Unannounced Inspection Report
27 and 28 October 2020

Belfast Health & Social Care Trust

Type of Service: Mental Health and Learning Disability Hospital
Muckamore Abbey Hospital
1 Abbey Road
Antrim
BT41 4SH
Tel No: 028 9446 3333

Membership of the inspection team

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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

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

MAH provides a service to people with a Learning Disability from the Trust, the Northern Health and Social Care Trust (NHSCT) and South Eastern Health and Social Care Trust (SEHSCT) areas. The Psychiatric Intensive Care Unit (PICU) closed on 21 December 2018 and has remained closed to that purpose since. It has now being used as a low stimulus area and the hospital's seclusion room.

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

- Cranfield One (male assessment);
- Cranfield Two (male treatment);
- Ardmore (female assessment and treatment);
- Six Mile (forensic male assessment and treatment); and
- Erne (long stay/re-settlement).

On the day of the inspection, there were 50 beds operational in the hospital, 45 patients who were accommodated in the hospital; three patients who were on trial resettlement leave; and two patients who were on extended home leave.

3.0 Service details

Responsible person: Dr Cathy Jack Belfast Health and Social Care Trust	**Position:** Chief Executive Officer
Category of care: Acute Mental Health & Learning Disability	**Number of beds:** 50
Person in charge at the time of inspection: Tracy Kennedy, Co-Director Learning Disability	

4.0 Inspection summary

An unannounced inspection was undertaken to all five wards located in MAH which commenced with an onsite inspection from 27-28 October 2020. The inspection was completed on 10 December 2020 following family and advocate engagement. Feedback from the inspection was delivered to the Trust's senior management team on 11 December 2020.

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

During August 2019 we served three improvement notices to the Trust in relation to adult safeguarding arrangements, staffing and the governance of patients' finances. Compliance with the improvement notice for staffing was determined in December 2019 and in April 2020 for adult safeguarding arrangements and the governance of patients' finances. The focus of this inspection included our determination whether the improvements made by the Trust since April 2020 had been maintained and embedded in practice at the hospital. In addition the areas for improvement identified in the previous Quality Improvement Plan (QIP) from December 2019, were examined during this inspection.

We were pleased to see good practice in relation to:

- the hospital's ethos of using the least amount of restrictive practices to manage patients' behaviours that challenge;
- the management and monitoring of patient's physical healthcare needs;
- the oversight of medicines management within the hospital; and
- the updated operational policy reflecting the varied use of close circuit television (CCTV) within the hospital.

We were concerned that:

- communication of information relayed to families by the adult safeguarding team was not clearly shared with ward staff;
- some families were not content with the level of communication from the ward/hospital/adult safeguarding team about their relative;
- staff were unsure about the actions to take if the ward's medicine refrigerator was found to be outside of the safe temperature range; and
- some patients had not received an audit of their finances by a senior manager.

4.1 Inspection outcome

Total number of areas for improvement	4

There were four new areas for improvement arising from this inspection. These are detailed in the QIP.

Details of the QIP were discussed with the senior management team (SMT) at an online feedback session on 11 December 2020, as part of the inspection process. The timescales for implementation of these improvements commence from that date. Findings of our inspection are outlined in the main body of the report.

This inspection did not result in enforcement action.

5.0 How we inspect

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

- previous inspection reports;
- review of the previous returned QIP;
- Serious Adverse Incident (SAI) notifications;
- information about complaints; and
- other relevant intelligence received by RQIA.

Each ward was assessed using an inspection framework. The methodology underpinning this inspection included discussion with patients, staff, relatives, observation of practice, and review of relevant documentation. Records examined during the inspection included nursing care records; medical records; senior management and governance reports; minutes of meetings; duty rotas; and training records.

Areas for improvement identified during previous inspections were reviewed and an assessment of achievement was recorded as met, partially met or not met.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection from 02-16 April 2020

The announced inspection from 02 -16 April 2020 was undertaken remotely to assess compliance with two extended Improvement Notices relating to the governance of patients' finances and adult safeguarding arrangements. Full compliance with the extended Improvement Notices was achieved in April 2020. The QIP generated from the unannounced inspection from 10-12 December 2019 was not reviewed during the April 2020 inspection and was reviewed during this inspection.

6.2 Review of areas for improvement from the previous inspection from 10-12 December 2019

Areas for improvement from the previous inspection		Validation of compliance
Area for improvement 1 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Third time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust must: 1. implement effective arrangements for the management and monitoring of CCTV within MAH and ensure: a) that all staff understand the procedures to be followed with respect to CCTV; b) that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively; 2. ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.3.1.	

Area for improvement 2 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First Time **To be completed by:** 28 August 2019	The Belfast Health and Social Care Trust must strengthen arrangements for the management of medicines in the following areas: 1. Recruit a Pharmacy Technician to support stock management and address deficiencies (stock levels/ordering/expiry date checking) in wards in MAH to assist with release of nursing staff and pharmacist time. 2. Undertake a range of audits of (i) omitted doses of medicines (ii) standards of completion of administration records and (iii) effectiveness & appropriateness of administration of "when required" medicines utilised to manage agitation as part of de-escalation strategy. 3. Implement consistent refrigerator temperature monitoring recording (Actual/Minimum & Maximum) across all wards in MAH.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.3.2.	
Area for Improvement 3 **Ref**: Standard 5.3.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall complete a review of how seclusion is provided on the site taking into account the safety of both patients and staff. The Trust should also take into account the dignity of patients and best practice guidance.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.3.3.	
Area for Improvement 4 **Ref:** Standard 5.3.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall outline a statement of purpose for the use of the PICU as a "Low Stimulus Area" taking account of the required standards and best practice guidance and ensuring the safety of patients and staff.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.3.4.	

Area for Improvement 5 **Ref**: Standards 5.3 and 7.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall develop and implement a systematic approach to the documentation used throughout the hospital for the recording of patients' physical health checks.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.3.5.	
Area for Improvement 6 **Ref**: Standards 5.3 and 7.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall ensure if physical health checks are declined by the patient, this must be recorded in the patient's care records and evidence retained of ongoing attempts to engage the patient.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.3.6.	

6.3 Inspection findings

6.3.1 Close circuit television (CCTV)

We reviewed the arrangements in relation to the oversight and governance for the use of CCTV within the hospital. We found that there was an effective process in place for contemporaneous monitoring and management of CCTV images. We were provided with records of contemporaneous CCTV viewing from 09 March to 20 October 2020. We found that CCTV viewing occurs, at various times over the 24 hour period of each day, 7 days a week, and across different wards including day care.

We reviewed the minutes of three live governance meetings (01- 15 October 2020) and found that the CCTV viewer's findings were discussed. The CCTV viewer's records evidenced where good practice was highlighted and where poor practice or incidents, which met the criteria for an adult safeguarding referral, demonstrated appropriate action was taken.

We reviewed patients' care records and adult safeguarding multidisciplinary team (MDT) protection plans. We saw evidence that CCTV images were used to assist in decision making if there was uncertainty about staff's use of Management of Actual or Potential Aggression (MAPA) restraints and in relation to making referrals to adult safeguarding.

We were informed that Assistant Service Managers (ASMs) and Designated Adult Protection Officers (DAPOs) were provided with CCTV viewing records every week to review and triangulate information relating to their wards. We found evidence that this was an effective process and found that adult safeguarding or practice issues were dealt with in a timely manner.

We reviewed the draft CCTV policy. The policy incorporated new areas relating to staff training and reflection and increasing the understanding of patient support needs. The SMT informed us that a CCTV working group had been set up to review the current use of CCTV within the hospital which included representation from staff of varying grades and disciplines, litigation services and trade unions. The group were finalising a survey seeking the views of patients, family, carers, patient advocates and staff on the current and future use of CCTV within the hospital. We were informed that Speech and Language therapists were supporting patients to provide their feedback to the working group about the use of CCTV. We were advised that the feedback obtained from the survey would further inform the final draft of the CCTV Policy.

Whilst the current CCTV policy remains in draft form, it has been made available to all staff pending further review when feedback from all relevant parties is considered. It is planned that the final draft of the policy will be presented to the Trust's Standards and Guidelines Committee in December 2020 for approval. We determined that this addresses the previous area for improvement outlined in section 6.2.

6.3.2 Medicines management

We reviewed how the Trust had strengthened arrangements for the management of medicines since the previous inspection. We found that the hospital's pharmacist hours had been increased from a 0.5 whole time equivalent (wte) to a 0.8 wte on 01 March 2020, for a temporary period until 31 December 2020. We were informed that plans were in place to review the increase of the pharmacy service in December 2020 and a decision will be made to either recruit a pharmacy technician or permanently increase the pharmacist's hours.

We spoke with staff on the wards and they were very positive about the pharmacist's input. They told us that the pharmacist attends the Purposeful Inpatient Admission (PIpA) meetings regularly and provides their specialist knowledge, which is welcomed. The PIpA model introduced by the Trust provides an increased multidisciplinary review of each patient and involves shared decision making around care and treatment issues and risk assessment. We reviewed audits that had been undertaken in relation to omitted doses of medicines; standards of completion of administration records; and the effectiveness and appropriateness of the administration of "when required" medicines, that are utilised to manage agitation as part of a de-escalation strategy. The SMT informed us that their plans to implement an audit schedule to provide the ongoing assurance of the high standards we observed was delayed due to the impact of the Covid-19 pandemic, however, they expected this audit schedule to become operational soon.

Ward staff informed us that the pharmacist provides a level of scrutiny over missed doses of medications and advice regarding drug interactions and cross titration of antipsychotic medications. The pharmacist also calculates the combined antipsychotic medication daily dose for individual patients to ensure this falls within safe limits. Staff told us that the pharmacist's input during the Covid-19 pandemic surge period regarding intravenous fluids and oxygen was invaluable. They also reported that the increase in the pharmacy service within the hospital has made the process of prescriptions for patients going on leave from the hospital much more refined, thereby reducing delays.

We reviewed a sample of 20 medicine kardexes and found a good standard of prescribing. We noted that recording of medicine administration was well completed and the patients' allergy status was documented on all kardexes reviewed. Antibiotic prescriptions included indications for use and treatment lengths were documented.

There was a minimal amount of multiple antipsychotic prescribing and a clear rationale was described by the Consultant in these cases. We found evidence that as and when required (PRN) medication was prescribed in the context of any regular prescriptions of the same medication. PRN medication usage was discussed daily at PIpA meetings and weekly live governance meetings for trend analysis. We found that PRN medication usage was proportionate, judicious, and fell within maximum dose limits which indicated that PRN medications were not used as a form of restrictive practice.

We reviewed the daily records for medicine refrigerator temperature monitoring to ensure these accurately reflected the actual, minimum, and maximum refrigerator temperatures. We found evidence that these checks were being completed daily and that records were being kept on all wards. We determined that the previous area for improvement outlined in section 6.2 had been met.

We spoke with staff about the actions to take on occasions when the medicine refrigerator temperature fell outside of the required temperature and found there was a lack of clarity about the correct actions to take. We established there was no advice available for staff to guide them on the appropriate steps to take to ensure the integrity of the medications contained in the refrigerator. An area for improvement is stated to ensure that an escalation procedure for managing temperature variances in medicine refrigerators is developed which guides staff to take the appropriate actions if medicine refrigerators fall outside the permitted temperature range.

6.3.3 Review of how seclusion is provided on the site

We reviewed the arrangements in place to provide seclusion on the site. The SMT informed us that a Restrictive Practices Working Group had been established to have oversight of all restrictive practices used within the hospital. The group was stood down during the initial months of the Covid-19 pandemic but had recommenced in October 2020 as part of the site's recovery and rebuild plan.

We saw clear evidence of where seclusion was used; as a last resort; proportionate to the risks presented by the patient and; after all deescalating techniques, as recorded in the patients' positive behaviour support plan, were implemented. These approaches include encouraging patients to avail of low stimulus areas with their agreement, within designated low stimulus areas designed to promote a calm environment for patients who have difficulty in managing their emotions and who require support during times of emotional dysregulation and distress. Patients can avail of therapeutic one to one time with a staff member allowing them to explore their feelings in an area that protects their dignity.

Staff described the use of voluntary confinement. This is the term used to describe requests from patients to be confined to their bedroom and to have the door locked as part of their behavioural support plans. Voluntary confinement, as part of an agreed care and treatment plan, is only in place for specific patients who have used this as an approach to manage their behaviour over a significant period of time. We established that the patients who use this approach to self-manage their behaviour can exit their voluntary confinement at any time of their choosing. We determined that when a patient requests voluntary confinement they are subject to the same level of support and observation levels that a patient would otherwise have, had they been in seclusion. We saw evidence that the decision making and care planning for voluntary confinement involves significant MDT discussion and consultation with family. We saw evidence of a care plan for a patient who uses voluntary confinement which was subject to regular review. We were satisfied that all appropriate safeguards were in place which included consideration for the patients' human rights.

Seclusion occurs when a patient is formally placed in a specifically designated room for the short-term management of disturbed/violent behaviour. We saw evidence of care planning for patients who may require this intervention which had been agreed by the MDT and shared with their family. The care plan and the seclusion policy outlined the strict monitoring and observation procedures to be followed by nursing and medical staff with the aim of ending seclusion at the earliest opportunity. It was good to see that the hospital applied the same monitoring and governance standards to all of these interventions.

All episodes of voluntary confinement/low stimulus/seclusion are discussed at PIpA meetings, MDT, and live governance meetings. A monthly audit is undertaken across all wards taking account of all episodes of voluntary confinement/low stimulus/seclusion use. We saw evidence that this information is reported in the weekly Safety Report reviewed by SMT and are reviewed bi-monthly at the Director's Governance Committee. We were assured by the systems and processes in place and determined that the SMT had good oversight and governance of restrictive practices including the use of voluntary confinement/low stimulus/seclusion within the hospital.

We observed that the site continues to have one operational seclusion room which is located in the former PICU. The PICU closed to its previous function on 21 December 2018. It is now being used as a Low Stimulus Area along with accommodating the seclusion room. The Restrictive Practice Working Group carried out a review of how seclusion was provided on the site and concluded that the current facilities available to patients were appropriate in meeting their needs to required standards.

We reviewed audits and found evidence that the use of low stimulus/voluntary confinement/seclusion on the site had reduced significantly and SMT told us they are committed to an ethos of least restriction. We determined that area for improvement as outlined in section 6.2 had been met.

6.3.4 Statement of Purpose for the "Low Stimulus Area"

A draft Statement of Purpose (SoP) for the Low Stimulus Area was provided by the Trust following the inspection. The draft clearly outlined the rationale for the provision of this area and considered how it would be provided within the former PICU and in Sixmile ward. The Trust planned to consult with staff, patients, their families and other stakeholders to ensure a wide range of feedback on the SoP could be considered. They plan to add to the SoP so that robust guidelines will be developed to direct staff about the required operational procedures to be followed when this area is to be used. We determined that the area for improvement as outlined in section 6.2 had been met.

6.3.5 Standardised documentation of physical health care records

We reviewed the arrangements in place for the management of patients' physical health care needs. We examined a sample of patient care records and evidenced that all patients had a robust medical history completed by a General Practitioner (GP), which included a comprehensive family history. These histories along with antipsychotic medication monitoring checks were located in one folder on each ward which made it easy for all staff to be quickly apprised of any specific patient's physical health care status. All care records reviewed also evidenced that anti-psychotic monitoring was up to date.

Population screening programmes have a key role to play in the early detection of disease and a range of programmes are currently available in Northern Ireland.

The SMT informed us that patients who meet the criteria set out by the Public Health Agency for population screening have had their screening completed and have been added to the registers to ensure they are appropriately called in line with the general population. Population screening programmes include abdominal aortic aneurysm screening and surveillance monitoring; routine breast screening; bowel cancer screening; cervical screening; and routine diabetic eye screening and surveillance monitoring.

We found that patients' physical health care histories were also stored on the PARIS electronic care records system. We found evidence that patients' physical health care was discussed daily at the PIpA meetings and all wards were documenting this information in the same way. We were assured that there were robust systems in place for the oversight and management of patients' physical health care needs and determined that the previous area for improvement as outlined in section 6.2, had been met.

6.3.6 Ongoing engagement of patients who decline physical health care checks

We reviewed how the hospital was identifying and meeting the physical health care needs of the patients and in particular what action was taken when a patient declined physical health care checks. We reviewed a sample of patient care records, ward diaries, and physical health care folders and saw evidence that when patients' decline a physical health care check this is recorded in their care record, the physical health care folder, and the ward diary to alert staff of the ongoing need to encourage the patient to participate in this check. We found an example of good practice and patient centred care in one ward where the ward manager allocated a blood sample to be taken on a specific day as the staff member on duty had a particularly good rapport with the patient. The ward manager had recognised that this professional rapport with the identified staff member could help to put the patient at ease during the procedure and reduce any anxiety or distress.

We were informed that the psychology department works closely with ward staff to help better understand the patient's rationale for declining a physical health care check. There was evidence that the MDT considers various strategies and collaborates with the behaviour therapists to encourage patients to accept necessary physical health care checks. Social Stories were used by ward staff and behaviour therapists to help patients understand the reason a procedure may be required and what the procedure may entail. This also applied to patients requiring dental care and treatment.

We were told that some wards have electronic visual control boards for use during PipA meetings and when patients on these wards decline a physical health care check/procedure it is highlighted in red on the board. The number of times the patient has declined the check is also recorded. We found evidence within the patients' care records that the urgency of requested blood samples or other procedures was assessed and discussed by the MDT. We determined that this addresses the previous area for improvement outlined in section 6.2.

6.3.7 Patients finances

We reviewed the arrangements in place for the management of patients' monies and valuables. We found that, in line with the Trust's policies and procedures, ASMs randomly selected records of monies and valuables held for two patients, per ward, per month. Staff confirmed that as these audits were random the monthly sample could include patients that had already been selected for an audit the previous month. We found that two patients, across all wards, had not been subject to an audit by the ASMs since April 2019.

We asked the Trust to prioritise these patients at the next monthly audit and to ensure that all patients are subject to an ASM audit at least annually. An area for improvement was made relating to the ASM's monthly audit of patients' monies and valuables.

Ward staff were adhering to the Trust's policy of two staff checking patients' ledgers at each handover. Most ward managers were randomly auditing patients' ledgers weekly, in addition to the daily checks.

We were informed by the Patients' Finance Liaison Officer (PFLO) that the ward managers receive patients' monthly transaction reports, which are forwarded from the Trust's cash office. The monthly reports detail the transactions undertaken on behalf of patients during the month and the balance of monies held for each patient at the end of the month. The ASMs include these transaction reports in their monthly audits of patients' monies and valuables. A copy of the monthly audit reports is forwarded to the PFLO who, along with the ASMs, compares them against the previous month's reports, notes any discrepancies/issues and if required, follows up with the service managers. This was found to be in line with the Trust's policies and procedures.

In relation to Patients' Private Property (PPP) accounts we saw evidence that patients' accounts were reconciled, and continue to be reconciled, to the benefits received on behalf of each patient, which the Business Services Organisation (BSO) Internal Audit had confirmed in February 2020.

The PFLO confirmed that SMT reviewed and approved the Policy for Patients' Finances and Private Property, however, the policy had yet to be approved by the Trust's Policy Committee. Discussions with ward staff also confirmed that they were adhering to the procedures for patients' cash within the new policy; however, the checks on patients' property were still performed annually rather than quarterly as per the new policy.

BSO Internal Audit had recommended that the procedure for patients' property to be checked quarterly, in line with the new policy, should be implemented by 31 December 2020. We will review this procedure at the next inspection of MAH.

We were informed by the PFLO that additional training materials for patients' finances and property were recently developed. The layout of the training materials was being finalised and this would be available for ward staff on the Trust's e-learning system in the near future.

Discussions with the PFLO confirmed that financial support plans had been developed for all patients in MAH. We reviewed a sample of the support plans and confirmed that the plans included the details of the current financial arrangements for patients, the financial support provided to patients and the details of the staff member within the Trust authorised to manage the patients' finances. The plans also provided details of the weekly/monthly income received for each patient and a breakdown of the estimated weekly/monthly expenditure for each patient.

Discussions with the PFLO confirmed that the Trust had a contract with an independent advice centre that assisted patients or their representatives with social security benefits. Patients were offered a full review of their benefits to ensure that they receiving the appropriate benefits. We were informed that four patients had not received a review offered by the advice centre. Of the four patients that did not receive a review, three had family members who acted as their appointee and they had declined the offer. The remaining patient's appointee was a member of staff from another Health and Social Care Trust. The BHSCT had contacted the other Trust however it had not received a reply accepting or declining the review.

A review of records evidenced that BSO Internal Audit had confirmed that all patients for whom the Trust manages patients' monies and valuables, in excess of 20k, had received consent from us to hold these monies and valuables for each patient in line with the legislation.

In general, we were satisfied that the processes for managing patients' finances and property had significantly improved from previous inspections in 2019. The practices and documentation developed and implemented by the Trust could be used as a benchmark for good practice by other Trusts managing patients' finances and property.

6.3.8 Staffing

We reviewed the staffing arrangements to ensure that they meet the assessed needs of the current patient population. We were provided with copies of each ward's Telford staffing model. This model considers patient acuity and dependency which in turn determines the level of staffing required to safely care for patients. The model was developed by the SMT, in conjunction with ward managers. The model can be used to respond quickly to temporary or unplanned variations in patients' assessed needs and/or service requirements.

We were informed by the SMT and ward staff that ward staffing levels were reviewed daily and on Fridays, there is a review of the requirements for the weekend. We were informed that there is an out of hours (OOH) Co-Ordinator who can review staffing levels and address any deficits on site during the OOH period. Staff were knowledgeable about the process of escalating staffing issues to the SMT and OOH Co-Coordinator. Staff told us about the on call rota for medical and senior management cover and reported that they felt very supported. Staff understood the need to assist other wards across the site if those wards were short staffed and they demonstrated a willingness to do so. They told us that the improved communication across the hospital helped them to understand the pressures each ward faced daily and we found that staff morale was good.

We reviewed the ward duty rotas and found that staffing levels were appropriate to meet the assessed needs of the patients accommodated and the staff informed us that prescribed patient observation levels could be met. The hospital continues to rely on agency staff to fill staff vacancies. Many of the agency staff had accepted block bookings which provides consistency of care to patients and demonstrates their greater level of commitment to MAH. One former member of agency staff had recently been recruited to a permanent Band 7 post. We determined that significant progress has been made to ensure agency staff were fully integrated into the day to day running of the hospital

We reviewed the induction plans and competency frameworks for staff taking up posts and found evidence of a structured plan which covered the required competencies. Additional competencies required for staff who take charge of the ward are in place. We sought assurances regarding agency staff training and were informed that staff at the hospital site do not have direct access to the agency staff member's training records. The SMT informed us that assurances relating to agency staff's training forms part of the contract the Trust has with the agency and that the responsibility for providing appropriate training lay with the agency. The process for booking agency staff includes the Trusts stipulation of the level of experience and training required, for example, MAPA and adult safeguarding, and the agency subsequently provides suitably qualified staff. However, the SMT did recognise the need to strengthen the governance arrangements with respect to agency staff training records and had begun to seek these assurances with the assistance of the Trust's Nurse Bank.

The SMT indicated that they were willing to offer agency staff access to the Trust's training programmes to make it easier for them to access updates. We were informed that the Trust had provided an adult safeguarding training session for agency staff the previous week.

Ward managers told us when they are planning staffing levels for the ward they take into account the impact of staff who remain subject to supervision plans due to the ongoing investigations into the historic allegations of patient abuse. Since the inspection we have been engaged in work with the Trust, PSNI and the Department of Health seeking ways to strengthen the assurance processes with respect to this cohort of staff.

6.3.9 Adult safeguarding

We examined the management of adult safeguarding arrangements within the hospital. We reviewed eight incidents that had resulted in referrals to adult safeguarding and found evidence that patient protection plans were in place, if required, and were held centrally on the ward. We spoke with staff and found they were knowledgeable about the content of the protection plans. We found evidence that information regarding protection plans and incidents were communicated at every handover, recorded on the daily safety briefs, documented in the patient's care records, and discussed with the MDT at the PIpA meetings.

The staff we spoke with, including agency staff, knew what would constitute a referral to adult safeguarding. They were able to describe the process of how to escalate incidents to the nurse in charge and how to make a referral to adult safeguarding, if necessary.

We were told by the SMT and ward staff that a Nursing Development Lead had conducted an adult safeguarding training session on the site the previous week. Most of the staff were aware of the terms DAPO (Designated Adult Protection Officer) and IO (Investigating Officer) as outlined in the Northern Ireland Adult Safeguarding Partnership: Adult Safeguarding Operational Procedures (2016). The staff that we spoke with knew who the aligned social worker was for the ward and the names of the DAPOs. We could see from a review of the competency framework, which allows agency nurses to take charge of a ward upon successful completion, that knowledge of safeguarding and the ability to make a referral to adult safeguarding was included.

We spoke with ward managers who were aware of the process of escalating allegations of staff abuse of patients to the SMT and of the requirement to inform the Trust's Nurse Bank if the staff member involved was agency staff so that the relevant agency would be notified. Ward managers were knowledgeable about staff whose practice was restricted until the adult safeguarding investigations were completed. They demonstrated good awareness about the requirement to inform other ward managers of the nature of the restrictions if the staff member was asked to provide cover on another ward.

We were informed that there was a weekly adult safeguarding team meeting which provided an opportunity for the team to discuss any new incidents, changes required to protection plans or to plan strategy meetings.

In some incidents we reviewed we were unable to establish if or when the patient's next of kin (NOK) had been notified about the incident. We were informed by ward staff that if an incident occurs during working hours the adult safeguarding team has the responsibility of informing the NOK. We found that there was potential for inconsistent communication of incidents to the NOK. An area for improvement has been stated to develop a clear and robust communication plan providing clarity to all groups of staff about the information provided to the NOK following an incident, the date and by whom the information was provided, the NOK's response to the

information and the follow up arrangements planned. This information should be recorded in a standardised manner across the hospital site.

6.3.10 Restrictive practices

We undertook a review of how restrictive practices are managed within the hospital to ensure that it was in line with best practice guidance. We reviewed the minutes of three of the hospital's live governance meetings (01/10/20 – 15/10/20), three of the hospital's weekly Safety Reports (28/09/20 – 08/10/20), three of the monthly Director's Oversight Meetings (June – August 2020), and the Trust Board Meeting for 02 July 2020. We saw evidence that the use of restrictive practices; seclusion; physical interventions; enhanced observations; and the use of PRN medication was discussed and monitored for trend analysis at these meetings.

We reviewed 12 patient care records and found evidence that a restrictive practice care plan was in place for each patient outlining the restrictions that the patient was subject to. In all the records sampled, we saw evidence that the rationale for the restrictive practice was recorded and there was evidence of MDT input during the assessment phase and review of the restrictions.

The 12 patients care records we reviewed had a positive behaviour support (PBS) plan in place which was reviewed regularly at PIpA meetings. These plans offered staff guidance on the most effective ways to provide support to patients who may be using a particular behaviour as a means of communication. These PBS plans were developed using a psychological formulation. In addition to the PBS plans, we found that every patient had a shortened version of that plan (the "grab sheet") which was available for staff to quickly understand the actions they should take to support the patient to de-escalate their behaviour. The "grab sheet" formed part of a pack that could be sent with any patient requiring emergency medical attention at another hospital to quickly inform staff who were unfamiliar with the patient's behaviours and how best to support them to reduce the likelihood of resorting to restrictive practices.

We spoke with ward staff who informed us that the focus of one PIpA meeting per week is to look more closely at restrictive practices. We observed staff supporting patients who were experiencing high levels of distress in a caring and compassionate way. The staff we spoke with demonstrated good knowledge about the range of practices that constituted a restriction and there was evidence of a culture of using the least restriction possible to effectively manage patient's behaviours. Staff told us that they felt supported through the structured debriefing sessions that followed incidents.

We examined audits in relation to the use of low stimulus/voluntary confinement/seclusion episodes and found good compliance with the recording in line with the Trust's policy and procedure, the required standards, and best practice. In one ward, we were provided with evidence of a substantial reduction in seclusion episodes for one patient and we were informed that the patient's quality of life had improved as a result. The patient now leads a more independent life and is able to engage in a wider variety of activities at locations outside of the hospital. We reviewed the care records of a patient who uses voluntary confinement and we were satisfied that this was being treated as seclusion and managed appropriately.

From our review of the restrictive practice audits, we saw evidence that the use of physical interventions had also reduced. We reviewed patient care records and could clearly see an ethos of attempts to de-escalate behaviours and use least restrictive options to support patients. We determined that the Trust had a robust governance and assurance framework regarding the use of restrictive practices.

6.4 Engagement

6.4.1 Patient engagement

We provided questionnaires to patients. Three patient questionnaires were completed, returned to us, and analysed following the inspection. All indicated a good level of satisfaction with the care provided to them in the hospital. However, a patient commented that changes to their personal care team were not communicated with them and another patient commented that the food was poor quality, particularly the meat. We provided this feedback to the SMT to address.

6.4.2 Engagement with relatives/carers

Due to the impact of the Covid-19 pandemic, restrictions to visiting were in place during our on-site inspection and as a result we did not have the opportunity to meet with the relatives/carers of patients. To ensure we captured relative/carer views we wrote inviting them to engage with us to share their opinions about the care and treatment provided to their relative in the hospital.

We received 12 completed returns from the relatives/carers we contacted. Of the 12 responses, 50% of the respondents were entirely satisfied with the care and treatment provided to their relative, 33% returned mixed feedback and 17% were unhappy with most of the care and treatment provided to their relative in the hospital. We raised the specific concerns, highlighted by relatives/carers, with the SMT who sought further information from the relevant ward managers. The SMT provided a timely, robust account of actions that had been taken. We were assured that they had previous knowledge of all of the issues which were highlighted to us and that appropriate actions were undertaken or were being taken to address the relatives'/carers' concerns.

We were informed by one relative/carer about the excellent communication strategy between themselves and the Trust. The result of which meant that their relative was able to access home leave two days every week which was a positive outcome for the patient and their family.

From the feedback we received, we found that whilst some families are very happy about the communication they have with the hospital, others either stated that it has been a long journey to reach the currently acceptable level of communication or that they had ongoing difficulties. One relative stated that all she wanted was a two minute phone call each day, particularly during the Covid-19 pandemic surge and the subsequently restricted visiting, to be updated on how their relative's day had gone. Another relative expressed how it was more beneficial for them to know how the patient's mood was than the more high level information about safeguarding referrals or medical information. A relative/carer also told us that they did not want to feel they were being a burden to staff by contacting the ward.

During our inspection, one of the ward managers was able to provide an example of an individual communication strategy that had been agreed with a patient's relatives. We commended this as good practice.

We determined that a blanket communication policy for all relatives/carers would not address their specific, individual requirements as the information they wanted regarding their relative varied greatly in type and level of detail.

An area for improvement has been stated in relation to developing and implementing a communication strategy that will ensure that relatives/carers receive their requested level of communication about their relative's care and treatment. The agreed communication strategy should be documented and accessible to relevant staff.

6.4.3 Staff engagement

During the inspection, we spoke with staff and also invited them to complete an electronic questionnaire, however, no completed staff questionnaires were returned to us.

6.4.4 Advocacy Services

We spoke with the two advocacy service managers who provide the advocacy service to patients in MAH and both reported a positive relationship with all staff on the hospital site and advised that members of the SMT are easily accessible. They told us that advocacy provision is a well-established service and that hospital staff ensure that referrals to the service are made promptly and that patients are facilitated in accessing this service.

We were told that patients are able to access the advocacy service upon admission to the hospital. Patients who are deemed not to have capacity or who have no verbal communication are routinely allocated an advocate. The advocacy service managers confirmed that the advocates are invited to appropriate meetings and feel empowered to challenge staff if required. It was positive to hear that the advocacy arrangements within MAH have been strengthened.

The advocacy service managers informed us that whilst face to face contact had been temporarily suspended, in March 2020, due to the impact of the Covid-19 pandemic advocates could maintain their role, to a degree, by participating in online video call review meetings and were provided with updates from ward staff at least every week for patients who had reduced verbal communication. We were advised that face to face contact has gradually resumed with some good infection prevention controls in place. The advocacy service managers did not have any concerns about the current care and treatment of any patients they are in contact with.

They informed us that most of the advocate's work relates to the resettlement of patients to accommodation outside of the hospital. We were told that the issue causing the most frustration currently for patients, carers, and staff is the slow pace of the resettlement of the patients.

Advocacy staff told us about the compassionate practice of ward staff in involving patients in the resettlement process. This included patients visiting the site of their new accommodation to help them understand the building process as they may be unable to understand it viewing the plans alone. This was commended as good practice.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the SMT, as part of the inspection process, on 11 December 2020. The timescales for implementation of these improvements commence from the date of the inspection feedback.

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

7.1 Areas for improvement

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

7.2 Actions to be taken by the service

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

Quality Improvement Plan

The Trust must ensure the following findings are addressed:

Communication between teams

Area for improvement 1 **Ref:** Standard 5.1 Criteria 5.3.2 (d) **Stated:** First Time **To be completed by:** 31 March 2021	The Belfast Health and Social Care Trust shall ensure that a communication plan is developed which provides clarity to all staff about the information provided to the NOK following an incident, the date and by whom the information was provided, the NOK's response to the information, and the follow up arrangements planned. This information should be recorded in a standardised manner across the hospital site. **Ref:** 6.3.9
	Response by the Trust detailing the actions taken: An escalation plan is in place outlining whose responsibility it is to notify the next of kin of an incident during working hours and outside working hours following an Adult Safeguarding referral. To ensure consistency of the information being shared with next of kin by ward staff, the Adult Safeguarding team has developed guidance which has been shared with the Service Manager, Assistant Service Managers and ward staff. In addition, the Adult Safeguarding team along with the operational management are in the process of agreeing a template, which will be completed and placed in the patient's file and on the electronic PARIS record. This will include the details of what information has been shared with the next of kin following an adult safeguarding incident, by whom, the date of the incident, the date the contact with the next of kin was made, the response of the carer and what follow up arrangements have been in place - by whom and by when.

Engagement with relatives/carers

Area for improvement 2 **Ref**: Standard 6.1 Criteria 6.3.2 **Stated:** First time **To be completed by:** 31 March 2021	The Belfast Health and Social Care Trust shall develop and implement a communication strategy that will ensure that relatives/carers receive their requested level of communication about their relative's care and treatment in Muckamore Abbey Hospital. The agreed communication strategy should be documented and accessible to relevant staff. **Ref:** 6.4.2
	Response by the Trust detailing the actions taken: The Trust has been developing a commitment to carers statement and a communication agreement template. This has been developed in conjunction with staff, a number of carers and advocacy services through the Carers Forum.

	This includes details of the next of kin's preferred method of keeping in touch, frequency of contact etc. This information will be recorded in the agreed template which will be kept in each patient's file within the ward and on the electronic PARIS system. A key contact information sheet containing the contact details of staff involved in each patient's care has also been developed. This will also be recorded in the agreed template which will be kept in each patient's file within the ward and on the PARIS system. There are plans for this to be rolled out.
Escalation procedure for temperature variances in medicine refrigerators	
Area for improvement 3 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First time **To be completed by:** 31 March 2021	The Belfast Health and Social Care Trust shall ensure that an escalation procedure for temperature variances in medicine refrigerators is developed to guide staff in Muckamore Abbey Hospital to take the appropriate actions if medicine refrigerators fall outside the permitted temperature range. **Ref:** 6.3.2
	Response by the Trust detailing the actions taken: An escalation procedure has been agreed and a flowchart developed to provide guidance to staff to ensure they are aware of what action is required when temperature variances occur in medicine refrigerators. The flowchart has been laminated and attached to each refrigerator. The flowchart is accessible to all staff and staff will be taken through the procedure as part of medication training.
Monthly audit of patients' monies and valuables	
Area for improvement 4 **Ref**: Standard 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1) **Stated:** First time **To be completed by:** 31 March 2021	The Belfast Health and Social Care Trust shall ensure that all patients in Muckamore Abbey Hospital are subject to the Assistant Service Manager's monthly audit of monies and valuables at least annually. **Ref:** 6.3.7
	Response by the Trust detailing the actions taken: A process has been implemented to ensure that a different patient's records each month forms part of the financial audit. A schedule has been developed per ward listing each patient and recording the date of when their financial records were last audited and the date they will audited next. This process will ensure that each patient's financial records including monies and valuables are audited at least annually.

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

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