Announced Enforcement Inspection Report
02 – 16 April 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

Assurance, Challenge and Improvement in Health and Social Care

Membership of the inspection team

Lynn Long	Acting Deputy Director Improvement Regulation and Quality Improvement Authority
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Abbreviations

BHSCT	Belfast Health and Social Care Trust
BSO	Business Services Organisation
DAPO	Designated Adult Protection Officer
IN	Improvement Notice
IO	Investigating Officer
MAH	Muckamore Abbey Hospital
MHO	Mental Health (Northern Ireland) Order 1986
NHSCT	Northern Health and Social Care Trust
PICU	Psychiatric Intensive Care Unit
QIP	Quality Improvement Plan
RQIA	Regulation and Quality Improvement Authority
SEHSCT	South Eastern Health and Social Care Trust

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 provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of the hospital

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 BHSCT, Northern Health and Social Care Trust (NHSCT) and South Eastern Health and Social Care Trust (SEHSCT). The Psychiatric Intensive Care Unit (PICU) had temporarily closed on 21 December 2018 and has remained closed since.

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).

3.0 Service details

Responsible person: Ms Cathy Jack Belfast Health and Social Care Trust	**Position:** Chief Executive Officer
Category of care: Acute Mental Health & Learning Disability	**Number of beds:** 83
Person in charge at the time of inspection: Bernie Owens, Director, Neurosciences, Radiology and Muckamore Abbey Hospital, BHSCT.	

4.0 Inspection summary

We undertook an announced remote inspection of Muckamore Abbey Hospital (MAH) from 2 to 16 April 2020 to assess compliance with the outstanding action points contained within the extended Improvement Notice (IN) - IN000004E which related to the governance of patients finances and Improvement Notice - IN000005E which related to adult safeguarding. We did not visit MAH as part of this inspection due to the current impact on all services as a result of COVID-19. We determined that the information we required to confirm compliance could be provided to us electronically and reviewed remotely.

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 Quality Standards for Health and Social Care DHSSPSNI (March 2006).

On 16 August 2019 RQIA issued three Improvement Notices (INs) to MAH in respect to a failure to comply with minimum standards.

- IN000003 - staffing
- IN000004 - financial governance ; and
- IN000005 - adult safeguarding

During our unannounced inspection on 10, 11 & 12 December 2019 we found sufficient evidence to validate full compliance with Improvement Notice - IN000003 relating to staffing. However, while we found evidence of improvement and acknowledge that progress had been

made to address the required actions within the other two Improvement Notices, IN000004 relating to financial governance and IN000005 relating to adult safeguarding we did not find sufficient evidence to validate full compliance with these two Improvement Notices.

We were able to validate compliance with action points 1, 2, 3 (a), 3 (b) and 3 (c) contained within IN000004 and with action points 1 (a), 1 (b), 1 (c),1 (d) and 2 contained within IN000005. While significant progress had been made, we were unable to evidence that action point 3 (d) of IN000004 and action point 3 of IN000005 were fully addressed.

RQIA senior management held a meeting on 13 December 2019 and a decision was made that the date of compliance for Improvement Notices IN000004 and IN00005 should be extended. Compliance with the extended Improvement Notices must therefore be achieved by 19 March 2020. The extended Improvement Notices – IN000004E and IN000005E were issued on 19 December 2019.

This inspection sought to assess the level of compliance achieved in relation to the following outstanding action points:

- IN000004E – that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in Muckamore Abbey Hospital

- IN000005E – implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital

4.1 Inspection outcome

Total number of areas for improvement	6*

**Six areas for improvement generated as a result of the inspection undertaken on the 10, 11 and 12 December 2019 were not reviewed as part of this compliance inspection and will be carried forward to the next inspection. No new areas for improvement were identified during this inspection.

As a result of the findings of this inspection we determined the Trust had achieved compliance with the outstanding action points contained within the extended Improvement Notices - IN000004E and IN000005E.

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Enforcement notices for registered establishments and agencies are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

5.0 How we inspect

Prior to the inspection, we reviewed a range of information relevant to the establishment including the following records:

- written and verbal communication received since the previous inspection;
- notifiable events received since the previous inspection;
- the previous inspection report;
- the QIP from the previous inspection; and
- The extended Improvement Notices - IN000004E and IN000005E.

During our remote inspection we requested the following records from the Interim Co-Director for Intellectual Disability:

- findings of the financial audit carried out by BSO;
- records of adult safeguarding and DATIX training provided for Designated Adult Protection Officers (DAPOs), Investigating Officers (IOs), line managers and medical staff;
- minutes of the monthly adult safeguarding forum (January and February 2020);
- evidence of outcomes from analysis of adult safeguarding data;
- minutes of Clinical Governance Meetings (January and February 2020);
- evidence of governance arrangements in place for staff on supervision plans moving around wards;
- outcomes from audits of patient protection plans, all adult safeguarding referrals for January and February 2020 and evidence of compliance with the adult safeguarding referral process; and
- evidence of the development of a communication strategy with carers.

We examined the following areas:

- arrangements for financial governance;
- results of the financial audit completed in February 2020; and
- oversight and management of adult safeguarding arrangements.

The findings of the inspection were provided to the Senior Management Team (SMT) and to Ms Cathy Jack, Chief Executive, BHSCT at the conclusion of the inspection by letter.

6.0 The inspection

6.1 Review of areas for improvement from the last care inspection dated 10, 11 and 12 December 2019

As previously outlined in section 4.0 this inspection focused on evidencing compliance with the outstanding action points in IN000004E and IN000005E. Six areas for improvement from the last inspection on 10, 11 and 12 December 2019 were not reviewed as part of this inspection

and are carried forward to the next inspection. The QIP in section 7.2 reflects the carried forward areas for improvement.

6.2 Inspection findings

Improvement Notice Ref: IN000004E

STATEMENT OF MINIMUM STANDARDS

The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).

Standard 4.1:

The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.

Standard 5.1:

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

Failure to Comply:

4.3 Criteria

The organisation:

(f) ensures financial management achieves economy, effectiveness, efficiency and probity and accountability in the use of resources;
(g) has systems in place to ensure compliance with relevant legislative requirements;
(h) ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory functions and in relation to inter-agency working;
(i) undertakes systematic risk assessment and risk management of all areas of its work.

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

(c) has policies and procedures in place to identify and protect children, young people and vulnerable adults from harm and to promote and safeguard their rights in general;

Improvement necessary to achieve compliance:

The Belfast Health and Social Care Trust Board, Chief Executive and Executive Team must ensure:

- that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in Muckamore Abbey Hospital.

On 2 April 2020 the Trust's (SMT) provided an update to RQIA on the progress made to address compliance with the outstanding action points included in the Improvement Notices via a remote inspection. They informed us that a full audit of the arrangements for financial controls relating to patients had been completed by internal auditors from the Business Service Organisation (BSO) and that a 'satisfactory' rating had been achieved. They told us that there were no Priority 1 findings. The audit identified some Priority 2 findings with associated recommendations. We discussed the findings of the financial audit in detail with the SMT and they provided us with the actions they had taken or where taking to address the recommendations made by Internal Audit.

The Trust advised that BSO Internal Audit had confirmed to them that documentation was in place from the Social Security Agency (SSA) authorising the Trust to act as the appointee for certain patients and that the correct benefits were being received on behalf of those patients. The Trust also advised that Internal Audit had highlighted some minor issues that had arisen from the financial audit which they were addressing.

The SMT told us that Internal Audit had acknowledged that the Trust had sought approval from RQIA to hold balances of patients' monies and valuables in excess of £20,000 in line with article 116 of the MHO.

As the Trust received a satisfactory grade from BSO Internal Audit, we were advised that a mid and end of year assurance report will be required to be submitted by the Trust to Internal Audit. We were told that Internal Audit will review the recommendations from all the Trust reports at a point in time and provide an update in terms of implementation i.e. fully implemented, partially implemented or not implemented for the Trust's Audit Committee in October 2020.

It was good to note that many of the findings in the Internal Audit report concur with RQIA's findings from the unannounced inspection on 10, 11 and 12 December 2019.

We were informed that the SMT within MAH will take the lead in liaising with the Trust's Finance Directorate in order for the Finance Directorate to have the overarching accountability of the financial arrangements for patients within MAH**.** SMT told us they believed links with the Finance Directorate had been greatly strengthened because of the financial audit and that the Patient Finance Liaison Officer based in MAH was a key role in maintaining improvements. SMT advised that they were planning to permanently appoint a Patient Finance Liaison Officer.

On 9 April 2020 the final copy of the audit report was shared with RQIA and reviewed by our inspection team. This verified the information previously provided to us by on 2 April 2020.

Outcome

We found sufficient evidence to determine that this action point had been addressed.

Improvement Notice Ref: IN000005E

STATEMENT OF MINIMUM STANDARDS

The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).

Standard 5.1:

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

Failure to comply:

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

(a) has effective person-centred assessment, care planning and review systems in place, which include risk assessment and risk management processes and appropriate interagency approaches;
(c) has policies and procedures in place to identify and protect children, young people and vulnerable adults from harm and to promote and safeguard their rights in general;

Improvement necessary to achieve compliance:

The Belfast Health and Social Care Trust Board, Chief Executive and Executive Team must:

- Implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital.

During the teleconference on 2 April 2020, the MAH SMT provided a presentation to us outlining how they had embedded into practice the safeguarding improvements we observed during our unannounced inspection of MAH on 10, 12 and 12 December 2019. They described to us the senior management oversight arrangements for the management of safeguarding within the hospital. They shared with us the flow chart displayed on each ward which showed the process for escalating a safeguarding incident and which highlighted the various staff roles in the process.

The SMT told us about good practice improvements which have been implemented which included a comprehensive review of policies and procedures including the seclusion policy, the observation policy and the admission policy. They told us that patients are engaged in more meaningful activity on and off the hospital site in the evenings and at weekends. They also informed us that CCTV is now live across the site and learning from the Adult Safeguarding (ASG) team's viewing of the CCTV is shared at ward manager meetings and at the ASG Forum.

The Purposeful Inpatient Admission (PIpA) model, which provides an increased multidisciplinary review of each patient and involves shared decision making around care and treatment issues and risk assessment, had been further developed and embedded within the hospital. We were

informed that a link person for contact with the Police Service Northern Ireland (PSNI) had now been established and a Service Manager with ASG responsibilities has been recruited.

The SMT told us that action had been taken by the hospital social work team to raise safeguarding awareness among patients through the Keeping Yourself Safe Programme. The programme informs patients about what safeguarding is and what actions they could take if they had a safeguarding concern. We were advised that this will be an ongoing programme for patients.

We were advised that since January 2018, the Keeping Yourself Safe programme had been delivered to 45 patients in MAH and another 33 patients were either offered the programme and declined or had insufficient capacity to participate or have now been discharged from the hospital.

It was established that the programme was not able to sufficiently meet the needs of 22 patients who experienced significant communication difficulties without specialist input and training from the Association for Real Change (ARC) to enable them to participate. The social workers on site have now all been trained in Talking Mats to assist in more effective communication with patients.

We were told that ARC will complete a baseline report of the views of all patients in relation to how safe they feel in the hospital. This will be reviewed every six months. ARC will also complete a post safeguarding investigation questionnaire for any patient involved in a safeguarding investigation. Preparatory work has been completed for both pieces of work to commence as a pilot in one ward.

The SMT informed us that the safeguarding team are now completing pre and post safeguarding investigation questionnaires with carers/relatives and the learning outcomes will be disseminated via clinical governance meetings, safety briefs and the ASG Forum as appropriate. These questionnaires were analysed by the DAPO and will be used to inform future practice. From this analysis, the need for clearer communication with families following a safeguarding incident/referral had been identified and work was underway to develop a communication strategy to engage more effectively with carers.

We were told that the SMT had increased audit activity to embed safeguarding practices within the hospital. Auditing is being used to ensure compliance with and adherence to safeguarding recording standards by both ward staff and safeguarding staff. We were given examples of how these audits had informed improvements in the service provided and patient experience. The current audits shared with us showed good compliance with safeguarding recording standards. Auditing of the contemporaneous viewing of CCTV was ongoing on a weekly basis (each ward was monitored for a 4 hour shift per week) and a viewing sheet was retained. Examples of good practice and areas for improvement were highlighted by the viewing team and addressed through ward managers meetings and by the assistant service managers. We were advised that the contents of the CCTV viewing sheets form part of the hospital's safety report. We noted that one safeguarding incident was identified from the contemporaneous viewing of CCTV footage and appropriate action had been taken.

During our inspection on 10, 11 and 12 December 2019 we evidenced good staff knowledge and awareness of what constitutes a safeguarding referral and the process on how to make a referral. The SMT informed us that in order to be assured of the continued good level of safeguarding knowledge and awareness, audits were conducted within the hospital to test staff

(twenty eight staff in total) about their knowledge of the new safeguarding processes implemented; escalation plans; protection planning; how to refer in and out of hours to ASG; staff responsibilities; how safeguarding information is communicated; and the contact details of the safeguarding team. The result of the audit demonstrated that among all grades of staff knowledge was found to be good.

SMT told us that there is now monthly auditing of ward managers' decision making to screen out safeguarding referrals. This audit showed that no safeguarding referrals had been inappropriately screened out. The SMT informed us about a further monthly audit completed to ensure there was MDT input into protection planning. This audit identified a significant improvement in MDT input into protection planning and risk assessment from October 2019 (52% compliance) to January 2020 (100% compliance).

From the information reviewed and discussed on 2 April 2020, we found that the Trust had made good progress in embedding good practice in respect of adult safeguarding across the hospital. In order to support our decision making about compliance with the outstanding action within IN00005E we asked the Trust to provide the following evidence:

- records of adult safeguarding and DATIX training provided for DAPOs, IOs, line managers and medical staff since our last inspection in December 2019;
- minutes of the monthly adult safeguarding forum (January and February 2020);
- evidence of learning outcomes from the analysis of adult safeguarding data;
- minutes of Clinical Governance Meetings (January and February 2020);
- evidence of governance arrangements in place for staff on supervision plans moving around wards;
- outcomes from audits of patient protection plans;
- all adult safeguarding referrals for January and February 2020 and evidence of compliance with adult safeguarding referral process; evidence of the development of a communication strategy with carers.

The information requested was provided to us on 10 April 2020 and we found that this verified the discussions we had with the SMT on 2 April 2020. Review of the information showed an improvement in training compliance; live discussions around the need for ongoing safeguarding training; staff positivity in relation to the benefits of sharing learning via the ASG forum; and the impact of the improvements on care practices and restrictive practices.

We reviewed evidence of the governance arrangements in place for staff on ASG supervision plans who were moving around wards. This was clearly stated in the escalation policy and we were informed this had been tested by SMT to assure compliance. We were assured that appropriate measures were in place to ensure the safety of patients when staff members on ASG supervision plans are asked to provide relief on another ward.

We were able to verify that the information regarding the outcomes from audits accurately reflected what the SMT told us during the remote inspection and that the results from auditing in relation to patient protection plans led to an improvement in the compliance rating for the next audit. Evidence that improvements were being embedded was also seen in relation to how and where information was stored on the PARIS information system, templates being updated and how and with whom information was shared.

We were assured that steps were being taken to address the concerns raised by carers in relation to safeguarding. We reviewed a draft 10 point communication plan for families and found that a communication strategy was being developed in consultation with the Carer's Consultant to ensure a consistent approach when engaging with carers.

Outcome

We found sufficient evidence to determine that this action point had been addressed.

6.3 Conclusion

We found sufficient evidence was available to validate compliance with the outstanding action points in the extended Improvement Notices IN000004E and IN000005E.

7.0 Quality improvement plan

There were no new areas for improvement identified during this inspection. The attached QIP contains the areas for improvement carried forward from the last inspection on 10, 11 and 12 December 2019. The six areas for improvement will be reviewed at a subsequent inspection.

The Trust should note that if the action outlined in the QIP is not taken to comply with areas for improvement this may lead to further 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 for improvement

No new areas for improvement were identified during this inspection. The attached QIP includes six areas for improvement identified during the last inspection on 10, 11 and 12 December 2019.

7.2 Actions to be taken by the service

The Trust is not required to return a completed QIP for assessment by the inspector as part of this inspection process. The QIP reflects the carried forward areas for improvement from the inspection on 10, 11 and 12 December 2019.

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 5.1 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.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.
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.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.
Area for Improvement 3 **Ref**: Standard 5.3.1 **Stated:** First Time	The Belfast Health and Social Care Trust shall complete a review of the necessity for a functioning seclusion room taking into account the needs of the patients accommodated in the hospital, safety of patients and staff and the required standards and best practice guidance.

To be completed by: 1 October 2020	**Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.**
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.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.
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.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.
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.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.

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