintain her dignity."*

Were these written in the patients care plans? Response: *"Do not know. The nurse in charge was aware of all of these."*

H206 (Ennis) interviewed. Question 11, Response: *"Doors were locked on the ward but there was always staff in the area. The door to the garden was locked when all the patients were on the ward. If patients were in the garden then this door was open or wedged open. A swimsuit was used on* **P39** *for dignity as she kept this on after removing her clothes. We were instructed to put on the swimsuit. Belt was used to keep her trousers up and* **P39** *liked to take this off and play with it.* **P39** *could take the belt off and was not considered as restrictive practise as other people wear a belt."*

H205 (Ennis) interviewed. Question 10, Response: *"No staff did not need assistance to put the belt on Tracey she always let you put the belt on her.* **P39** *liked her belt and if she did not have one on she would take staff to her room to get one for her.* **P39** *s weight fluctuated so the belt was needed to keep her trousers up, she felt secure with the belt on."*

H869 (Ennis) interviewed. Question 11, Response: *"Bottom half of ward was locked. Garden area was secure/enclosed. Kitchen was locked. Level 3 observations. Patient* **P43** *has drop attacks and these usually were in the mornings. On occasions she would return to ward from day care in her wheelchair staff would have kept her in her wheelchair with the strap on to prevent injury to herself as she would have been drowsy and unsteady on her feet. Once she was fully recovered staff would take her from the wheelchair. Patient* **P39** *wore a swimsuit and or a vest."*

H203 (Ennis) interviewed. Question 10, Response: *"No you did not need assistance to put a belt on* **P39** *as she liked a belt. The belt was never on too tight so that she could not remove her clothing or that it would leave marks on her."*

B6 (Bohill) interviewed. Question 10, Response: No

B5 **P39** (Bohill) interviewed. Question 10, Response: *"I was commencing night duty and was taken to a chair and a belt was put on quite tightly. One staff was 22 to 23 years of age with different hair colours the other one was older probably in her 40's."*

When asked if she was made aware of how and why this was done she responded: *"I did not say anything as I was not sure if two staff were needed this was the only occasion."*

B7 (Bohill) interviewed. Question 10, Response: *"Cannot remember"*

Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager)

The investigation team concluded that P39 did wear a belt but that the tightness of the belt could not be determined. The investigating team were unable to substantiate this allegation.

37. H159 MAH Staff – said 'thank God you are taking her, she's a pain/ pest/ hard work', referring to P39 (patient). Not known if this was said within earshot of patients. (Source: B10 Bohill Staff)

B6 B7 and B4 (Bohill) interviewed re: this and no issues/ concerns raised by any of these staff.

B5 (Bohill) interviewed. Question 13, Response: *"Nothing bad was said regarding this. I felt part of the Ennis team Staff were friendly and helpful I would apply for a job at Muckamore."*

No reference was made during any of the interviews that comments between staff were derogatory about patients.

Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigating team concluded that the allegation could not be substantiated.

39. H159 – very set in routines – e.g. P39 gets changes at these times only – no need to take her now. (Source: B10 Bohill Staff)

Bohill staff interviewed B7 B5 B4 and B6 did not raise any issues regarding this.

The Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigation team identified that the ward had routines in place to ensure the safe and effective operation of the ward.

The investigating team were unable to substantiate the allegation

49. 9th October 2012 (B3 Bohill Staff also there) H197, MAH Staff (a Bank nurse) and H159, MAH Staff (care assistant). P39 taking her clothes off – H197 got up and grabbed P39, who was wearing a hoodie, at the chest area, said 'get the f* out of my face', and pulled P39 over to the sofa and pushes her onto it. P39 got up again and tried taking her clothes off. She lay on the floor and took her trousers down past her hips. H159 and H197 got out of their chairs and lifted her up, pulled her trousers up, pulled her belt quite forcefully and pulled the belt tightly. H159 and H197 took an arm each and pulled other out of the living room.**

They walked her to the fire doors, opened them, put P39 outside where it was raining and closed the door (no handle on outside). Then they walked away. (source: B4 , Bohill Staff)

B4 (Bohill) interviewed. Question 7, Response: "No I seen two staff pull a patient up from the floor tighten her belt she was wearing, one nurse held her and said to her to get the f*** out of my face and heavily pushed her onto the sofa. One of these staff was called H159 and description of H159 the other staff was blond and called H197 who was banking that day."

When asked how she addressed what she witnessed she said that she did not raise this with any staff in Ennis. When questioned why she didn't speak to other staff in Ennis about this incident she responded: "I did not know these people I was in a new environment. I reported these to my manager B1 at the Bohill the next day, this was then reported to B15 The next thing the CID came to the Bohill to interview me."

When asked she confirmed that she had attended Vulnerable Adults training prior to working in Muckamore and that this was around the second week in September.

She was asked to confirm when she raised this as a concern and how it was addressed and she responded: "I reported this the next day to my manager B1 this was then reported to B15 The next thing the CID came to the Bohill to interview me."

B4 (Bohill) Question 9, Response; "Yes on one occasion I seen staff pull P39 by her hoodie and place her outside in the garden." If so who was this staff member, Response; "Cannot be 100% sure may have been H159 This was the same day I seen staff pull P39 up from the floor."

Both H159 (Ennis) and H197 (Ennis) denied this allegation.

Anomalies identified by Investigating Team in relation to the above allegation as follows:

1. Timeline discrepancy to be accounted for as this allegation is similar to allegation 50 dated the 9th October 2012; however issues/concerns were not reported until the 8th November 2012. The investigation team have checked duty rotas and it was on the 9th October that B4 and B3 worked in Ennis, both of these staff were not on the duty rota for the 7th November 2012. B15 , Bohill Manager has clearly stated that she was made aware of concerns/issues on the 8th November 2012 and in resettlement minutes dated 21st October 2012 it states clearly that B1 (Bohill Manager) was in attendance and highlighted no concerns.

2. Weather report checked with the Met Office for the 8th and 9th October 2012. Records show that it did not rain on these two days and the moisture content was low.

3. B4 during interview with the internal investigation team stated that she thought it was H159 who had pulled P39 by the clothing and placed her outside however in the allegations reported in the Adult Safeguarding it states that B4 had identified H197 and H159 as the staff members who allegedly did this.

4. Meeting 9th October 2012 in Erne with Community Integration Officer, ward sister of Erne ward sister Ennis Care Manager and Dr H194 no issues/concerns raised.

25/10/12 B1 expressed no concerns at meeting with H491

The Investigating team unable to interview B3 or B1 (Bohill Manager).

The investigating team were unable to substantiate this allegation and found some evidence to undermine its validity.

50. 9th October 2012 – P43 (patient) sitting outside on the grass and was soaking. B4 (Bohill Staff) asked H197 (MAH Staff) and H159 (MAH Staff) would she bring her in. H197 said she was alright where she was and that she had a wet suit if it got any heavier. (source B4, Bohill Staff)

Refer to Allegation 49

Anomalies identified by Investigating Team in relation to the above allegation as follows:

1. Timeline discrepancy to be accounted for as this allegation is similar to allegation 49 dated the 9th October 2012; however issues/concerns were not reported until the 8th November 2012. The investigation team have checked duty rotas and it was on the 9th October that B4 and B3 worked in Ennis, both of these staff were not on the duty rota for the 7th November 2012. B15 Bohill Manager has clearly stated that she was made aware of concerns/issues on the 8th November 2012 (Appendix 20) and in resettlement minutes dated 21st October 2012 it states clearly that B1 (Bohill Manager) was in attendance and highlighted no concerns.

2. Weather report checked with the Met Office for the 8th and 9th October 2012. Records show that it did not rain on these two days and the moisture content was low.

3. B4 during interview identified one member of staff, H159 placing P39 outside in the rain and in the allegation it states that B4 identified two staff doing this, H159 and H197

4. Different patient identified during interview

Investigating team unable to interview B3 (Bohill) or B1 (Bohill Manager).

The investigating team were unable to substantiate this allegation and found some evidence to undermine its validity.

52. 9th October 2012 8am -8pm. P39 was removing her clothing frequently and needing dressed. A bank nurse got up from her chair and said either "this is doing my head in "or "she is ****ing doing my head in". She grabbed P39 by the clothing at the chest and forcibly pulled her over to a sofa where she pushed her into the sofa. Later on P39 couldn't get her top off so she lay on the floor and was trying to get her trousers off. She had got them down a bit when the bank nurse and a care assistant got up and went over to her. They tied her belt very tightly and lifted her up and marched her to the back door beside the living room, opened it, pushed her out and locked it, leaving her outside by herself. The care assistant described as being in her 50s, really thin. The two staff left and went into the dining room. B3 let P39 back in. Bank nurse described as heavy set, brown or dirty blonde hair styled in a bob, wore glasses, said she was retired and was banking, would say she was in her 60s. (source B3 Bohill staff, worked 8am-8pm on 8/10/12)

Refer to allegation 49 and 50

The Investigating team unable to interview B3 or B1 (Bohill Manager).

In relation to the allegation made by B3 the investigating team concluded that the allegation could not be substantiated and as per allegation 7 there is some evidence to discredit it.

B4 B3 during interviewed stated to the investigation team that she was not happy that had taken off to Australia and that she was left to deal with all of this. She stated that she did not want to be involved and that she had been to her doctor as this was affecting her mental health. B4 stated that she would not be attending the pending court case if she got support from her GP. The investigation team feel that if allegations involving B4 proceed to disciplinary hearing that she will not attend.

Meeting 9th October 2012 in Erne with Community Integration Officer, ward sister of Erne ward sister Ennis Care Manager and Dr H194 no issues/concerns raised.

25/10/12 B1 expressed no concerns at meeting with H491

The investigation team found the anomaly relating to the time of the alleged incident and the confirmed reporting of the incident 4 weeks later to be of significance and passed this information to the PSNI.

4. Limitations of Investigation Process

The investigation team would acknowledge that this investigation has had its limitations. The allegations were reported on the 8th November 2012 and immediately following this there was an Adult Safeguarding Investigation in joint protocol with the PSNI investigation. The Internal Investigation Team used the Adult Safeguarding Report as a frame of reference and with the exception of the recommendations to discipline 2 named staff, the general outcomes, conclusions and recommendations where similar. The Internal Investigation Team met with the Senior Officer leading the Adult Safeguarding Investigation in June 2015 to discuss these differing conclusions and acknowledged that some evidence given to the Adult Safeguarding Team from Bohill staff in December 2012 differed from evidence given to the Internal Investigation Team when they were re-interviewed in June 2014. The Adult Safeguarding Team also had access to interview 2 key witnesses one of whom declined to be interviewed by the Internal Investigation Team and the other was not contactable. The Internal Investigation Team also was able to interview staff directly involved in the allegations that weren't accessible to the Adult Safeguarding Team. The Senior Officer acknowledged this but re-stated that the recommendations to discipline 2 named staff remain valid.

This internal investigation commenced in September 2013 and was concluded in February 2015. The duration of the internal investigation was delayed due to a number of factors:

Reviewing patients notes, staff duties, accident and incident forms

Gaining access to the allegations

Gaining access to all parties' statements - the investigation team were unable to view the statements taken by the PSNI from Ennis and Bohill staff

Engaging staff in the investigation process

Some relevant staff who worked in Ennis in November 2012 have since left the service and the investigation team had to make proactive attempts to engage them in interviews

Interviews being cancelled and rescheduled at short notice

Staff who worked in the Bohill in November 2012 having left the service and the investigation team making proactive attempts to engage them in interviews – the Team Leader B1 cancelling appointment for interview on day they were scheduled to take place on three occasions.

To consider any other issues of concern relevant to the investigation .Report any other matter which may undermine the investigation or any issues of concern not relevant to the terms of reference to the appropriate senior manager for action.

1. **Induction**

The ward staff on Ennis all gave good accounts of what their expectations were of the Bohill staff and this had been communicated to them, however, Sr H491 had instructed the staff in Ennis to induct Bohill staff using the Hospital Induction book which requires to be completed over a period of 5 days. This proved difficult for staff to complete as Bohill staff only worked 3 days maximum and were not always there as per rota i.e. different staff names/sickness/changed.

The ward communication book was used to communicate induction requirements to staff and staff were familiar with this process, this was then recorded using the ward diary for each day of induction. Pen pictures and care plans were shared with the Bohill staff. Ennis staff had visited Bohill and the Bohill Team Leader, B1 attended resettlement meetings and was given information about the individual patients.

Band 8A staff report that they were in contact with the Bohill Team Leader over this period and the feedback was very positive, no issues/concerns were raised or identified. Ennis staff reported that some Bohill staff were not working with the patients transitioning choosing to spend time with other patients.

On examining staff records it is clearly recorded that staff on Ennis have received an Induction when they commenced work on the ward using the hospital induction booklet. The information elicited during interview highlighted that the quality of the induction received by Bohill staff was dependent on the member of registered staff completing this.

2. **Training**

The investigation team reviewed staff training records within Ennis. H159 had completed her mandatory training to include Management of Actual or Potential Aggression however she had not attended Adult Safeguarding training as was the same for other staff on Ennis ward. There is evidence of continuing development and training for registered staff to provide a skilled and highly motivated workforce, the ward sister highlighted that additional training had been sought for registered staff on care planning.

Health Care Support Workers had no formal training on how to support people with behaviours that challenge and little or no other training outside of the required Trust Mandatory Training. The ward sister had completed the Trust Leadership programme which addresses the needs of good clinical and managerial leadership.

All staff on Ennis interviewed had a good understanding of their personal accountability. The Health Care Support Workers had limited understanding of the legislation as most viewed the use of the belt on one patient as not being a restrictive practice.

The investigation team noted that prior to the allegation Ennis was a nursing practice placement for student nurses. No students have raised any concerns within this placement and the ward is audited at regular intervals by Queens University as a suitable learning environment; last audit was in September 2012.

3. Staffing (numbers, attitudes, team working, morale)

It is evident from this investigation that there were significant staffing deficits on Ennis ward prior to the allegations. Sr H491 had reported her concerns about staffing to Senior Nurse Manager H377 and H77 and had completed incident forms on the 18/9/12 and 23/10/12 regarding staffing deficits on the ward.

Bohill staff have reported a perception of lack of staffing and Ennis staff also reported that this was a concern in the period before the allegations were made. The incident reports correlate with this.

The Senior Nurse Manager with responsibility for Ennis, Mr H377, was interviewed by the investigation team. During interview Mr H377 stated he was responsible for Erne, Ennis, Moylena, Iveagh and Night Staff plus he had input to Forrest Lodge during this period. He works eighteen and half hours per week. There were widespread shortages within the whole hospital site at this time and this was a regular agenda on the Senior Nurse Manager Meetings and Senior Managers meetings involving the Service Manager for the hospital. He reported to the investigation team that Iveagh at this time was his main concern and priority as it also had staffing shortages and given the location of this service, i.e. being geographically isolated from the main MAH site, it was difficult to staff as resources within the hospital were already stretched and staff did not want to travel to Belfast to work. At this time staffing was addressed on a day to day basis as no wards were in a position to release staff to work in other areas.

A meeting was held at the Millennium Centre on the 24.9.12 with Mr Veitch, Dr H50 Dr O'Kane, Mrs Rafferty and Mrs McLarnon to address the shortfall of staff within the site. It was agreed that Finglass would close sooner than anticipated to help address the staff shortage within the hospital. A meeting with Sr H491, Mrs McLarnon and Mr H377 was held the week prior to the allegations to address the shortfall of staff within Ennis. It was agreed that staff from Greenan ward would be released to work in Ennis to help alleviate the staff shortages within this ward.

Banking within the ward was carried out mainly by internal experienced staff or staff who had worked with this group of patients for a number of years. The majority of bank shifts used to cover the shortfalls within Ennis were booked directly by staff within Ennis and this resulted in staff time being taken up to cover these shifts.

Ward reports prior to the allegations were fairly static. When unfamiliar staff came onto the ward to work towards resettlement of patients, it was highlighted to Mr H377 by the ward sister that this had an unsettling effect on the patients. The resettlement process increased the workload within the ward in that additional assessments needed to be completed for the care manager, resettlement meetings etc.

Telford Assessment for staffing levels was completed for the ward. The 1st level of enhanced observations was included in the staffing ratio. Ennis had two enhanced level of observations so staffing should have been 6. Telford was reassessed post allegations and there were no big changes to staffing ratios. The Telford Assessments were completed by the Service Manager Ward Sister and Mr H377

Staff from Ennis who were interviewed stated that the staff team worked short staffed but they all worked together to help each other. Some staff stated that there they were stressed due to the shortage of staff. No staff raised any concerns or issues regarding attitudes, or morale, all staff stated they worked as a team.

Staff from the Bohill who were interviewed clearly stated the ward was shorted staff. Some said the staff were friendly and made them fell welcome; one said there was a clique on the ward and one said she was not made feel welcome, however, later in interview at a different question said staff spoke away and got on well together. One said staff in Ennis were 'lovely'. She stated the following in interview: "*The staff in Ennis worked really well together they kept the ward going. They knew what they were doing I could not praise the staff enough for the work they do. I was shocked when I heard the allegations about Ennis. They are excellent staff.*" Another staff said 1st day was good we were observing the staff on that day. Staff Nurse with long blonde hair just qualified gave us a very good induction Second day there was different staff on duty and the atmosphere was flat.

The investigation team concluded that the staffing levels impacted on the ward regarding the safety and quality of the care to the patients. The investigation team did not feel that there was a culture of poor attitude within the ward environment, however, the reduced staffing levels, challenging behaviours described and restricted ward environment would most probably have impacted on morale without the staff within the team realising this.

4. Supervision

Staff within Ennis all stated they had their Personal Contribution Plan and Appraisal completed. They all stated that they had no concerns/issues on the ward and the investigation team felt confident that the staff felt safe and comfortable to raise anything they thought was wrong. While some staff in Ennis had not completed their Safeguarding training staff were clear in their roles and responsibilities as they stated they reported behaviours etc. to the nurse in charge.

Sr H491 stated during interview that when Fairview staff came to the ward in 2010 KSF supervision was a new process for them and attempting to implement this within a busy, short-staffed ward was difficult.

Mr H377 Senior Nurse Manager, stated during interview that copies of team meetings were forwarded to him on a two to three monthly basis and that he was satisfied that Supervision and Appraisal processes were in place and occurred on a regular basis.

Families and other visitors were allowed access to the ward or individual patients' bedrooms. This meant there was opportunity for outsiders to observe daily living in the ward and limited the opportunity for a closed culture to develop on the ward, the ward was open and transparent.

The investigation team concluded from the evidence provided that staff had supervision and annual appraisals completed.

5. The Environment (Physical and General Atmosphere)

The ward as described by all staff interviewed was divided into two parts; the upper end of the ward where the patients who were more independent lived and the lower end of the ward were the patients (11) who were more dependant lived; these patients were mainly patients from Fairview and were transferred to Ennis when Fairview closed (2010). These patients'

behaviours were challenging in that they stripped, pushed/shoved etc. It was in the lower end of the ward where all the incidents were alleged to have taken place.

The upper end of the ward was described by all staff as brighter with lighter paint work. It had artwork and the windows were draped. Each patient had their own individual personal items on display. One patient had a double room that had been converted into her own personal space with a settee and TV and this patient refers to this as her apartment. The lower end of the ward was darker in paint work, had no personal items on display, windows are not draped and many of the patients are in one room.

Physical changes had been made to the ward over the previous few years by Sr H491 these included:

Feb 09 – activity room created for beauty activity

Aug 09 – storage for kitchen. Re-decoration and 3 new shower rooms. Bathroom on ward was changed to create staff toilet and locker room

Aug 09 – New blinds

Jan 10 – Additional medication cupboard put up

Jan 10 – Snozelum Room created and swing

Oct 10 – highlighted that ward was small – reported challenging behaviours and requested fence which took a full year to get

Jan 11 - New flooring replaced

June 11 – re-painting of ward

June 11 – activity room turned into a second office, this was good for observation – other office doubled up as a visitors' room and office.

Staff on Ennis who were interviewed stated that they were informed of the changes but were not consulted. The investigation team were informed by all staff interviewed that the activity room being converted into an office had impact as it was missed by the patients and staff who previously could utilise this room to separate patients and do activities that helped to manage behaviours e.g. hair, nails etc.

A Bathroom was converted to a staff toilet and locker room and this also had an effect on the patients as they only had one bathroom left to use. When patient P198 became challenging this caused delays as the bathroom became blocked and other patients were unable to have their hygiene completed which caused them and staff additional distress.

The investigation team concluded that the wards physical environment did not meet the needs of the patients; the lower end of the ward was over-crowded; there was limited room available for the patients and the behaviours they displayed. The conversion of the activity room resulted in patients being confined to one room in the lower end of the ward further impacting on behaviours.

The investigation team note that the ward was due to close in 2012 with the resettlement agenda therefore no major work was being commissioned for this ward.

6. Resources

The investigation team noted from interview with Mr H377 that the resettlement wards, Ennis being one of them, do not have the same service delivered by Patient and Client Support Services (PCSS) as wards within the CORE Hospital do. Nursing staff on the resettlement wards still maintain the responsibility of bed making and laundry whereas in the CORE wards this is completed by PCSS staff. There were also limited resources from psychology Adult Behaviour Services (ABS) as these services were concentrated on the Core Hospital.

The investigation team spoke to ABS and their manager Mr H77 they stated that all referrals are forward to Mr H77 and that these are allocated to a member of the Behaviour Team, each behaviour nurse will then prioritise each case. In most case prioritising is based on the intensity of the behaviour presented i.e. high level of restrictive practice used i.e. Seclusion, Physical intervention and PRN medication. ABS confirmed that they had not received any referrals for P39 , P40 or P43 pre the allegations.

Sr H491 stated during interview that patients from the Core Hospital who came to Ennis had Support Plans but that the other patients on Ennis did not have these and that they wouldn't be requested unless there was a significant change in a patient's behaviour. She stated that LD nurses are trained in behaviour and how to manage this and that generally challenging behaviours are managed by activities, however, she acknowledged that scope for activity was reduced due to low staffing levels.

The investigation team concluded that referrals for the behaviours described by the staff in Ennis should have been referred to Adult Behaviour Services.

7. Reporting processes

P39 P43 P40 and P41 's care plans were reviewed; Roper, Logan and Tierney was the model used. The named nurse and associate nurse were identified and evidence of person-centred care including personal care needs, protection plans recorded, body charts completed, daily entries by registered nurses, multidisciplinary meetings/Community Integration meetings and entries in relation to accident and incident forms, Adult Safeguarding and Physical Intervention. There was evidence of multidisciplinary team working. The investigation team found that there was a description of the types of behaviour that patients displayed recorded in the care plans there was little detail in strategies for staff to manage or de-escalate these behaviours.

A record of physical interventions employed within the ward was reviewed, September 2012, October 2012 and November 2012, however, none of these was with any of the patients identified in the allegations.

The number of safeguarding incidents was reviewed by the investigation team from April 2012 to March 2013. It was noted that in November 2012 there was a dramatic increase in the number of referrals from an average of 3.57 for the period April 2012 to October 2012 to an average of 22.4 for November 2012 to March 2013 (Appendix 23). This would be in keeping with reports from Ennis staff that the challenging behaviour of the patients increased with strange people coming onto the ward. The November 2012 data correlates with the monitoring commencing on the ward and new staff starting to work in Ennis. It is also possible that this increase post allegations represents previous under reporting. The investigation can only present these variables but are unable to identify a specific cause.

Review of Incidents/Accidents in Ennis was reviewed from April 2012 to March 2013. It was noted that in November 2012 there was a dramatic increase in the number of incidents from

an average of 7.57 for the period April 2012 to October 2012 to an average of 30.6 for November 2012 to March 2013 (Appendix 17). This would be in keeping with reports from Ennis staff that the challenging behaviour of the patients increased with strange people coming onto the ward. The November 2012 data correlates with the monitoring commencing on the ward and new staff starting to work in Ennis. It is also possible that this increase post allegations represents previous under reporting. The investigation can only present these variables but are unable to identify a specific cause.

There was evidence on the ward of information sharing via the ward communication book and care plans in relation to visitors/carers/advocates, patient's requests and staffing levels.

Monitoring of the ward took place post the allegations; this was over a 24 hour period and was carried out by registered staff both employed at Muckamore Abbey Hospital and from staff within the Trust. This allowed for observation of staff interacting with the patients and practices on the ward. This supportive process gave a clear picture of what was happening on the ward and formed part of the reporting of risk management up through its governance. The investigation team noted on reviewing these monitoring forms that supervision and observations for patients were maintained. An area highlighted for concern was the ward environment i.e. overcrowding, décor.

Prior to the allegations there was an incident reported in May 2012 when a day-care staff reported a Band 2 bank nursing assistant who was working on Ennis Ward as handling a patient roughly and threatening them. This incident was investigated by the police who did not take any further action. Senior management undertook a full investigation and concluded that there was a case to answer, recommendations were sent to Human Resources but the member of staff left the employment of the Trust before disciplinary action took place. The matter was referred to ISA. This demonstrates that Ennis had accountability and governance in place.

In summary the investigation team noted a number of themes that, not individually, but collectively created a situation on Ennis Ward that created vulnerability for both the patients and the staff:

1. Reduced staffing levels across the entire service
2. Ennis' status as a Resettlement Ward – reduced support from PCSS as opposed to the wards in the CORE Hospital.
3. A cramped and dark environment in the lower end of the ward
4. Environmental changes being agreed that had a negative effect on patients and the staff managing the patients
5. Poor skill mix on the ward – i.e. staff working in the lower end of the ward were mostly unregistered staff
6. Poorly documented evidence based practice for managing/ de-escalating identified challenging behaviours
7. Lack of communication to and training of unregistered staff in understanding and being able to articulate the strategies that they were using to manage challenging behaviours
8. Lack of knowledge generally within the ward staff re: legislation around restrictive practices and their implications

The allegations as noted in this report were thoroughly investigated but in the majority of cases the investigating team were unable to substantiate these. During this internal investigation however, a number of statements given by Bohill staff and interpreted as 'incidences' were subsequently refuted by the staff. One allegation was re-iterated by B4 B4 (Bohill) during interview however, during interview B4 informed the investigation team that she was not happy that B3 had *"taken off to Australia"* and that she was *"left to deal with all of this."* She stated that she did not want to be involved in this case and that she had been to her GP as this was affecting her mental health. B4 B4 stated that she had hoped to be exempt from attending the pending court case with support from her GP but she was informed that this was not permissible and could result in legal action being taken against her. The investigation team do not anticipate the attendance or co-operation of B4 if the allegation she has made were to proceed to disciplinary hearing as she has refused to engage with the investigation team since her interview with them and has refused to take phone calls from the investigation team. Of note, the investigation team found evidence to discredit other allegations made by B4 The Senior Officer who led the Adult Safeguarding Report states that the recommendations made by the PSNI to proceed with a court hearing both H197 and H159 remain valid.

8. Recommendations

In view of the findings elicited through this process the investigation team recommend the following:

- An overview of this Report should be shared with all the staff involved. During interviews staff reported that they found the process of investigation immediately post allegations to be covert and unsupportive and for some this has had a lasting and negative impact.
- Immediate training for all staff on the legislation and use of restrictive practice
- Refresher training for all staff on manual handling techniques
- All care plans to be updated to include strategies for managing behaviours
- Mechanisms within the ward to be introduced to ensure all staff – registered and unregistered - understand and can articulate practices/ techniques employed to respond to patients needs e.g. MAPA, Manual Handling techniques, restrictive practices, diversionary techniques, de-escalating techniques
- A review of how future allegations are handled by mapping and reflecting on the process from 8th November 2012 to present
- Increased supervision for H491 and support re: roistering to ensure good skill mix and support for all staff
- Future stringent review and justification of any environmental changes on wards
- All staff to be made aware of Here4U and Staffcare services available to them for extra emotional support if needed.

- Adult Safeguarding Team to consider NMC referral for B1 Manager of Bohill at time of allegations to investigate non-reporting of incidents alleged to have taken place on Ennis on 9th October 2012.

- The internal investigation team are unable to support the recommendation to progress to formal disciplinary action in relation to the allegations made re: H159 due to the following:

  1. The internal investigation were unable to substantiate the allegations based on the available evidence
  2. Four witnesses from the Bohill were unavailable for interview B1 B2 B3 and B10.

9. Signatures

Signed_____

Rhonda Scott,

Senior Nurse Manager,

Learning Disability Manager

Date_____

Signed_____

Geraldine Hamilton

Service Improvement Manager

Mental Health and Learning Disability

Date_____

Appendix 1

Summary of Allegations under Investigation RO53
Taken from Adult Safeguarding Report

[redacted]

RO53

1.005d1

Appendix 2

2.004

[redacted]
H198'S address

Rhonda,

I will not be attending the disciplinary meeting on 16/4/14 as I no longer work for the Belfast trust on Muchamore Abbey Hospital.
My nursing career was terminated on the grounds of my failing Ill Health which was exasserbated by events over the last 16 mths.

I am forewarding to yourself a statement of events for 7/11/12.

Kinds Regards.

[redacted]
H198

8/4/14.

(1)

I have been nursing in Muckamore Abbey Hosp since 80's and I have always maintained my professionalism throughout my career.

On the morning of the 7th March '12 I commenced working E/H at 7.25am in Ennis to learn I had only one permanent ward staff one Barber and a relief staff from Erne. Altogether 4 staff when in fact I should have had 7 staff. There was then another relief staff from Oldstone at 9.30

The student and the Priory Nurse commenced duty @ approx 10.45am. The Priory nurse was in to shadow some of our ladies who were part of the resettlement process to the Priory in Coleraine.

The Student commenced her own studies working in the front office. I introduced the Priory nurse to the staff down at the back end of the ward and ask them to keep the Priory nurse informed on what to do as I was extremely busy. I didnt get time to give her an introduction as I was dealing with many ward issues on that particular morning. i.e. Incident o Aggression, Family coming on ward to take their sister to a APP in R.A.H. and dealing with a Patients relative Per Phone. Altogether I had an extremely busy Stressfull morning. I continued to carry out the remain of my office duties for the morning.

Staffing levels dropped back down to 4 over lunchtime when the 2 relief staff left at 12.noo

We commenced giving out lunch and doing medicat Another Inc occoured over lunch time which was dealt with by myself. The Ward was very noisy at this Period in time as workmen were in all morning carrin out repair work to many of the doors.

The afternoon was much quieter. I worked on Sor

(2)

Peices for the resettlement programme. The Primary nurse took the opportunity to go through some care plans in the afternoon.

I again was busy after tea time typing up my report for the nursing office, Completing Progress and evaluation sheets, checking patients money drawers and entering Bank slips on the Computer.

The staff were busy Putting away laundry and getting Patients ready for bed and giving out Suppers The student and Primary staff were Supernumary and did help after tea time at my request.

Another one accured @ 8.pm which I dealt with accordingly and to the best of my ability.

Altogether I feel the day was stressfull due I had an excellent Ward team on duty who kept along with myself the ward running smoothly and so Therefore I had no Concerns and was happy and Conte all was well Considering the staffing levels were low.

our staffing levels were $\frac{4}{17}$ 7.30 - 9.30 $\frac{5}{17}$ to 12 no $\frac{4}{17}$ over lunch time and $\frac{5}{17}$ remainder of Pm. our staffing levels should have been 7 - 6 - 7.

There was also daycare Consultations noon & afternoon and as a result the ward was unsettled at different intervals.

I handed over to the night staff with no Worries, reports, or Concerns from any member of staff on duty that day. I went off duty at 8.30Pm.

Appendix 3

H870's address

[redacted]

Dear Rhonda Scott,

From what I can recall on the day of question I was working in Ennis ward, on relief from ddstone I think the hours I spent in Ennis wse 9am - 12pm.

During the hours I spent in Ennis Ward I seen nothing untoward or unproffessional during that time. For the 3 hours I was in Ennis I was allocated to supervise the backdayroom alongside Ennis staff and then for a short while alongside a community staff member who was working with particular patients.

As I am no longer an emptyee of muckamore Abbey I would prefer to have no more contact regarding this issue. The information I have given is true to my knowledge and what I recall.

Yours Sincerely,

H870

Appendix 4

2.008

Notes of Interview with

Sr H491

29th April 2014

Question 1

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you as the ward manager ensure the following;

Patient Safety

Highlighted staffing via e mails to line manager from May 2012 ie about incidences, safety, danger and the changing needs of the patients from 2008 to present.

Poor staffing Staff banking on top of their contracted hours in substantive post.

Could not do activities these are very important to decrease incidences. Used experienced staff to engage patients in activities to reduce incidences

Incidences increased when Bohill staff came to ward. Communicated with Duty Nurse Manager re staff shortages, Duty Nurse Managers changing every day which made this difficult

Wards working on safety levels. Telford was completed but this incorrect - Ennis worked below safety numbers. Highlighted this on the 12.10.12 to H77 via email as own Line Manager on leave

Current levels insufficient to run resettlement programme on ward

Incidences increased once monitoring commenced

Issues highlighted at resettlement meetings

2010 patients from Fairview moved over

7-8 referrals made to Behaviour Support Services

Changes in behaviours of patients highlighted in Care Plans

Patient P43 was allocated additional space on ward

We believed Ennis was closing Dec 2012 but still had a Bar B Que and Picnic in the summer of 2012

Staff Safety

Supervision was completed as and when it could be given – I try to be as approachable as possible to staff

In 2010 when Fairview closed the two staff teams amalgamated in Ennis which was difficult

Locked doors on ward – and patient P43 had extra area

Snozelum room

Meetings held on ward to bring team together every 2-3 months – topic covered were; waste, KSF, supervision, restrictive practices

Routines were reviewed constantly to look at safety, staff practices, allocation, standards, activities, policies, staff development – e.g.number of patients in dining room

ABS had no remit on Ennis but referrals were made re: P39 & P44?

Staff team were not used to working with behaviours

There was difficulty with staff sickness on ward

Specific management of patients was discussed one patient at a time and how to manage the behaviours

Staff handovers

The Resource Nurse was used to improve Care Plans from 2010 to 2011

Patients from Core Hospital caused anxiety amongst staff (P201 & P198)

Safety alarms were installed

Security on ward re-looked at as ward not for challenging behaviours

Telford assessment completed – this resulted in working one staff down due to level of observations on the ward – worked on 7 staff pre- the Telford assessment but 6 was deemed safe. Telford showed 6 in the morning and 5 in the afternoon staffing levels. This was not completed by me but by H377 and Esther

There were no hotel services on Ennis which had significant impact

Skill mix allocation

Talked to Line Manager in Supervision regularly – I felt skill mix on ward was inadequate e.g. in August 2012 the only full time band 5 was on capability. There was always 2 qualified staff on duty then the rest were nursing assistants

It was agreed that night duty was to be covered in the first instance -the communication book was used for daily communication

Gave all band 5s turns at taking on new roles and responsibilities

There was a lot of staff sickness on ward this was highlighted in supervision and informal discussion

Duties were allocated by ward allocation sheet of which several versions had been tried

The rota was heavily subsidised by banking staff but they were predominantly ward staff which lead to tiredness and sickness

There was more enrolled nurses in Ennis than in any other ward and therefore there were learning issues such computers

Staff Rotation

Band 5 turn taking – i.e. band 5s all got opportunity to be nurse in charge

Staff rotated between front and back of ward

Duty rota shortages were covered by ward staff

One staff was re-allocated to anther ward as she got promotion

Ward Manager felt she was doing a Band 5 role

Small senior staff team taught other staff on ward

Patient engagement in activities

Activities ongoing on ward – gardening and cookery

Valentine's Day – Build a Bear

Easter Hunt every year

December 12 Ennis was to close and in Summer 2012 there was a Summer Fair on the Ward

Patients re: allegations lived in a more protective environment

Ward environment was not being maintained as ward was due to close however new floors were laid

Visits to Ramada Hotel

Visits to Nail Bars

The workload of staff in resettlement wards .i.e laundry, bed making

Engagement was ongoing but reduced due to staffing levels

There was an activity rota on the ward but not in individual care plans

There was a record on the ward of patient activities that H491 monitored

The ward vehicle was removed

Question 2

Was staff's annual appraisal, supervision and team meetings all carried out consistently within Ennis.

As much as possible I was not supernumerary

New to KSF supervision - Fairview ward came in 2010 – this was a new process for staff which they had to learn, this was hard to meet due to staffing levels

Question 3

Have any staff raised any issues with yourself regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that they were not comfortable with pre the allegations.

One staff raised her voice and this was reported by a Band 3 to me. I witnessed this and spoke to the staff member – this was documented and monitored

Band 5 nurse – this was addressed

If yes how did you address these issues

Re: Band 5 - Spoke to staff, recorded and documented, monitored the behaviour and no further issues appeared

Question 4

Please tell us how you monitored staff's practices, attitudes and professional conduct.

That is my role

I monitor everything – my job is a problem solver. I monitor everything from patient happiness, safety, families and staff interaction

I identify problems and act upon these

Induction of staff, induction booklets

Clear expectations from Ward Manager outlined at meetings to all staff and followed up with email e.g. April 2011

Regular meetings

Monitored and addressed issues with staff such as motivation

Supervision – identified issues staff would have and talked about how to change things

Question 5

Can you explain the Induction that was in place for the Bohill staff and how this was disseminated to your staff team?

Staff knew through the communication book that they needed induction

Communication book relayed to staff that they had to go through the Hospital Induction Booklet with Bohill staff – Nurse in Charge or the 'back-up' nurse had responsibility to make sure this was allocated and done. This was not identified on an allocation sheet as staff knew to do this

B1 (Bohill Manager) attended resettlement meetings on ward pre the Bohill staff coming to work on Ennis – it was expected that she would give her staff information on working on Ennis and the patients they would be working with

When Bohill staff arrived on ward I got the impression that these staff were not experienced and that these patients needed a high level of trained staff and the Bohill staff were not trained and had limited experience

Bohill staff asked could they work with patients not identified for their service

Patients' behaviour changed when new faces arrived on ward

Question 6

Was there restrictive practice employed in Ennis

Yes – 2 doors locked most times – dining room and door near office were locked

At times the door at the back of the ward was locked to allow for personal hygiene

All in one suits were not allowed to be used on the ward – P39 wore a swimsuit – this was not deemed to be restrictive as it was not always worn and was used to maintain her dignity

A belt was used to hold up another patient's trousers but was not used to stop her stripping

If Yes how were these monitored and audited

Documented in Careplan re locked doors

Were these written in the patients care plans

Yes documented in care plans – not sure if P39 s swimsuit was in care plan

Question 7

How were Behavioural Support Plans developed and how often where they reviewed?

Patients from Core Hospital who came to Ennis had Support Plans – other patients on Ennis did not have these

There was 4 handovers a day on the ward

Support Plans were not required until the patients' behaviour changed. LD nurses are trained in behaviour and how to manage this. Behaviours are managed by activities but these reduced due to staffing levels.

Question 8

Was there any CRA's completed for the patients in Ennis

No – except for the patients from the core Hospital- the CRAs came with them

The Consultant would not sign the CRAs as he felt they were for Forensic patients only – Ward Manager had brought 16 completed CRAs to be signed – these were not signed and he refused to look at them. Discussed this with Senior Management and Resource Nurse

I was unaware if CRAs were kept updated and reviewed by the Consultant

No MDT Meeting and Social Worker withdrawn in 2008 however we could call on them if required

When resettlement commenced in May 2012 annual reviews were discontinued – there was a high level of work with resettlement i.e. All About Me

Question 9

Was there any Risk Screening Tools completed for the patients in Ennis

They were competed for all patients but not agreed by an MDT as there was none and the Consultant refused to sign

Question 10

Did patients have it identified in there care plans their behaviours such as stripping, allegations

P197 and P40 – making allegations should be in their care plan

Stripping should be in their Care plans

If yes was it documented how staff where to manage these behaviours.

Yes it was expected to be

Ward Manager monitored care plans

If new behaviours occurred I would check Care plan to see if this was documented – if this was not documented I would either add this myself or leave message for Named Nurse to do this

Evaluation sheets read every day

Care plans audited by EQC

Resource Nurse offered additional training and support for Care plans

Question 11

Did Support Workers have access to the care plans and how often did they read them

They were encouraged to read them and to write in them. The nurse in Charge would be the one responsible to review this. Mostly NAs would not write in the care plans – it was generally left to trained staff

Question 12

There were environmental changes to the ward. Can you please tell us how you consulted with staff on these changes and what were the outcome of these changes for patients and staff?

Feb 09 – created activity room for beauty activity

Aug 09 – requested storage for kitchen – did not do this initially but then did. Requested re-decoration and 3 new shower rooms. Bathroom on ward was changed to create staff toilet and locker room

Aug 09 – ordered new blinds

Jan 10 – there was an extra medication cupboard put up

Jan 10 – Snozelum Room created and swing

Oct 10 – highlighted that ward was small – reported challenging behaviours and requested fence which took a full year to get

Jan 11 - New flooring requested – same replaced

June 11 – re-painting of ward

June 11 – activity room turned into a second office – this was good for observation – other office doubled up as a visitors' room and office – staff did not like this but I felt this was improvement for patients and staff

Ward was over-crowded

Is there anything that you would like to tell us that you feel would be helpful to the investigation

The 11/10/12 highlighted at resettlement meeting that patients' behaviour had deteriorated – Bohill staff arrived in 3s and 4s and did not adhere to rota issued to them re: their shifts. Also swapped shifts amongst themselves. If on sick leave they would report sick to the ward but not to Bohill. Male staff came onto ward who should have been in Erne

12/10/12 email to H77 re: staffing levels on ward saying resettlement could not conitune due to staffing levels

25/10/12 B1 expressed no concerns at meeting with H491

2/11/12 identified unsafe staffing levels to H377 Staffing was poor. Highlighted risks re: own health and well-being and how situation unmanageable – H491 on leave following this

ADDITIONAL NOTES

Interview with WD/SR H491

29th April 2014

Patient Safety

- Incident forms were completed with reference to 5 separate days reporting issues of patient and staff safety caused by staffing shortage. These were completed during my own time.
- Telford. Actual form devised Duty Nurse Office had incorrect information, no plus on ennis form indicating that no extra staff were to be provided for levels of supervision led to confusion amongst duty nurse managers
- SNM H77 informed Service Manager Mrs Rafferty of this who asked SNM H377 to discuss this with me following his leave
- Outside Garden party was attended by almost all patient's families and ex patients with community staff and other patients. SNM x 2 attended. Monies were provided by the trust for the hire of a marquee as this was also a Closing Party.

Staff Safety

Patient P43 had extra garden area fenced off, also built due to fact P39 and P30 would leave ward on occasion

Staff team were not used to working with SEVERLY CHALLENGING behaviours

Staff Sickness was discussed with SNM. Noticable rise from Oct 11 and explained that this was when patients from Core Hospital were transferred to Ennis

Specific Management of patients was discussed at ward meetings and opportunity given at daily handovers

Daily handovers – 3 minimum per day and introduced another for 6/11 worker when they came on duty.

Behaviour of patient P201 deteriorated only when Monitoring began. Patient begun to block doorways, removed her clothing and agitated others causing major disturbance to running of the ward re routines and reactions of peers. Ward staff and visiting could not walk through the ward feely, patients were more disturnbed. Staff were dealing with this whilst being monitored. What was being witnessed was not usual behaviour of patients in Ennis and there was less staff to who knew patients to deal with this.

Hotel Services in Ennis was minimal since core hospital opened. No improvement despite requests for extra staff. No bedmaking, assistance with breaks/suppers, laundry and putting away of linen. Required significant time. Service manager secured extra time for putting away of linen during this time.

Skill Mix Allocation

Sickness was not casual and was noted to have risen when patients came from Core Hospital

Ward Allocation – changed as patient need changed therefore a number of templates were tried

Enrolled Nurses – Had not been Named Nurses before, this required considerable and consistent direction from small senior team

Staff Rotation

One staff re-allocated was loss of senior staff who was one of two full time staff and was not replaced

No band 6 on ward

Patient Engagement in Activities

Had explained there was a Full Rota from Morning until nightime for all patients displayed which was followed.

Protective Enviroment provided at one end of the ward was described and photos evidenced provided of soft furnishings and high back chairs

Question 5

Staff were instructed to induct staff using the Hospital Induction book. A request was made in the ward Communication book. Staff were familiar with this process using the ward diary for each day of induction. As this induction is completed over a period of 5 days it became difficult for staff to complete as community staff only worked an of 3 days maximum and were not always there as per rota ie diff staff names/sickness/changed shifts.

Review meeting held, I explained the volatile nature of some of the patients in Ennis to [redacted] B1 giving examples also requested that she would ask her staff to come to myself or other nic.

Visiting Community Staff read care-plans almost all day everyday, was told they declined to do activities with patients on occasions

Question 6

Explained that patients came to Ennis wearing all in one vests/suits and that It required significant work to change staff attitudes/behaviour and to encourage patients into other clothing. Also that there was significant amount of shopping for clothing/shoes and perfume in an effort to improve standards.

Re wearing of a swimsuit P39 – explained this was being discussed fully through MDT with B1 B1 present, the reason for this was explained to B1, current MDT considered this was necessary on occasions to maintain P39 dignity.

Question 7

Behavioural Support plans explanation was given that P42 P45 had one, P46 and P44 in process of.

Was explained that prior to investigation/presence of monitoring the behaviours of patients in ennis were not thought to have been severe.

By giving examples explained how the behaviours of the patients changed dramatically when monitoring begun explained clearly this was an artificial situation both what staff were trying to manage and what others may have perceived.

Also that ABS did not have a remit to work in Resettlement wards but we could make a referral if we deemed it necessary

Question 8

Risk Screening tools had been completed for all. CRA's for 7/8

Consultant declined to sign explaining he felt they were for forensic patients

Question 10

Phrase removing of clothes was used as opposed to stripping (staff had been asked to use this terminology also)

When reviewing incident forms I would then add newly denoted behaviours to cplan or leave message for staff to do this

Question 11

Nurse in charge responsible to ensure entries in care plans by nurse assistants were appropriate and to guide staff

Question 12

States staff did not like this - I had explained that I learned that one particular staff member did not like the change of office but she had not come to discuss this with myself at any point

Helpful to investigation

12/10/12 As before explained that SNM H77 shared my concerns with Service Manager who requested that SNM H377 would discuss them with me on return from his leave. Explained that this was done just before I went on leave and that some action was agreed at this point.

25/10/12 B1 expressed that she had no concerns at a Resettlement meeting with full MDT. I explained there are minutes available which evidence this. Also that this meeting was weeks after a date reported in local paper as to when alleged assaults had taken place.

I explained following no response from anyone regarding Incident forms I had submitted of a serious nature I had lost faith in the Incident Reporting System within the trust. I gave examples of how the system in the hospital prior to this flagged up issues immediately and action was taken as a result.

I explained on three occasions that I felt I was not being given enough time to answer the questions I was being asked in full.

RCN Michael McQuillan was present during this interview.

H491

August 2014

2.008d5

Appendix 5

Notes of Interview with H377

16th April 2014

Administration Building

Muckamore Abbey Hospital

Question 1

It is acknowledged that the ward worked with limited resources. How did you address the staff shortages?

I was responsible for Erne Ennis Moylena Iveagh and Night Staff plus I had input to Forrest Lodge during this period. There were widespread shortages within the whole hospital site at this time and this was a regular agenda on our Senior Nurse Manager Meetings and Senior Managers meetings involving the Service Manager for the hospital. Iveagh at this time was a main concern as it also had staffing shortages and given the location of this service it was difficult to staff as resources within the hospital was already stretched and staff did not want to travel to Belfast to work. At this time staffing was addressed on a day to day basis as no wards were in a position to release staff to work in other areas.

A meeting was held at the Millennium Centre on the 24.9.12 with Mr Veitch Dr H50 Dr O'Kane Mrs Rafferty and Mrs McLarnon to address the shortfall of staff within the site. It was agreed that Finglass would close sooner than anticipated to help address the staff shortage within the hospital.

A meeting with Sr H491 Mrs McLarnon and myself was held I believe the week prior to the allegations to address the shortfall of staff within Ennis. It was agreed that staff from Greenan ward would be released to work in Ennis to help alleviate the staff shortages within this ward.

The staff shortages was continually raised at meetings with Senior Managers. The staff shortages within the hospital was placed on the Risk Registar.

Question 2

As the Senior Nurse Manager was there annual appraisal, supervision and team meetings all carried out consistently with Ennis staff and did you get copies of team meetings.

Yes copies of team meetings were forwarded to me on a two to three monthly basis. I am satisfied that the above processes, Supervision and Appraisal were in place and occurred on a regular basis.

Question 3

Did the Ward Sister keep you fully appraised of patient activities, nursing staff levels and was there any risks highlighted to you.

Ward Sister kept me fully appraised of staffing levels within the ward on a regular basis. No risks were raised with me. There were a few issues with a few of the patients such as P198 and her epilepsy and Restrictive Practices these should be well documented within her care plan. Issues re patient P201 and her behaviours were raised by the ward sister. Prior to her moving to Ennis I did voice my objection to her suitability for the ward at our Senior Nurse Mangers meeting as this was a resettlement ward and P201 was a Delayed Discharge patient however regardless of this the patient did move to Ennis.

Banking within the ward was carried out mainly by internal experienced staff or staff who had worked with this group of patients for a number of years. Ward reports prior to the allegations was fairly static. When unfamiliar staff came onto the ward to work for the resettlement it was highlighted to me by the ward sister that this had an unsettling effect on the patients. The resettlement process increased the workload within the ward in that additional assessments needed to be completed for the care manager, resettlement meetings.

Telford Assessment for staffing levels was completed for the ward. The 1st level of enhanced obs was included in the staffing ratio. Ennis had two enhanced level of obs so staffing should have been 6. Telford was reassessed post allegations and there were no big changes to staffing ratios. The Telford Assessments were completed by the Service Manager Ward Sister and me.

Question 4

Within Ennis there was a proportion of shifts that was covered with banking did you monitor this and was any issues raised by the ward sister regarding this

Ward Sister raised issues re the banking within the ward on a regular basis and unfamiliar staff. A large % of the deficits were covered by experience staff who worked in Ennis, internal staff within the hospital or staff who had retired from the hospital and banked. Ennis was short staffed as was all wards within the hospital at that time. The majority of bank shifts used to cover the shortfalls within Ennis was booked directly by staff within Ennis this resulted in staff's time being taken up to cover these shifts.

The resettlement wards within the hospital do not have the same support as the Core Hospital wards i.e. PCSS Services put away laundry, bed making again staff time in Ennis was spent on these chores instead of with the patients. There were also limited resources from psychology ABS as these services were concentrated on the Core Hospital.

Question 5

Did you raise the shortage of resources with your line manager

On a regular basis. There were widespread shortages within the whole hospital site at this time and this was a regular agenda on our Senior Nurse Manager Meetings and Senior Managers meetings involving the Service Manager for the hospital.

Staffing shortages within the hospital was requested to be placed on the Risk Register.

Question 6

Have you ever had any issues raised with you regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices pre the allegations in Ennis.

There was one incident of an allegation from a patient about a staff member regarding the patient's cup. The patient later withdrew this allegation.

RQIA reports on Ennis were positive and Ennis was expressed as an area of good practice at Moylena's inspection feedback one year prior to the allegations.

The resettlement wards are environmentally not up to 21st Century standards.

No issues have been raised re staff attitudes, treatment of patients etc in Ennis.

If yes how were these issues addressed

The process regarding allegations was followed

Question 7

Will you explain the patient group that was in Ennis at the time of the allegation and any difficulties that this posed to the staff team?

The ward at the time of the allegations accommodated 17 patients. Patients P198 and P201 were two Delayed Discharge patients that moved from the Core Hospital into Ennis a resettlement ward; this changed the dynamics of the ward due to the challenging behaviour of these two patients.

The ward was divided into two; the more independent patients (approx 6) were accommodated at the front/upper end of the ward. These patients' behaviours would have been more physically aggressive. These patients would have had a better environment in that they had more individual rooms. The patients who were more dependant (11 patients) were accommodated at the back/lower end of the ward; these patients were mainly patients from Fairview and were transferred to Ennis when Fairview closed. These patients' behaviours were challenging in that they stripped, pushed/shoved etc. Patient P201 was accommodated in the back/lower end of the ward and some of her behaviours included stripping and blocking doors with her body. This patient's presence on the ward made a big change to the ward dynamics and may have impacted on the behaviours of the other patients in this area. P201 was a large lady and intimidating person. She would have stood at the door blocking entry and exit to the area particularly at meal times when there was additional traffic in the area. When the door was opened she would pushed through as she was very focused on food and the kitchen. Staff would have to use persuasion techniques to move her or navigated her to move.

Environmentally the ward was not good.

Is there anything that you would like to tell us that you feel would be helpful to the investigation

Mr H377 demonstrated how to move a patient blocking a doorway by placing two hands on each shoulder and using a push/pull technique to move a patient left or right. This is a technique taught in MAPA on how to move patients. Staff in Ennis would have been trained in this technique when attending MAPA training. All staff would be up to date with MAPA training.

Any previous issues/concerns of this nature would have been addressed within the hospital in line with procedures.

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Appendix 6

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Notes of Interview with B4

19th May 2014

Priory Coleraine

Question 1

Can you please tell us what time and shifts you worked on Ennis Ward?

I worked from 8am to 6pm on Ennis ward I was only there for a short space of time I think I worked on the ward on the 6th to the 8th ?November cannot remember exactly the dates.

Question 2

Can you please tell us the Induction you had to Ennis Ward?

I was given limited information from Bohill management on the ladies in Ennis prior to going there. Given limited information on patient P39 and the wee lady who like to carry the cigarette paper. We were told we were going to observe staff managing the patients and to ask questions and then after a few days we were to work with the patients.

On the ward the Ward Sister spoke to me and B3 re the patients and introduced us to the patients and staff. We were given a set of keys for the ward. We shadowed staff who were working with the patients. We were given a good Induction and made feel welcome.

Question 3

Did you feel supported while working on the ward and did you get support from your line manager?

I thought that the staff was very good they gave us information on the patients. Staff took me with them when working with the patients; the staff knew the patients very well and gave me good information about them, it was amazing what they were able to tell me about the patients.

I felt supported by my line manager and was looking forward to going to work in Muckamore.

Question 4

What was your understanding of the communication that was given to yourself re coming to work in Ennis and how was this information disseminated to you?

B1 the manager, at one meeting, informed us that the patient's from Ennis Muckamore Abbey Hospital was to come to the Bohill. We were going to Muckamore to work with these patients and staff. Pen pictures of the patients were given to us. Initially we were informed that we were to shadow the staff at Muckamore.

Question 5

Did you read the identified patients care plans?

No. Did read care plans in Erne but not in Ennis I did not think I asked to read the care plans in Ennis did not think about this.

Question 6

Did you ask staff on Ennis for information pertaining to these patients and if so how useful did you find this?

Yes I asked about the likes and dislikes of the patients. Asked about had they ever tried P39 without the use of the swimsuit. Staff was very knowledgeable about the patients and gave me good information on them. I asked about other patients on the ward as well.

Question 7

Have you ever raised any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with?

No I seen two staff pull a patient up from the floor tighten her belt she was wearing, one nurse held her and said to her to get the fuck out of my face and heavily pushed her onto the sofa. One of these staff was called H159 and had a Description of H159 the other staff was blond and called H197 who was banking that day.

If yes how were these issues addressed

No did not raise these issues with Ennis staff

If no why not

I did not know these people I was in a new environment. I reported these to my manager B1 at the Bohill the next day, this was then reported to B15 The next thing the CID came to the Bohill to interview me. I have attended my Vulnerable Adults training prior to working in Muckamore this was around the second week in September.

Question 8

Did you raise any concerns with your line manager at the Bohill?

I reported these to my manager B1 at the Bohill

If yes when you did raise these concerns and how were they addressed?

I reported this the next day to my manager B1 this was then reported to B15 The next thing the CID came to the Bohill to interview me.

Question 9

Did you witness staff push and/or pull P39 items of clothing? If yes please describe what you witnessed.

Yes on one occasion I seen staff pull P39 by her hoodie and place her outside in the garden

If so who was this staff member

Cannot be 100% sure may have been H159. This was the same day I seen staff pull P39 up from the floor.

B3 went over and opened the door and let P39 back in.

This was reported to B3 my manger at the Bohill the day I reported the other incident Both of these happened on the one day.

Question 10

Did you witness staff use abusive language to patients on Ennis. If yes please tell us the words you heard.

Yes I heard a staff say to a patient "get the fuck out of my face". This occurred around lunchtime or the afternoon This was the only time I heard abusive language.

If so who was this staff member

H197 the Bank Nurse I had been talking to these staff so I knew their names. Stated she was in her 60's and her husband had passed away.

Question 11

Did you witness staff put a patient outside in the rain.

Yes

If so who was this member of staff

H159 I think was her name

If yes who was the patient

P39

If yes please describe the clothing the patients had on

P39 was wearing a hoodie and Jeans

If yes did you make any attempt to bring the patient back in

No B3 brough her back in immediately I did not say anything

Question 12

Did you hear staff say to patients what you were doing on the ward and if so what was said?

H491 (Ward Sister) introduced me the first day Explained I was there to see the patients.

Question 13

How did you observe staff to transfer patients from one area to another?

Staff would have taken P39 s hand to move her other patients walked on their own Staff did not have to help them.

Question 14

How did staff on Ennis interact with the patients?

Staff spoke to the patients there was not a lot of interaction as the staff were very busy on the ward.

Question 15

What activities were the patients on Ennis engaged in and did you participate in these activities

Staff on the ward were busy I did not witness any ward activities. I mainly shadowed staff working with P39 She was hard to work with re her stripping, grabbing and attention seeking behaviours.

Asked what was the routine like at Meal Times

The patients were taken in small groups three I think at a time this was organised. P39 P39 was to go in for her meals as she would have over loaded her mouth and it took longer than the others to feed her as she needed help with feeding and drinking.

Question 16

Please describe how you found the atmosphere on the ward

The ward was very busy. Atmosphere was quite dull the ward décor was outdated with not much colour.

Atmosphere between staff was quite they got on with their work. The ward staff were stretched, staff were busy and the patients had many needs which was tough on the staff.

1st day was good we were observing the staff on that day. Staff Nurse with long blonde hair just qualified gave us a very good induction Second day there was different staff on duty and the atmosphere was flat.

Question 17

Have you attended any training in Physical Restraint such as MAPA?

Not MAPA prior to working in Ennis but did attend some form of PI training prior to working in Ennis cannot remember the name of it.

If yes please tell us when and what training.

Attended MAPA training a few weeks ago

Is there anything that you would like to tell us that you feel would be helpful to the investigation

No

Appendix 7

Notes of Interview with B7

19th May 2014

Priory Coleraine

Question 1

Can you please tell us what time and shifts you worked on Ennis Ward

I was only there for a day and a half this was only if someone had to go to Ennis and did not want to be there on their own, I was there to work with the boys in Erne. I worked with B8 I think, on Saturday 6th in Ennis and I think the 1st

Question 2

Can you please tell us the Induction you had to Ennis Ward

We were to work with the patients prior to them coming to the Bohill to find out their daily routine, personal care, care plans etc to add to our own care planning. The first week was information gathering and for the patients to get used to us and us to them, this was to happen over several weeks.

There was not much of an Induction we arrived about 7.30am on the Saturday and staff were having a cup of tea in the dining room. We sat at one table and the Ennis staff sat at another table. We were told they were not expecting us until 8am. Me B8 and B10 were in Ennis that day. The Nurse in Charge was a big lady I cannot remember her name. We were not given any keys, there was not much chat with the staff and we did not feel very welcome. Erne was a different ward very welcoming

Question 3

Did you feel supported while working on the ward and did you get support from your line manager

I didn't feel supported on Ennis ward I felt a bit abandoned. We took a lady to the shower room she had on two pads from the night duty. We were shown were the pads etc were dept. There was not much information given to what was happening, staff what they were doing and went about this.

B1 line manager called at the ward to see how we were doing I reported to her that everything was fine.

Question 4

What was your understanding of the communication that was given to yourself re coming to work in Ennis and how was this information disseminated to you.

Our manager informed us that the patients were coming to the Bohill we were to go to Muckamnore to get to know the ladies, get the ladies familiar with us, read their care plans, learn how to work with them and commence our own care plans for the ladies.

Question 5

Did you read the identified patients care plans

Yes I did read the care plans the medical files were better but I was looking specifically at physical health.

Question 6

Did you ask staff on Ennis was for information pertaining to these patients and if so how useful did you find this

We would have asked the staff in Ennis about the ladies and they gave us advise. Regarding the other patients on the ward there was no explanation given to us on these patients on how to manage the behaviours and reasons for staff practices.

Question 7

Have you ever raised any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with.

I didn't have concerns when I was there the only thing was the pads which was more of a query than a concern.

If yes how were these issues addressed

If no why not

Question 8

Did you raise any concerns with your line manager at the Bohill

No I didn't raise anything I had no concerns. I was approached by line manager afterwards post the allegations. I was interviewed regarding the VA process I did not see any abusive practices.

If yes when you did raise these concerns

Question 9

Did you witness staff push and/or pull P39 items of clothing? If yes please describe what you witnessed.

No

If so who was this staff member

Question 10

Did you witness staff put a belt around P39 ?

Cannot remember

If yes, can you explain how and why this was done?

Question 11

Did you witness staff throwing P39 's shoes away to occupy her or were you informed that staff did this?

No

Question 12

Did you witness staff use abusive language to patients on Ennis. If yes please tell us the words you heard.

No

If so who was this staff member

Question 13

Did you hear staff say to patients what you were doing on the ward and if so what was said

We did not really get introduced staff in Ennis showed us their rooms and we introduced ourselves

Question 14

How did you observe staff to transfer patients from one area to another?

Patients moved themselves

Question 15

You have stated that you were informed if you offer the patients too much attention they will want it all the time. Can you please tell us who said this when it was said and under what context it was said?

This was pertaining to one patient who was not moving to the Bohill. She was singing in the day room one staff said do not give too much attention to this. This was not a concern.

Question 16

You have stated that staff was putting on 2 pads at a time on a patient. When you queried this staff said to you patients were wetting too much. Can you please tell us

Who said this to you

This was not said by a member of staff in Ennis it was said by a member of staff Erne I believe when I was talking about it in this ward.

What context was this said in

It was said in the context that when a patient was incontinent they passed a large volume of urine. They was no concerns re this.

Question 17

How did staff on Ennis interact with the patients?

Ennis staff spoke to each other there was not much interaction between patients and staff. The music channel was on the staff were busy there was a lot going on there were patterns of routine there may have been more time in the afternoon for staff to interact with patients.

Question 18

What activities were the patients on Ennis engaged in and did you participate in these activities

None it was very un-stimulating

Question 19

Please describe how you found the atmosphere on the ward

The ward was segregated the dining room was the focus of the ward. There was two sides to Ennis the doors between each side was locked. The lower end of the ward was quite dark but this was the design of the building and the décor was very plain it was an institutional building. The staff spoke away and got on well together.

Question 20

Have you attended any training in Physical Restraint such as MAPA?

Yes

If yes please tell us when and what training.

Prior to working in the Priory worked in Muckamore and did my MAPA training there

Is there anything that you would like to tell us that you feel would be helpful to the investigation

I never seen abuse I think the building contributed to the allegations. Staff would have done what was right for the patients but may not have explained this to the staff from the Bohill. What the others witnessed sounds more like older practices. Our staff had little experience of Learning Disability especially Challenging Behaviour. They probably did not know what to expect and this may have been a shock to them.


Appendix 8

2.012

Notes of Interview with [redacted] B5

19th May 2014

Priory Coleraine

Question 1

Can you please tell us what time and shifts you worked on Ennis Ward?

I worked a lot of shifts at Muckamore. Not sure of the dates I worked but will have them in my old diary. It was agreed that these would be e-mailed to R Scott.

Question 2

Can you please tell us the Induction you had to Ennis Ward?

We were going to Muckamore to shadow the staff working with the patients and we were supernumery. We were to get involved with the patients care when we felt confident to work with them.

I got a very good induction by Mary she was great.

Question 3

Did you feel supported while working on the ward and did you get support from your line manager?

Yes got good support from Ennis staff and my line manager at the Bohill Staff in Ennis were lovely

Question 4

What was your understanding of the communication that was given to yourself re coming to work in Ennis and how was this information disseminated to you?

We were going to Muckamore to shadow the staff working with the patients and we were supernumery. We were to get involved with the patients care when we felt confident to work with them.

Question 5

Did you read the identified patients care plans?

Yes I was on night duty one night and read the care plans They gave good detail and insight into the patients.

Question 6

Did you ask staff on Ennis for information pertaining to these patients and if so how useful did you find this?

Staff were really informative Staff kept me updated as we went along and worked with the patients.

Question 7

Have you ever raised any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with?

No

If yes how were these issues addressed?

If no why not?

No issues

Question 8

Did you raise any concerns with your line manager at the Bohill?

On one occasion there was rough handling of P39 I was commencing night duty and P39 was taken to a chair and a belt was put on quite tightly. I did not say anything as I was not sure if two staff were needed this was the only occasion.

If yes when you did raise these concerns?

How were they addressed?

Question 9

Did you witness staff push and/or pull P39 items of clothing? If yes please describe what you witnessed?

No

If so who was this staff member?

Question 10

Did you witness staff put a belt around P39 ?

I was commencing night duty and P39 was taken to a chair and a belt was put on quite tightly. One staff was 22 to 23 years of age with different hair colours the other one was older probably in her 40's.

If yes, can you explain how and why this was done?

I did not say anything as I was not sure if two staff were needed this was the only occasion.

Question 11

Did you witness staff throwing P39 's shoes away to occupy her or were you informed that staff did this?

I saw this twice in one day by the same staff member. P39 was on the floor and was stripping her clothes off. The staff member removed her shoes and set them to the side to divert P39 from stripping. This was acceptable for the staff to do this as it was used as a diversion for P39 to stop her stripping.

Question 12

Did you witness staff use abusive language to patients on Ennis. If yes please tell us the words you heard?

Not to patients sometimes amongst staff

If so who was this staff member?

Question 13

Did you hear staff say to patients what you were doing on the ward and if so what was said?

Nothing bad was said regarding this. I felt part of the Ennis team Staff were friendly and helpful I would apply for a job at Muckamore

Question 14

How did you observe staff to transfer patients from one area to another?

Staff would have held patients hands to transfer them.

Question 15

How did staff on Ennis interact with the patients?

Staff were good Patients were not left sitting staff interacted with them Staff were very calm and made an effort

Question 16

What activities were the patients on Ennis engaged in and did you participate in these activities?

None that I saw

Question 17

Please describe how you found the atmosphere on the ward?

The staff in Ennis worked really well together they kept the ward going. They knew what they were doing I could not praise the staff enough for the work they do. I was shocked when I heard the allegations about Ennis. They are excellent staff

Question 18

Have you attended any training in Physical Restraint such as MAPA?

Not sure will check diary

If yes please tell us when and what training?

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

No

2. 912 of 9

Appendix 9

2.013

Interview Questions B6

19th May 2014

Priory Coleraine

Question 1

Can you please tell us what time and shifts you worked on Ennis Ward?

I worked in Erne for ½ a day I worked in Ennis 2 to 3 days as far as I can remember but I am not sure what month this was. I drove in one day with B7 and worked with her and one day with B13 and one day on my own.

Question 2

Can you please tell us the Induction you had to Ennis Ward?

A young nurse with long blonde hair did my induction. She was very nice and friendly. She showed me around the ward, informed of ward routines, informed me I was there to observe initially, introduced me to the staff and patients and answered any questions I had, She made me feel welcome.

Question 3

Did you feel supported while working on the ward and did you get support from your line manager?

We were told that we were going to Muckamore and that was it. There was limited communication given to us. Line manager was not really involved and I did not feel supported.

Question 4

What was your understanding of the communication that was given to yourself re coming to work in Ennis and how was this information disseminated to you?

We were told just to go up to get to know the routines, read the care plans and get to know as much as possible about the patients. Not really discussed with line manager, this was discussed among staff, it was identified on the duty sheet who was to go and that was it.

Question 5

Did you read the identified patients care plans?

Yes they contained good information and were useful. Care plans were given to us by staff in Ennis.

Question 6

Did you ask staff on Ennis for information pertaining to these patients and if so how useful did you find this?

Yes I asked questions staff were very helpful they seemed to know the patients well this was very helpful.

Question 7

Have you ever raised any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with?

No

If yes how were these issues addressed?

If no why not?

Staff pushed patients away from dining room door. Not sure that this was right or wrong.

Question 8

Did you raise any concerns with your line manager at the Bohill?

Yes re patients at window of dining room door how they were moved and them staring into the dining room. Did not think it was abusive how staff worked with the patients. Staff did not give an explanation on what they were doing when working with the patients.

If yes when you did raise these concerns?

I reported these the next time I seen my line manager but at his stage issues of concerns had already been raised about Ennis.

Would you have reported this if concerns had not already been raised?

No did not think it was abusive practices.

How were they addressed?

I was told not to worry about it, other things had come to light about Ennis and that this was being taken further.

Question 9

Did you witness staff push and/or pull P39 **items of clothing? If yes please describe what you witnessed?**

No.

If so who was this staff member?

Question 10

Did you witness staff put a belt around P39 ?

No

If yes, can you explain how and why this was done?

Question 11

Did you witness staff throwing P39 s shoes away to occupy her or were you informed that staff did this?

No

Question 12

You have stated that staff in Ennis would push P39 away when she came up and held your hand. Can you please tell us:

What exactly did staff say?

Staff said if you take her hand P39 will pull you around all the time. Staff knew the patients.

How did they remove P39 's hand from yours?

This did not happen No one took P39 s hand away I allowed her to hold my hand.

Was there any reason given to you by staff on why they did this?

As stated above

Did you ask staff in Ennis why they did this?

Question 13

Did you witness staff use abusive language to patients on Ennis. If yes please tell us the words you heard?

No

If so who was this staff member?

Question 14

You have stated that when 2 patients emptied out all the laundry bags staff came in and shouted aggressively "who did this"? Can you please tell us:

Where you were at this time, what were you doing and where was the staff?

I was coming out of the office walking towards the bottom of the ward. I was not in the room I did not see the patient I only heard

Who were the two patients?

Do not know

Who were the members of staff?

Do not know did not see

What did the staff in Ennis do when a staff member made the assumption that a patient had done this?

Was walking towards bottom of ward when I heard this I could not see.

What did you do when staff allegedly shouted aggressively?

Walked on past

Who did you report this to at the time?

No

Question 15

Did you hear staff say to patients what you were doing on the ward and if so what was said?

Staff told me about the patients but I was not introduced to them I did this myself

Question 16

How did you observe staff to transfer patients from one area to another?

No did not see this

Question 17

How did staff on Ennis interact with the patients?

Staff were a bit abrupt but not all of them. Got the impression that they did not have much time for them. Staff on this day may have been having a bad day. Lunch time was stressful for staff on this day patients meals appeared rushed.

Question 18

What activities were the patients on Ennis engaged in and did you participate in these activities?

I helped with feeding patients, changing patients. I got a couple of patients changed and helped staff out when I could. The ward was busy.

Question 19

Please describe how you found the atmosphere on the ward?

Décor and age of the place did not help and it was not homely. Staff did not speak to each other very much Seemed to be a click of staff on the ward Did not feel that I could join them at breaks etc or join in on the conversations. Felt staff were a bit stressed out for no reason. This was on both my shifts.

Question 20

Have you attended any training in Physical Restraint such as MAPA?

Not while employed at the Bohill Have not done any training whilst at the Bohill

If yes please tell us when and what training?

Did this training while completing my degree training as nurse

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

No

2.013 d 10

Appendix 10

Notes of Interview H197

12.5.14

Question 1

As a Bank Nurse in Ennis did you feel supported while working on the ward?

All the time

What supports were available to you?

The ward sister was a good support had previously worked with her in 2010. All the staff on the ward were a great bunch.

Question 2

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you ensure the following?

Patient Safety

Your duty of care was to the patients. You had to work faster made sure you prioritised your care of patients. One staff that morning was on a relief staff from another ward this was a good help her name was H870 and she came from Oldstone. Group one patients were left in bed to allow the other patients to get their personal hygiene attended to. Then I and the relief staff worked together. Staff was usually taken from Ennis to go on relief to Greenan or one of the Core Wards.

Staff Safety

There were two patients on the ward who required level 3 observations. I usually worked on groups 2, 3 or 4 all these patients had challenging behaviour. We had to contain the patients by locking doors so that we could supervise them and observe them. I have nursed for 42 years and knew these patients. I never felt unsafe on the ward. The ward manager had risen issues regarding staffing on the ward and she was aware of the locked doors as this was at her direction. A lot of the trained staff time was wasted looking for additional staff to come into the ward to work to cover the shortfalls of staff. The nurse in charge would have prioritised the workload of staff to meet the staffing levels.

Was there Staff Rotation within the ward?

Yes there was staff rotation this helped staff to know all the patients; I worked in all areas of the ward although staff who knew the patients generally worked with these patients. The behaviours of the patients increased when there were strange people on the ward.

Was there clear allocation of duties for each shift?

There was not clear allocation of duties on the 7.11.12 due to limited staff on the ward. There was only three staff on the day of the allegation, one staff to each area. I had changed duty to accommodate the staff shortages. Two staff was required for group 2, 3 and 4. Group 1 can dress themselves and need help with personal hygiene. At the start of each shift you were given a hand over. The nurse in charge on the day of the allegation did the breakfasts that morning she was on her own until 10am.

Was there scope for patient engagement in activities apart from day care?

The patients on the ward have severe Learning Disability and have Challenging Behaviour. Few of the patients would engage in activities, one patient was blind. [redacted] P39 threw items out the window, P201 stripped of her clothes lay on the floor and defecated, other patients had ADSD. There was no time to engage patients in activities as there were staff shortages. Group 2 patients had their own TV, music colouring in books, spools etc. One patient in the bottom areas had PICA. Main role was to supervise the patients and maintain their safety due to staffing levels. Ward did have a bus but could not be used due to staffing levels.

Question 3

As a Bank Nurse did you have annual appraisal, supervision and team meetings all carried out consistently with Ennis.

Did b=not attend meetings minutes of these were available. I attended all my in service training. I have no PCP or supervision in any ward.

Question 4

Have you ever raised any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with pre the allegations.

There was never anything to report. Is a good ward to work in and staff are good.

If yes how were these issues addressed

Question 5

Can you explain the Induction that was in place for the Bohill staff and how this was disseminated to you?

Bohill staff said they were there to familiarise themselves and to observe the patients. Nurses on the ward said they were to work with the patients. Nurse in charge said they were there to work with the patients. Bohill staff did not start until 8am at the earliest, I did not work with a lot of staff from the Bohill if they were asked they helped some of them were more helpful than others. I was informed of what Bohill staff were on duty that day by the nurse in charge. The staff from the Bohill arrived and came into the ward and sat down they had the opportunity to read care plans. The nurse in charge was doing the medication round which took two hours when they arrived so an Induction was not done then but this was done later in the shift I think. The strange people on the ward were unsettling for the patients.

Question 6

Can you please describe the behaviours that would be exhibited by patient P40 P40 ?

P40 displayed different behaviours from day to day and from hour to hour. She liked to interact with staff and referred to me as Nurse H197 Was very vocal, striped clothing at will and would say get me my buttons; I want chocolate I want lemonade, loved sweets and chocolate. She moved furniture around with her shoulder on the floor. When having a bowel motion sat on toilet and screamed. Was very vocal especially during hygiene and would shout leave me alone. She would also laugh a lot.

How were these behaviours managed at ward level?

She was nursed in group 2 with two other patients; she got on well with P44 and P199. She was in day room with group 3 and4.

Question 7

Have you ever heard P40 allege that a member of staff or patient had hit her?

Quite a few times this was one of her behaviours. Would have said this and laughed. Sometimes no one was in the area. Was vocal during hygiene shouting leave me alone or would have squealed.

If yes how was this addressed?

You would have said no one was there or you would have diverted her attention.

Question 8

Can you please explain what you recall the evening that it was alleged that a staff member assaulted patient P40?

P40 was in the day room. I apparently cleaned her mouth I cannot remember this I and the student nurse H196 were administering an enema the student nurse went to get pyjamas for the patient. The only patient I changed that night was P41 after her enema I was supervising the day room. I cannot recall P40 P40 saying a staff had hit her if so I would not have paid much attention to this as this was normal behaviour for P40 she alleges these things all the time.

Question 9

Did you hear B2 (Bohill Staff) request help to settle P40 on this evening (7.11.12) and if so how did you respond?

I cannot remember as I was so involved with P41 If I had been called I would not have been in a position to help as I could not leave P41

Question 10

Can you please describe the behaviours that would be exhibited by patient P39 P39 ?

P39 is hard work as she had very challenging behaviours. Openly masturbates in public, wilful incontinence to command attention, smearing faeces over people or the ward or will attempt to eat this, striping clothing, pulling her hair out. She is very destructive on the ward will throw clothing out the window, steal food, stuff her mouth with food, regurgitate food and then eat same is obsessed with food, throw items out the window such as clothes and shoes.

How were these behaviours managed at ward level?

She was nursed in the bottom day room so she could be observed. Staff had to maintain her dignity so was continually redressed. Would walk along the ward corridor. Parts of her day she could display no challenging behaviours, Bohill staff where informed that she demanded attention and not to let her stand in front of you as she would nip you. Staff kept boundaries with the patients to manage their behaviours. They prevented her from striping by distracting her. All new and strange staff were informed of her behaviours.

Question 11

Did you or did you ever witness staff throwing P39 s shoes away to occupy her?

No staff ever did this. P39 would have removed her own socks and shoes and would throw them away this was one of her behaviours.

Question 12

Did you or did you ever witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

No, staff would have turned P39 away by the shoulders to de-escalate her behaviours.

Question 13

Have you or have you ever heard staff shout at P39 with a raised voice?

No not shouting. If she was about to hit another patient staff would have used a firmer tone to stop her, she responded to this.

Question 14

Were patients P39 and P43 ever placed outside in the garden areas?

P43 loved out in the garden. All the patients liked this area and used it in the summer.

P39 was never outside unless staff was with her. The door was always open. If there was no staff outside patients would have come inside, only out there when staff was out there. There are tables and a swing out there.

Question 15

Can you please describe the behaviours that would be exhibited by patient P41 P41

Some days there are no issues/concerns with P41 she likes music and would sit and listen to this in her chair would sit with her legs underneath her. Have involuntary movements so jerks all the time due to this would hit her head of her chair frequently. Would become agitated at times and this may indicate that an enema is required as she suffers from constipation. She has Bi-polar so moods can fluctuate can display self-injurious behaviour.

How were these behaviours managed at ward level?

P41 loves music so this was used to settle her. She likes to sit in the same chair and staff would sit her in this. Enema's when required were administer this is usually mid-week to alleviate constipation.

Question 16

Can you describe how P41 is assisted to mobilise?

P41 has a very unsteady gait; she walks on her tip toes. When out of the ward uses a wheelchair. When walking with P41 you would take her arm to guide her where you wanted to go. When you put her in her chair you placed her arms on the arms of the chair, P41 then put her legs below her when sitting and moved in the chair to position herself. She has upper and lower body involuntary movements and her head would have hit off the back of the chair due to this.

Question 17

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

No

Question 18

Have you ever raised your voice or used foul language to any patient or staff

No

Question 19

Was there restrictive practice employed in Ennis?

Not at all. Environment was restrictive. The space was small for the type of patients in the area. Doors were locked for patient's safety and to prevent accidents. Some patients have distasteful habits and this was to prevent this. Belt was used but this was not used as a restrictive practice it was used to hold up the patients trousers to maintain her dignity.

Were these written in the patients care plans?

Do not know. The nurse in charge was aware of all of these.

Question 20

Was there Behavioural Support Plans in place for the patients in Ennis?

Do not know, not aware of this.

If yes how was this information disseminated to you

Question 21

Did patients have it identified and noted in their care plans their behaviours such as stripping, making allegations etc.?

Yes

If yes was it documented how staff where to manage these behaviours?

Risk assessment was completed for P40 re making allegations.

Question 22

Have you attended your MAPA training and updates?

Yes

Question 23

Did you employ MAPA techniques within Ennis Ward?

Yes. P39 we would place our hands on her two shoulders and turn her around, this was used when we wanted to redirect her and would have been employed daily this was also used with P41

P41 on the day of the allegation went over to P22 who was lying on the couch P41 jumped up and down on P22 I went over and took P41 P41 by her arm and elbow. P41 put her legs down on the ground and I walked her to another chair. B2 was at the window in the day room and her view of this was restricted as I was between her and P41 I put P41 into her chair and she settled herself as described earlier.

If yes can you please give a description of the MAPA techniques employed?

P39 we would place our hands on her two shoulders and turn her around, this was used when we wanted to redirect her and would have been employed daily this was also used with P41

Question 24

How would you describe the atmosphere on the ward within the staff team during this time?

The ward was good to work in. The staff all worked as part of a team and were helpful to each other. There was no stress on the ward; all staff helped each other to address the staff shortages on the ward. Everyone helped each other. The patients were in a small area and they all had Challenging Behaviour.

Question 25

Is there anything that you would like to tell us that you feel would be helpful to the investigation

Some of the staff from the Bohill did not want to be there. B2 told me that she had been told horrendous stories about Ennis. The Bohill staff were watching and looking at the staff in Ennis they did not want to be there. The patient's behaviour deteriorated when the Bohill staff were there as they were strange to the patients. Bohill staff had made comments about Ennis said it was a horrible place.

The environment on the ward was too small for the number of patients and their challenging behaviours. Day care was cancelled regularly for the patients in Ennis as the day care staff were used to cover the shortfalls of staff on the wards within Muckamore Abbey Hospital.

I did not leave B2 for 20 minutes in the day room alone as she stated. I did go to the toilet but H870 was in the day room with B2 When I returned to the day room P39 had faeces on her hands. B2 had no keys for the ward; she had taken P39 to the toilet. H870 went down to the toilet to assist B2 B2 and she was the staff who got P39 her change of clothes' I thought I had heard someone shout but I am not sure.

I left B2 with 2 patients while I gave out the lunches to the other patients; I gave B2 a full explanation the reason for this. I then brough B2 into the dining room and asked her to give P39 her lunch; I gave B2 a full explanation of P39 's behaviours during mealtime and explained how to feed her.

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Appendix 11

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Interview Questions **H159**

12.5.14

Question 1

As a Support Worker in Ennis did you feel supported while working on the ward.

Yes

What supports were available to you?

Staff were great The ward sister was approachable There was a good staff team in Ennis and we all worked and got on well together

Question 2

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you ensure the following;

Patient Safety

On occasions had to lock a door to keep patients safe and in one area for supervision and observations this was at the direction of the nurse in charge. Staff assisted each other and the work was prioritised to keep self and patients safe.

Staff Safety

There was usually a second staff present, staff had alarms. Felt safe on ward as we knew the patients really well and their behaviours.

Was there Staff Rotation within the ward

Generally worked on the same group usually at the bottom of the ward were the patients had challenging behaviour. It was better as this allowed the patients to get used to the staff and the staff to know the behaviours of the patients. Patients at the

top end of the ward had Challenging behaviour as well but these were not as challenging and they knew the staff that worked with them. Strange staff on the ward could escalate these behaviours.

Was there clear allocation of duties for each shift?

The nurse in charge gave the handover this was three times a day and was always completed regardless of staffing levels. There were allocation sheets on ward for staff, communication book and the ward diary. Changes were discussed with staff.

Was there scope for patient engagement in activities apart from daycare

Not really. Doors were open for the patients to go outside weather permitting. The Snoozelem Room off the dayroom was well used. Walks etc were not possible due to staffing levels on the ward. Music was on for the patients. Daycare would have been the main activity for the patients.

Question 3

As a Support Worker did you have annual appraisal and team meetings all carried out consistently with Ennis.

I had my KSF and PCP completed annually I did not have supervision like the trained staff. Team meetings were held monthly approx. I attended these and there were helpful. There was also the ward handovers.

Question 4

Have you ever raised any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with pre the allegations.

No never. The ward had a lot of students families members of the MDT on ward nothing was ever reported. Patient care was a priority to the staff. I was never asked to do anything I did not feel comfortable with.

If yes how were these issues address

Question 5

What was your understanding of the communication that was given to yourself re the Bohill staff coming to work in Ennis and how was this information disseminated to you.

They were coming to Ennis to familiarise themselves, get to know and work with the 3 patients who were to resettle to the Bohill. They were to ask staff in Ennis questions about these three patients. We knew when staff were coming and at what time. The staff did not come onto the ward until after all the patients were up washed and away to daycare, some staff from the Bohill would have followed them to daycare when they arrived. Some staff from the Bohill stayed on the ward and sat around in the day room. [redacted] spent three and half hours in the office reading care plans on the 7.11.12. Bohill said that the ward was not what they had expected though it may have been more like a nursing home said it was dismal, thought they were coming to the ward to paint patients nails etc. The staff from the Bohill was made to feel welcome by the staff in Ennis.

Question 6

Can you please describe the behaviours that would be exhibited by patient [redacted]

She had an unsteady gait walked with her chin in her chest. Would squeal and yell say I hate you I don't like you epically at toileting times or she won't give me that. Accused peers and staff of hitting her and hating her. Also striped of her clothing, pulled trousers down did not wear pyjamas. Liked to play with tops or buttons and would crawl about the floor moving furniture to retrieve her tops. Did not like strangers on the ward none of the patients did. Was known for bleeding gums and generally had bad breath. I had a good rapport with her.

How were these behaviours managed at ward level?

Was nursed in the middle day room of the ward on occasions would have come into the lower of the day rooms. Was settled when she had a top or button to play with, this made her content.

Question 7

Have you ever heard P40 allege that a member of staff or patient had hit her?

Oh yes frequently

If yes how was this addressed?

You would have cajoled P40, distracted her of offered her a drink and biscuit. Never made an allegation against me until the 7th November when later on I was informed of this.

Question 8

Can you please explain of what you recall the evening that it was alleged that a staff member assaulted patient P40

I was there on my own H196 came down to help about ten minutes later as we were short staffed. I decided that I would start the self-care after tea, I cannot remember the order I carried this out on the patients. I did not change P40 that evening. She was in the toilet and I was in the bathroom. I could hear P40 squealing and yelling as she was on the toilet having a bowel motion, she more than likely had taken her clothes off as that is what she normally does but I do not know as I did not see her; I heard her but did not see her.

Between 6.15 and 6.30pm I was changing the girls and bringing them to the day room. I finished this about 7pm locked the bathroom door and began to help with the suppers for the patients. I was in the day room for about ten minutes when P43 was very badly soiled and I took her to the bathroom to change her. H196 brought P40 to the bathroom to change her she was naked. B2 came down to bathroom to help when I was changing P43 she stood and watched me but did not help. I asked B2 to get fresh pyjamas for her which she did and then went back to the day room. I did not do P40 oral hygiene that evening nor did I see any blood. No staff was made aware of anything P40 had said that night that I am aware of. P40 immediately stripped going to bed each night and again first thing in the morning when she went into the bathroom.

Question 9

Did you hear B2 (Bohill Staff) request help to settle P40 on this evening (7.11.12) and if so how did you respond?

No

Question 10

Can you please describe the behaviours that would be exhibited by patient P39 P39 ?

P39 can display very challenging behaviours. She is obsessed with food, stripes off her clothing, masturbates, will PR herself and smear faeces or attempt to eat this and can be wilfully incontinent throughout the day. These behaviours increase when there are strangers in the ward. She would throw things out the window such as her clothes and toys and pull down curtains. P39 knew that she had to have her clothes on at meal times so would attempt to dress herself if she had striped at these times.

How were these behaviours managed at ward level?

Staff tried to amuse P39 with soft balls, toys that sang or played music, this help her to behave. Staff constantly redressed her. P39 s behaviours usually got worse between lunch and tea time. New or strange staff were informed not to let P39 grab your hand as she would nip you or pull you around you had to set boundaries with P39

P39 wore a crop top or swimsuit to prevent her putting her hands down her trousers to prevent her masturbating in the day room. She also wore high waist trousers with a belt to maintain her dignity.

Question 11

Did you or did you ever witness staff throwing P39 's shoes away to occupy her?

No P39 threw her shoes away in the day room or put them out the window. She did not like new shoes.

Question 12

Did you or did you ever witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

No never

Question 13

Have you or have you ever heard staff shout at P39 with a raised voice?

The day room is very noisy there is eleven patients with Challenging Behaviour Staff would have been more assertive to be heard and changed tone when Challenging Behaviour was evident. Staff did not shout.

Question 14

Were patients P39 and P43 ever placed outside in the garden areas?

No P43 likes to be on her own and loves the garden she sits in the same area all the time. P43 was able to get back into the ward by the door but generally staff had to go and get her to bring her back in. P43 would have become agitated or self-injurious if she wanted out to the garden. P43 was only out in the garden if the weather permitted this and was observed by staff.

P39 did not go out unless staff were with her she was never put out.

Question 15

Can you please describe the behaviours that would be exhibited by patient P41 P41 ?

P41 constantly has jerking movements, throws her head back this usually gets worse when she becomes agitated or annoyed. Has problems with her bowels and needs an enema to manage this, when she becomes agitated this is usually a sign that she is constipated. P41 could be aggressive in that she could kick out or hit. She also had pre menstruation pain. She could have thrown cutlery/crockery across the room.

How were these behaviours managed at ward level?

You always stayed to the side when walking or working with her due to her jerking movements P41 loved music. Needed supervised at all times. I had a very good way with P41 on occasions you had to wait until her agitation decreased to work with her. When she was constipated she had an enema.

Question 16

Can you describe how P41 is assisted to mobilise?

At times needed her wheelchair such as when she was outside the ward would have walked her to the bus for day care. You always placed her away from other patients to prevent them getting injured. P41 jerked while sitting. You walked to the side of P41 and if you needed would have placed you hand on her elbow to prevent her jerking her elbow into and to protect you. Staff also placed their hand on her back to guide her in the right direction. When she sat in a chair she always jerked and moved around to get comfortable.

Question 17

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

Never

Question 18

Have you ever raised your voice or used foul language to any patient or staff

Definitely not. May have changed my tone depending on the behaviours of the patients but never yelled or squealed at the patients.

Question 19

Was there restrictive practice employed in Ennis?

No restrictive practices. When questioned further stated the doors would have been locked into middle day rooms. Doors in the bottom area of the ward locked for the patient's safety. Swim suit was not used as a restrictive practice as the patient could remove this it was for her dignity and for the environment for the other patients.

Were these written in the patients care plans?

I would have thought so but I did not read these everyday as I would not have had time to do this. Read care plans when patients first come to the ward.

Question 20

Was there Behavioural Support Plans in place for the patients in Ennis?

Not with the patients at the bottom of the ward.

If yes how was this information disseminated to you?

Question 21

Did patients have it identified and noted in their care plans their behaviours such as stripping, making allegations etc.?

Not sure. Nursing staff that came from the ward that the patients had come from worked with us on the floor and informed us on how to work with these patients.

If yes was it documented how staff where to manage these behaviours?

Staff from the other ward worked with you on the floor and told you how to work with the patients.

Question 22

Have you attended your MAPA training and updates?

Yes

Question 23

Did you employ MAPA techniques within Ennis Ward?

Yes.

If yes can you please give a description of the MAPA techniques employed?

Covering a patient's elbow or putting your hands on a patients shoulder to redirect them or turn them away. This was used with patients P39 and P41.

Question 24

How would you describe the atmosphere on the ward within the staff team during this time?

The ward was very busy but we all worked well as a team and helped each other out, you looked out for each other. There was stress on the ward especially in the mornings as the workload was greater at this time and there was staff shortages.

Question 25

Is there anything that you would like to tell us that you feel would be helpful to the investigation

The ward was very short staffed. Nothing untoward happened on the ward. The staff from the Bohill did not want these three patients said there was other patients on the ward that they could take that had not been identified.

When B2 and I went out for a smoke she did not raise any concerns with me she talked to me about hair, nails etc.

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Appendix 12

Notes of Interview with H205

29th April 2014

Administration Building

Muckamore Abbey Hospital

Question 1

As a Support Worker in Ennis did you feel supported while working on the ward?

Yes I was supported by own staff on the ward. We all mucked in as we were under stress due to staff shortages but we managed. I got support directly by my Ward Manager H491. The workload on the ward was adjusted to meet the staffing levels we prioritised our work.

Question 2

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you ensure the following?

Patient Safety

This was our main priority and I always ensured this. I always made sure someone was with them or within eyesight and not away doing other things. We prioritised our work.

Staff Safety

We completed our main duties things that needed to be done. We helped each other out and looked out for each other.

Was there Staff Rotation within the ward?

Most of the time you stayed with the same group the patients were dependant on staff who knew them well, You generally worked on the group you were key worker for. I mainly worked on Group 4 the girls at the front of the ward and I worked well with patient P198

Was there clear allocation of duties for each shift?

There was an allocation sheet on the ward showing who was to work were this was adjusted when there was staff shortages. The allocation sheet identified what groups you were working with and who was doing the escorts.

Was there scope for patient engagement in activities apart from day-care?

The ward car would have been used even just to take the girls out for a drive. The activity room was used for beauty treatments. There was DVD's Games Cold Cookery in the evenings and the garden was used depending on the weather.

Question 3

Did you as a Support Worker have an annual appraisal and attend regular team meetings within Ennis?

I think I may have had my KSF completed once. There was ward meeting regularly and if you did not attend you received minutes of the meeting.

Question 4

Have you or any staff raised any issues regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that caused concern pre the allegations.

Never had to

If yes how were these issues addressed

Question 5

Have you ever heard P40 allege that a member of staff or patient had hit her?

Yes but about patients only not staff. Heard her say patient P43 had hit her but this patient was not in the area at the time she was in the garden area. Patient P40 was coming from the bathroom on that occasion. P40 would have alleged this a lot.

If yes how was this addressed?

Asked patient were she had been hit and I identified that the patient was not on the ward at the time.

Question 6

Have you ever heard staff shout at P39 with a raised voice?

Not in a raised voice but in a firm voice when P39 was displaying her behaviours. This was not in an angry way.

Question 7

Did you witness staff throwing P39 's shoes away to occupy her?

No P39 would take her shoes off herself and bring them to you this was her way of gaining attention. If the shoes were off P39 would bring them to staff to put them on. If she had new shoes she frequently took them off and threw them away until she got used to them.

Question 8

Did you witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

No never

Question 9

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

Never

Question 10

Did you ever assist staff to put a belt around P39 ?

No staff did not need assistance to put the belt on P39 she always let you put the belt on her. P39 liked her belt and if she did not have one on she would take staff to her room to get one for her. P39 s weight fluctuated so the belt was needed to keep her trousers up, she felt secure with the belt on.

If yes, can you explain how and why this was done?

Question 11

Can you explain the Induction that was in place for the Bohill staff and how this was disseminated to you?

When they came onto the ward they were introduced to the staff they were to shadow the staff who worked with the patients identified for the Bohill, these were the only patients they were to shadow us for. Many times they did not work with the identified patients and would be with other patients eg P202 The manager of the Bohill arrived on the ward to talk to the staff and they were outside with patient P202 P202 the three of them stayed outside during this time. I worked quite a bit with the Bohill staff and never seen them work with patient P199 who was identified to go there.

The Bohill staff did not arrive on the ward until late morning we would have put back the personal hygiene on the patients going to the Bohill for as long as we could to allow them to work with them but generally the patients would have been at daycare by the time they arrived. The Bohill staff would then have went to daycare to see the patients there. I cannot remember the Bohill staff being there in the evenings I recall that they usually left about 5.30pm or before this.

Question 12

Was there restrictive practice employed in Ennis?

No

Were these written in the patients care plans?

Question 13

Was there Behavioural Support Plans in place for the patients in Ennis?

No We worked with the patients and their behaviours by trying different things to see what worked and what did not and knowing our patients. This was communicated within the staff team at handovers and through each other.

If yes how was this information disseminated to you?

Question 14

Did patients have it identified and noted in their care plans their behaviours such as stripping, making allegations etc.?

Yes I think it was as we reported these behaviours to the trained staff.

If yes was it documented how staff where to manage these behaviours?

I am not sure We would have looked at any new patients care plan but we did not have time to read the care plans on a daily basis Infomration regarding patients was communicated between staff.

Question 15

Have you attended your MAPA training and updates?

Yes

Question 16

Did you employ MAPA techniques within Ennis Ward?

Yes

If yes can you please give a description of the MAPA techniques employed?

Level 1 and 2 holds were used with the patients at the front of the ward. I think it may have been used on patient P30 for Self Injurious behaviour but this would have been a level 1 hold to prevent her injuring herself as she was banging her head.

Patient P39 would have stood at the door of dining room There was no reason to move P39 from the this door as she would move herself when asked by staff to do so.

Question 17

How would you describe the atmosphere on the ward within the staff team during this time?

Stressful due to staffing levels and the additional work with the Bohill staff. This put pressure on staff as the patients behaviours increased as they were not familiar with these staff. Some of the Bohill staff appeared very inexperienced. The staff team in Ennis all worked together.

Question 18

There was environmental changes to the ward Can you please tell us how you were consulted on these changes and what was the outcome of these changes for patients and staff.

We were informed of the changes but were not consulted. The bathroom on the front corridor was changed to make this a staff cloakroom. This had an effect on the patients as they only had one bathroom left to use. When patient P198 became challenging this caused delays as the bathroom became blocked and other patients were unable to have their hygiene completed which caused them distress.

The activity room was converted to an office. This was used for patients activities pre this such as beauty, spas and cold cookery this only left the big dayroom for this. This impacted on the patients if one patient was watching the TV and another activity was taking place in this room which could cause challenging behaviour.

Snoozlen room was of no benefit as all the patients could open the door if someone was using it.

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

We were under pressure and stress due to staffing levels on the ward and we did the best we could. Our main priority was the care of the patients.


Appendix 13

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Notes of Interview with **H869**

16th May 2014

Administration Building

Muckamore Abbey Hospital

Question 1

As a Support Worker in Ennis did you feel supported while working on the ward?

Yes I enjoy my work in Muckamore Abbey Hospital the only thing was the staff shortages. My colleagues and the nurses in charge gave me support. Everyone helped each other out we got on well as a team and you only had to ask for help if you needed it.

Ward Sister had e-mailed Senior Nurse Manger regarding the staff shortages on the ward. Staff on the ward did cope with the staff shortages.

Question 2

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you ensure the following?

Patient Safety

We had a level 3 observation in the lower end of the ward her staff was always with her. There were 2 groups in the lower end of the ward on occasions one staff had to do the two groups.

Staff's knowledge and experience of the patients helped to keep them safe. P39 P39 loved to walk and I would have taken her with me when doing laundry etc.

Staff Safety

Staff had a good knowledge of the girls and because I knew the girls I felt safe. The area was never left without staff supervision if I had to leave the area I would have asked the Nurse in Charge to come to the area to let me leave. I would never had left the area and left one member of staff on their own.

Was there Staff Rotation within the ward?

There was rotation but I was generally down the lower end of the ward. I was allocated to these girls as I was their associate nurse. I preferred to work in this area of the ward as I knew these girls, I loved working with these girls and being down the back.

Was there clear allocation of duties for each shift?

Yes there was a communication book allocation sheet on the ward. I knew what I had to do. Allocation sheet identified groups. Escorts and laundry etc was work that everyone knew had to be completed

Was there scope for patient engagement in activities apart from day-care?

There was the Snoozlem Room, music was always on as the girls liked this, TV which was generally the music channel. The garden area was used which summer seats and swings, one patient in particular had liked outside. Foot spa's was carried out in the dayroom in the afternoons and evenings.

Question 3

Did you as a Support Worker have an annual appraisal and attend regular team meetings within Ennis?

Yes I had my KSF/PCP completed 2 to 3 times in Ennis.

Team Meetings I did not get to a lot of them as I do voluntary work. I cannot remember how often they occurred but I did get minutes of these meetings. These meetings contained information on resettlement, use of ward vehicle updates on patients and any items staff raised.

Question 4

Have you or any staff raised any issues regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that caused concern pre the allegations.

No. When the patients moved from Fairview to Ennis it was a smaller ward but the patients adapted well to this environment change. The two staff teams when combined as one worked well together and gelled.

If yes how were these issues addressed?

Question 5

Have you ever heard P40 allege that a member of staff or patient had hit her?

No never

If yes how was this addressed?

Question 6

Have you ever heard staff shout at P39 with a raised voice?

I have never heard staff shout or use aggressive language. Staff would have lifted their voices because of the noise levels within that area. Patients P202, P43 and P41 P41 could be very vocal and it could be hard to be heard.

Question 7

Did you witness staff throwing P39 's shoes away to occupy her?

No P39 liked her shoes, she could take these off. She would have thrown her won clothing and shoes out the window on occasions.

Question 8

Did you witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

No. P39 wore a belt to help keep her trousers up as she wore incontinence products which resulted in her hips being wider than her waist. Her trousers were usually too big for her on the waist as a result of this so a belt was used to keep her trousers up. On occasions she wore tracksuit bottoms so she did not need a belt.

Question 9

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

No some of the patients wore vests with poppers at the bottom.

Question 10

Can you explain the Induction that was in place for the Bohill staff and how this was disseminated to you?

The Bohill staff were there to get to know the patients. I saw some of the Bohill staff getting their Induction by the nurse in charge. They were shown around the ward, introduced to staff and patients and it appeared to be well done. A few of the Bohill staff worked with me I would have given them information on the patients. Sometimes it was hard to get them to concentrate on the patients going to the Bohill as P202 would have taken up some of their attention. Some of the staff were young and had said they had not worked in an environment like Ennis before.

I worked a 1230 to 2300 on the 7.11.12. I worked in the lower end of the ward until 1800 that day and the remainder of my shift I worked with the girls at the upper end of the ward I think I may have been carry out P198s level 3 observations.

Question 11

Was there restrictive practice employed in Ennis?

Bottom half of ward was locked. Garden area was secure/enclosed. Kitchen was locked. Level 3 observations.

Patient [P43] would have drop attacks and would these usually were in the mornings. On occasions she would return to ward from day care in her wheelchair staff would have kept her in her wheelchair with the strap on to prevent injury to herself as she would have been drowsy and unsteady on her feet. Once she was fully recovered staff would take her from the wheelchair.

Patient [P39] wore a swimsuit and or a vest.

Were these written in the patients care plans?

Yes [P22] level of observations.

Not sure about the others

Question 12

Was there Behavioural Support Plans in place for the patients in Ennis?

Would have completed sheets on patients behaviours in the lower end of the ward this would then have went to ABS not sure if this was pre or post the allegations.

If yes how was this information disseminated to you?

Asked to complete these sheets

Question 13

Did patients have it identified and noted in their care plans their behaviours such as stripping, making allegations etc.?

Yes

If yes was it documented how staff where to manage these behaviours?

Yes

Question 14

Have you attended your MAPA training and updates?

Yes

Question 15

Did you employ MAPA techniques within Ennis Ward?

Yes blocking to prevent patients being self-injurious

If yes can you please give a description of the MAPA techniques employed?

Hand over their hand to prevent patient nipping themselves

To move patients would have put hand on their elbow and the other hand on their waist.

Question 16

How would you describe the atmosphere on the ward within the staff team during this time?

I always found it a good team we were short staffed but we got on with our work. I was not stressed re this.

Question 18

There was environmental changes to the ward Can you please tell us how you were consulted on these changes and what was the outcome of these changes for patients and staff.

I was not consulted I am not sure about other staff being consulted. I probably would have kept the activity room if I had been asked

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

I have worked with these girls (patients) so long and I am really attached to them that if I though anyone hurt them I would speak up immediately I would not hide anything. H833 is very passionate about these patients it is clearly evident)

2.017d14

Appendix 14

2.018

Notes of Interview [redacted]

12TH May 2014

Administration Building

Muckamore Abbey Hospital

Question 1

As a Support Worker in Ennis did you feel supported while working on the ward?

Response

Not all of the time we were short staffed. There was a lot of bus outings still going on but it was always the girls/patients at the top end of the ward who went out on these. This left us with all the other girls/patients down at the bottom end of the ward, one of which was on level 3 observations, the girls from the bottom end of the ward all had challenging behaviours such as stripping. Sometimes staff from the upper ward would give the staff help in the lower end of the ward if they were not out on the bus. Support dependant on what staff were on duty.

There was a click on the ward and these staff usually worked with the patients at the upper end of the ward. When they were finished they would be in the office.

There was support from the staff who worked in the bottom end of the ward they helped each other out.

Question 2

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you ensure the following?

Patient Safety

We did our best most of the time we were running around like headless chickens. We tried our best to supervise the patients at all times. In the good weather we opened the doors to allow patients outside, P43 and P202 liked outside. The middle dayroom was utilised. The AM shifts were easier to manage as a lot of the patients were out at day care. The majority of the work such as laundry was done in the mornings to allow staff to supervise the patients in the afternoon as not as many patients were at day care then. The staff team worked together.

Staff Safety

Staff were hit or slapped by patients. There was only enough seating in the dayroom for the patients, staff had to sit on the arms of chairs this was when we got hit or slapped. I have had a jumper ripped off and items threw at me, I never really felt safe. I tried to know my patients and the triggers for their behaviours.

When patients from the upper end of the ward became challenging they were placed in the lower end of the ward. This was as the top end of the ward had ornaments etc sitting about and this was to prevent them getting broke. When the patients came down to the lower end of the ward due to challenging behaviour they would have broken items in that end of the ward. This resulted in the lower end of the ward being baron and dismal.

Was there Staff Rotation within the ward?

Some people worked in the same groups I would have liked a change as the lower end was constant. The staff in the lower end of the ward always did the laundry for the whole ward as staff from the upper end of the ward was working with patients.

Was there clear allocation of duties for each shift?

Not really only groups, activities and outings were allocated. Laundry escorts etc were not allocated.

Was there scope for patient engagement in activities apart from day care?

No the activity room had been turned into an office. There was not a lot of activity for the patients in the lower end of the ward. Jigsaws etc well not well maintained with pieces missing. The upper end of the ward had more activities such as bingo for the patients. The Snoozelem room at the bottom end of the ward was taken over by patient P202. Music was always on at the lower end of the ward as patient P41 liked music.

The activity room had been used for the patients in the lower end of the ward to do hairdressing, make-up painting, games etc this was a great wee room for these patients.

Question 3

Did you as a Support Worker have an annual appraisal and attend regular team meetings within Ennis?

KSF/PCP completed once by the Ward Sister a couple of years ago.

There were team meetings one or two a year for all staff; minutes were available for these meetings. There were more frequent meetings for trained staff; I was not given minutes of these meetings.

Meetings contained the Ward Sisters agenda. Any issues brough up by staff was given lip service such as staffing levels on ward.

Ward Sister delegated al lot of tasks to staff, I was asked on occasions to phone staff to see if they would work to cover shortfalls. The Ward Sister never came to the lower end of the ward except to get the drug trolley. She did not know the patients and would not have understood how hard it was.

Question 4

Have you or any staff raised any issues regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that caused concern pre the allegations.

No never

If yes how were these issues addressed?

Question 5

Have you ever heard P40 allege that a member of staff or patient had hit her?

Frequently alleged that other patients had hit her eg P44 or P43. If she said that P43 had hit her then this would be true. Does not think that she has said that staff have hit her.

If yes how was this addressed?

P40 would be comforted by staff a bit like when you sooth a toddler. We would have reported this to the NIC or another trained staff member that day.

Question 6

Have you ever heard staff shout at P39 with a raised voice?

Not shouting at her staff may have used a firmer tone if P39 was displaying Challenging Behaviour.

Question 7

Did you witness staff throwing P39 's shoes away to occupy her?

No

Question 8

Did you witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

No

Question 9

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

No

Question 10

Did you ever assist staff to put a belt around P39

No you did not need assistance to put a belt on P39 as she liked a belt. The belt was never on too tight so that she could not remove her clothing or that it would leave marks on her.

If yes, can you explain how and why this was done?

She liked a belt

Question 11

Can you explain the Induction that was in place for the Bohill staff and how this was disseminated to you?

I was informed that the Bohill staff were coming to see certain patients. I was told they could come with us to learn for the first few days and then the Bohill staff were to work with the patients directly.

It was felt by the staff in Ennis that the Bohill staff did not want to be there and they did not want the patients that had been identified to go to the Bohill when they seen their behaviours especially P39 . They spend most of their time with patient P202 P202 in the garden area. Some of the Bohill staff came in and sat most of the shift in the day room and did not interact with the patients. Some of the staff from the Bohill did interact with patients and staff.

Question 12

Was there restrictive practice employed in Ennis?

Patients in the lower end of the ward were moved from the dayroom when a patient from the upper end of the ward was there due to aggression.

There were locked doors on the ward at the lower end of the ward

Were these written in the patients care plans?

I don't think so I am not sure

Question 13

Was there Behavioural Support Plans in place for the patients in Ennis?

Some of the patients from the upper end of the ward had Incentive Plans the patients in the lower end of the ward did not

If yes how was this information disseminated to you?

This is written up in their Incentive Plan which is kept in the office and that can be easily read by staff. Patients were able to inform you of their Incentive Plans.

Question 14

Did patients have it identified and noted in their care plans their behaviours such as stripping, making allegations etc.?

I do not know as I never got the chance to read the care plans as I was never in the office. Due to my shift pattern I was always covering ward duties during handovers and did not get a handover when I came on duty. Other staff kept me up to date on what was happening within the ward.

If yes was it documented how staff where to manage these behaviours?

Question 15

Have you attended your MAPA training and updates?

Yes

Question 16

Did you employ MAPA techniques within Ennis Ward?

Yes

If yes can you please give a description of the MAPA techniques employed?

P198 full PI

P46 full PI

Both of the above either sitting or standing

Question 17

How would you describe the atmosphere on the ward within the staff team during this time?

The atmosphere on the ward was awful due to staff shortages; ward was always working short staffed, staff were stressed due to this. In the lower end of the ward it was the same routine day after day.

The atmosphere between staff was good we worked really well together and everyone got on with the work. Staff helped each other out and pulled together as a team.

Question 18

There was environmental changes to the ward Can you please tell us how you were consulted on these changes and what was the outcome of these changes for patients and staff.

Activity room was made into an office we were not consulted on this it was just done. The patients enjoyed the activity room it was an area to allow the patients in the lower day room to be spaced out and separated.

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

No

Since the allegations there was a new Ward Sister on the ward which made a big difference she was;

- Approachable
- She knew the patients, had a relationship with the patients and they all liked her
- She help out on the ward and was hands on
- She was a breath of fresh air
- She made a big difference

2.018d15

Appendix 15

2.019

Notes of Interview with H206

29th April 2014

Administration Building

Muckamore Abbey Hospital

Question 1

As a Support Worker in Ennis did you feel supported while working on the ward?

Yes felt supported by the staff team. Staff shortages were a big issue but we got used to this and adopted to it. Trained staff would be allocated to work on groups, usually they were allocated to work on the group they were named nurses for, in the morning and evenings and would then be in the office. The trained staff came to help/assist when asked but we mainly worked with Support Workers without direct supervision of trained staff. The Nurse in Charge would do the tablets and office work.

Question 2

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you ensure the following?

Patient Safety

Patients were supervised by staff. Observations of patients and patients on Constant Supervision was completed.

Staff Safety

The staff in Ennis worked as a team helping each other out.

Was there Staff Rotation within the ward?

No generally you worked on the group you were Key Worker for. I was on night duty so would have floated between groups but mainly worked with the patients at the back of the ward. Only change was if you were on a Level 3 Observation.

Was there clear allocation of duties for each shift?

You looked to see what group you were on there was no allocation of other duties. Staff worked a team to complete other duties.

Was there scope for patient engagement in activities apart from daycare?

We used the car pre the allegations this was taken away just after the allegations. There was an activity room on the ward but this was turned into an office, not sure when this occurred. The patients from the top end of the ward went to the cinema every Sunday. All the patients went on holidays in small groups about two years ago there has been no holidays since this.

Question 3

Did you as a Support Worker have an annual appraisal and attend regular team meetings within Ennis?

I had my appraisal completed annually by H325 on the ward. Staff meetings were once every six months I attended these on a couple of occasions those I did not attend I got minutes of the meeting.

Question 4

Have you or any staff raised any issues regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that caused concern pre the allegations.

No Nobody ever raised any issues with me

If yes how were these issues addressed?

Question 5

Have you ever heard P40 allege that a member of staff or patient had hit her?

Yes P40 would say this about other patients never heard her say this about a member of staff.

If yes how was this addressed?

If we had not witnessed anything we would have reported this to the Nurse in Charge.

Question 6

Have you ever heard staff shout at P39 with a raised voice?

No

Question 7

Did you witness staff throwing P39 's shoes away to occupy her?

No P39 will throw her shoes out the window or throw them across room especially if they are new shoes.

Question 8

Did you witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

No P39 stripes her won clothing off and throws away clothing and shoes.

Question 9

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

No

Question 10

Can you explain the Induction that was in place for the Bohill staff and how this was disseminated to you?

I was just told Bohill said were coming to the ward, no other communication was given to me regarding this. There was no clear guidance given on how to work with the Bohill staff.

Bohill staff did not come at the times they were planned to be on the ward. They would have arrived late in the mornings, could have been 10am, by this time the patients identified for the Bohill were already up and dressed and on occasions would have been at day care. Sometimes the staff from the Bohill would have gone to day care at other times they stayed on the ward and interacted with others. They rarely saw patients getting up in the morning getting washed dressed etc.

Bohill staff also left early, could have left at 6pm, therefore they did not see the patients getting ready for bed. One staff did a night duty on Ennis she arrived after the patients had received their suppers and medication, approx after 10pm, then left at approx 430am, patients would still have been in bed at this time.

Question 11

Was there restrictive practice employed in Ennis?

Doors were locked on the ward but there was always staff in the area. The door to the garden was locked when all the patients were on the ward. If patients were in the garden then this door was open or wedged opened.

A swimsuit was used on P39 for dignity as she keep this on after removing her clothes. We were instructed to put on the swimsuit. Belt was used to keep her trousers up and P39 liked to take this off and play with it. P39 could take the belt off and was not considered as restrictive practise as other people wear a belt.

Were these written in the patients care plans?

I do not know

Question 12

Was there Behavioural Support Plans in place for the patients in Ennis?

Not that I know off not aware of any.

If yes how was this information disseminated to you?

Question 13

Did patients have it identified and noted in their care plans their behaviours such as stripping, making allegations etc.?

I reported these behaviours to the Nurse in Charge but I do not know if it was in the Care Plan

If yes was it documented how staff where to manage these behaviours?

Question 14

Have you attended your MAPA training and updates?

Yes

Question 15

Did you employ MAPA techniques within Ennis Ward?

Yes

If yes can you please give a description of the MAPA techniques employed?

Arms holds on patients P198 and P46 No moves used to move patients at doors

Question 16

How would you describe the atmosphere on the ward within the staff team during this time?

Ennis is a good ward with good staff team. The ward worked short staffed but that became the normal and we got on with it. The staff shortages did annoy some staff.

Question 17

There was environmental changes to the ward Can you please tell us how you were consulted on these changes and what was the outcome of these changes for patients and staff.

Bathroom was converted to a staff toilet and locker room. Clinical room was changed to a a staff room about 4 to 5 years ago.

The Activity room was converted to a second office this was for the Nurse in Charge and staff. The first office was the Ward Sisters Office the only other time I seen it used was for the ward report to be completed at 7am in the morning by the Nurse in Charge.

The Snozelem Room was created when Fairview patients came.

The Activity Room was missed by me. I felt that the patients missed this room as it was used every day for art and craft, footspa, etc. Staff were not consulted re the changes to the ward environment.

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

No

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Appendix 16

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Notes of Interview H196

29th April 2014

Administration Building

Muckamore Abbey Hospital

Question 1

As a Student Nurse in Ennis did you feel supported while working on the ward?

Response

I only worked 8 shifts on Ennis pre allegation

Yes felt supported by

- Opportunity to ask questions
- Given an induction
- Supported by staff team
- Used a buddy system on ward
- Shadowed staff and the Nurse in Charge

Question 2

Did you have a Comprehensive Induction to the ward and where you given pen pictures of the patients on the ward?

Response

Had a good Induction

Cannot remember is she was given pen pictures

Question 3

Did you ever raise any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with?

Response

No

If yes how were these issues addressed

Question 4

Can you please describe what you recall the evening that it was alleged that a staff member assaulted patient P40 ?

Response

I was in the front office of the ward reading care plans this was to help me do management plans, I worked a PM shift that day. I was asked to give a hand to put away laundry in the back of the ward. Later on I was at the front of the ward with a patient. I spent most of the shift in the office going over care plans.

I was down back of ward putting away laundry I put slippers on one of the girls I cannot remember the patients name or time. I cannot remember anything else.

Question 5

Did B2 request assistance to try and settle patient P40 and if so how did you respond?

Response

Can remember the staff from the Bohill but cannot recall her name. Conversation was that it was B2 s first day. B2 had stated that she had applied for nursing but did not get in.

Cannot remember B2 asking for assistance.

Question 6

Did you witness a member of staff wipe patient P40 s mouth roughly with a mitt?

Response

No

Question 7

Did you hear patient P40 say anything on that evening regarding staff?

Response

No I cannot remember

Question 8

Have you ever heard P40 allege that a member of staff or patient had hit her?

Response

No I cannot remember

If yes how was this addressed?

Question 9

Did you inform patient P40 that she would not get her sweets and lemonade if she did not put her clothes on?

Response

No

Question 10

Have you ever heard staff shout at P39 with a raised voice?

Response

No

Question 11

Did you witness staff throwing P39 's shoes away to occupy her?

Response

No

Question 12

Did you witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

Response

No

Question 13

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

Response

No

Question 14

How would you describe the atmosphere on the ward within the staff team during this time?

Response

Cannot comment as duration on ward was short. Cannot remember

Question 15

What was communicated to you about the Bohill staff being on Ennis?

Response

I had attended a resettlement meeting so I knew what Bohill staff were doing on ward. Did not have much involvement with Bohill staff.

Meet a few of the staff but cannot recall their names. Would not have worked with Bohill staff as I was shadowing other staff.

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

Response

No

Notes of Second Interview H196

2nd June 2014

Administration Building

Muckamore Abbey Hospital

Question 1

A number of staff have described the night that P40 alleged that a member of staff had hit her. Staff have stated that you were in this area at this time. Can you please clarify for us what you recall from that evening?

I took laundry down to the back area of the ward. I put slippers on a patient

Question 2

Did you take patient P40 to the bathroom area that evening?

I cannot remember the patients names

Question 3

Did you help staff with patients routines that evening?

Yes I did help with bedtime changes but do not remember who

Question 4

Do you recall the staff on duty that evening?

Cannot remember

2.02.17

Appendix 17

Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
9	12	10	2	9	6	5	2	31	38	53	29

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Appendix 18

2.022

Appendix 3

BELFAST HEALTH AND SOCIAL CARE TRUST

MUCKAMORE ABBEY HOSPITAL

MEMORANDUM

From: Mrs K Murray
Day Care Services Manager

To: Mrs R Scott
Senior Nurse Manager

Ref: **KM/**os

Date 8th May 2014

Re: **Requested Information**

Please see attached information requested regarding Ennis patients' attendance on 7th November 2012 and for the month of November 2012.

Please do not hesitate to contact me if you need further information or clarification.

K. Murray

Kim Murray
Day Care Services Manager

In response to your request for information regarding Ennis patients' attendance on 7th November 2012 and for the month of November 2012, information was gathered from the following sources:-

- Epex
- Duties
- Situation Sheets
- Diary
- Care Plans
- Staff files

In relation to 7th November 2012 the following patients' Day Care was cancelled:-

- P30
- P39
- P41
- P200
- P197

The reason for this cancellation was due to the fact that Moyola had four members of staff on sick leave and one on Jury Service. This, therefore, necessitated the closure of Room 7 and Room 3 affecting the aforementioned patients.

In relation to the other days in November 2012 please see the following:-

Thursday 1st November 2012

No patient Day Care was cancelled, however, both P198 and P40 P40 refused to attend.

Friday 2nd November 2012

All Ennis patients attended.

Monday 5th November 2012

Room 7 in Moyola was closed and the following patients were cancelled:-

- P30
- P39
- P41

The reason for the closure of Room 7 lies with the fact that four staff were on sick leave and one staff was on Jury Service. P198 did not attend on this day and records indicate she was sick.

Tuesday 6th November 2012

P30 P39 and P41 did not attend Day Care on this date. The records indicate that the reason for this was that a ward escort was not available. The following patients were cancelled by Day Care:-

- P42
- P46

The reason for this cancellation was due to four members of Moyola staff being on sick leave and one on Jury Service. P40 did not attend on this day and the records indicate that she refused.

Wednesday 7th November 2012 – as previously outlined.

Thursday 8th November 2012

The following patients' Day Care was cancelled:-

- P198
- P197
- P46
- P42
- P40

The reasons for this cancellation was due to four staff being on sick leave but also records indicated that four Nursing Assistants were sent to the ward on relief. This would have impacted and resulted in closure of Room 4 in the afternoon affecting P46 and P42

Friday 9th November 2012

The following patients' Day Care was cancelled:-

- P46
- P42
- P45

The reason for this cancellation was due to two Nursing Assistants being sent to the ward on relief due to ward shortages. P40 did not attend due to an appointment.

Monday 12th November 2012 – Friday 16th November 2012

The following patients' Day Care was cancelled for the week:-

- P198
- P19
- P40
- P45
- P41
- P30
- P39

The reason for this cancellation was due to having three members of staff on sick leave for the week.

P44 did not attend on Monday 12th November '12 and records indicate she had an appointment.

Monday 19th November 2012

Day Care was cancelled for the following patients:-

- P43
- P47

The reason for this cancellation was due to three members of staff being on sick leave, one member of staff being on compassionate leave and one member of staff being on Carers' Leave.

Tuesday 20th November 2012

All Ennis patients were in attendance.

Wednesday 21st November 2012

All Ennis patients were in attendance.

Thursday 22nd November 2012/Friday 23rd November 2012

The following patients' Day Care was cancelled:-

- P30
- P39
- P41

The reason for this sick leave was due to three members of staff being on sick leave.

Monday 26th November 2012

The following patients' Day Care was cancelled:-

- P30
- P39
- P41
- P198
- P197
- P40
- P45

The reason for this appears to be three staff members on sick leave as well as one staff getting an emergency annual leave day.

Tuesday 27th November 2012

All Ennis patients attended on this day.

Wednesday 28th November 2012

The following patients' Day Care was cancelled:-

- P198
- P197
- P40
- P45
- P40

The reason for this was due to three staff being on sick leave and one member of staff being on Compassionate Leave.

Thursday 29th November 2012/Friday 30th November 2012

All Ennis patients attended, there were no cancellations.

See attached table with shows an overview of Ennis patients' attendance for November'12

Kim Murray
Day Care Services Manager

Ennis Attendance Numbers for November 2012

Name	T 1	F 2	M 5	T 6	W 7	T 8	F 9	M 12	T 13	W 14	T 15	F 16	M 19	T 20	W 21	T 22	F 23	M 26	T 27	W 28	T 29	F 30
[redacted] P30 P33 P41 P202 P44 P43			RC	WENA	RC			RC								RC	RC	RC				
[redacted]			RC	WENA	RC			RC								RC	RC	RC				
[redacted]				WENA	RC			RC								RC	RC	RC				
[redacted]					F	U	L	L		A	T	T	E	N	D	A	N	C	E			
[redacted]								APPT										APPT				
[redacted]													RC									
[redacted] P19 P7 P26 P42 P196 P204 P40 P45 P47	R		S		RC	RC		RC	RC	RC	RC	RC						RC		RC		
[redacted]					RC	RC		RC	RC	RC	RC	RC						RC		RC		
[redacted]				RC		RC	RC															
[redacted]				RC		RC	RC															
[redacted]					F	U	L	L		A	T	T	E	N	D	A	N	C	E			
[redacted]					F	U	L	L		A	T	T	E	N	D	A	N	C	E			
[redacted]	R			R		RC	APPT	RC	RC	RC	RC	RC						RC		RC		
[redacted]							RC	RC	RC	RC	RC	RC						RC		RC		
[redacted]													RC									

R-Refused **S-Sick** **WENA-Ward Escort Not Available** **RC- Room Closed** **Appt-Appointment**

2,022d19

Appendix 19

Ennis Resettlement Meeting 21/10/2012

Belfast Trust

Present

Dr H50

Dr H194

Rhonda Scott

Mary Mc veigh

B1 (Bohill)

H196 STD N

Catherine O'Callaghan

Liz Moore

Catriona Mulvenna

Bohill Update

The 3 ladies from Erne for Bohill are P199, P43 and P39

Care plans will be discussed with a hope of signing off when amendments have been made.

Timescales will also be discussed.

No concerns from Bohill staff that have been working in Ennis with the 3 ladies.

Timescale discussed for ladies to move W/C 12th November 2012, it is thought that it would be best for all 3 to move together. Staff from Ennis will visit Bohill on a daily basis for the first 2 weeks initially (an Ennis staff member there 24 hrs) but this can be reviewed, H377 has agreed to same.

It was discussed after discussion surrounding behaviours of some female patients that single gender units would be the best way forward.

Restrictive Practices will be discussed further with H92 Kell for his opinion.

Issue with registering with G.P still on-going, B1 is dealing with this at present.

B1 had enquired as to wither a month supply of medications could be prescribed from M.A.H, Dr H194 will enquire with Pharmacy regarding same.

Risk Assessments will be completed for all and monitored 3 monthly.

Advocacy is happy with arrangements.

P199

Care plan was discussed and amendments noted, B1 will make amendments with signing off at a further date.

It was discussed that P199 will need encouragement in the mornings.

Funeral plan, H491 will update when completed and hope that the plan will be finished before the move to Bohill.

P43

Care plan discussed and amendments noted, B1 will update. Discharge summary from Ennis.

Family have visited Bohill, they are still nervous regarding resettlement but were impressed with staff, they are aware that there will be male staff on duty but they will not administer personal care.

Wheel chair is used for P43 's own safety when she has a seizure, this will need to be noted as a restrictive practice and on Bohill's risk register.

P39

Care plan discussed and amendments noted, B1 to update.

Even though seizures are historical the procedure in the community when a seizure occurs is to call 999.

Staff from Bohill had stated they were concerned re P39 removing her clothing as there would be male peers in the same unit it was discussed that P39 wears a swimsuit under her clothing and the possibility of a body suit will be explored, she could also be withdrawn to her bedroom and that every way of managing her behaviour has been explored, for this reason it was discussed that there would be issues surrounding vulnerable adults and restrictive practices, Catherine will refer to B.S.S for further clarification.

At this stage the possibility of single gender units was discussed, B1 will speak to RQIA regarding this issue as B1 felt that RQIA would seem more favourable towards mixed units in the community.

Rhonda will discuss further with H92 issues surrounding vulnerable adults and get his views on the issue.

All updates will be discussed at the next meeting.

2.023 of 20

Appendix 20

Scott, Rhonda

From: B15 B15's email address
Sent: 22 October 2014 16:39
To: Scott, Rhonda
Cc: Gavin OHare-Connolly; Rosemary Dilworth
Subject: RE: Ennis Investigation

Hello Rhonda

The actual date that I was made aware was the 8th November 2012 by the Team Leader at the time.

Kind regards

B15

Home Manager
ore Care

Tel: 028 70 325180
Fax: 028 70 325185
B15's email address

From: Scott, Rhonda [mailto:rhonda.scott@belfasttrust.hscni.net]
Sent: 22 October 2014 14:22
To: B15
Subject: RE: Ennis Investigation

B15

I am keeping well how are you everything good at your end
Thank you for this B15 can you just clarify for us I know the report states the 8th Nov 2012 but what I need you to
ıfirm for me is when you where first alerted to concerns in Ennis
you
Rhonda

From: B15 B15's email address
Sent: 22/10/2014 13:59
To: Scott, Rhonda
Cc: Gavin OHare-Connolly
Subject: RE: Ennis Investigation

Hello Rhonda

Hope you are keeping well.

The initial report date of allegations are the 8th November 2012.

Kind regards

B15

lome Manager
.more Care

el: 028 70 325180
ax: 028 70 325185
B15's email address

From: Scott, Rhonda [mailto:rhonda.scott@belfasttrust.hscni.net]
Sent: 22 October 2014 13:23
To: **B15**
Subject: Ennis Investigation

B15

Can you confirm for me the date that staff at the Bohill raised concerns around the practices in Ennis As you know I am
npleting the internal investigation and just need clarity on this issue

R. ..

2.025 d 21

Appendix 21

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Week commencing 15th October 2012

	Monday 1st	Tuesday 2nd	Wednesday 3rd	Thursday 4th	Friday 5th	Saturday 6th	Sunday 7th
B7	ERNE 8-8	ERNE 8-8				ERNE 8-8	ERNE 8-8
B14			ENNIS 8-8	ENNIS 8-8	ENNIS 8-8		
B16	ERNE 8-8	ERNE 8-8					ERNE 8-8
B10	ENNIS 8-8	SICK 8-8				SICK 8-8	SICK 8-8
B5			ENNIS 8-8	ENNIS 8-8	ENNIS 8-8		
B13			ERNE 8-8	ERNE 8-8	ERNE 8-8		
B9						ENNIS 8-8	
B17			ERNE 8-8	SICK 8-8	SICK 8-8		
B8	ENNIS 8-8	ENNIS 8-8				ENNIS 8-8	ENNIS 8-8

Week commencing 8th October 2012

	Monday 8th	Tuesday 9th	Wednesday 10th	Thursday 11th	Friday 12th	Saturday 13th	Sunday 14th
B3	ENNIS 8-8	ENNIS 8-8	ENNIS 8-8				
B4		ENNIS 8-8	ENNIS 8-8	ENNIS 8-8			
B16	ERNE 8-8	ERNE 8-8			ERNE 8-8		
B5	ENNIS 8-8				ENNIS 8-8		
B9			ERNE 8-8	ERNE 8-8			ENNIS 8-8
B17					ERNE 8-8	ERNE 8-8	ERNE 8-8
B12			ERNE 8-8	ERNE 8-8		ENNIS 8-8	

Week commencing 15th October 2012

	Monday 15th	Tuesday 16th	Wednesday 17th	Thursday 18th	Friday 19th	Saturday 20th	Sunday 21st
B11				ENNIS 8-8		ERNE 8-8	
B12	8-8	8-8			8-8		
B16	ERNE 8-8	ERNE 8-8			ERNE 8-8		
B13			ENNIS 8-8	ERNE 8-8			ERNE 8-8
B9	ENNIS 8-8	ENNIS 8-8				ENNIS 8-8	ENNIS 8-8
B17			ERNE 8-8		ERNE 8-8	ERNE 8-8	ERNE 8-8
B8	ERNE 8-8	ERNE 8-8	ENNIS 8-8	ENNIS 8-8			

Week commencing 22nd October 2012

	Monday 22nd	Tuesday 23rd	Wednesday 24th	Thursday 25th	Friday 26th	Saturday 27th	Sunday 28th
B7			8-8 Erne		8-8 Erne		
B18							8-8 Ennis
B10		11-11 Ennis		11-11 Ennis	11-11 Ennis		
B5	11-11 Ennis		11-11 Ennis				
B13	8-8 N/D Erne	8-8 N/D Erne				8-8 N/D Erne	8-8 N/D Erne
B17				8-8 N/D Erne	8-8 N/D Erne		ERNE 8-8
B12				8-8 Erne		8-8 Ennis	

Week commencing 29th October 2012

	Monday 29th	Tuesday 30th	Wednesday 31st	Thursday 1st	Friday 2nd	Saturday 3rd	Sunday 4th
B16	ERNE 8-8	ERNE 8-8				ERNE 8-8	ERNE 8-8
B5			8-8 Erne	8-8 Erne	8-8 Erne		
B10	11-11 Ennis	11-11 Ennis				11-11 Ennis	11-11 Ennis
B2	8-8 RATHMULAN						
B13			11-11 Ennis	11-11 Ennis	11-11 Ennis		

Week commencing 5th November 2012

	Monday 5th	Tuesday 6th	Wednesday 7th	Thursday 8th	Friday 9th	Saturday 10th	Sunday 11th
B2			11-11 Ennis				
B10			8-8 Erne	8-8 Erne	8-8 Erne		
B13		8-8 Erne				8-8 Erne	
B6	11-11 Ennis						
B5		ENNIS/N/D 8-8	ENNIS N/D 8-8			SICK	

Week commencing 22nd October 2012

	Monday 22nd	Tuesday 23rd	Wednesday 24th	Thursday 25th	Friday 26th	Saturday 27th	Sunday 28th
B7			8-8 Erne		8-8 Erne		
B14		8-8 Erne					~~8-8 Ennis~~
B18							
B10		11-11 Ennis		11-11 Ennis	11-11 Ennis		
B5	11-11 Ennis		11-11 Ennis			8-8 N/D Erne	8-8 N/D Erne
B13	8-8 N/D Erne	8-8 N/D Erne					
B17				8-8 N/D Erne	8-8 N/D Erne		
B12				8-8 Erne		8-8 Ennis	

Week commencing 29th October 2012

	Monday 29th	Tuesday 30th	Wednesday 31st	Thursday 1st	Friday 2nd	Saturday 3rd	Sunday 4th
B11							
B4			8-8 Rathmullan	8-8 Rathmullan	8-8 Rathmullan		
B8	8-8 Rathmullan	8-8 Rathmullan				8-8 Rathmullan	8-8 Rathmullan
B5			8-8 Erne	8-8 Erne	8-8 Erne		
B10	11-11 Ennis	11-11 Ennis				11-11 Ennis	11-11 Ennis
B2	8-8 Erne	8-8 Erne				~~8-8 Erne~~	8-8 Erne
B16			11-11 Ennis	11-11 Ennis	11-11 Ennis		
B13							

B18

Week commencing 5th November 2012

	Monday 5th	Tuesday 6th	Wednesday 7th	Thursday 8th	Friday 9th	Saturday 10th	Sunday 11th
B2			11-11 Ennis	11-11 Ennis	11-11 Ennis		
B10			8-8 Erne	8-8 Erne	8-8 Erne		
B13	8-8 Erne	8-8 Erne				8-8 Erne	8-8 Erne
B6	11-11 Ennis	11-11 Ennis				11-11 Ennis	11-11 Ennis

2.025d22

Appendix 22

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CONFIDENTIAL

Muckamore Abbey Hospital
2nd Briefing report by M Mannion – 9th January 2013

Actions completed

- Over the Christmas period, I undertook a further two unannounced leadership walk arounds time commitment 4hrs x 2 =8hrs,
- I have completed a review of patient's notes, medical files, and drug kardex, 4 files that were requested to be reviewed by the strategy group and a further 4 files randomly selected from the remaining population of patients on Ennis. Time commitment 18 hrs.
- I have completed analysis of the monitoring forms submitted since the 19th of December taking an inclusive approach by integrating and reviewing previous data from the first briefing completed for the 20th of Dec 2012. Time commitment 10 hours.
- I have completed a review of the learning environment using the Learning and Assessment Standards created and regulated by the Nursing and Midwifery Council NMC. This involved reviewing the student evaluations over the last 2 yrs, requesting if there were any student or external reviewers concerns about the practice environment or behaviours of staff i.e. the NMC annual reviewers, the nursing Practice Education Facilitator the clinical tutors who act as the pre-registration nursing students placement supervisors from Queens University. Time commitment 5hrs.
- Update on the draft improvement plan;
    - Environmental concerns are being addressed cleaning schedules have been improved,
    - Repair of estates issues progressing,
    - Fire safety and environmental issues have been addressed,
    - Admin support officer time increased to support the ward sister,
- Communications with:
    - Executive Director of Nursing and the Director of the Adult Social and Primary Care Directorate,
    - Associate Director of Nursing,
    - Ward Sister and Deputy Ward sister,
    - Monitors present on the ward environment when I was present,
    - Co-Director of the Adult Social and Primary Care Directorate,
    - Service manager of Ennis,
    - Behaviour support officers x 2,
    - Medical staff in the unit,
    - Relatives visiting the unit,
    - Ergonomics trainer,
    - MAPA trainer.

Preparing this briefing paper time commitment 8 hrs

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Review of patient's notes, medical files, and drug kardex

Documents were reviewed and completed in the care environment and at all times documentation remained in the clinical environment. The information governance policy was respected in this activity.

There were 8 patients files reviewed, 4 named patients as requested by the strategy group and a random selection of files from the other 13 patients. A patient who observed me taking out her records for review asked what I was doing, when an explanation was offered she declined giving her consent for the review to take place, this request was respected. One patient is expected to be discharged within the coming week therefore not selected for review.

There is a corporate commitment for MAPA behavioural strategies to be implemented when appropriate. All of the current patients in Ennis ward are described as presenting with challenging behaviours that on occasion will require the MAPA range of interventions. Registered Nurses, unregistered Health Care Support Workers and Nursing Auxiliaries, are trained in this process. Staff requiring updates are provided with update training which has included observation by a recognised trainer of the staff member when required to use this form of intervention.

There was evidence of an audit conducted in the last year of the MAPA process reported win the patient notes. The audit outcome was positive.

Active promotion of all other prescribed personal life story work i.e. get to know me documentation recorded in each note file reviewed, personal de-escalation strategies particular to individual patients as per care plan is expected and evidence of adherence to this process is recorded within the notes.

I found within my discussion with the MAPA trainer that the moves noted as potential allegations (Allegations were not discussed with the Trainer) could have been MAPA moves designed to protect both patient and others during perceived challenging behaviour episodes.

In my discussion with the Ergonomics trainer, I was advised that staff need to position themselves in such a manner to reduce potential harm to themselves and patients therefore patients with presenting Jerk like behaviours will require a firm and appropriate paced manoeuvre personal to the individual patient. Also it was noted with patients who are potentially unsteady in gait and are perceived or known to be somewhat over weight this must also affect a change of manoeuvres, further acknowledgement of furniture which is set lowly (as it is in Ennis) although comfortable is also a feature of staff when required to assist and support movement of patients, this may appear that some one could be "hauled out of a chair" staff are encouraged to support a patient who has their legs in under their body on a chair to manoeuvre their legs to the floor as a first step, prior to expecting them to stand or be assisted to stand. It was also noted that when moving someone who exhibits rocking movements backwards and forward or side wards rocking that staff are encouraged to move backwards and forward or sideways with them this reduces the risk of falls during dressing and moving activities.

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In my discussion with the behaviour officers it was noted that behavioural plans are regularly reviewed and that the nursing team are engaged in behavioural plans on each shift, it was noted by the 2 staff that much progress has been achieved from previous behavioural base lines in the previous ward environment prior to the transfer to Ennis this they both said was extremely positive yet constant.

In my discussion with the Ward sister regarding resettlement and community integration, she shared the following information. As a team they had been informed that the ward was due to close in March 2013 and that the Resettlement Process commenced in March 2012. All patient Annual Reviews were postponed by the Ward Consultant to facilitate weekly Resettlement meetings.

The Resettlement process began and progressed through the assessments despite working through times when there were unfortunately high levels of staff sick leave. At times the staffing suffered gross shortage ie 4 AM staff plus staff at 9.30AM.

This was highlighted with the Nurse Manager for the ward via emails, conversations and incident reporting. The manager for the ward spoke to me about my concerns.

The nursing staff's interest and morale did not appear to have lessened and every opportunity was still being provided to introduce the patients to the community. During the summer of 2012 a leaving party was held for the patients and their families. With Marquee and a musical entertainment, the patients had a great time on the day. We invited one of our ex patients, who had been successfully resettled in 2011 and she attended with a group of her friends to the dance.

Prior to this Allegation there had been a decision taken amongst patient's families, advocates and Multi disciplinary team that three patients would go to the Bohill Care Home on Trial Resettlement. Assessments have been collated and care plans drawn up. The team leader and manager had visited Ennis and had been in attendance at Resettlement meetings along with R.Scott CIP and Care Managers from the Belfast Trust.
Staff from the Bohill had begun a 6 week period of visiting the patients in Ennis and getting to know them and their needs. Unsettled behaviours of some patients were noted early on and reported to me as ward sister, this was relayed to the Resettlement team. I expressed concern that a period of 6 weeks may be too long if the patients continued to be upset.

At a meeting held in Erne ward to Review the progress of the visiting staff and patients it was requested that the "Bohill staff come to myself if they had any concerns", "I had to redirect member of Bohill staff as a disturbed patient was directing verbal aggression towards them, during their time on the ward".

The staff visits by Bohill had commenced before the ward sister in Ennis had a copy of their duty rota. Staff on duty found this confusing at the time. It was explained that there was problems with the Bohill Care Homes emailing system. The duty received did not reflect the names or numbers of all the staff who reported for duty.

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On one occasion a nurse in charge received four staff who thought they should be in Ennis that day. The staff rotated on a 3 daily basis, two and sometimes three staff together every three days. Induction for this amount of people under the conditions we were working proved to be extremely difficult. The induction process that had been agreed did take place with staff from Bohill but Bohill had sent additional staff without first communicating with the ward sister to inform her of the same. This did result in confusion.
I found evidence of adherence to Trust policy and guidance by the nursing team and active leadership by the ward sister and deputy ward sister.

Documentation review findings;

1. **Patient Nursing notes spanning last two years 2011-2012**

- Roper, Logan and Tierney model care plans in use, fifteen activities of living completed and a review process conducted each six months. This is a person centred care planning process for Nursing Care.
- Named nurse and associate named nurse identified within each set of notes, each record was signed by the nurse recording the information.
- The ward team is actively implementing the need to care for each individual patient in accord with the RCN Dignity Standards;
  - understand my health,
  - respect me,
  - get to know me,
  - having choices,
  - making decisions,
  - feeling safe and promoting my safety.
- Current Patient Protection Plans evident within the notes.
- Patient body charts were used recording bruise/marks noticed, when supporting personal hygiene care, with appropriate medical intervention when required.
- Behavioural plans with Antecedent, Behaviour and Consequences charts, known as ABC charts evident within the plans.
- Contemporary daily care reports written by registered nursing staff.
- Incident reports, Vulnerable Adult forms with associated person centred interventions recorded.
- Personal requests made by patients to be reviewed by the medical team regarding care were recorded.
- Nursing staff concerns relating to aspects of care recorded.
- Not all notes had a current Social Work report but evidence of an historical report.
- I found evidence of basic personal care, personal hygiene, Oral hygiene, fingernail and hand care, toe nail and foot care, hair care and clothing care were all appropriate and respected choice and identified personal preferences of the patients.

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- For some patients there were transitional plans covering moves from the previous clinical environment to the present.
- Multi-disciplinary care reviews were recorded and more recently the integrated community plan meetings were recorded with invitation to family to be involved but not always availed off.
- All patient notes reviewed held the status of delayed discharge from 2007, with many care environments having been assessed and deemed not appropriate or the external providers deeming the patients to be complex and challenging and unsuitable for their environments.
- All files reviewed were consistent with multi professional working relationship, ie the drug kardex was in line with medical review, nursing record and other records. There was evidence of active consultation between members of the multidisciplinary team with record made in the respective notes.
- All patients reviewed had high levels of co-morbidity including learning disability, sensory impairment, communication difficulties, physical ill health, severe and enduring mental illness and challenging behaviours.

2. Drug Kardex

- Pharmacy reviews were present in the files. Current and past documentation evidenced practice adhering to the controlled drugs standards and drug trolley key . storage of drugs, administration of drugs standards by Nursing and Midwifery Council .

3. Medical file which included Allied Health Professionals interventions

- All eight files had Capably Assessment completed in 2010 for access to personal funds; Patient Financial review documentation was not reviewed.
- Regular Blood results.
- ECGs reports.
- Blood test results required for mental health drugs completed at prescribed time frames.
- Dental care, and recorded pre-intervention drug therapy to calm the individual patient were appropriate.
- Foot care.
- Speech and Language Therapist involvement.
- Behavioural plans and review.
- Day care plans and review.
- Other medical interventions and associated documentation recorded concerning physical health issues relevant to individual patients, Heart care, diabetic care, gynaecological care, assessment for dementia.

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Analysis of Monitoring Forms and Evidence of effective care process found in the review of patient files

I thematically reviewed all monitoring forms submitted and the evidence found in the patient files using The Early Indicators of Concern (University of Hull) and the RCN Dignity Standards.

A total of 118 monitoring forms covering 1519 hours of observed practice have been submitted over an eight week period by independent monitors, to observe practice over a 24 hour cycle.

Results from the monitoring form review and direct observation:

All 118 monitoring forms identified many examples of good practice and positive interaction by staff with patients and similar was directly observed.

The positive themes were;

- The monitoring forms and patient files showed that concerns about patients care and wellbeing is a high priority for all staff in Ennis. Each concern is rapidly addressed by appropriate intervention.
- I found evidence from the monitoring forms of proportionate use of supervision and observation. There was evidence that staff were aware of the need for personal privacy for patients and that intrusion must be proportionate.
- I found evidence that the nursing care and the environment encourages;
  - The care of personal processions; where there is minimal family involvement, the named nurse and associate staff promote personal belongings, as appropriate with life story work and individual preferences when possible,
  - Financial care promoting independency in appropriate manner,
  - Supporting patients to care for their personal space promoting self care appropriate to the skill and needs of each patient,
  - Essential records are being kept effectively,
  - Known personal choice/ preferences are supported e.g. country and western music, car outings, garden time, object reference such as bottle tops which supports one patient to self calm herself, time alone, etc.
- Staff anticipating behaviour escalation between patients and defusing the same when and where possible by appropriate intervention. The nursing team actively intervene to prevent challenging behaviours between patients and towards staff. When an incident occurs it is recorded and reviewed to change practice if required.
- I found evidence of a high level of critical appraisal of evidence i.e. analysis of patient behaviour, the aim of which was to understand the behaviour and therefore make an informed decision about care approaches to meet the needs of the individual. This level of attention to the caring process was complimented by

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knowledgeable staff who demonstrated understanding of the diverse and complex care needs of the patients in Ennis.

- I found evidence of appropriate AHP input to personal protection plans which were also acknowledged as potential restrictive practice and recorded in patient care plans e.g;
  - Protection plan, that only three patients be present in the lower dining room to facilitate proportionate support for meal time behaviours which promote reduction of risk of choking the promotion of fluid intake and self management of dining cutlery, recommended by Speech therapist,
  - Protection plan, for some patients the requirement of doors being locked near the kitchen area to reduce the risk of self injury,
  - Protection plan, locked doors near the hall way close to the Nursing office as some patients have been assessed as requiring this intervention for self protection,
  - Care plan, promotion of personal dignity by use of bathing suit as an under garment and belt to "divert" i.e. behavioural therapy approach to reduce the behaviour of the removal of clothes.
  - Care plan recorded oral bleeding and ongoing treatment needs for one patient, this bleeding generates distress for the patient and she would be known to scream and cry out when she notices the bleeding. Staff reassures her at these times but often she appears inconsolable. She requires drug there prior to each dental visit and or potential intervention. It is also noted that there is minimal family involvement and desire to be involved in the community integration plan.
  - A patient was diagnosed in 2012 with an emergency condition requiring quick identification and transfer to the local general hospital along with her specific medication kept on the ward. A protection Protocol was developed and is explained to all staff in the practice environment this has facilitated staff intervening appropriately and the patient remains well.
- I found evidence of communication needs from a person centred care perspective for each patient in the care plans e.g. Pictorial support aids, Simple verbal consistent instruction, behavioural redirection, de-escalation strategies, Sensory stimulation or reduction of stimuli. This evidence was complemented by the demonstration of staff knowledge within their skills of communicating with individuals and their correct interpretation of patient's behaviours and what the behaviour may be aiming to communicate. The outcome within their approaches promoted calm and responsive care, both within the monitoring reports and my personal observation.
- I found evidence that involvement with external agencies, relatives, multi-professional staff are all openly facilitated. There is also an unrestricted visiting time freedom for visitors. The ward was an open environment with the daily contact with estate management staff, hotel services staff, administration staff, transport staff and professional staff.
- Patients are encouraged and facilitated to talk to staff and visitors, on the ward and in private. I did not find any example, during direct personal observation, of staff preventing patients speaking to staff or visitors, nor was there evidence of such

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restriction on the monitoring returns. Each patient is offered an explanation of who you are and your purpose within the environment, openness is encouraged.

- I found evidence of dietary needs, choices, preferences and consistency of food requirements are individual to each patient and are meet, as far as is possible,
- I found evidence of fluid intake encouragement is promoted and supported no restrictions for patients both observed and recorded.
- I found no evidence of a culture that may be accepting of behaviours or communications that could be defined as abusive or any evidence of systemic abusive practice.
- It has been reported to me by Ester Rafferty has been given 4 induction papers that were jointly signed off as having had the opportunity and completed the induction process by Bohill staff and Ennis staff. This evidence will challenge the comments alleging that no induction took place. Ester Rafferty will report on this matter.

From the 118 monitoring forms only 67 that had identified concerns the key themes were;

- Staff levels at key times in the day impairing the ability to facilitate the needs of patients for activity based interventions,
- The challenge of keeping the curtains up with the frequency of the patients pulling them down,
- The challenge for staff maintaining dignity for some patients with the behaviour of removal of clothes,

Nursing Practice Placement Review

Prior to this practice allegation there have been no concerns with respect to this practice placement area over the last 2 years. This is inclusive of professional staff from Queens University.

Ennis currently has 3 mentors. 2 sign-off mentors and 1 mentor who are registered on the live mentor register.

The ward area was last audited in September 2012.The outcome of the audit agreed two students but reduced to one following temporary move of band 6 to Donegore. A Band 6 nursing position had not replaced by an equivalently experienced nurse at the time of the allegation. This has been resolved in November 2012. This learning environment is audited to facilitate novice to the final placement in management students, this is a commendation for the ward practice area.

The student evaluations themed were all positive about the learning and supportive experience offered them by the nursing staff in the ward some of the quotes were:
"Great support from mentor", "staff supportive", "all my learning outcomes achieved", "the induction to the ward was informative and gave me knowledge about the ward and practice". Progressive development of an orientation pack for students is underway; also a further member of staff will be commencing the mentor training in Sept 2013.

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The ward area is still open for future student placements although the recent student was re-allocated therefore no student currently on placement.

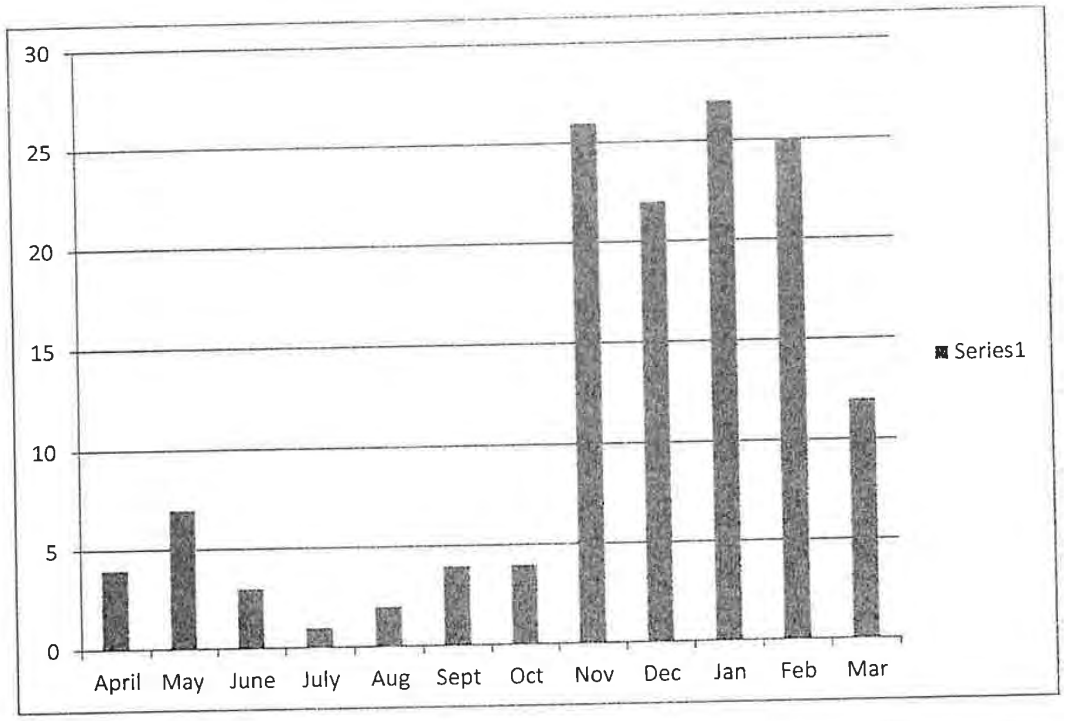
We await the outcomes and recommendations of the investigation before advising Academic Education Institutes (AEIs) of any changes to the area prior to the next QUB allocations. Allocations will take place in January for March students.

Recommendations

- That the current protection plan of continuous monitoring activity be discontinued as there is no evidence that there is a culture tolerant of behaviours that could be defined as abusive or support systemic abuse.
- Complete investigations as rapidly as possible to allow normalisation of the care environment.
- Recommence student allocations to this practice environment for the March students in Queens University.
- That we progress with the improvement plan for staff in the Ennis environment .

Moira Mannion
Co-Director of Nursing: Education and Learning
8th of January 2013

Appendix 23



Vulnerable Adult Referral 20012 to 2013

April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
4	7	3	1	2	4	4	26	22	27	25	12