ORGANISATIONAL MODULES 2024

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Wendy McGregor

Date: 28 March 2024

I, **Wendy McGregor**, make the following statement for the purpose of the Muckamore Abbey Hospital ("**MAH**") Inquiry.

The statement is provided by me in my capacity as an employee of the Regulation and Quality Improvement Authority ("**RQIA**") in response to a request for evidence by the Inquiry Panel.

This is my first statement to the Inquiry.

I will number any exhibited documents, so my first document will be "**Exhibit 1**".

Qualifications and Positions

1. My first experience of supporting people with a learning disability was at the age of 16 as a volunteer at my local Gateway club, which was a social club for adults with learning disability. I started my learning disability nurse training at the Southern Area College of Nursing in 1991 and qualified as a registered nurse in learning disabilities in 1995.

2. In the period 1995 to 2012, I worked across a range of services, both statutory and private, starting my career in Longstone hospital (1995 – 1996) then moving to the private sector (1996 – 2002). In 2002, I took up post as a community learning disability sister in the Southern Health and Social Care Trust, where I remained until 2012. During my time working in the community, I completed a first class honours degree in community nursing learning disabilities. During this time, I won two awards in recognition of my work "Improving the experiences of

patients with a learning disability who have been admitted to an acute hospital setting". I received a UK nationwide award and the RCN Nurse of the Year "Directors Choice" award for my work.

3. I began working for RQIA as a Mental Health and Learning Disabilities ("MHLD") inspector in October 2012. I remained in this role until 2019. In 2019, I took up post as a Senior Inspector and in 2020 I became Assistant Director of Mental Health, Learning Disability and Prison Healthcare and I have continued in this role until the present day. I have remained in the MHLD directorate throughout my time at RQIA.

Module

4. I have been asked to provide a statement for the purpose of M5: RQIA and MHC.

5. My evidence relates to paragraph 13 of the Inquiry's Terms of Reference.

6. I have been asked to address a number of questions for the purpose of my statement. I will address those questions in turn from paragraph 10, below.

RQIA's Inspection methodology

7. The Inquiry has requested that I explain the methodology of my visits to MAH. I am able to provide the Inquiry with details of my experience for the period from 2012 to the present day.

8. Initially, my experience of inspections came through shadowing of an experienced inspector before completing a primary inspection as a lone inspector.

9. The first inspections that I was involved with at MAH were supporting and shadowing an experienced inspector on a primary inspection. I then completed a series of Patient Experience Interviews ("**PEIs**") as a solo inspector. PEIs were an ideal way to gain experience as they were less intensive, with a focus on patient interviews and documents and information relating to patient experience, such as, access to advocacy, access to activities and knowledge of patients' rights. PEIs included a review of care and treatment plans and observations of

patients' environment. I completed a number of PEIs before I led my first primary inspection at MAH.

Q1. Please explain the methodology of your visits to MAH as an RQIA Inspector throughout the time within the Inquiry's Terms of Reference, that is between 02 December 1999 and 14 June 2021? It would be helpful if you could include detail on matters such as (but not limited to) the following:

i. How inspector(s) were selected to conduct an inspection

10. All MHLD inspectors come from a professional background, either in nursing or social work and have experience in mental health and / or learning disability. We are required to have a working knowledge of The Mental Health (Northern Ireland) Order 1986 ("**the 1986 Order**").

11. **Between 2013 and 2019**, MHLD Inspectors were 'aligned' to a case load of wards. This meant that each inspector was allocated responsibility for inspecting wards from across all five HSC Trusts. In allocating inspectors to particular wards, regard would be had to the following:

    a. Whether wards were indicated as high, medium or low risk (as assessed through the inspection planning tool). The inspection planning tool is a risk assessment tool used to rate risk and assist with determining when to inspect a service;

    b. Ensuring that each inspector had a variety of wards in their case load, for example a mixture of psychiatric intensive care units ('**PICU'**), learning disability, mental health acute admission, dementia and addictions; and

    c. How long the inspector had been inspecting the service. To prevent risk of complacency and to encourage wards being seen with 'a fresh pair of eyes', caseloads would be reviewed and changed accordingly.

12. Around February of each year, inspectors and management of the MHLD team reviewed caseloads. Caseloads were then realigned based on the above considerations.

13. During this period of time, if additional expertise were required to undertake an inspection, the aligned inspector could seek help from other inspection teams within the RQIA, for example, pharmacy, estates, or finance.

14. Inspections up until 2016 were mostly undertaken by one or two MHLD inspectors. Between 2016 and 2019, some inspections were undertaken by a MHLD inspector and a RQIA sessional consultant psychiatrist.

15. **In 2019**, the alignment of inspectors to services changed. From this point, each MHLD inspector became aligned to a particular HSC Trust rather than to individual wards across multiple HSC Trusts. This change occurred around the same time that there was a significant change to RQIA's inspection methodology, whereby RQIA introduced a 'systems' based approach to inspection. This involved inspecting the entire service, as appropriate, rather than inspections of individual wards.

16. This change allowed the aligned inspector to have an overarching view of facilities across a HSC Trust, thus enabling them to consider hospital-wide patterns and trends and also emerging trends across the HSC Trust.

ii. The information inspectors were provided with in advance of an inspection

17. In the paragraphs below, I provide detail of the information that inspectors would be provided with in advance of an inspection.

18. Methodology changes have meant that inspectors received and considered different information in preparation for an inspection at different points in time, in accordance with the methodology used at the time of the inspection. I explain below how this changed over time:

    a. Between **2012 and 2013**, inspectors received self-assessment information from service providers. This information was requested six weeks before an inspection.

    b. Each ward completed this self-assessment and rated themselves against defined inspection standards. The ward also forwarded supporting documentation to RQIA alongside the self-assessment response.

c. In addition to the above, in preparation for an upcoming inspection, the previous inspection report for the ward and Quality Improvement Plan ("**QIP**") was reviewed. This included the ward's response to previous RQIA recommendations.

d. In relation to PEIs, the previous inspection report of the ward was reviewed and any patient experience issues therein were identified. The inspector would prepare to explore those issues to consider whether concerns were continuing or had been addressed.

e. Between **2015 and 2018**, information was received prior to a ward inspection as per the pre-inspection information request template **(Exhibit 1)** and documentation request. Information and documentation requested included that which related to staffing arrangements, ward profile, monitoring of admission/discharge, governance, incidents, safeguarding vulnerable adults and complaints. The service was required to submit this requested information to RQIA by a specified date. Therefore, the service was aware that an inspection was to be undertaken by RQIA within the next three months, but the ward was not informed of the date of the inspection in advance.

f. As had previously been the case, the inspection report and QIP from the previous inspection were reviewed in preparation for the inspection, and recommendations were followed up during the inspection.

g. **Since 2019**, developments in RQIA's information technology system (iConnect) improved how inspectors received and managed information and intelligence received from HSC Trusts and other sources. Intelligence includes early alerts, whistleblowing reports, Serious Adverse Incident ("**SAI**") reports, adult safeguarding notifications and concerns received from patients, relatives, carers, and other stakeholders.

h. This information is reviewed by RQIA upon its receipt and frequently throughout the year. If further investigation is warranted due to the severity of the report or the potential emergence of a theme, the Inspector might complete a Situation Background Assessment Recommendation ("**SBAR**")

(Exhibit 2), which will support the inspector to reach a decision on how to appropriately respond to the intelligence received. The intelligence serves two purposes, firstly, it allows us to monitor services and supports RQIA to instigate a regulatory response if required. Secondly, the intelligence received helps to inform the preparation for an inspection; in particular, assisting inspectors to understand whether they need to focus inspection efforts on particular areas.

i. Inspectors complete a pre-inspection audit tool prior to every inspection.

j. For the majority of inspections (those which are unannounced), advance information is no longer requested from the provider. Instead, the records and information required from the provider is requested by inspectors on the first day of the inspection.

iii. The process of preparing for an inspection

19. The way that inspectors prepare for inspections has developed over time in line with changing methodology.

20. In the period **2012 to 2014**, RQIA would decide upon its inspection date and inform the HSC Trust of the date of inspection. The inspector sent a self-assessment request to the provider and reviewed the information received prior to the inspection.

21. Inspectors would review intelligence about a service prior to the inspection, but that process was not as streamlined as it later became due to the lack of a purpose-built document management system at that time.

22. At that time, RQIA recorded intelligence and information about a service in a log. Any contact from or about the service would be logged with a short overview of the information. Prior to an inspection, this information was reviewed with a view to identifying key concerns for further review at the inspection. Inspectors also reviewed the previous inspection report and QIP in readiness for the inspection.

23. RQIA continued to develop its pre-inspection planning process. In the period **2015 to 2019**, Inspectors requested information in advance of inspections using

the pre-inspection request template **(Exhibit 1)** and reviewed this information on receipt. In advance of the inspection they would also consider a number of forms of intelligence and seek to identify any common themes and trends that require a closer examination on inspection. At **Exhibit 3**, I have provided a pack of pre-inspection planning documents that inspectors used during this period.

24. **Since 2019**, the process of planning an inspection has been more intensive. In advance of the inspection, the MHLD team considers the composition of the inspection team for the upcoming inspection and a pre-inspection meeting is held. The inspectors review all intelligence held by RQIA relating to the service and they are required to complete a pre-inspection audit tool document.

25. The way in which RQIA records and saves intelligence changed with the introduction of a more sensitive document management system to the MHLD team in 2019. The 'iConnect' system allowed intelligence to be recorded comprehensively and retrieved easily in advance of an inspection. Themes and trends can also be retrieved from this system, albeit with the current system, this still requires a possible trend to be identified by inspectors. A report can then be run using key words and search parameters to check whether the evidence supports that theme or trend. Through this process, inspectors identify common themes and identify areas that may need a closer examination during the upcoming inspection.

26. In advance of the inspection, inspectors review the template record of inspection and key lines of enquiry to shape and plan their inspection accordingly. If there are areas that require a particular focus at the inspection then it might be agreed in advance by the inspection team that more than one inspector will review that particular aspect of compliance. The lead inspector prepares a team briefing, an inspection timetable/plan and aligns inspectors and others to either a ward or a particular theme. An inspection pack is agreed and printed for each Inspector.

27. Inspectors review their pack and ensure that they understand the area that they will be inspecting. All queries prior to the inspection are discussed with the lead inspector in the first instance. A second pre-inspection meeting may be required.

28. A senior inspector provides oversight during this preparation process and may attend the inspection. At times, the Assistant Director or Director of MHLD will also provide oversight and attend for part of the inspection. Whether such senior involvement is required, will depend upon the type of inspection and whether significant concerns have been identified via the pre-inspection process. For example, if concerns relating to leadership are highlighted in the pre-inspection preparation then senior RQIA staff member involvement might be considered appropriate.

iv. Communications with MAH and others in advance of an inspection

29. **Until 2015**, MAH received advance notice of an inspection or a PEI. HSC Trusts were informed of the date of an announced inspection six weeks prior to the inspection taking place. On the date that the HSC Trust was informed, a formal letter was sent to the ward manager and a copy of the letter was sent to the HSC Trust's Chief Executive. The self-assessment request was also sent, along with questionnaires for patients and relatives and a poster announcing the inspection for the service to display. The deadline for the return of the self-assessment and supporting evidence was four weeks later. I have exhibited a template self-assessment document at **Exhibit 4**.

30. **Between 2015 and 2019**, RQIA continued to submit a request to the HSC Trust for pre-inspection information. However, the HSC Trust was not notified of the date of an upcoming inspection and there was no other communication with MAH relating to the inspection except the request for, and receipt of, the self-assessment and associated information.

31. **Since 2019**, if an inspection is unannounced (as most are) then there is no communication with MAH specifically relating to the inspection. There are occasions where inspections are announced, for example, targeted inspections such as finance inspections. Where this is the case, the HSC Trust is informed of the upcoming inspection and a request for particular categories of information is requested to be available to the inspector(s) when they attend the inspection. This can be advantageous because records are easily available which allows inspectors to maximise their time while on site. It should be noted that RQIA does not advise the provider in advance of the inspection which particular records

within the categories requested it wishes to review. For example, RQIA might advise in advance of a focussed finance inspection that the HSC Trust should make patient finance records available for review. Only when the inspector arrives at site will he or she confirm which particular records they wish to review.

v. The mechanics of the inspection itself (including the approach adopted to communications with staff and patients and the inspection of records)

32. The mechanics of an inspection have developed over time in line with the changing methodology.

33. The duration of an inspection has also changed over time but continues to be dependent on the nature of the inspection.

34. **In the period 2012 to 2015,** all inspections were single ward inspections. An inspector or inspectors would arrive at the hospital and go directly to the ward inspected. Introductions were made and an explanation given to the most senior person on the ward (nurse manager/ nurse in charge) about the purpose of the inspection.

35. The ward staff informed the service manager of RQIA's arrival and the service manager normally attended the ward shortly afterwards. The inspection commenced with a tour of the ward, which provided the inspector with an opportunity to both observe the environment and introduce themselves to patients. During this period, the inspections focused on the operational functions of the ward and care of patients. Patient care and treatment records, ward-based governance records, restrictive practice records, policies and procedures and recommendations from any SAIs since the last inspection were reviewed. Recommendations made by RQIA at the previous inspection of the ward were reviewed and progress assessed. Patients, ward staff and MDT staff were interviewed. Any visiting professionals or visiting relatives were also approached for feedback.

36. Inspections during this period were generally completed in one or two days. Feedback was provided to ward staff and hospital senior managers before Inspectors left the ward.

37. In the period **2015 to 2019,** the mechanics of an inspection were similar to that which is explained at paragraphs 34 to 36 above. Inspections continued to be undertaken of single wards. New methodology was developed during 2015. The theme of these inspections was “patient centred care” with the introduction of stakeholder outcomes, which initially were 'safe, effective and compassionate care'. These outcomes were later supplemented by the outcome of 'well-led'. Templates for each stakeholder outcome were used on these inspections **(Exhibit 5)**. During the inspection, inspectors observed care and practice on the ward, reviewed relevant onsite documentation, patient care records, ward governance information and policies and procedures. Inspectors talked with patients, relatives, ward staff, MDT staff, visiting professionals and advocates, using questionnaires. Each ward was assessed using the environmental checklist tool kit **(Exhibit 6)**, ward environment risk assessments were reviewed, such as ligature and fire safety. The treatment room and medication trolley were checked along with evidence that emergency equipment checks had been completed. Recommendations from previous inspections and recommendations made from SAIs were reviewed. Feedback was provided to ward staff and hospital senior staff before leaving the ward.

38. **Since 2019**, upon RQIA arriving at a service to undertake an inspection, the Chief Executive of the HSC Trust is informed by telephone and by a formal letter sent via email. In addition, the lead inspector notifies the most senior person on site that RQIA has arrived to undertake an unannounced inspection.

39. If the inspection is a ward-based inspection, the inspector goes directly to the ward or, in the case of a whole-hospital inspection, the lead inspector will attend the office / admin block and advise the most senior member of staff on site that RQIA inspectors have arrived to undertake an unannounced inspection.

40. The inspector provides the service with an overview of the plan for the inspection, explaining the reason why the inspection is taking place, introducing the members of the inspection team and requesting the information and documentation that is required from the provider. The inspector will also advise which staff they require to speak with during the course of the inspection. A base room is provided for the inspection team. The HSC Trust appoint an affiliate,

normally a member of hospital administrative staff, to share the information requested and organise meetings between RQIA and senior HSC Trust staff.

41. The inspector introduces themselves to staff on the ward(s). Inspectors request to speak to a range of ward staff ensuring that skill mix is covered. The inspection involves speaking with MDT staff (for example, occupational therapists, psychologists, behavioural support staff, medical staff), and management (including ward, middle and senior management at the hospital sometimes more senior management at the HSC Trust). We also speak with governance leads at the HSC Trust. The adult safeguarding team are also interviewed.

42. Meetings with the adult safeguarding team are arranged by supporting RQIA administrative staff and the HSC Trust affiliate. Who attends these meetings depends on the nature of the inspection (whether single ward or whole-service), or as inspection findings dictate. These meetings are usually held between an RQIA senior inspector and/or assistant director and senior HSC Trust staff. On occasion, meetings are held between RQIA and HSC Trust directors.

43. Posters aimed at staff with a QR code are displayed which allow for staff to submit their views discretely if they would prefer to do so.

44. The inspector attends the ward(s) and introduce themselves to patients and offers the opportunity to speak and share their experiences. Patients are mostly spoken with on a one to one basis, depending on risks.

45. Inspectors offer to speak with all patients during an inspection. Some patients choose not to speak with us and others may be unable, or too unwell to communicate with us. Posters are displayed across the site advising that an inspection is taking place; the purpose is to inform patients and visitors and to encourage contact with the inspectors.

46. We currently use an 'easy read' questionnaire to seek feedback from patients. These were developed together with patients and the 'Telling It Like It Is' Project. In or around 2018, this replaced a previous MHLD questionnaire that I had developed in association with patients/service users with a learning disability and

ARC UK; a national charity supporting providers of Learning Disability and Autism services.

47. The inspector provides leaflets seeking patient and relative feedback. Those are provided to staff at the service and the inspector requests that those are distributed. The leaflets are not intended to replace speaking with patients and relatives directly, which is preferred and encouraged, but the leaflets do provide an alternative route by which patients and families can provide feedback discretely to RQIA and, anonymously if they wish, and are able, to do so.

48. **In 2023**, across all MHLD services during inspection, RQIA began requesting contact details of relatives from the service provider to allow RQIA to contact relatives directly, with patients' consent if they had capacity to provide consent. There are some patients who do not consent to us doing so. Where patients do not have capacity to consent, perhaps due to a severe learning disability, RQIA will contact relatives for feedback.

49. Observations of staff and patient interaction has always been an important part of the inspection. There was a period of time between 2015 and 2019 when the process of observations was formalised by way of a 'QUIS' (quality of interaction audit schedule). While this formal tool is no longer used, inspectors still consider and report upon staff interaction with patients, including regular engagement with patients and management of patient distress or incidents. In 2015, two lay assessors with learning disabilities were working with inspectors and joined our inspections to learning disability wards. They developed an easy-read observation tool for use on inspections.

Patient records

50. Invariably, inspections include review of a sample of patient care and treatment records. Records of particular patients might be chosen for review prior to inspection, if intelligence dictates. Otherwise, a random sample is chosen of at least 25-30% of patients. Both detained and voluntary patients are included in the sample. The sample should also include patients undergoing active care and treatment as well as patients who are delayed in their discharge. Of those patients who are undergoing active care and treatment, it is highly likely that

Inspectors would request to see the records relating to those patients receiving ECT. Records relating to patients prescribed clozapine and lithium may also be selected. Inspectors might wish to select records for patients with specific needs, such as those who are peri-natal or presenting with an eating disorder. Patients who are presenting with a physical health care need will also normally form part of the sample. Other patients might be selected based upon the inspectors' review of incidents or adult safeguarding records.

51. I refer to the 'Record of Inspection' template that is exhibited to RQIA's second corporate statement to the Inquiry at **Exhibit BD2/4.** Inspectors began using the Record of Inspection template in 2019. That document provides a comprehensive summary of the particular records and evidence that might be considered by an inspector**.** The Record of Inspection document is used as an *aide memoir* for inspectors. The full Record of Inspection is not generally used at each inspection; there is flexibility afforded to inspectors about the areas of focus of a particular inspection, and the Record of Inspection provides a helpful checklist when considering particular topics. Inspectors can make dynamic decisions about the areas of interest for an inspection, including making decisions about areas of focus based upon their findings while on site.

52. I have outlined below the types of evidence that an inspector may consider. This is not intended to be an exhaustive list.

Physical health

53. In relation to physical health of patients, we will consider a range of patient assessments and risk assessments (examples include skin, dysphagia assessments, nutrition and epilepsy risk assessments). We review care plans and evidence of physical health care monitoring and onward referrals where required. This includes access to routine public health screening such as breast and bowel.

Incidents / accidents and Adult Safeguarding

54. A sample of at least 25-30% of incidents / accidents and adult safeguarding reports are reviewed.

55. Governance information pertaining to incidents and adult safeguarding is reviewed. Inspectors consider the service's system for establishing trends and themes, its identification of risks, evidence of governance meetings, governance reports, the systems in place for sharing learning and the processes for escalation of incidents. Inspectors seek evidence that there is information flow from operational staff, to HSC Trust senior staff, to HSC Trust board and vice versa.

Staffing

56. Inspectors review the staffing arrangements of a service. The staffing model is reviewed to assess whether it adequately addresses the needs of the patients. The governance system in place to oversee staffing is also reviewed. We consider whether the service is operating with safe staffing levels (considered in tandem with patient profile), staff skill mix and the use of agency and bank staff. Inspectors review staff inductions (of agency and bank staff as well as those staff who are directly employed). We look for evidence of staff support mechanisms, training and supervisions, and staff meetings.

57. Interviews with staff members cover reporting concerns; knowledge of patients and their needs; knowledge of pertinent policies and procedures, in particular relating to incidents and adult safeguarding. Inspectors seek staff members' views of the service; is care effective, safe and compassionate? We also seek their views on leadership and support that is in place. Staff are also now asked for their views on morale and culture. We seek their input on suggested improvements.

Environment

58. Inspectors observe each environment within a ward, including, communal areas, bedrooms, bathrooms, dining spaces, outdoor spaces, medicine rooms and activity rooms. Since 2015, an environmental check list tool has been used and the physical environment is assessed against expected standards. Inspectors observe treatment rooms and check the medicine trolley along with evidence that emergency equipment checks have been completed.

59. Environmental risk assessments are reviewed, for example, infection prevention, fire, and ligature risk assessments.

60. Ward restrictions are observed, with inspectors observing where there are locked doors and, on those wards where there is a seclusion room (being the PICUs), we observe that environment.

Restrictive practices

61. In relation to restrictive practices, inspectors review relevant risk assessments and care plans. We are looking for evidence of whether any restrictions are used as a last resort and whether they are proportionate to the risk. Inspectors consider whether the measures in place are in-keeping with deprivation of liberty and mental health legislation and, more recently, the Department of Health's Regional Policy on the use of Restrictive Practices in Health and Social Care Settings' (2023).

62. In terms of assessing governance in this area, we consider evidence of oversight in relation to the use of restrictive practices. We would wish to see that the provider is analysing themes and trends in the use of restrictive practices and that systems are in place to reduce the use of restrictive practices.

63. Inspectors seek evidence that all restricted practices are recorded in care plans and that risk assessments are in place that consider the negative impact on the patient's liberty, privacy and dignity, and detail how those can be mitigated and minimised. Inspectors also look for evidence that there is a proactive approach to reducing the use of restrictive practices for patients.

64. Inspectors consider whether patients who are voluntary patients are free to leave, should they wish, and that they are not 'de facto' detained. If an individual is not detained under the 1986 Order but restrictions are placed on their liberty, inspectors consider whether there is an appropriate Mental Capacity Act (NI) 2016 'Deprivation of Liberty' in place.

65. The use of PRN medication as a restrictive practice is considered in the section below.

Medicines management

66. Inspectors review a sample of medication administration records to assess whether those are being completed in line with the HSC Trust's policy on medication management.

67. The use of PRN and rapid tranquilisation is considered. Inspectors take a sample of medication administration records to consider whether the records indicate an appropriate use of PRN in the circumstances in which it is used. Care plans and risk assessments should state when an individual might require administration of such medication and the order in which different PRN medication should be administered. The planning for use, and the use itself of PRN medication, should be carefully documented.

68. From the standpoint of reviewing governance arrangements, inspectors seek evidence that medicine audits are being undertaken at the service.

Patient experience

69. In assessing patient experience, inspectors will consider evidence including:

    a. The provider's system for monitoring and addressing patient experience concerns;

    b. Patient meetings;

    c. Access to advocacy services;

    d. Communication with patients and adjustments where patients present with requiring support with communication;

    e. Food and fluids;

    f. Meal time matters;

    g. Engagement processes with relatives and carers; and

    h. Sharing information with patients on their rights, and their involvement in decisions relating to their care and treatment.

Patient flow

70. Inspections of MHLD hospitals consider the system in place for oversight of patient flow. Inspectors look to see how the HSC Trust monitors admission, length of stay, discharge, delayed discharge, bed vacancies, and movement of patients across the service, for example, from initial admission into PICU through to rehabilitation.

71. Inspectors consider resettlement and discharge processes and the associated care planning, as well as the service's links with community MHLD staff, and services in the preparation for discharge.

72. While this is an aspect of governance that inspectors would generally consider, it is important to note that this is not applicable to the current position at MAH where there is not that flow of patients, and few are under active care and treatment. From past inspection reports, it is evident that Inspectors considered, in particular, the progress with patients in MAH who were delayed in their discharge and requiring resettlement.

Governance

73. Inspectors' consideration of the governance of the service has been the most significant change to RQIA's approach to MHLD inspections in my time as an inspector. Consideration of governance began with the introduction of the 'well led' criteria in 2017 but the significant change came in 2019, when there was a clear shift of focus onto governance at HSC Trust level, rather than ward management level.

74. While 'governance' is considered as a theme in its own right, inspectors' consideration of the other areas identified above also feeds into RQIA's assessment of governance. Specifically relating to 'governance', RQIA considers:

    a. accountability structures;

    b. vision of the HSC Trust;

    c. models of care;

d. the HSC Trust's internal communication and escalation channels, communication with the Department of Health, other HSC Trusts and other stakeholders;

e. complaints management;

f. senior managers meetings; and

g. links with other HSC Trust directorates, for example, whether the Mental Health Directorate communicates with the Primary Care Directorate within the HSC Trust. We would also consider how learning is shared across the HSC Trust.

vi. The process of reporting

75. **Between 2012 and 2014**, any areas requiring immediate escalation were reported during an inspection to senior HSC Trust staff and to an inspector's line manager at RQIA. If no such escalation was considered necessary, the findings from the inspection were delivered prior to the inspector leaving the ward to the most senior person on the ward and, on rare occasions, to the hospital manager. If the inspector's findings required escalation, but there was considered to be no immediate risk to patients, then these were discussed with the inspector's line manager and actions agreed. Such escalation may have been considered necessary where there was no evidence of progress on previous recommendations. Following this internal discussion, RQIA would formally correspond with the HSC Trust about its concerns, usually through a formal letter requesting action be taken by a date agreed by RQIA. In addition, the HSC Trust might be requested to attend a formal meeting. This was followed up accordingly by RQIA and assurances sought those actions had been taken.

76. If there were no escalation, an inspection report was completed and sent to the HSC Trust as part of the factual accuracy process, and for response to the QIP within 28 days of the inspection. The HSC Trust was required to respond within 21 days. Once the report was returned, RQIA would finalise the report.

77. A QIP was issued with a draft inspection report. The QIP includes the following: the recommendation / area requiring improvement; the date by which the required improvement is to be implemented; and confirmation of whether it is the first, second or third time that the particular recommendation has been stated. The QIP also identifies the 2006 Quality Standard to which the recommendations relate.

78. Recommendations / areas for improvement were reviewed on the next inspection of the service.

79. **Between 2015 and 2019**, the process for escalation remained as per paragraph 75, above, and the process of reporting was similar. However, the way that inspectors recorded and issued areas for improvement changed. Timescales required for improvement continued to be set by RQIA, but these were given a priority status (on a scale of 1 to 3) for implementation. A Priority 1 rated improvement was to be addressed within a period of between 24 hours and four weeks; a Priority 2 improvement was up to be implemented within a period of between four weeks and three months; and a Priority 3 improvement must be addressed within three to six months of the inspection.

80. The HSC Trust were informed of all areas for improvements at the conclusion of the inspection and the timescales for implementation of those recommendations. The QIP included this detail and the QIP template was updated to allow for the HSC Trust to attach supporting evidence.

81. The monitoring of required improvements using this methodology was done by the monitoring of priority deadlines, and not only at the next inspection as before. For example, if areas for improvement received a 'Priority 2' rating with a timeframe for implementation of three months, the HSC Trust was required to submit evidence of the actions taken and progress made after three months.

82. The process of tracking and monitoring was difficult for RQIA to manage, noting this process was used on all single wards, during a period where inspections occurred on a more frequent basis than in more recent years. A single QIP might have multiple improvement Priority deadline dates. Inspectors depended on diary management and a spreadsheet system with some support from

administrative staff. HSC Trusts often needed to be reminded if no progress update was submitted in accordance with required timescales.

83. **Since 2019**, the process is that, during the inspection, the inspection team attend a daily debrief to establish any themes, to discuss potential escalation and agree next steps. Ward managers are kept updated on progress. HSC Trust Senior managers are also kept informed and any matters that require urgent attention, for example, where immediate risk to patients have been observed, they are escalated to senior managers immediately and assurances sought that these will be addressed within an agreed timeline, sometimes before the end of an inspection. Inspectors also report to RQIA senior management during the course of the inspection.

vii. The time taken to complete the inspection process

84. The time taken to complete an inspection varies. An unannounced inspection commences as soon as the inspection team arrives at the service. The inspection concludes once feedback is given.

85. For whole service inspections, it may be up to two weeks before feedback is given after an inspection because there is much discussion amongst the inspection team and feedback can take some time to prepare.

86. An announced inspection commences on the date at which RQIA requests information from the HSC Trust and the inspection concludes on the date that feedback is given.

viii. Communications with MAH and others post-inspection

87. Following the inspection visit, inspectors conduct a deliberation meeting with an RQIA senior manager in attendance. Decisions are made with respect to key and high level findings, escalation areas for improvement and possible enforcement action. If the team agrees that enforcement action is required then an enforcement decision making meeting is arranged.

88. The HSC Trust's senior management are informed that the inspection has concluded. Some preliminary inspection findings may be provided to them. This includes any additional escalation where enforcement action may be taken. The HSC Trust is informed that RQIA will notify them of enforcement decisions following an internal Enforcement Decision Making meeting held by RQIA.

89. RQIA provides a date and time when it will deliver formal feedback to the HSC Trust. For single-ward and focused inspections this might be provided at the conclusion of the onsite inspection. Following this, if there is no escalation or enforcement then written reporting is through the completion of the inspection report and QIP.

90. If the inspection results in no escalation / enforcement, the next communication with the HSC Trust is through sharing the draft inspection report for a factual accuracy check. The HSC Trust is given 28 days to return the draft report with any factual accuracy comments.

91. Throughout my time as an inspector, RQIA has always sent the inspection report to the relevant HSC Trust's Chief Executive. The inspection reports historically were also sent to the ward manager but this is no longer the case since around 2018.

92. Once returned, factual accuracy responses are considered by the inspector(s) and the HSC Trust is informed whether the factual accuracy comments have been accepted or otherwise. If accepted, the draft report is amended to reflect any changes and the report is finalised and published.

93. If escalation is required, there is communication with MAH and the HSC Trust with respect to them submitting an action plan and through subsequent meetings to discuss progress with the action plan.

94. Prior to 2019, the Department of Health were only informed if escalation and enforcement procedures were instigated following an inspection. Since 2019, the Department is informed of all RQIA MHLD inspections and high level findings.

Q2: As a former RQIA inspector, are there other matters that you wish to bring to the Panel's attention for the purpose of its consideration of paragraph 13 of the Terms of Reference?

95. There is nothing more I wish to bring to the Panel's attention at this stage.

MAH Inquiry Questions to RQIA

96. The inquiry has provided me with a copy of the Rule 9 questions that have been submitted to RQIA in relation to Module 5.

97. In my current role as RQIA's Assistant Director of Mental Health, Learning Disability and Prison Healthcare and, given my role at RQIA dating back to 2013, I have supported RQIA's Chief Executive and Director of Mental Health, Learning Disability and Prison Healthcare to gather the information provided in RQIA's corporate statements to date.

98. I am continuing to provide support to RQIA's Director of Mental Health, Learning Disability and Prison Healthcare with RQIA's corporate response to questions relating to Module 5 of the MAH Inquiry. Therefore, in response to the questions to RQIA, my input into the majority of these questions will be by way of RQIA's corporate statement to the inquiry.

Q1: RQIA inspected individual MAH wards until in or around 2018, when it began to inspect MAH as a whole. Please explain:
i. Why there was a change in approach?
ii. What were the advantages and disadvantages of each approach?

99. Please see paragraph 96 to 98, above.

Q2: Before 2015, RQIA used a method of inspection that included self-assessment and pre-inspection analysis, along with ward visits. RQIA than changed this, to *exclude* self-assessment, and to use slightly different criteria (i.e. 'safe', 'effective' and 'compassionate', and later 'well-led'). Why were these changes made?

100. Please see paragraph 96 to 98, above.

Q3: Why did some RQIA inspections involve one or two inspectors, and others involve very large numbers of inspectors?

101. Please see paragraph 96 to 98, above.

Q4: How effective were RQIA's system(s) of mental health and learning disability inspection(s) at MAH during this period of the Terms of Reference, that is 02 December 1999 to 14 June 2021, in:
i. Developing key lines of inquiry.
ii. Analysing key themes over time.
Iii. Following up on recommendations
Iv. Responding to individual patient concerns identified at inspections

102. Please see paragraph 96 to 98, above.

Q5: On average, RQIA inspections appear to have been spread over two days. In relation to these inspections:

i. What proportion of time was spent speaking to staff?

103. In relation to this question to RQIA, it may be appropriate for me to provide evidence of my own experience. It is very difficult to quantify the proportion of time spent on various aspects of the inspection and how that has changed over time.

104. In relation to the proportion of time spent speaking with staff, inspectors engage with staff throughout the duration of the inspection; formally sitting down with staff to record their views on a questionnaire as well as speaking with staff on a less formal footing in conversations on the ward during the inspection visit and making requests of staff, such as, requests for records or information. I estimate that time spent speaking with staff under the current methodology is 40%. This percentage includes the following staff: nursing, MDT staff, medical, middle and senior management, adult safeguarding, and governance leads.

105. The following is a rough estimation of the proportion of time spent speaking with staff during inspection prior to 2019:

    a. 2013 – 2015; 30%; and

    b. 2015 – 2019; 40%.

106. For PEIs, my estimate of the proportion of time spent speaking with staff is 20% across all years.

ii. What proportion of time was spent checking paper/electronic records?

107. The following is a rough estimation of the proportion of time spent checking paper/ electronic records prior to 2019:

    a. 2013 – 2015 – 30%; and

    b. 2015 – 2019 – 40%.

108. I estimate that the proportion of time spent checking records under current methodology is 40%.

iii. What proportion of time was spent interviewing patients?

109. MAH currently has a limited number of patients who can verbally communicate their needs. Those who are able to communicate verbally are encouraged to speak with inspectors. Those that cannot are observed by Inspectors for their interaction and engagement with staff, how their needs are being met and how they present in the presence of staff.

110. Our current methodology includes a family engagement process. This has increased the number of families we engage with in comparison to previous methodologies.

111. I estimate that 5% of an inspector's time during inspection is spent interviewing patients and 15% on observing patients.

112. The following is a rough estimation of the proportion of time spent interviewing patients during inspection prior to 2019:

a. 2013 – 2015; 5% and 15% observing patients; and

b. 2015 – 2019; 5% and 15% observations.

113. For PEIs, my estimate of the proportion of time spent speaking with patients is 80% across all years.

iv. Was sufficient time was spent on each of the above?

114. The inspection process has limitations, as I believe would be the case with any methodology. In relation to communication with staff, we speak with those staff who are working during the inspection and thus may not capture relevant experience and feedback from all staff members. We try to cover all staff, by attending wards across different shifts including capturing night staff.

115. As mentioned above, there are a limited number of patients who can verbally communicate with us; our observation of patients during the inspection is therefore crucial. The time spent observing patients can vary considerably depending on each inspection. One focused PEI had 36-hour patient observations over several wards at MAH.

116. In relation to review of records, in my experience, inspectors review records until they consider that they have sufficient information to inform their findings. In my experience, inspections are not concluded until all members of the team are satisfied with the level of information obtained; we have extended inspections on occasions and we have finished inspections earlier than anticipated.

Q6: Does RQIA conduct meta-analysis of inspections to identify recurring themes? If so, please provide details:

117. Please see paragraph 96 to 98, above.

Q7: From in or around 2015, a direct observation schedule was used ('QUIS'). In relation to this schedule:
i. Was it useful?
ii. What, if anything, did it reveal that other methods did not?

118. Please see paragraph 96 to 98, above.

Q8: Some RQIA inspections were announced, and some were unannounced.
i. How was this decided, and who was this decided by?
ii. Were there any differences in outcome? If so, what were they?

119. Please see paragraph 96 to 98, above.

Q9: Did RQIA inspectors who visited MAH have learning disability training? If so, please provide details.

120. Please see paragraph 96 to 98, above,

Q10: In respect of wards which were inspected by RQIA:
i. Were there obvious and sustained differences between wards? If so, what were those differences and what does RQIA attribute those differences to?
ii. Were those differences in 'culture' between wards? If so, what were those differences, and how can they be explained?
iii. How were families selected for consultation during RQIA inspections?

121. Please see paragraph 96 to 98, above.

Q11: Some wards and staff have been extensively criticised by families, however these criticisms do not appear in RQIA inspection reports. How can this be explained?

122. Please see paragraph 96 to 98, above.

Q12: Were inspections ever carried out because of complaints received from families of patients? If so, was an investigation ever initiated following a single complaint, or was more than one complaint on an issue required before an inspection would be carried out?

123. Please see paragraph 96 to 98, above.

Q13: How can the difference between what was seen by inspectors on the MAH wards and what happened on the CCTV in 2017 be explained?

124. Please see paragraph 96 to 98, above.

Q14: Occasionally RQIA focussed inspections on topics, for example, finance or resettlement. What led to a topic focussed inspection being carried out?

125. Please see paragraph 96 to 98, above.

Q15: What role did RQIA have in the investigation into the allegations in November 2012 arising from Ennis ward?

126. I am not able to provide evidence or support to the Inquiry in response to questions relating to the allegations in November 2012 arising from Ennis ward. I did not have any involvement with that investigation or with the Ennis ward during that period.

Q.16: When and how did RQIA receive the Ennis report? Please provide details.

127. I refer to paragraph 126, above.

Q17: What was RQIA's response to the Ennis report?

128. I refer to paragraph 126, above.

Q18: What role did RQIA have in the oversight of the implementation of recommendations arising from Ennis?

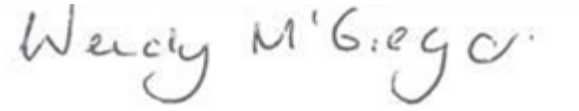
129. I refer to paragraph 126, above.

Q19: What steps, if any, did RQIA take to investigate other wards following the situation that arose at Ennis ward? What actions were taken following any such investigations?

130. I refer to paragraph 126, above.

Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed: 

Date: 28 March 2024

List of Exhibits (Wendy McGregor)

Exhibit /1: Pre-Inspection Information Request Template

Exhibit /2: Situation Background Assessment Recommendations ("SBAR")

Exhibit /3: Pre-Inspection Planning Documents

Exhibit /4: Template Self-Assessment Documents

Exhibit /5: Templates for Stakeholder Outcomes

Exhibit /6: Environmental Checklist Tool Kit

MUCKAMORE ABBEY HOSPITAL INQUIRY

WITNESS STATEMENT

Statement of Wendy McGregor

Regulation and Quality Improvement Authority ("RQIA")

Date: 22 March 2024

Exhibit 1

Section 1 – Ward Specific Information – Staffing

MAHI - STM - 214 - 32

WARD		**WARD MANAGER**	
COMPLETED BY		**DATE OF COMPLETION**	
WARD ADVOCATES		**ADVOCATE CONTACT DETAILS**	

(S,E) Please provide details of the **multi- disciplinary staffing establishment,** number of staff in each post and WTE allocation to the ward	**STAFF POSITION**	**NUMBER IN POST**	**WTE**	**GENDER**	
				M	**F**
	Consultant				
	Other medical staff (please list)				
	Band 7 Nurse in Charge				
	Band 6 Nursing Staff				
	Band 5 Nursing Staff				
	Healthcare Assistants				

	Psychology Staff (please list)				
	Occupational Therapy Staff (please list)				
	Speech & Language Therapy Staff (please list)				
	Social Work Staff (please list)				
	Other Health Care Professionals Staff (please list)				
(S) Please provide details of any use of bank/agency staff in the **last six months**	**Average number of hours per week filled by bank staff per grade**	**Average number of hours per week filled by agency staff per grade**			
(S)Please provide details of any vacant posts and also any details of temporary, acting or locum staff					

(S,E)Please provide details of any changes in key posts in last 12 months		
(S,E) Please provide details of supervisions and appraisals for ward based staff undertaken in the last 12 months	**Staff appraisals**	**Staff Supervisions**
	Nursing Staff	**Nursing staff –** 1 supervision in last 12 months **Nursing Staff –** 2 supervisions in last 12 months
	Healthcare Assistants	**Healthcare Assistants –** 1 supervision in last 12 months **Healthcare Assistants –** 2 supervisions in last 12 months
Additional information or comments		

Section 2 - Ward Specific Information – Ward profile, use of Mental Health Legislation and monitoring of admission/discharge

(S) **Please provide details of the typical profile and diagnoses of patients admitted to this ward**

(S) **Information required**	**Number**
Total number of patients who can be accommodated in the ward	
Number of patients aged under 18 years admitted in the last 12 months (Article 118)	
Number of patients currently detained for more than 6 months (Article 12)	
Number of patients detained for assessment in last 12 months (Article 9)	
Number of patients detained for treatment in last 12 months (Article 12)	
Number of patients referred to Mental Health Review Tribunal in last 12 months (Article 71)	
Number of improper detentions in last 12 months (Article 11)	
Number of detained patients who required Form 22 in last 12 months for continued administration of medication (Article 64)	
Number of detained patients who required Form 22 in last 12 months for the administration of ECT (Article 64)	
Number of detained patients who required Form 23 in last 12 months for continued administration of medication (Article 64)	
Number of detained patients who required Form 23 in last 12 months for the administration of ECT (Article 64)	

Number of patients who are currently on leave for more than 28 days (Article 15)	
Average length of stay (days)	
Average % weekly occupancy in last 12 months	
How many times has the ward been “over-occupied” in the last 12 months?	
Any other information or comments	

Section 3 – Ward Specific Information – Governance

(S) 1. **Please provide details of governance arrangements for analysis of <u>ward specific</u>** • **risks** • **accidents** • **adverse incidents** • **serious adverse incidents** • **whistleblowing** • **safeguarding referrals** • **staff disciplinary matters** • **complaints** • **inpatient deaths** **Please describe how governance mechanisms effect change at <u>individual ward level and Trust wide</u> to improve safety through analysis of information. Please append any related records and/or other supporting documentation**.
(S, E) **2. Please describe how:** • **the information is disseminated to frontline staff** • **implementation of new or revised practices to improve safety is monitored** • **the effectiveness of new or revised practices to improve safety is monitored** **Please append any related records and/or other supporting documentation.**

(S)

3. Please describe lines of staff accountability for this ward and the governance arrangements for:

- **monitoring of staff performance in line with their role, responsibility and level of accountability**
- **timely completion of staff supervision**
- **timely completion of staff appraisal**
- **monitoring of safe staffing levels**

Please append any related records and/or other supporting documentation.

(S,)

4. Please describe governance arrangements for adherence by staff in the ward to requirements of the Mental Health (Northern Ireland) Order 1986 to ensure that patients' rights are upheld.

Please append any related records and/or other supporting documentation.

(S, E) **5. Please describe governance arrangements for:** • **monitoring of average length of stay, monitor discharge in accordance with HSCB commissioning plans, monitor over a period of time** • **monitoring of positive results in delivery of care and treatment measured against the expected outcomes of the care pathway** • **monitoring of timely discharge, monitor this performance over a period of time** **Please append any related records and/or other supporting documentation.**
(S, E, C) **6. Please describe governance arrangements for monitoring of patient experience including:** • **collecting and analysing patient and carer views regarding their care and treatment at various stages of the care pathway** • **devising and implementing action plans to address areas identified for improvement by patients and carers** • **monitoring the overall patient experience.**

Please append any related records and/or other supporting documentation.

Section 4 – Policies, Procedures & Relevant Documentation 2015/16

(Generic and/or patient population specific) Please complete the template below and attach copies of the named documents. Please add any other policies/procedures/documents that may be relevant.

Documents Required

	(S) **Document Name**	**Attached**
1	Operational policy or statement of purpose for the ward	Choose an item.
2	Supervision template	Choose an item.
3	Appraisal template	Choose an item.
4	Copy of the ward's most up to date health and safety audit and associated action plan	Choose an item.
5	Copy of the ward's most recent ligature risk assessment and associated action plan	Choose an item.
6	Copy of the ward's most recent fire safety audit and associated action plan	Choose an item.

(S, E, C) Policy/procedure area	Please list relevant policies/procedures	Issue Date	Review Date
Risk assessment and risk management (patient specific & environmental)			
Health & Safety (to include areas such as fire safety etc)			
Referral to Mental Health Review Tribunal			
Staff supervision, staff appraisal, training and development			
Needs assessment and care planning (to include discharge planning)			

Management of behaviour that challenges, Use of Special Observations & Seclusion, Restrictive Practices and Deprivation of Liberty			
Complaints Management			
Monitoring of patient experience			

Section 5 – Complaints Summary and Incidents Report

Please list details of complaints received between **1 April 2014 and 31 March 2015**.

Name of ward: _____

(S, E, C) **Date of Complaint**	**Source:** select -	**Main Issue:** select -	**Level of Complaint**	**Outcome:** select -
	• Service user • Relative • Informal advocate • Formal advocacy service • Other	• Care practice • Environmental issue • Staff attitude • Service user finance • Food and Nutrition • Other	• Formal • Informal	• Fully satisfied • Partly satisfied • Not satisfied (i.e.with Ombudsman)

Please list details of incidents reported between **1 April 2014** and **31 March 2015**.

Name of ward: _____

(S, E, C) **Date of Incident**	**Who was involved in incident?**	**Nature of the Incident**	**Was this reported as a SAI?**	**Was a safeguarding referral completed following incident?**	**Status of Incident**
	• Service User • Relative/Visitor • Member of Staff • Other	• Abuse • Equipment • Fire Incidents • Food, Fluid & Nutrition Issues • Harassment • Infection Control Issue • Information Breach • Medication • Needle Sticks • Security • Self-Harm • Slips, Trips & Falls • Staffing Issues • Violence • Other	• Yes • No	• Yes • No	• Incident Closed • Incident Review in Progress • Incident Review Pending

MUCKAMORE ABBEY HOSPITAL INQUIRY

WITNESS STATEMENT

Statement of Wendy McGregor

Regulation and Quality Improvement Authority ("RQIA")

Date: 22 March 2024

Exhibit 2

RQIA IMPROVEMENT DIRECTORATE: SBAR Assessment

To			
From		**Date**	
Subject matter			
SITUATION			
BACKGROUND			
ASSESSMENT			

RECOMMENDATION(S)

Options

COMMENTS/DECISION

MUCKAMORE ABBEY HOSPITAL INQUIRY

WITNESS STATEMENT

Statement of Wendy McGregor

Regulation and Quality Improvement Authority ("RQIA")

Date: 22 March 2024

Exhibit 3

REVIEW OF INFORMATION PRE-INSPECTION			
Ward name:		**Lead/Reviewing Inspector:**	
Date of planned inspection:		**Date of Review:**	
Since the last inspection have there been any:			**Inspector comments:**
SAIs in this ward?	Choose an item.		[.....]
SAIs in the hospital or Trust that may be relevant to the inspection?	Choose an item.		[.....]
Whistleblowing reports about this ward?	Choose an item.		[.....]
Concerns/information regarding detention processes, MHRT referrals, treatment plans, letters from patients/relatives, any other intelligence/information?	Choose an item.		[.....]
If yes to any of the above, has the IPT been reassessed?	Choose an item.		[.....]
Has the IPT changed?	Choose an item.		[.....]
Has the ward responded appropriately following previous inspections – e.g full implementation of recommendations?	Choose an item.		[.....]

Ward profile (section 2)	
Details of the typical profile and diagnoses of patients admitted to this ward	
Relevant good practice guidance to be consulted ..\..\Inspector Guidance\Guidance Docs	
Any concerns identified following the review of pre-inspection information and good practice guidance?	

Inspectors comments - overall ward profile

Include information regarding any areas of good practice/concerns on use of the Mental Health (NI) Order 1986, under 18 admissions, monitoring of admission & discharge, occupancy, safeguarding referrals, inpatient deaths, available intelligence about the ward, governance arrangements etc. (Sections 2, 3 & 4)

Inspector comments - staffing arrangements

Include information regarding areas of good practice/concerns about the staffing establishment, changes in key personnel, vacant posts, use of agency and bank staff, staff supervision and appraisal arrangements, disciplinary matters, governance arrangements etc. (sections 1, 3 & 4)

Inspector comments - governance, complaints and incidents analysis

Include information regarding areas of good practice/concerns about governance arrangements, number of complaints, themes, outcomes, adherence to regional policy/timelines etc., number of incidents, patterns/trends, outcomes, etc., monitoring of patient experience (sections 3, 4 & 5)

Inspector comments – environmental safety Include information regarding areas of good practice/concerns about environmental safety – audits, action plans, procedures etc. (section 4)
Summary – inspector to indicate if there are any additional or particular areas of focus required during the inspection as a result of the review of information

PHT F1 Ward specific information – documents required

WARD		WARD MANAGER	
COMPLETED BY		DATE COMPLETED	

	Document Name	Attached
1	Operational policy or statement of purpose for the ward	Choose an item.
2	Pre-Inspection Information Template (attached) - Details of multi- disciplinary staffing establishment, breakdown of skill mix, gender balance, use of bank/agency staff, staff supervision and appraisal, staff training and development records, details of any vacant posts and changes in key posts in last 12 months	Choose an item.
3	Supervision template	Choose an item.
4	Appraisal template	Choose an item.
5	Copy of the ward's most up to date health and safety audit and associated action plan	Choose an item.
6	Copy of the ward's most recent ligature risk assessment and associated action plan	Choose an item.
7	Copy of the ward's most recent fire safety audit and associated action plan	Choose an item.
8	Template PHT F4 attached - Ward profile, referrals to MHRT in past 12 months, admission and discharge monitoring, use of Mental Health (NI) Order 1986	Choose an item.
9	Template PHT F5 attached - Numbers and types of: • complaints in last 12 months	Choose an item.
10	Template PHT F6 attached - Numbers and types of: • incidents by type in last 12 months	Choose an item.
11	Template PHT F7 attached - Details of safeguarding referrals in last 12 months	Choose an item.
12	Governance mechanisms for: • Analysis of risks, accidents, adverse incidents, serious adverse incidents, whistleblowing, safeguarding referrals, staff disciplinary matters, complaints, mortality rates • Communication of learning to staff and monitoring implementation of required changes • Timely completion of staff supervision and appraisal • Maintenance of staffing levels • Adherence to statutory requirements of mental health legislation • Monitoring of average length of stay and discharge • Monitoring of positive results in delivery of care and treatment measured against the expected outcomes in the care pathway	Choose an item.

	• Template PHT F8 attached - Monitoring of patient experience and action plans to address areas for improvement	

MUCKAMORE ABBEY HOSPITAL INQUIRY

WITNESS STATEMENT

Statement of Wendy McGregor

Regulation and Quality Improvement Authority ("RQIA")

Date: 22 March 2024

Exhibit 4

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7530 Fax: 028 9051 7531

MENTAL HEALTH & LEARNING DISABILITY INSPECTION - SELF ASSESSMENT (ADULT)

Name of Facility/Ward:	
Date of Inspection:	
Lead Inspector:	

Section 1 - Introduction

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. We were 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.

From 1 April 2009 RQIA assumed responsibility for a range of functions under the Mental Health (Northern Ireland) Order 1986. RQIA has a specific responsibility to assess the health and social care services provided to people with a mental illness or learning disability. Our responsibilities include promoting good practice; preventing ill-treatment; remedying any deficiency in care or treatment; terminating improper detention in a hospital or guardianship; and preventing or redressing loss or damage to a patient's property.

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

For the 2013-14 inspection period, the focus of the mental health and learning disability inspections will be on the principles of protection.

Section 2 - Guidance on completion of the self assessment document

This self-assessment document sets out the standards and associated criteria to be assessed during the inspection.

You are asked to provide brief narrative in each 'Ward's Self-Assessment' grey text box evidencing how the service addresses the question and meets the expectation of the referenced criterion, set out immediately above the box. Please use plain English and note that the response is limited to approximately 300 words for each question.

As well as narrative for each question, the ward manager should also complete the compliance statement box. Clicking in the 'Compliance Level' box activates a drop-down menu, from which you can select the appropriate option.

The definitions for compliance levels are listed below in table 1 to assist the registered provider or manager in completing the document:

Table 1: Levels of compliance

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 requirement or 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 requirement, 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.

Following completion of the self-assessment, please email the self-assessment document to team.mentalhealth@rqia.org.uk no later than **6 January 2014**.

If your establishment has been identified for inspection, any response within the self-assessment documentation may be discussed with staff during such inspection. It is important that staff are aware they may be asked to discuss the information provided within this self-assessment.

Providers are asked to note that any responses made on the self-assessment document will form part of the inspection report for your establishment.

MAHI - STM - 214 - 64

Inspection Standards – The organisation has appropriately trained staff and robust procedures to support and meet the needs of patients **Ward Self-Assessment**	
Statement 1. – **The ward has robust arrangements in place that ensure the safety and well-being of patients that are consistent with legislative and best practice guidance documents;** **The ward monitors these arrangements to ensure that they are appropriately and consistently applied;** **Staff ensure that vulnerable adult procedures are followed and all vulnerable adult issues are addressed promptly, appropriately and in accordance with local and regional policies and procedures.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
	Ward manager to complete
Inspection Findings: FOR RQIA INSPECTORS USE Only	

Inspection Standards – Assessment of need and risk Ward Self-Assessment	
Statement 2. – **Patients' needs are accurately assessed, risks identified and responded to appropriately.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
	Ward Manager to Complete
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

Inspection Standards – Awareness and application of safeguarding procedures Ward Self-Assessment	
Statement 3 . –The ward safeguards patient rights in relation to the use of: **(i) Restrictive Practice;** **(ii) Isolation/Seclusion;** **(iii)Close Observation;** **(iv) Use of Restraint.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
	Ward Manager to compl
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

Inspection Standards – Provision of and access to therapeutic activity Ward Self-Assessment	
Statement 4. – **The ward provides patients with an appropriate range of therapeutic individualised and group activities;** **The daily programme with details of professionals involved is available and accessible;** **Clear and accurate documentation is maintained.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
	Ward Manager to complete
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

Inspection Standards – The organisation operates effective procedures for managing patients' finances and property Ward Self-Assessment	
Statement 5. – **The ward has robust processes in place to ensure the safety of patients' monies and property.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
	Ward Manager to complete
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

Inspection Standards – There are procedures in place for the effective management, support, supervision and training of staff. Ward Self-Assessment	
Statement 6. – **The ward has an appropriate training and development plan in place to address the training needs of all staff ;** **Records of training evidence that all staff have attended mandatory training in accordance with policies, and training plans;** **Staff have the necessary skills knowledge and competence for the role they undertake;** **All staff have formally recorded supervision meetings in accordance with policies and procedures;** **All staff have formally recorded annual performance appraisal meetings;** **Additional support is provided for staff through various mechanisms, such as regular ward meetings.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
	Ward Manager to complete
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

Inspection Standards – There is an appropriate organisational structure for the ward that defines staff and management roles, responsibilities and the accountability arrangements Ward Self-Assessment	
Statement 7. – **Patients and staff are aware of the organisational structure and accountability arrangements;** **Staff can describe their reporting procedures;** **Senior staff can describe their role in the accountability framework for the ward, and how/if this works in practice.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
	Ward Manager to complete
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

Inspection Standards – Information for patients and carers Ward Self-Assessment	
Statement 8. – **Patients and their family/carers have access to appropriate information in relation to their rights;** **There is a defined complaints procedure in place in a format appropriate to the needs of patients and their carers;** **The ward maintains appropriate records of complaints, concerns, suggestions and compliments.** **There is evidence of feedback from the Governance leads in relation to complaints and concerns raised.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
	Ward Manager to complete
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

Inspection Standards – The organisation has a clear policy for documentation and management of records, confidentiality and sharing of information. Ward Self-Assessment	
Statement 9 – **Care plans are written in an individualised and person-centred manner that is consistent with professional and legislative requirements.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
	Ward Manager to complete
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

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Inspection Standards – The organisation has a clear policy for the reporting of accidents, incidents and serious adverse incidents Ward Self-Assessment	
Statement 10. – **Staff report accidents, incidents and serious adverse incidents in accordance with policies and procedures and regional guidance and follow up these up appropriately.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
	Ward Manager to complete
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

Ward Manager's overall assessment of the ward's compliance level against the statements assessed	**COMPLIANCE LEVEL**
	Ward Manager to complete

Inspector's overall assessment of the ward's compliance level against the statements assessed	**COMPLIANCE LEVEL**
	Inspector to complete

SUPPLEMENTARY INFORMATION

For information or incidents within the last 12 months, this is interpreted as being from the date of the inspection.

Within the last 12 months, please confirm the number of Under 18 admissions to the ward and the age, gender and length of stay for each placement.							
Admission number	Age	Gender	Length of Stay (days)	Admission number	Age	Gender	Length of Stay (days)
1				8			
2				9			
3				10			
4				11			
5				12			
6				13			
7				14			

Within the last 12 months, please confirm the number of investigations undertaken on the ward and their outcomes.			
Adult Protection Investigations		**Child Protection Investigations**	
Substantiated Allegations		Substantiated Allegations	
Unsubstantiated Allegations		Unsubstantiated Allegations	
On-going Allegations		On-going Allegations	
Total		Total	

Please confirm the names of the following contacts for safeguarding children and vulnerable adults.	
The wards Nominated Manager for Safeguarding Vulnerable Adults	

MUCKAMORE ABBEY HOSPITAL INQUIRY

WITNESS STATEMENT

Statement of Wendy McGregor

Regulation and Quality Improvement Authority ("RQIA")

Date: 22 March 2024

Exhibit 5

RECORDING TEMPLATE FOR INSPECTION

IS CARE WELL LED?

There is effective leadership management and governance which creates a culture focused on the needs and experiences of patients in order to deliver safe, effective, compassionate and well led care

Ward Name:	**Date of Inspection:**

Key Indicator WL1 - There are appropriate management and governance systems in place to meet the needs of patients.

	Yes/No	Info Source	
All staff are aware of their roles and responsibilities and actions they should take if they have a concern (safeguarding, child protection, escalation, whistleblowing).	Choose an item.		
Robust governance arrangements are in place to monitor the prescription and administration of medication.	Choose an item.		
All policies and procedures are relevant, up to date and are easily accessible by staff.	Choose an item.		
There is governance oversight of patient plans and timely discharge in accordance with HSCB commissioning plans/ average length of stay/ over occupancy.	Choose an item.		

Systems are in place to: • analyse risks, accidents and adverse incidents, serious adverse incidents, complaints, safeguarding referrals and the effectiveness of protection plans, staff disciplinary matters, whistleblowing, mortality rates, with a focus on learning when things go wrong. • effect change to improve safety through analysis of information • share learning with relevant staff • identify and disseminate outcomes of any audits, reviews or investigations with all appropriate staff including frontline staff • monitor the implementation of change to improve safety. • good working relationships are evident between the multi-disciplinary team.	Choose an item.		

Key Indicator WL2 - There are appropriate management and governance systems in place that drive quality improvement.			
Ward staff and management monitor overall patient experience, with systems in place to collect and analyse patient and carer views regarding their care and treatment including; • complaints and compliments • patient forum meetings • patient feedback surveys • Action plans are devised and implemented to address areas identified for improvement by patients and carers.	Choose an item.		
Key Indicator WL3 - There is a clear organisational structure and all staff are aware of their roles, responsibility and accountability within the overall structure. There are appropriate supervision arrangements in place.			
There is a defined organisational and management structure that identifies the lines of responsibility and accountability with specific roles and details of responsibilities of all staff clearly understood.	Choose an item.		
Appropriate training, supervision and staff development: • staff have received up-to-date training in all relevant areas, and there is a regular review of the skill mix of the team to identify gaps in training. • staff are supervised appropriately in their deliver of planned evidenced based therapeutic .	Choose an item.		

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Key Indicator WL4 - There are effective staffing arrangements in place to meet the needs of the patients.			
There are effective staffing arrangements in place. • staff shortages are responded to in a way which minimises disruption to patient care and treatment. • there are governance arrangements to monitor the appropriate / effective use of bank / agency staff. • the multi-disciplinary team for the facility is agreed and all staff are currently available. • arrangements in place for all staff to access their line manager and to support staff (e.g. staff meetings, appraisal and supervision) • management are responsive to suggestions/concerns raised by the multi-disciplinary team.	Choose an item.		
Additional Comments			

RECORDING TEMPLATE FOR INSPECTION IS CARE EFFECTIVE? The right care is provided, at the right time in the right place with the best outcome			
Comprehensive Co-produced Personal Well-Being Plans			
Total number of personal well-being plans reviewed		**Info Source**	**Additional Comments**
Number of personal well-being plans that evidence:			
Patients and/or their representatives are consulted about their individualised needs by the relevant professionals.			
plans are holistic and co-produced in conjunction with the patient and/or their representative			
include treatment goals, safety goals, family & social goals, health and lifestyle goals and support recovery and /or maximise health and well-being			

Plans are implemented in a way that encourages and promotes patient autonomy, participation and consent			
There are defined care pathways, with reference to evidence based guidance			
There is a weekly ward round, attended by all relevant disciplines.			
Accurate and detailed records are maintained to confirm decisions agreed at the ward round, the person responsible for implementing agreed actions and the timeframe for implementation.			
There is a range of care and treatment options which are planned and delivered in line with current evidence based guidance, standards, best practice and legislation.			
The evaluation of care and treatment provided to patients considers the effectiveness of the interventions in place in producing the best outcome for individual patients; changes are made when and where necessary.			
Discharge planning commences early in the care pathway and the patient is actively involved; appropriate community support mechanisms have been discussed with patients nearing discharge.			

Promotion of Autonomy and Independence; Avoidance of Use of Restrictive Practices			
Environment		**Info Source**	**Additional Comments**
The physical environment is designed to be enabling, and makes use of best practice design guidance relevant to the patient population.			
Whilst ensuring appropriate levels of security, the environment is open and patients experience the least restrictive environment possible.			
The need for the use of restrictive practices, including deprivation of liberty, restraint and seclusion is based on individualised assessment of need. This assessment indicates that the use of such practices are used proportionately, used only as a last resort and regularly reviewed.			
Good practice guidance is comprehensively understood and considered in any use of restrictive practices			
Human rights are strongly embedded in the culture. Staff actively consider the implications of any care and treatment provided for patients' human rights.			

Patient Experience			
Complaints		Info source	**Additional Details**
Number of Patients and/or their representatives confirm that:			
They have the opportunity to meet with staff in all disciplines involved in their care and treatment.			
They were provided with enough information to make informed choices about types of care and treatment options available.			
They have access to the full range of services they require for their care and treatment			

They are active participants in their care and treatment planning, including discharge planning.			
The care and treatment they are getting is beneficial because they feel better than when they were first admitted to hospital, or are hopeful that they will get better.			

Number of Patients Consulted		**Number of Relatives Consulted**	

Additional Comments

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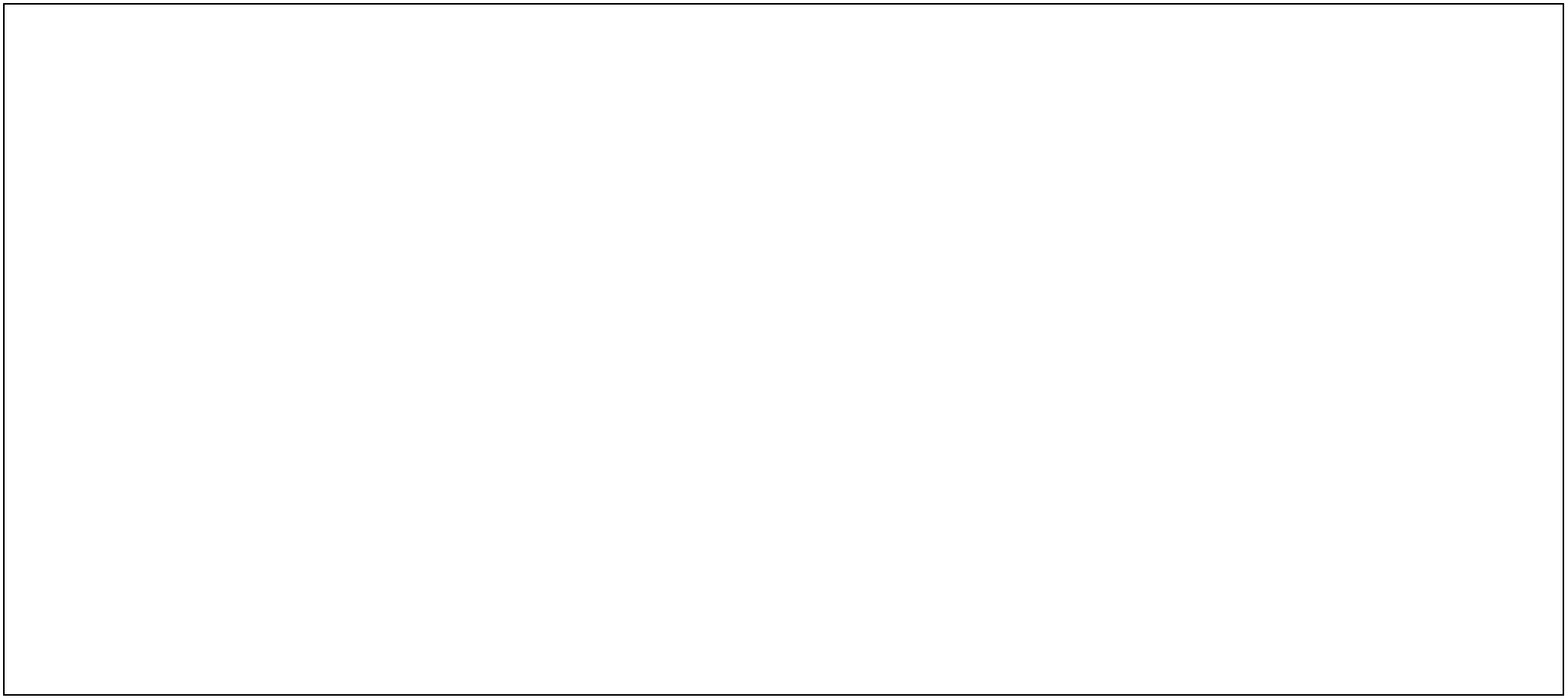

INFORMATION SOURCE KEY	
Information Source	**Code**

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Observations	Obs
Records	Rec
Patient	P
Carer	C
Relative	Rel
Front-line Staff	S
Multi-disciplinary team	MDT

RECORDING TEMPLATE FOR INSPECTION IS CARE SAFE? Avoiding and preventing harm to patients from the care, treatment and support that is intended to help them			
Ward Name:		**Date of Inspection:**	
Patient Safety / risk management Plans			
Total number of plans reviewed		**Info Source**	**Additional Comments**
Number of patient personal safety / risk management plans that evidence:			
Patients and/or their representatives are actively involved in designing and managing their own personal safety / risk management plans.			
Patient's personal safety / risk management plans are developed and reviewed the multi-disciplinary			
Are individualised, with appropriate actions devised and implemented			
Used to inform personal well-being plans / care plans which help to build capacity to self-manage health and well-being			
Regularly reviewed and amended where required			
Environment			

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Environment		Info Source	Additional Details
The ward is clean and comfortable, and in a state of good repair?	Choose an item.		
Ward facilities are available and accessible to patients	Choose an item.		
Staff are available and accessible	Choose an item.		
Patients can have access to safe outside spaces, recreational spaces and therapeutic spaces	Choose an item.		
Environmental risk assessments are up to date. If necessary an action plan is devised which is; • regularly appropriate to the purpose of ward and the patient population, • Implemented where required. • reviewed and amended	Choose an item.		
Patients have an individualised risk assessment and action / care plan in place where environmental risks have been identified.	Choose an item.		

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There is an up to date health and safety audit undertaken, with appropriate action plans to address any deficits. These are regularly reviewed and amended where required.	Choose an item.		

Staffing			
There is evidence that:	**Yes/No**	**Info Source**	**Additional Comments**
the multi-disciplinary team for the ward is agreed and all staff are currently available	Choose an item.		
There are appropriate numbers of staff on the ward to meet the needs of the patients.	Choose an item.		
Any staff shortages are responded to quickly and adequately with limited use of bank / agency staff	Choose an item.		

Staff raise and, if necessary, escalate concerns about environmental safety, patient safety or the level of care provided to patients.	Choose an item.		
Staff do not work beyond their role, experience and training.	Choose an item.		

Staff raise and, if necessary, escalate concerns about environmental safety, patient safety or the level of care provided to patients.	Choose an item.		

Patient Experience			
Complaints		**Number of respondents (Info Source)**	**Additional Details**
Number of patients and/or their representatives confirm that:			
They know how to make a complaint.			

Any complaints made have been responded to appropriately.			
They know who to talk to if they have concerns about their safety.			
Staff respond quickly when help is needed.			
They can access independent advocacy support			
Detention in accordance with the Mental Health (NI) Order 1986 and associated rights have been explained and understood; they have been facilitated to make application to the Mental Health Review Tribunal if applicable.			

Number of Patients Consulted		**Number of Relatives Consulted**	

Additional Comments

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INFORMATION SOURCE KEY	
Information Source	**Code**
Observations	Obs
Records	Rec

MAHI - STM - 214 - 96

Patient	P
Carer	C
Relative	Rel
Front-line Staff	S
Multi-disciplinary team	MDT

RECORDING TEMPLATE FOR INSPECTION IS CARE COMPASSIONATE? Patients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support	
Ward Name:	**Date of Inspection:**

Patient Experience			
It is confirmed that:	**YES/NO**	**Info Source**	**Additional Comments**
Staff seek consent before each intervention.	Choose an item.		
All appropriate available methods are used to assist with independent decision making prior to someone making a decision on their behalf.	Choose an item.		
Patients can decide who attends any meetings where decisions are made about care and treatment	Choose an item.		

Staff establish and use the patient's preferred name	Choose an item.		
Staff listen to and respect patient views, opinions and preferences and incorporate these in care and treatment planning and delivery.	Choose an item.		
Patients feel included in care and treatment planning, implementation and evaluation.	Choose an item.		
There are no blanket restrictions; the need for the use of any restrictive practice has been explained clearly and understood.	Choose an item.		
Patients can refuse treatment if they wish to and this decision is respected.	Choose an item.		
Staff respond compassionately to pain, discomfort and/or emotional distress.	Choose an item.		
The need for privacy is respected.	Choose an item.		

Family and friends can visit and are active participants in the recovery processes.	Choose an item.		
Patients can keep in touch with other family and friends by phone.	Choose an item.		
Spiritual needs, culture, and values are respected and can be freely expressed.	Choose an item.		
Overall patients and/or their representatives are satisfied with the care and treatment provided	Choose an item.		
Feedback from patients and/or their representatives, and stakeholders is positive about the way staff treat people	Choose an item.		

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Additional Comments

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INFORMATION SOURCE KEY	
Information Source	**Code**
Observations	Obs
Records	Rec
Patient	P
Carer	C
Relative	Rel
Front-line Staff	S
Multi-disciplinary team	MDT

MUCKAMORE ABBEY HOSPITAL INQUIRY

WITNESS STATEMENT

Statement of Wendy McGregor

Regulation and Quality Improvement Authority ("RQIA")

Date: 22 March 2024

Exhibit 6

The Regulation and Quality Improvement Authority

Ward physical environment observational tool / checklist.

"A physical environment that is fit for purpose delivering a relaxed, comfortable, safe and predictable environment is essential to patient recovery and can be fostered through physical surroundings." Do the right thing: how to judge a good ward. Ten standards for adult in-patient mental health care Royal College of Psychiatrists June (2011)

Guidance

This inspection tool has been designed to be used as a guide to gather evidence by carrying out a ward physical environment observation.

This evidence will feed into the overall information gathered to identify whether patients on the ward are begin treated with dignity and are receiving care that is safe effective and compassionate care. This document must be fully completed along with the Quality of Interaction Schedule (QUIS). All areas of the ward should be covered when completing the tool.

Standards and Good practice

This tool has been devised from the following standards and good practice guidance.

The Quality Standards for Health and Social Care; Supporting Good Governance And Best Practice In The HPSS; (March 2006)

Health Building Note 03-01 Adult acute mental health units; Department of Health (2013)

NICE Quality Standards for service user experience in adult mental health (December 2011)

Service framework for mental health and well-being DHSSPSNI (2011)

Environmental and Therapeutic Issues in Psychiatric Design: Toward Best Practices; Karlin B, E and Zeiss R, A; Psychiatry Online (2006)

Do the right thing: how to judge a good ward. Ten standards for adult in-patient mental health care Royal College of Psychiatrists June (2011)

Improving the patient experience Developing Supportive Design for People with Dementia The King's Fund's Enhancing the Healing Environment Programme 2009-2012Dementia Care Environmental Standards.

The Regulation and Quality Improvement Authority

Ward Physical Environment Observational Tool/Checklist

Facility Details:

Trust	Hospital	Ward

Date of inspection:

Carried out by:

Number of patients on the ward

Number of patients detained

Number of patients who met with the inspector: X Detained X Voluntary

Number of questionnaires completed

Ward advocate email address X

Ward environmental checklist

Ward environment	Checklist	Yes ✓ No X	Comments *(should cover areas for improvement as well as positive comments)*
The ward has a method for greeting patients that reflects customer service values and patient centeredness (Compassionate)	There is information about the purpose of the ward i.e: There is a ward information / welcome booklet and all the contents are up to date and relevant There is information about the wards performance e.g information in relation to releasing time to care, ie incidents, compliments, complaints etc. The ward has a mechanism for patient feedback on service development, patient experience; areas that patients say need improved etc….		
The staffing levels meet the needs of the patients (Safe and effective)	There are enough staff on the ward to assist patients with their activities of living, recreational and therapeutic activities and support patients who are enhanced observations. (check duty rota, level of patient assistance required as above)		

Enhanced observations are carried out with dignity (Effective)	Are there any patients in receipt of enhanced observations? Enhanced observations are carried out with respect and dignity. Staff are considerate.		
The ward is clean, tidy, well maintained and clutter free. There is good lighting and ample natural daylight. The air quality is good, there is good ventilation and neutral odours (Safe)	Are your first impression are conducive to the statement. Think about it in terms of what a patient or relative sees.		
Patient bays are single sex (Safe and compassionate)	Patients sleeping bays are single sex There are appropriate routes for patients to use single sex bathrooms and toilet facilities		
Patients can access a quiet private areas (Compassionate)	There are quiet private areas for patients		
A ligature risk assessment has been completed with an action plan (Safe)	The ward has a ligature risk assessment and an action plan has been implemented Check all beds are ligature free/check ward environment		
Patients can meet with their visitors in private and comfort (Compassionate)	There are visitor facilities – these are comfortable with enough seating etc.		
Ward furnishings, interior design are clean well maintained and comfortable. (Safe)	Furnishings are clean, maintained, comfortable, meet the needs of the patients (where appropriate meet		

	the needs of elderly care, LD) There is enough seating for patients and staff.		
Patients have access to a telephone (Safe, compassionate)	Patients can access a telephone in private		
Patients are informed of all staff who they will come into contact with (Compassionate)	All staff wear name badges. There is information on display about staff - that includes nursing staff and MDT team. There is information on display about who is on duty that includes the ward doctor. There is information about other members of the MDT on display There is information about patients named nurse and associate nurse or key worker There is information on which staff are allocated therapeutic 1:1 time with patients. Where appropriate this information is in a format that meets the communication needs of the patients on the ward		
There is clear signage on the ward for patients and visitors (Safe)	There is signage to orientate patients and visitors Signage is in a format that meets the patients communication needs		

Patients are informed of their rights (Safe)	There is information available in relation to Human Rights, complaints, advocacy, Mental Health Order, MHRT, the right to access information held about patients Information is in a format that meets the patients communication needs		
The ward environment promotes patients dignity and privacy (Compassionate)	Screens, curtains used for sleeping bay areas etc are well maintained. Patients can lock their bedroom doors (and en suite if applicable) Patients can lock bathroom / toilet doors Staff can open these if required		
Patients have open access around the ward environment and can access an outside space (Effective)	Patients can access their bedrooms, bathrooms and toilet facilities. Patients can access the outside space The outside space is well maintained. There are areas to sit. Check if the ward door is locked (a risk assessment / DOLS should be in place if patients do not have access)		

	There is information displayed in relation to DOLS.		
Precautions are taken to prevent information being shared inappropriately (Safe)	Staff telephone conversations are not over heard, computer screens cannot be viewed, patients details are not on white boards in view of the public (except patients names) Confidential records are stored appropriately		
The medical room and its contents are clean, maintained and accessible (Safe)	The medical room is clean, organised and well maintained. Medications are stored appropriately. The resuscitation trolley has been checked in accordance with trust policy.		
Patients can alert staff when needed (Safe)	Staff present in the patients communal areas Is there a call / alert system for patients and staff ie, is there a call system in bathrooms.		
Patients know what is happening in their day (Safe Compassionate)	There is information on activities available every day – a ward schedule. Is this all in the one place and includes the activity and the member of the MDT who is facilitating the activity. There is a good range of appropriate activities that meet the patient's needs.		

	There is information on the days of the ward rounds There is information when the advocate visits the ward There is information on the next patient forum meetings Patients have individual activity schedules and these are accessible for patients ie they have a copy. Staff record if any of the above has been cancelled the reason why and there is a mechanism for informing patients.		
Patients are clean, comfortable and suitably clothed to promote dignity (applicable on wards where there are patients who require support and assistance with personal care etc.) (Compassionate)	Patients appear to have had their personal hygiene attended to. Patients' clothing appears clean and free from food stains.		
Meals are appetising and appropriate to the needs of the patients (Compassionate) **Patients can eat their meals in a clean comfortable dining area and have access**	Patients are informed of meal times. Meal times are protected. There is fresh water available. Is there tea and coffee making facilities		

to fluids during the day **(Compassionate)**	There is information on the menu for the day. The dining area clean and comfortable. There is adequate space, seating i.e not overcrowded. The hospital menu offers a good choice of meals. The menu meets dietary requirements of the patients i.e culture, vegetarian etc.		
Patients with a learning disability or who have a cognitive impairment can orientate themselves around the ward **(Effective)**	Patients are orientated to time and space – signage, time. The ward physical environment meets the needs of patients who have dementia.		
Patients can control their level of social contact **(Effective)**	Patients have the ability to control their level of social contact. There are spaces where patients can retreat, including spaces where they can form social relationships. There are no areas that are prone to overcrowding. Day rooms are open and furniture is arranged that encourages staff interaction while allowing for personal autonomy.		

The seclusion room is designed in accordance with policy and procedure and good practice guidance **(Safe Effective Compassionate)**	Seclusion must only be delivered in a room designed expressly for that purpose. The seclusion room is designed to minimize the traumatic potential of seclusion interventions. Check the following There is facility for constant observation The room is away from other patients and other areas that are the site of frequent non-clinical interaction ie exits. • The room must be large enough to accommodate up to six staff members • The seclusion room contains limited furnishings. • The seclusion room is designed to enable protection of the patient, and prevent harm to self and others by eliminating or avoiding any weak points, ligature points, corners, edges or other safety hazards. • All features of the seclusion room are durable, tamper- and impact-resistant, washable, and can withstand significant and repeated force.		

	• Walls and floors are of seamless construction. • Walls are painted a calm, definitive colour • The seclusion room should have an unbreakable window allowing natural light into the space, and a view of a natural or outdoor setting. The window should be large enough and placed so that a patient may be able to see out of it while sitting on the floor, and cannot kick the window sill. It should be fitted with blinds that nursing staff can operate remotely. • Lighting in the seclusion room is mounted securely, unbreakable, and operated on patient request via the nurses. • The door to the seclusion room is heavy, solid-core, and opens outward on a spring loaded mechanism stalled securely with attention to preventing self-harm. The door contains a glazed observation panel with a blind on the outside to be controlled by staff. • Door locks are operated from exterior, with a mechanism that is easy to operate, and set to unlock		

	automatically if the fire alarm is triggered. • The seclusion room is fitted with sanitary facilities including a hospital-grade toilet and sink. • The seclusion room has adequate airflow and a healthy air temperature, and should be air-conditioned. • The seclusion room is fitted with appropriate safety mechanisms. including a staff-operated alarm system.		