Announced Inspection Report
11 August 2020

Belfast Health & Social Care Trust

Type of Service: Orthopaedic and Rehabilitation Service
Meadowlands Ward 2, Musgrave Park Hospital
Address: Stockman's Lane, Belfast, BT9 7JB
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Membership of the Inspection Team

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

1.0 What we look for

2.0 Profile of service

Musgrave Park Hospital (MPH) is a non-acute hospital managed by Belfast Health and Social Care Trust (BHSCT). The hospital provides a range of regional specialist healthcare services to people from across Northern Ireland. These services include a range of dedicated orthopaedic and rehabilitation services, such as the Mitre Rehabilitation Unit, the Regional Acquired Brain Injury Unit and the Neurology Unit.

Meadowlands Ward 2 is one of two rehabilitation units on MPH site which specialises in the care of older people with a particular focus on the rehabilitation of patients following fractures. The ward had capacity for 20 beds with 18 beds occupied at the time of the inspection.

3.0 Service details

Responsible person: Dr Cathy Jack	**Position:** Chief Executive Officer
Category of care: Orthopaedic and Rehabilitation Service	**Number of beds:** 20
Person in charge at the time of inspection: Margaret Devlin, Manager BHSCT	

4.0 Inspection summary

We undertook an announced inspection of Meadowlands Ward 2 on 11 August 2020. This was a focused inspection which was carried out following receipt of adult safeguarding (ASG) concerns. We were informed of these concerns by the BHSCT Adult Protection Gateway Team (APGT) which identified allegations of staff on patient physical and verbal abuse.

We used a blended approach when carrying out this inspection which consisted of the submission of documentation by the service for review; a remote inspection using digital technology; and a focused physical inspection undertaken by a reduced inspection team. The onsite inspection was carried out on 25 August 2020 from 14.00 – 17.00 and included a night time inspection from 20:30 – 22:00. This approach ensured a high level of assurance whilst balancing the ongoing risk of Covid-19 transmission.

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

The focus of this inspection was to assess arrangements for Adult Safeguarding in Meadowlands Ward 2. We additionally followed up on areas for improvement from a previous infection prevention and control (IPC) inspection of Meadowlands Ward 2 which was carried out in May 2018.

We acknowledged the efforts being made by the senior management team (SMT) to improve ASG processes on Meadowlands Ward 2 from the commencement of this inspection. However, immediate improvement is required to implement robust safeguarding arrangements within the ward in relation to staff knowledge and awareness; training; availability and accessibility of information for staff, patients and visitors; incident management and the robust application of ASG assurance measures.

4.1 Inspection outcome

Total number of areas for improvement	5

There are five areas for improvement arising from this inspection. Four of the five areas of improvement relate to staff knowledge and awareness of ASG; training in ASG; incident management and governance. One area for improvement has been repeated as a result of a previous inspection to Musgrave Park Hospital.

Two of the three areas for improvement identified during our inspection to Meadowlands Ward 2 in May 2018 were reviewed during this inspection, one has been met and the other partially met and has been repeated. The third area for improvement will be reviewed as part of any future IPC inspection to the hospital.

Details of the inspections findings and Quality Improvement Plan (QIP) were discussed with the SMT, MPH, on 3 September 2020.

Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the onsite inspection we reviewed a range of information relevant to the service and specific to safeguarding, including the following records:

1. previous QIPs
2. minutes of various meetings - ward meetings, Sisters meetings, and governance meetings, safety briefs
3. staff off duty rosters
4. education / training records
5. Datix incident reports
6. policies and procedures
7. operational accountability structure
8. directorate and corporate risk registers
9. briefing report for the three ASG referrals, including local action plan.

We assessed the ward using a standardised inspection framework. The methodology underpinning our inspection to the ward included the following – a review of relevant documentation; interviews with staff; discussions with patients and relatives; and observations of practice. We examined samples of records during the inspection which included: nursing care records; medical records; SMT and governance reports; minutes of meetings; duty rotas; and staff training records.

Posters informing patients, staff and visitors of our inspection were displayed while our inspection was in process.

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

We received one postal questionnaire from a patent’s relative and found the feedback of care on the ward to be positive.

6.0 The inspection

6.1 Review of areas for improvement from the previous IPC inspection from May 2018

Areas for improvement from the previous IPC Inspection May 2018		
Action required to ensure compliance with the DHSSPSNI Quality Standards for Health and Social Care (March 2006)		**Validation of compliance**
Area for Improvement 1 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First time	**The Belfast Health and Social Care Trust must:** Ensure that environmental cleaning of the public toilet is improved and its fixtures and fittings refurbished. Robust monitoring of the public toilet should be in place to provide continued assurance of cleaning practices**.**	**Not assessed**
	Action taken as confirmed during the inspection: This area for improvement was not reviewed as part of this inspection and will be included in any future IPC inspection to the hospital.	
Area for Improvement 2 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First time	**The Belfast Health and Social Care Trust must:** Ensure that the standard of cleaning of domestic cleaning equipment is improved. Robust monitoring of domestic cleaning equipment should be in place to provide continued assurance of cleaning practices.	**Met**
	Action taken as confirmed during the inspection: There were no issues identified with domestic cleaning equipment during the inspection.	
Area for Improvement 3 **Ref:** Standard 5.1 Criteria 5.3 .1 (c) (d) **Stated:** First time	**The Belfast Health and Social Care Trust must:** Ensure all staff comply with Trust policies relating to restrictive practices.	**Partially Met**

	Action taken as confirmed during the inspection: This area for improvement has been assessed as partially met, further detail provided in section 6.2.6.	

6.2 Inspection findings

6.2.1 Staff and patient engagement

During this inspection we engaged with a wide range of staff disciplines including nursing and medical staff, social workers, support service staff, the APGT and middle and senior managers. Staff who worked day and night duties were included in our interviews. We found staff at all levels to be helpful and supportive throughout the inspection process.

Inspectors met with two patients and one relative, all of whom gave positive feedback about the care they received during their stay on the ward,

6.2.2 Adult safeguarding - staff knowledge and awareness

During interviews with staff, we identified that staff knowledge in respect of the recognition and awareness of signs of harm, reducing opportunities for harm, and knowing how and when to report ASG concerns was in need of immediate improvement. Only a small number of staff who had direct contact with patients could confidently describe the ASG reporting process. All staff described safeguarding as "protecting the patient and protecting the staff" however during discussions with staff there was more emphasis on the protection of staff. There was no indication of staff recognition for ASG in its wider terms to include abuse, exploitation or neglect. All staff interviewed as part of the inspection told us that they have never had to make an ASG referral while working on the ward.

Awareness of safeguarding structures and roles was not widely understood by staff. When questioned staff were unaware of ASG terminology such as Designated Adult Protection Officer (DAPO), Investigating Officer (I/O) and ASG Champion. We interviewed middle management staff who told us that they have identified one Band 5, one Band 6 and the Band 7 nurse to undertake ASG Champion roles on the ward. Of note, the ASG Champion should be a senior position within the organisation and held by someone who is suitably skilled and experienced to undertake the role[1]. The role includes responsibility for strategic and operational leadership and oversight for the organisation in relation to adults at risk of harm.

We were informed during our onsite inspection that protection plans were in place for three patients on the ward. Protection plans are records which set out an identified range of actions to be taken to keep an individual safe.

[1] http://www.hscboard.hscni.net/download/PUBLICATIONS/safeguard-vulnerable-adults/niasp-publications/Adult-Safeguarding-Operational-Procedures.pdf

It was unclear from the documentation in both the safety brief and the protection plans as to whether these plans were designed to protect staff or protect the patient. Additionally, staff were uncertain where protection plans were retained within the ward.

6.2.3 Training

Following a review of staff mandatory training records, we identified a number of staff who had not received up to date ASG training. Of the staff who had received ASG training, many could not clearly recall what level of training they had received.

A number of staff (particularly night staff and medical staff) told us that they had not received ASG training for a number of years. Domestic and Catering staff told us that they have not received any safeguarding training. It is important that all staff receive safeguarding training and update their safeguarding knowledge and skills at a level commensurate with the post for which they are employed. We were informed that face to face bespoke ASG training was being organised for staff at all levels to attend by the ASGT.

6.2.4 Availability of safeguarding information

The ASG referral pathway was displayed behind the nurses' station for staff however we did not see relevant safeguarding information displayed on the ward for visitors and patients. Following the inspection, we received evidence to confirm that a safeguarding information board is now displayed for visitors and patients. The information board highlights the safeguarding referral pathway for staff to report ASG concerns however it should be further enhanced to include relevant information for visitors and patients regarding the recognition of signs of abuse and contact details of how to raise concerns in relation to safeguarding.

6.2.5 Incident management

As part of our announced inspection we reviewed the Datix reports of clinical incidents or "near misses" in the ward during the previous six months to the end of July 2020. Of the Datix reports reviewed, only one recorded incident identified any potential ASG concerns in Meadowlands Ward 2, this was a patient on patient assault. The incident coding for this Datix was incorrectly categorised as insignificant, which resulted in a local informal review of the incident being undertaken. The incident was not referred to the APGT for screening.

Additionally, of the ASG incidents reported in July 2020, only one case had a corresponding Datix referral completed by a staff member, reporting an alleged incident of verbal abuse by a patient to the staff member. There was no additional Datix or update to this Datix entry recorded when the situation escalated and the Police Service of Northern Ireland (PSNI) became involved. The recording and grading of incidents on Datix is a significant governance tool for any organisation to understand its risks and potential threats to patient safety. Ineffectively using this resource could lead to missed opportunities for identifying ASG concerns and trends.

We reviewed a Datix referral that had been completed by a staff member after the inspection had commenced. This Datix report was referred to APGT and subsequently screened out. We were pleased to note that staff awareness of the recognition of potential ASG incidents appeared to be heightened as a result of the focus on safeguarding processes in the ward.

During our interviews with staff we were told that there have been no reports of ASG concerns from Meadowlands Ward 2 in the past two years. We were concerned of a potential underreporting of ASG incidents from the ward. This concern was also recognised during our remote meetings with the SMT responsible for the service. We were informed of plans to undertake a retrospective review of incident management on the ward, particularly around concerns relating to the potential underreporting of ASG incidents. We welcomed this review and requested a copy of this report to be shared with RQIA once it has been completed.

6.2.6 Governance

Knowledge, awareness, and understanding of safeguarding arrangements are critically important if trust management teams are to be assured that their staff will be able to recognise and respond appropriately to ensure vulnerable patients and service users are protected. In Meadowlands Ward 2 we found these arrangements were not sufficiently effective to protect adults at risk of harm. This was largely due to failings in the robust application of accountability and assurance measures.

We found no robust mechanisms in place to review the effectiveness of training and staff adherence to the safeguarding policy and procedures. We were informed that additional bespoke ASG training, commensurate to staff roles, has been sourced from APGT. Competency assessment of all staff should form part of this training and be prioritised.

Records identified that the majority of staff have received supervision within the last six months. We were told that staff received group supervision which included the monitoring and effectiveness of the Trust ASG Policy. The effectiveness of this process needs to be improved.

On review of the information submitted by the Trust, there was little evidence of safeguarding being standing agenda item on meetings throughout the wards governance structures. Senior managers advised us that they are in the process of improving how safeguarding information is being reported throughout the service.

Overall policies and procedures in respect of safeguarding were accessible for staff and in date. We noted that the use of restrictive interventions policy had passed its review date. A number of staff had reviewed the Trust policy and procedures for restrictive practices. We were told that the management of restrictive practices was discussed as part of clinical supervision for all staff. We reviewed minutes of staff meetings, one of which discussed the management of restrictive practices. Dementia Companions have been employed between the two wards in Meadowlands Unit to engage with patients and provide ongoing compassionate reassurance. Diversional therapies such as Breakfast Clubs and Wander with Patients have been introduced as a result of a multi-disciplinary working group which was developed to promote a dementia friendly unit.

We reviewed the Trust risk registers at corporate and directorate level relevant to Meadowlands Ward 2. We found that the Corporate Risk Register referenced safeguarding risks in the outpatient departments of the Trust, and recommended the use of a referral pathway flow chart as an aid to escalate ASG concerns in a timely and effective way. The Directorate risk register included identification of risk associated with a reduction in ASG referrals during Covid-19 in relation to care homes but did not identify any ASG risks at ward level.

During our discussions with the APGT they described their service as being reactive rather than proactive. We were informed that the Trust's safeguarding gateway service does not have a fully joined up integrated system to allow each team to have full surveillance and oversight of the Trust's safeguarding activity. Additionally the APGT identified that they have limited resources to complete trend analysis of data.

The safeguarding concerns identified during this inspection had been raised with the Trust as a result of previous inspections, most recently following RQIA's review of the Trust's Governance of Outpatients Services in 2018. Our inspection to Meadowlands Ward 2 is evidence of a missed opportunity and highlights the immediate need for the Trust to improve its reporting systems for the sharing of safeguarding improvement work across all its services. We intend to engage directly with the Trust to seek assurance that robust governance mechanisms will be put in place for the reporting and sharing of safeguarding information across the organisation.

We recognised that during our inspection many improvements regarding ASG have already taken place on the ward. Safeguarding is now a standing agenda item discussed at meetings at all levels including ward safety briefs and collective leadership meetings.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with SMT on 3 September 2020 as part of the inspection process. The timescales for implementation of these improvements commence from that date.

The Trust should note that if the action outlined in the QIP is not taken to comply with the quality standards this may lead to enforcement action.

It is the responsibility of the Trust to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas of improvement

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

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to meet the areas for improvement identified. The Trust should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the DHSSPSNI Quality Standards for Health and Social Care (March 2006)

Area for Improvement 1 **Ref**: Standard 5.3.1 5.3.3 **Stated:** First time **To be completed by:** 29 January 2021	**The Belfast Health and Social Care Trust must ensure that there is an immediate improvement in staff knowledge and awareness in the recognition of safeguarding incidents. This is to be achieved by ensuring that:** 1. all staff receive safeguarding training and training updates commensurate to their role, and inclusive of competency assessment; 2. robust mechanisms are in place to provide assurance of staff adherence to Trust safeguarding policies and procedures; and 3. robust systems are in place for the implementation, oversight and management of protection plans. **Ref 6.2.2 & 6.2.3**
	Response by the Trust detailing the actions taken: To ensure that staff all receive safeguarding training and training updates commensurate to their role, and inclusive of competency assessment: • Bespoke face-to-face training sessions on adult safeguarding have been completed, all grades and disciplines of staff on Meadowlands wards have attended training**;(N= 83 staff, 100% of available staf have attended training)** • All Multi-disciplinary Team (MDT) Managers have ensured that staff attend both mandatory online training and the face-to-face training being provided by the Adult Safe Guarding team (ASG team). • Bespoke training programmes for medical staff have been arranged all medical staff have attended this training. **N=31, 100% medical staff** • Throughout the training staffs understanding of ASG was assess though scenario testing. • Increased leadership walk rounds. Unannounced leadership visits by Assistant Service Manager (ASM), Service Manager (SM), Divisional Social Worker and Co-Director. There were 2 unannounced visits per week for a period of 6 weeks between Sept to 15 Oct. Out of hours unannounced visits continue. The following mechanisms have been put in place to provide assurance on the safe delivery of care including monitoring staff adherence to Trust safeguarding policies and procedures. • All incidents are reviewed by Meadowlands management team to ensure that policies and processes have been followed • Reflective learning sessions have been undertaken with staff as part of the learning from leadership walk-a-rounds.

The following mechanisms have been put in place to provide assurance of staff adherence to Trust safeguarding policies and procedures; and

- All incidents are reviewed by Meadowlands management team to ensure that policies and processes have been followed
- All incidents are reviewed at the daily white board meeting in the presence of senior social worker, this discussion includes a review of actions taken.
- All Incidents graded moderate and above are reviewed at the Divisional Weekly Live Governance meeting.
- All incidents and ASG referrals are discussed at monthly governance meeting with the MDT.
- ASG has been added to the agenda for discussion with the collective leadership team to identify issues and share learning.
- Locally all ASG protection plans are reviewed daily
- ASG incidents and protection plans are discussed at the ward twice daily safety huddle.
- Audit of safeguarding referrals to identify ASG understanding, competency and implementation of safeguarding policies. Identify themes and trends and any additional staff training needs. Review and maintain staff Adult Safe Guarding training monthly.

Systems are in place for the implementation, oversight and management of protection plans and include:

- All incidents are reviewed and protection plans implemented in partnership with senior social workers/ ASG team in line with ASG policy and procedures.
- ASG protection plans are communicated through and detailed on the ward safety brief.
- All protections plans are reviewed by senior management team to ensure that they are robust and patient focused.
- ASG strategy meetings are facilitated by the DAPO from ASG team or the ward manager to discuss all ASG incidents and agree protection plan
- Outcomes of strategy meetings discussed with staff teams at team meeting, sisters meetings and governance meeting to disseminate information and share learning.
- Since July 2020, 10 incidents have been reviewed as potential safe guarding concerns. 50% have been screened out by ASG
- Audit of protection plans by senior team to ensure that they a line with the identified safeguarding requirement. Identify and address themes, trends and any additional staff training need. Assessment of staff competency by reviewing protection plans with staff involved to ensure competency in developing protection plans.

Area for Improvement 2 **Ref**: Standard 6.3.2 8.3 **Stated:** First time **To be completed by:** 11 November 2020	**The Belfast Health and Social Care Trust must ensure that:** 1. the relevant safeguarding information and contact details are available and displayed for staff, patients and visitors to the ward. **Ref 6.2.4**
	Response by the Trust detailing the actions taken: An Adult Safeguarding notice board has been set up at the entrance of Meadowlands 1 & 2 & 3. This notice board provides information on ASG including guidance on how to raise concerns. Safeguarding information and contact details for the ASG team are displayed on this board, which are visible to patients, visitors and staff. Details on how to make a safeguarding referral both in and out of hours, is displayed at Nurses station and on the fore mentioned notice board. Leaflets are available at ward level for patient's families and carers –at the entrance to the ward. If any concerns are raised Safe Guarding information is shared.
Area for Improvement 3 **Ref**: Standard 5.3.1 5.3.2 **Stated:** First Time **To be completed by:** 29 January 2021	**The Belfast Health and Social Care Trust must ensure that:-** 1. all staff have Datix/incident reporting training at a level commensurate with their role; 2. there are robust systems in place to review, approve and escalate all incidents in a timely manner; 3. all incidents and risks are graded appropriately; and 4. a retrospective review of incident reporting from the ward is undertaken. **Ref 6.2.5**
	Response by the Trust detailing the actions taken: Datix / incident reporting training at a level commensurate with their role: • A rolling program of training is available through the Trust Datix team and Meadowland staff will avail of that training • The Datix training compliance will be reviewed with staff as part of review of mandatory training. • Bespoke Datix incident training has been arranged for all staff. To date 24% of staff have completed this training with the outstanding training planned for completion by Feb 2021. The ward manager will keep compliance with DATIX under review to ensure this training target is met. • Datix training for new start will be included as part of induction for all staff.

	Systems are in-place to review, approve and escalate all incidents in a timely manner: • The Ward Sister reviews all incidents weekly and discusses with Assistant Service Manager. A weekly safety report is completed for the director and co-director which details an analysis of incidents and ASG referrals. This report is discussed with exec team and further monthly assurance report is prepared by the Director and shared with Trust Board. • All incidents graded moderate or above are discussed at the Adult Community Older People's Service Senior Management weekly live governance meeting. • During the weekly review of incident's the Ward Sister and ASM will identify themes and learning from incidents and this will be disseminated to the nursing team at safety brief and team meetings. • Themes and learning from incidents are at the monthly MDT Governance and Mortality & Morbidity meetings. • ASG incidents are discussed at the Adult Community Older People's Service Senior Management weekly live governance meeting. All incidents and risks are reviewed graded appropriately; • The grading of risk is reviewed with ward teams by ASM and ward manager at weekly meetings • Incidents graded as moderate or above are reviewed and discussed at the Senior Management live governance weekly and re graded if appropriate A retrospective review of all incident reported during 2020 for Meadowlands 2 is being completed by the ward sister. It is anticipated that this review will be completed by Feb 2021. Finding including themes, trends and learning will be presented at March Governance meeting and shared with the senior management team.
Area for improvement 4 **Ref**: Standard 5.3.1 **Stated:** First Time **To be completed by:** 1. January 2021	**The Belfast Health and Social Care Trust must ensure the robust application of ASG accountability and assurance measures. This can be improved by ensuring that:** 1. ASG is an agenda item on all safety briefs and meetings at all levels within the Trust and robust communications between each; 2. ASG is considered and discussed at all supervision and appraisals for staff; and 3. the risk registers are reviewed to accurately identify, assess, categorise, monitor and escalate ASG risks on the ward. **Ref 6.2.6**
	Response by the Trust detailing the actions taken: An ASG resource file has been developed and is available at ward level. This information file contains a flow chart on the referral

	pathway and actions to take in the event of an ASG incident. This flow chart is also displayed on the wall at the nurse's station. The referral pathway has been disseminated to all staff through safety briefs and team meetings. ASG is an agenda all Governance meetings. ASG is an agenda item on all safety briefs Safety Briefs take place at 7.45am 13.00 and 20.30 on the ward. The safety brief has been updated to include: • ASG, • Protection plans in place. • ASG is included in ward clinical supervision reflexive sessions for RN's • ASG included in all annual appraisal for all staff as part of mandatory training requirement • ASG competence framework for nurses will be completed by all staff –by Feb 2021 • Assurance in the form of o this is currently daily sit report, o weekly report to directors, o weekly update to exec team and monthly assurance report to Trust Board • Monthly risk register reviews to be commenced with ASM / SM to review grade and monitor risks Directorate risk register meeting is held quarterly
Area for Improvement 5 **Ref:** Standards 5.3.1 **Stated:** Second Time **To be completed by:** 11 November 2020	**The Belfast Health and Social Care Trust must:** 1. ensure all staff comply with Trust policies relating to restrictive practices. **Ref 6.2.6**
	Response by the Trust detailing the actions taken: To ensure that all staff comply with Trust policies relating to restrictive practices: • Nursing Staff have each received a copy of the restrictive practices policy. • Each member of staff has been required to read, date and sign that they have received read and understood the restrictive practice policy. Staff's understanding of the policy is tested by use of scenario-based questions by Ward Managers, ASM and SM. The use of restrictive practice is risk assessed by MDT and discussed with the patient and family to ensure it is the least restricted option is in place. All risk assessed needs are reviewed daily, outcomes are recorded in patient's notes and are time limited and in-line with individuated care need. This includes the use of 1:1 supervision,

	changes to automatic door opening, use of tab monitor and ramble-guard to prevent falls.

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

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