Unannounced Enforcement Inspection Report
10, 11 & 12 December 2019

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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Abbreviations

BHSCT	Belfast Health and Social Care Trust
BSO	Business Services Organisation
CCTV	Closed Circuit Television
DFC	Department for Communities
DAPO	Designated Adult Protection Officer
DoH	Department of Health
GP	General Practitioner
IN	Improvement Notice
MAH	Muckamore Abbey Hospital
MAPA	Management of Actual or Potential Aggression
MDT	Multi-disciplinary Team
MHO	Mental Health (Northern Ireland) Order 1986
NHS	National Health Service
NHSCT	Northern Health and Social Care Trust
NIASP	Northern Ireland Adult Safeguarding Partnership
OCP	Office of Care and Protection
PICU	Psychiatric Intensive Care Unit
PIpA	Purposeful Inpatient Admission
PRN	pro re nata “as needed”
QIP	Quality Improvement Plan
RQIA	Regulation and Quality Improvement Authority
SAI	Serious Adverse Incident
SEHSCT	South Eastern Health and Social Care Trust
SEA	Significant Event Audit
SMT	Senior Management Team
SITREP	Situation Report

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 (BHSCT). 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). There were 83 beds in the hospital at the time of the inspection. The Psychiatric Intensive Care Unit (PICU) temporarily closed on 21 December 2018 and has remained closed since that date.

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)
- Erne (long stay/re-settlement).

A hospital day care service was also available for patients.

During the inspection there were 53 patients receiving care and treatment in MAH.

3.0 Service details

Responsible person: Mr Martin Dillon	**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 unannounced inspection to MAH over three days commencing on 10 December 2019 and concluding 12 December 2019. Five wards were inspected over the course of the inspection which included a night time inspection on 11 December 2019 from 03:00 – 04:00 of all wards.

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).

On 16 August 2019 RQIA issued three Improvement Notices (INs) to MAH in respect to a failure to comply with minimum standards. This inspection sought to assess the level of compliance achieved in relation to the Improvement Notices. The areas identified for improvement and compliance were:

- IN000003 - management of staffing levels
- IN000004 - governance of patients' finances; and
- IN000005 - adult safeguarding arrangements.

The date by which compliance with the Improvement Notices must be achieved was 16 November 2019.

We found sufficient evidence to validate full compliance with Improvement Notice - IN000003 relating to the management of staffing levels.

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 the governance of patients' finances and IN000005 relating to adult safeguarding arrangements. However, we did not find sufficient evidence to validate full compliance with these two Notices.

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 these Notices must therefore be achieved by 19 March 2020. The extended Improvement Notices – IN000004E and IN000005E were issued on 19 December 2019.

We had previously raised serious concerns and identified areas for improvement during inspections in February and April 2019 in relation to restrictive practices (seclusion) and the management of patients' physical health needs. The Trust submitted information following the April inspection to provide assurance in relation the progress made to address these concerns and we also used the information provided as part of this inspection. We found that significant improvements had been made and the two areas for improvement had been fully addressed.

We reviewed an additional five areas for improvement that were made following the previous inspection in April 2019 which related to CCTV policy and procedures; the management of patients' observations; discharge planning; strategic governance; and hospital governance. We were able to evidence that sufficient progress had been made to fully address four of the areas for improvement, however, the area for improvement relating to CCTV policies and procedures was only partially met and has been stated for a third time.

One area for improvement in relation to medicines management was not reviewed as part of this inspection and is carried forward to the next inspection.

4.1 Inspection outcome

Total number of areas for improvement	6

Total number of Improvement Notices	2 (Extended)

There are six areas for improvement arising from this inspection, comprising of four new areas for improvement. The four new areas of improvement relate to developing and implementing a systematic approach to the documentation used throughout the hospital for the recording of patients' physical health checks; implementing a system of assurance in respect of delivery of physical health checks; reviewing the hospital's need to provide a seclusion room; and outlining a statement of purpose for the use of the "Low Stimulus Area".

One area for improvement in relation to medicines management identified during our inspection in February 2019 was not reviewed during this inspection and will be carried forward for review at a subsequent inspection. One area for improvement in relation to CCTV was assessed as only partially met and has been stated for a third time.

Ongoing enforcement action resulted from the findings of this inspection. As a result of this inspection the date of compliance with two Improvement Notices, IN000004 and IN000005 was extended to 19 March 2020.

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/

Improvement Notices for Health and Social Care Trusts are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children services.

Details of the inspections findings and QIP were discussed with MAH SMT on16 December 2019.

5.0 How we inspect

Prior to the inspection, we had a meeting with the MAH Senior Management Team (SMT) on 2 November 2019 in the office of RQIA. At this meeting the SMT presented the actions they had taken to address the improvements necessary in relation to restrictive practices and the management of staffing levels as set out in the Improvement Notice IN000003. We tested the information they provided during this inspection. We also reviewed a range of information relevant to the service including the following records:

- previous inspection reports;
- Serious Adverse Incident (SAI) notifications;
- written and verbal information received following the previous care inspection in April 2019 and the previous finance inspection in July 2019;
- adult safeguarding referrals; and
- complaints received by RQIA.

We assessed each ward using a standardised inspection framework. The methodology underpinning our inspections included; discussions with patients; observations of practice; interviews with staff; and a review of relevant documentation. 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.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection from 15-16 April 2019

<table>
<tr><th colspan="3">Areas for improvement from the previous inspection 15-16 April 2019</th></tr>
<tr><th colspan="2">Action required to ensure compliance with the DHSSPSNI Quality Standards for Health and Social Care (March 2006)</th><th>Validation of compliance</th></tr>
<tr><td>Area for Improvement 1

Ref: Standard 5.1
Criteria 5.3 (5.3.1)

Stated: Second time</td><td>The Belfast Health and Social Care Trust must:

1. Implement effective arrangements for the management and monitoring of CCTV within MAH and ensure:
2.
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;

3. Ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH.

Action taken as confirmed during the inspection:
This area for improvement has been assessed as partially met and has been stated for the third time, further detail is provided in section 6.3.1.</td><td>Partially Met</td></tr>
<tr><td>Area for Improvement 2

Ref: Standard 5.1
Criteria 5.3 (5.3.1, 5.3.3)

Stated: Second time</td><td>The Belfast Health and Social Care Trust must:

1. Undertake an urgent review of the current and ongoing use of restrictive practices including seclusion at MAH whilst taking account of required standards and best practice guidance.
2. Develop and implement a restrictive practices strategy across MAH that meets the required best practice guidance.
3. Ensure that the use of restrictive practices is routinely audited and reported through the BHSCT assurance framework.
4. Review and update BHSCT restrictive practices policy and ensure the policy is in with</td><td>Met</td></tr>
</table>

	best practice guidelines.	
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met due to the substantial process made by the Trust to address these matters, however, a further area for improvement was made in respect of the environment used for seclusion and further detail is provided in section 6.3.2.	
Area for Improvement 3 **Ref:** Standard 5.1 Criteria 5.3 (5.3.3) **Stated:** Second time	The Belfast Health and Social Care Trust must address the following matters in relation to patient observations: 1. Engage with ward managers and frontline nursing staff to ensure that a regular programme of audits of patient observations is completed at ward level. 2. Ensure that there is an effective system in place for assessing and managing patient observation practices, which is multi-disciplinary in nature and which enables staff to deliver effective care and learn collaboratively.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met and further detail is provided in section 6.3.4.	
Area for Improvement 4 **Ref**: Standard 5.1 Criteria 5.3.1(f) **Stated:** First time	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.	**Carried forward to the next inspection**

	Action taken as confirmed during the inspection: Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next inspection.	
Area for Improvement 5 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time	The Belfast Health and Social Care Trust must develop and implement a systematic approach to the identification and delivery of physical health care needs to: 1. Ensure that there is an appropriate number of qualified staff to ensure that the entire range of patients physical health care needs are met to include gender and age specific physical health screening programmes. 2. Ensure that patients in receipt of antipsychotic medication receive the required monitoring in accordance with the hospital's antipsychotic monitoring policy. 3. Ensure that specialist learning disability trained nursing staff understand and oversee management of the physical health care needs of patients in MAH. 4. A system of assurance in respect of delivery of physical healthcare.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met and further detail is provided in section 6.3.5.	
Area for Improvement 6 **Ref**: Standard 5.1 Criteria 5.3 (5.3.3 (b) **Stated:** Second time	The Belfast Health and Social Care Trust must ensure that ward staff have access to detailed and current information regarding patients who have completed their active assessment and treatment and are awaiting discharge from MAH.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met and further detail is provided in section 6.3.6.	
Area for improvement 7 **Ref**: Standards 4.1 & 8.1 Criteria 4.3 (b, d and e), 8.3 (b) **Stated:** Second time	The Belfast Health and Social Care Trust must address the following matters to strengthen hospital planning: 1. Ensure that a comprehensive forward plan for MAH is developed, communicated, disseminated and fully understood by staff. 2. Ensure that stated aims and objectives for the hospital's PICU are developed and	**Met**

	disseminated to frontline nursing staff so that there is clarity regarding both the unit and staff positions.	
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met and further detail is provided in section 6.3.7.	
Area for Improvement 8 **Ref**: Standards 4.1 and 5.1 Criteria 4.3 (a) and 5.3.1.(f) **Stated:** Second time	The Belfast Health and Social Care Trust must review the governing arrangements in MAH and consider the following matters in order to strengthen the governance arrangements: 1. Enhance communication, staff knowledge and understanding of relevant committees and meetings to support local leadership and governance on the MAH site. 2. Embed the recently introduced Daily Safety Huddle (at ward level) and the Weekly Safety Pause (hospital level) meetings. 3. Implement an effective assurance framework.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met and further detail is provided in section 6.3.8.	

6.2 Inspection findings

Improvement Notice Ref: IN000003

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

4.3 Criteria

The organisation:

(i) undertakes systematic risk assessment and risk management of all areas of its work;

(j) has sound human resource policies and systems in place to ensure appropriate workforce planning, skill mix, recruitment, induction, training and development opportunities for staff to undertake the roles and responsibilities required by their job, including compliance with:

- departmental policy and guidance;
- professional and other codes of practice; and
- employment legislation.

(n) has a workforce strategy in place, as appropriate, that ensures clarity about structure, function, roles and responsibilities and ensures workforce development to meet current and future service needs in line with Departmental policy and the availability of resources.

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

(f) Has properly maintained systems, policies and procedures in place, which are subject to regular audit and review to ensure: protection of health, welfare and safety of staff.

5.3.3 Promoting Effective Care

The organisation:

(c) promotes a culture of learning to enable staff to enhance and maintain their knowledge and skills;
(d) ensures that clinical and social care interventions are carried out under appropriate supervision and leadership, and by appropriately qualified and trained staff, who have access to appropriate support systems.

In relation to this notice the following four actions were required to comply with the standards.

The BHSCT, Chief Executive, and Executive Team must:

1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at Muckamore Abbey Hospital, which:

a) is based on the assessed needs of the current patient population; and
b) incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements.

2. Implement an effective process for oversight and escalation of challenges relating to staffing across the hospital site; this should include ward sisters, hospital managers, Trust senior managers and/or the Executive Team as appropriate.

3. Implement effective mechanisms to evidence and assure its compliance with good practice in respect of the current staffing model and associated escalation measures.

4. Engage the support of, and work in partnership with, other HSC organisations (including the Health and Social Care Board, the Public Health Agency and HSC Trusts) to define future model(s) for nurse staffing in mental health and learning disability in-patient services / wards. The design and testing of future staffing models must be supported by appropriate assurance processes and tools.

6.2.1 Staffing

We gathered evidence in relation to the four action points contained within the Improvement Notice IN000003, to establish if the BHSCT, Chief Executive, and Executive Team had complied with the minimum standard and developed a model that would ensure nurse staffing at ward level and across the MAH site was planned and managed on the basis of assessed patient need. We established the following in relation to each action:

Action Point 1

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

1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at Muckamore Abbey Hospital, which:

a) is based on the assessed needs of the current patient population; and
b) incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements.

Prior to the inspection we met with the SMT from BHSCT on 2 November 2019 in our offices. At this meeting the SMT presented to us a revised staffing model which incorporated the Telford model for calculating registered staff numbers. They informed us that the model was based on the assessed needs of the patient population in MAH, was patient centred, flexible and adaptable enough to meet the changing needs of the patients in the hospital. The model also enabled management to ensure that the skill mix of staff in each ward was appropriate to deliver the required care for patients.

During the inspection we visited the five wards and reviewed the implementation of the revised staffing model by reviewing staffing levels, skill mix and the assessed needs of patients on the each ward. We found the model had been implemented effectively and staffing levels were appropriate to meet the needs of patients on each ward. Staff reported to us that they were involved in the development of the model and this had helped raise staff morale. Staff told us that while delivering on the proposed skill mix does not always happen on every ward on every day, the numbers of staff required for each ward is as close as possible to the numbers required to meet the patients assessed needs. Staff told us that staffing levels had significantly improved since our last inspection.

Outcome of action point 1

We were assured by discussion with the SMT; review of documentation; discussion with staff; and review of rotas and skill mix in relation to assessed needs of patients that sufficient progress had been made to address the staffing levels in MAH. This action point has been addressed.

Action point 2

2. *The Belfast Health and Social Care Trust, Chief Executive, and the Executive Team must:*

   Implement an effective process for oversight and escalation of challenges relating to staffing across the hospital site; this should include ward sisters, hospital managers, Trust senior managers and/or the Executive Team as appropriate.

Prior to the inspection the SMT informed us during the meeting on 2 November 2019, that a process had been implemented to ensure that senior staff were available 24 hours every day to support ward staff to escalate challenges relating to staffing levels; this included ward managers, lead nurses and members of the SMT. We were informed that both the operational and executive team have oversight staffing levels to ensure that they are safe.

During the inspection we reviewed the process in place for oversight and escalation of challenges relating to staffing levels. We found the role of the night time co-ordinator had been developed to include an oversight of staffing arrangements on each ward for each day to ensure that the staffing levels and skill mix met the assessed needs of patients on each ward. A report was produced by the night time co-ordinator each morning for the SMT to review.

We were informed communication had improved significantly across the site between wards and members of the SMT. We found that mechanisms were in place to ensure that relevant staff were informed well in advance (every month) and kept up to date regarding the availability of senior and medical staff for out of hours cover. Staff told us that incidents of staff shortages were responded to in a timely way.

We were informed that the same agency staff were generally booked for a block of shifts which provided consistency of care for patients and stability across the hospital. We found that agency staff were now more embedded into the overall staff team and it was reported that wearing the BHSCT uniform had helped with this integration process. The SMT told us that this had also helped patients understand that agency staff and trust employees were all part of the same team and all staff were equally responsible for ensuring the provision of their care. We established that agency staff undertake a rigorous induction programme which is delivered at Trust, site and ward level. We reviewed these induction programmes and determined that they were robust and covered all key areas.

We were informed that there has been a policy change in the Trust that enables agency staff who have worked on the site for some time to now take charge of a ward. A comprehensive and supportive framework was designed to ensure agency staff are assessed as competent in all the challenges that may arise when taking charge of a ward. Agency staff are signed off after completing each phase of the framework by the ward manager and night time coordinator. We reviewed one of these assessment frameworks and were satisfied that the assessment process was robust. Ward managers told us that agency staff being able to take charge of the ward had been invaluable. It had enabled senior ward staff to attend a variety of meetings which helped in progressing various pieces of quality improvement work and had contributed to the overall increase in staff morale.

Across all wards, managers, deputy managers, nurses, doctors and nursing assistants informed us that there was a more visible presence of members of the SMT. Staff who spoke with us were knowledgeable regarding which members of the SMT were responsible for the oversight of individual wards and particular pieces of work. Staff reported to us that members of the SMT are approachable and supportive. Staff told us that they felt empowered to share their concerns with SMT and believed that their concerns were heard and considered. Both front line staff and the SMT informed us that they welcomed the increased numbers of senior staff as this provided the required capacity to address any emerging challenges and issues identified.

We found that each week a designated member of the SMT produced a report that illustrated the percentage of shifts filled for each ward. This information along with the Situation Report (SITREP) was shared fortnightly with the ward managers across the hospital. Ward managers informed us that these reports coupled with the weekly safety brief and live governance meetings had been instrumental in helping each ward recognise and understand the pressures that other wards experienced at times across the hospital. This increased level of understanding by Ward Managers and staff, through the sharing of written data and reports, had contributed to a genuine desire in the staff to assist other wards during challenging periods. We were advised that there was also a shared understanding between the wards that this level of support will be reciprocated when required.

Ward staff informed us that all staff had the option to self-refer to the on-site staff counsellor and were offered the option of having counselling sessions on or off the hospital site, if they required additional support. Staff told us that reflective practice sessions are scheduled on a weekly basis and they considered the counselling and reflective practice sessions supportive.

Through discussion, we confirmed that all ward managers were aware of staff on their ward that were subject to a protection plan and/or supervision plan. These plans were in place to protect patients and staff while investigations of specific allegations remain ongoing.

During our previous inspections we identified that behaviour nurse specialists were subsumed into the staffing compliment of each ward and did not have protected time to review or devise positive behaviour support plans for patients.

Staff who spoke with us reported that the behaviour nurse specialists are no longer subsumed into the overall staffing compliment thus are able to focus on their original role. This has been beneficial for staff and patients because bespoke positive behaviour support plans are now in place and being actioned. We found that a new behaviour support assistant role had been created and assigned to each ward. Staff reported that this new role had a positive effect and was benefitting the overall patient experience. The behaviour support service is managed through the psychology department.

We established that each ward had a schedule of evening and weekend activities for patients to participate in. A number of art, music, beauty and specialist therapists visit the hospital to provide activities. Some of these are specific to patients, wards or provided as group activities. Staff reported that patients were now more engaged in meaningful activities which had reduced boredom leading to a decrease in incidents of aggression and assaults on staff. Although incidents of aggression and assaults can still occur, staff told us that the reduction had helped improve staff morale and reduced sickness and absenteeism.

Some staff who spoke with us advised that they had appreciated the opportunity to participate in the learning exchange programme with a Trust based in the UK. A team of multi-disciplinary professionals from MAH visited another Trust's low-secure ward for patients with learning disabilities and MAH agreed to host to an exchange visit. Staff reported that they found this opportunity invaluable and inspiring. They were able to see and experience how the other learning disability inpatient service managed similar challenges they were facing. Staff expressed that they would be keen for this learning exchange programme to continue as they could see the benefits for staff participating in this ongoing educational and shared learning environment.

We were advised that the hospital was facing an on-going challenge in relation to retaining and recruiting nurses and other staff. However there was a consensus among staff that the current SMT had made positive strides in stabilising the site; listening, responding to and acting on staff concerns; improving communication; being visible and approachable to staff; raising confidence; and re-establishing pride within the learning disability nursing profession in the hospital.

Outcome of action point 2

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

Conclusion

We found sufficient evidence to validate that BHSCT had made the necessary improvements to achieve compliance with the Improvement Notice – IN000003.

Improvement Notice Ref: IN000004

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.

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;

In relation to this notice the following four actions were required to comply with the standards.

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

1. That the Trust is appropriately discharging its full responsibilities, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986.

2. In respect of those patients in receipt of benefits for whom the Trust is acting as appointee, that appropriate documentation is in place and that individual patients are in receipt of their correct benefits.

3. Implementation of a robust system to evidence and assure that all arrangements relating to patients' monies and valuables are operating in accordance with The Mental Health (Northern Ireland) Order 1986 and Trust's policy and procedures; this includes:

a) that appropriate records of patients' property are maintained;

b) that staff with responsibility for patients' income and expenditure have been appropriately trained for this role;

c) that audits by senior managers of records retained at ward level are completed in accordance with Trust policy;

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

6.2.2 Financial Governance

Action point 1

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

1. That the Trust is appropriately discharging its full responsibilities, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986.

At the last inspection on 1 July 2019 we reviewed the draft policy in relation to the management of patients' monies and valuables. We identified several weaknesses within the policy and determined it was insufficient to ensure that the Trust met with all its responsibilities under the Mental Health (Northern Ireland) Order 1986. Through speaking we staff we identified that discussions with ward managers had commenced for the purpose of familiarising staff with the revisions of the policy however this did not constitute staff training.

We were advised, during this inspection, that the Patients' Finances and Private Property – Policy for Inpatients within Mental Health and Learning Disability Hospitals had been revised and implemented. The policy was used to form part of the training programme provided to members of staff in each ward. We reviewed the policy and determined it to be satisfactory.

We found evidence that staff were adhering to the new policies and procedures implemented by the Trust. We were informed that due to feedback from staff further revisions were being made to the policy and the Trust intends to implement the changes by January 2020.

Outcome of action point 1

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

Action point 2

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

2. In respect of those patients in receipt of benefits for whom the Trust is acting as appointee, that appropriate documentation is in place and that individual patients are in receipt of their correct benefits.

We were shown evidence that the Trust had contacted the Department for Communities (DFC) requesting written confirmation that the Trust was the authorised appointee for the thirteen patients identified at previous RQIA inspections in April 2019 and July 2019 and that the patients were receiving the correct benefits owed to them. We reviewed the written replies from the DFC which confirmed that the Trust was the patients' appointee and that the patients were receiving the correct benefits. We noted that DFC also confirmed if patients had been over or under paid benefits during the period the Trust was the appointee. Discussions with the Trust and a review of records confirmed that one patient had been overpaid benefits for almost six years, however, as the Trust had notified the DFC at the time when the financial circumstances for the patient had changed, the DFC deemed the overpayment was non-recoverable.

We were informed that in addition to confirming appointeeship the Trust had entered into discussions with an external advisory organisation to provide advice to patients and their families in relation to managing their finances. This included ensuring that patients were receiving the full amount of social security benefits owed to them. At the time of our inspection the Trust was in the final stages of contracting with the independent advisor.

Outcome of action point 2

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

Action point 3

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

3. Implementation of a robust system to evidence and assure that all arrangements relating to patients' monies and valuables are operating in accordance with The Mental Health (Northern Ireland) Order 1986 and Trust's policy and procedures; this includes:

e) that appropriate records of patients' property are maintained;

f) that staff with responsibility for patients' income and expenditure have been appropriately trained for this role;

g) that audits by senior managers of records retained at ward level are completed in accordance with Trust policy;

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

We were informed that a patient liaison officer had been appointed by the Trust and part of their duties was to coordinate monthly audits of patients' monies and liaise with patients' family members.

We were advised that financial planning meetings had been implemented since the previous RQIA inspection in July 2019. Review of records from the meetings showed that a member of the MDT from the Trust met with patients' family members to discuss the spending plan for patients with significant finances. There was evidence that the Trust was in regular contact with family members to provide updates on the planning process and to seek agreement for the planned expenditure from patients' monies. We found there was also evidence of the decisions made by the MDT in relation to financial matters for patients who had no next of kin.

We evidenced that members of staff within each ward had received training in relation to the handling of patients' monies. The records we reviewed showed the dates members of staff received the training and we were provided with a copy of the training programme provided to staff. We noted that in addition to the training provided by the Trust, training was also provided by the Directorate of Legal Services from the Business Services Organisation (BSO). This included an overview of the responsibilities for being a patient's appointee and other protective measures in place for safeguarding patients' finances.

We noticed a significant improvement within each ward in relation to the recording of transactions undertaken by members of staff on behalf of patients.

Following the finance inspection in July 2019 a new system for recording financial transactions was implemented by the Trust. We sampled a number of patients' records within each ward and evidenced that the full details of the transactions were recorded; two signatures were recorded against each of the transactions; good practice was observed as the amounts deducted to make the purchases and the remaining monies returned from the purchases were recorded separately; and receipts from the transactions were retained for inspection. A record of patients' personal property held for safekeeping within each ward was also found to up to date. We confirmed that in line with good practice, records of patients' monies and property held for safekeeping were checked on a weekly basis and signed by two members of staff.

We found that additional monthly checks of patients' monies held within each ward were undertaken by the assistant service managers. Records of the checks showed that any discrepancies were identified and addressed by the Trust immediately. We were informed that the outcomes of the findings from the monthly checks were discussed at the monthly governance meetings and any learning or actions required was disseminated among members of staff at ward level.

We found that patients' personal property held for safekeeping within the wards was not included in the monthly checks by the assistant service managers. We discussed this finding with the Trust and highlighted the benefits of including a review of patients' personal property in the monthly checks and future governance meetings.

We were provided with a copy of an audit assignment plan from the Internal Audit Service at BSO to audit the management of property and monies by the BHSCT on behalf of patients within MAH. The plan identified the scope of the audit to be undertaken and the planned date of commencement for the audit was 20 January 2020, however, we were informed that the audit may be delayed until February 2020.

Outcome of action point 3

As the audit of financial controls by the Internal Audit Service had not taken place by the time of this inspection we were unable to gather sufficient evidence to determine that this action point had been fully addressed.

Conclusion

We acknowledged the actions taken by BHSCT to achieve compliance with the minimum standards and the significant improvements made since the last finance inspection. However, as the audit of all financial controls has yet to take place, the improvement notice IN000004 was extended to 19 March 2020 to allow time for the findings from the BSO audit to be reviewed by the Trust and RQIA.

Improvement Notice Ref: IN000005

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.

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;

In relation to this notice the following three actions were required to comply with the standards.

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

1. Implement effective arrangements for adult safeguarding at Muckamore Abbey Hospital and ensure:

a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations;

b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively;

c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care;

d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding is improved.

2. Implement an effective process for oversight and escalation of matters relating to adult safeguarding across the hospital site; this should include ward sisters, hospital managers, Trust senior managers and / or the Executive team as appropriate.

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

6.2.3 Safeguarding

Action point 1

1. Implement effective arrangements for adult safeguarding at Muckamore Abbey Hospital and ensure:

a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations;

b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively;

c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care;

d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding is improved.

We were informed that staff had received training in adult safeguarding. Staff who spoke with us demonstrated a good awareness of the types and indicators of abuse and the actions to be taken in the event of a safeguarding issue being identified; including the need to make timely referrals. We found on that the training matrix for each ward evidenced that not all staff had received safeguarding training and there was no evidence to confirm the individual levels of training staff had received were in accordance with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016).

The Adult Safeguarding Lead for the hospital was aware of the deficit and informed us that they planned to be more involved in ensuring that training was up to date and provided to the correct level. We were further assured from our discussions with SMT that they were also aware of the gaps in safeguarding training and had made plans to address it.

We spoke with staff of different grades (including agency staff) and were satisfied that staff had a clear understanding of the process for making safeguarding referrals and their individual roles and responsibilities. From review of the care records, we evidenced that timely referrals were being made.

We were informed that all wards had access to copies of the BHSCT Safeguarding Policy, the regional Adult Safeguarding Prevention and Protection in Partnership policy (July 2015) and Adult Safeguarding Operational Procedures (2016) and these were easily accessible to staff. We observed that flow charts were displayed on each ward which provided guidance to staff about the process of referral to the Adult Safeguarding Team and on how to escalate concerns to the SMT.

We found that all wards had folders containing interim protection plans and MDT protection plans for patients. Samples of protection plans were reviewed and all were found to be appropriate, meaningful and corresponded to information contained in the patient's care plans and care records.

We evidenced that safeguarding incidents and referrals were being discussed at the daily safety brief and at some of the Purposeful Inpatient Admission (PipA) meetings. The Purposeful Inpatient Admission (PIpA) model was introduced by the Trust which provides an increased multidisciplinary review of each patient and involves shared decision making around care and treatment issues and risk assessment.

We observed that the protection plans are standardised throughout the hospital which enables staff to be quickly updated following a period of leave or when required to work in another ward at short notice.

Staff were aware of their responsibilities to be familiar with the content of the plans. Staff reported that having this information stored in one file, ensures they can quickly be updated with regards to the specific protection plans within each ward therefore maintaining the patients' safety. Staff spoke positively to us about the introduction of this process and can see its benefit. Staff were aware of the procedures around trigger points for a referral to safeguarding.

In relation to staff supervision plans, we found that ward managers had a good knowledge of which staff were subject to supervision plans and had a good understanding of what was required in relation to implementing the plans. This demonstrated a good balance between maintaining the appropriate supervision requirements and providing confidentiality, respect and support for those staff involved.

We examined care records and evidenced that family members and relevant professionals were being updated about safeguarding concerns in a timely manner. There was appropriate referral to PSNI and communication with RQIA when required. We found timely screening of safeguarding referrals at ward level and we were assured that the Designated Adult Protection Officers (DAPOs) had oversight of all referrals made, even the ones that had been screened out at ward level, which provided an additional level of scrutiny.

We noted an improved awareness of safeguarding generally throughout the hospital which was driven by discussion of safeguarding concerns at PIpA meetings, live governance meetings and daily safety briefs. We were told about the improved working relationships across disciplines by staff who reported feeling supported by the safeguarding team. We were informed that there are now weekly safeguarding MDT meetings on most wards. Staff reported a greater presence on the wards of the safeguarding team and felt confident in contacting the team outside of the planned meetings for advice and support. We were told that at the weekly meetings all new safeguarding referrals and interim protection plans were discussed and protection plans were formalised collaboratively. Existing safeguarding cases were reviewed and protection plans were updated as required. Staff who spoke with us knew the names of the relevant safeguarding personnel and how to contact them.

We spoke with the Adult Safeguarding Lead for the hospital and saw evidence of the monthly audit of the screening of safeguarding incidents which enabled trend analysis. This information was shared with the SMT and provided assurance of safeguarding oversight at this level. We were informed that the Adult Safeguarding Lead and the DAPOs meet weekly to discuss any concerns and a new Adult Safeguarding Forum is planned to commence which will allow for discussion of safeguarding cases and will serve to further improve and share learning outcomes.

We observed the complex nature of some of the patient behavioural challenges presented to staff. As previously discussed, staff reported to us the benefits of the increased activities for patients and the positive effect this had on individual behaviours.

A review of safeguarding incidents by the Trust found that many were due to clashes between patients or patients not having a sense of their own personal space. As a result of this review, ward environments had been creatively reconfigured to provide extra personal space for some patients to the extent that self-contained apartment type "pods" had been created. This had contributed positively to the overall safeguarding of patients and staff reported feeling supported by the current SMT in relation to safeguarding.

Outcome of action point 1

We were able to evidence that improvements had been made to address this action point.

Conclusion

We were able to evidence that the BHSCT had made significant improvements to achieve compliance with the minimum standards dictated within IN000005. However, in order to be assured that these improvements have been embedded into practice the notice will be extended until 19 March 2020 to provide time for such sustained assurance to be gained.

6.3 Review of areas for improvement from previous inspections

6.3.1 Close Circuit Television (CCTV)

We reviewed the arrangements in relation to the oversight and governance for the use CCTV within the hospital. We found that there was an effective process in place for contemporaneous monitoring and managing of CCTV images. We were informed by the SMT that monitoring of CCTV was undertaken by a MDT team and was used to demonstrate and share good practices with staff. It was also used as a mechanism for sharing learning outcomes and directing improvements.

Staff told us they understood the procedures to be followed in regards to CCTV and were able to describe the process for CCTV viewing after an incident. Some staff told us that they were fearful of the CCTV monitoring and shared with us their lack of ownership and understanding regarding the use of CCTV and some felt that it was not supporting them in their work.

We were advised that consideration is being given to how best to utilise the current CCTV footage as a learning tool to enhance quality improvement in the Management of Actual or Potential Aggression (MAPA) and related matters to obtain a better insight of events when screening safeguarding incidents.

We were advised that the hospital's CCTV policy and procedural guidance had been reviewed by the SMT; however, they had not updated the documents as they were waiting for the publication of national guidelines. We reviewed the policy and found that it did not reflect the current multiple uses for CCTV at MAH. As highlighted at previous inspections, this policy must be reviewed and updated to reflect current practice as it is used to inform and direct staff in relation to use of CCTV across the hospital.

We acknowledge that progress had been made in relation to the arrangements for the management and monitoring of CCTV, however further work was needed in relation to the CCTV policy and procedure; embedding the new practices; staff understanding the purpose and benefits of CCTV at MAH. An area for improvement in relation to CCTV has been stated for the third time.

6.3.2 Restrictive Practices (Seclusion)

Prior to this inspection we held a meeting with the MAH SMT at RQIA offices on 2 November 2019. At this meeting the SMT presented improvements they had made in relation to the use of restrictive practices. We tested the information provided at the meeting during this inspection.

We reviewed the use of restrictive practices including seclusion at MAH and found evidence of continued reduction and improvement in relation to the use of these practices. We noted the hospital's seclusion policy and procedure had been reviewed and updated.

We found the Trust had introduced an effective strong governance and assurance framework in relation to the use of seclusion. Restrictive practices were routinely audited and reported through the BHSCT assurance framework. We observed that restrictive practices were reviewed at ward level; by the MDT; at Live Governance meetings; by the SMT and also system wide by the MAH Directors Operational Group; by the Executive Team; and bi-monthly at the Trust Board meetings.

We found the Trust had developed and implemented a restrictive practice strategy and was continuing to embed a positive behavioural support culture and practice across the hospital. As previously discussed, behaviour assistants had been recruited and patients with the most challenging behaviours had a positive behaviour support plan in place and the Purposeful Inpatient Admission (PIpA) model was introduced. There was evidence that low stimulus areas were used as a means of deescalating behaviours rather than using seclusion.

We found the use of seclusion had significantly reduced across the site. In September 2019 we established there was a total of 23 seclusion events across the hospital site and we contrasted this with the previous year and found that there had been 120 seclusion events in September 2018. The number of seclusion events had further reduced to 10 in October 2019. We noted that seclusion events in September and October 2019 lasted less than four hours. We examined the audits in relation to the use of seclusion events during this period and found good compliance with the recording of seclusion events in line with the Trust's policy and procedure, the required standards and best practice. We were told about plans to perform a robust audit within the next twelve months in relation to the use of PRN medications to ensure that other forms of restrictive practice were not emerging.

We found good evidence in patient care plans of the decision making process relating to the use of restrictive practices including the use of seclusion. Staff told us that morale had improved, with staff feeling that they now have a better perspective and involvement in decision making on the use of restrictive practices. We found the need for the use of restrictive practices was continually discussed at patients' MDT meetings and during weekly MAH live governance meetings. We found that a report of contemporaneous CCTV viewing is also being produced and reported at governance meetings. It was good to note that the hospital had introduced a strong governance and assurance framework in relation to the use of seclusion and that this practice was being well led.

We observed that staff involved in managing patients with challenging behaviour (in particular patients for whom restraint and/or seclusion may be required) were being supported through structured debriefing and were being provided with the opportunity to discuss incidents. The introduction of the PIpA model was providing opportunities to identify and share learning with greater frequency and in a more timely way so that if changes to patients care plans were required this could be done quickly and with MDT input.

It was encouraging to note that ward managers across the hospital continued to closely monitor staff training including training in relation to the use of restrictive practices. Training records reviewed by us detailed that approximately 95% staff had completed up to date MAPA training. The remaining 5% had been scheduled to complete retraining in the near future.

However, we established that the seclusion room within MAH was accommodated in the PICU. As the PICU remains closed to its previous function the environments currently used for seclusion do not meet required standards. To manage some challenging behaviours in line with best practice the hospital requires access to an operational seclusion room when necessary for patient safety. The Trust should 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. An area for improvement was made in this regard.

6.3.3 Repurposing of PICU as low stimulus area

The Psychiatric Intensive Care Unit (PICU) temporarily closed on 21 December 2018 and has remained closed since that date in relation to its original function. We found that the Trust had repurposed the PICU as a low stimulus area for patients. We found that patients were being escorted from their wards by staff to the PICU for time limited periods to enable the provision of a low stimulus environment and the de-escalation of challenging behaviours.

We met with a patient experiencing low stimulus in the PICU and with the staff member supporting the patient. We were concerned that as the low stimulus area is some distance from the wards, the ratio of one patient to one staff member could become a safety issue and there could be potential patient safety and comfort issues when transferring patients to this area. If the previous PICU is to be used as a Low Stimulus Area a Statement of Purpose is needed to clearly show how and when the area would be used, taking into account all of the concerns that we raised. An area for improvement was made in relation to the repurposing of PICU as a low stimulus area for patients.

6.3.4 Patient Observations

We reviewed the systems in place for assessing and managing patient observations practices within MAH and found it to be effective. We were informed that the reasons for patients requiring enhanced observations is discussed and agreed by the MDT. We discussed if this was considered to be the least restrictive option and if this was proportionate to the presenting and current risks. We were informed that enhanced observations were reviewed every day by nursing staff and weekly or earlier if required by the MDT. We found that decisions were clearly made and rationales for enhanced observations being continued, reduced or discontinued were recorded in the patients risk assessment and care plan.

6.3.5 Physical Health Care of Patients

We reviewed how the hospital was identifying and meeting the physical health needs of the patients. We found the staff rotas evidenced there was an appropriate number of professionally qualified staff and good availability of the MDT to ensure that the entire range of patients physical health care needs could be met. This included patients accessing gender and age specific physical health screening programmes.

We were informed that the hospital had employed a locum GP since September 2019 who was undertaking work to compile every patient's medical history and current physical health needs into one summary document. Specific attention was being been paid to each patient's eligibility for general population screening and to any individual specific monitoring that may be required e.g. antipsychotic monitoring and diabetic retinopathy screening. This was good to note as some patients had been admitted to the hospital for many years and therefore many of these patients were not registered with a community GP and would not receive automatic general population screening reminders. In addition we found that many of the patients in the hospital presented with complex medical histories and an accessible summary of their physical health was beneficial in relation to meeting their assessed care needs.

We found these summaries were comprehensive, accessible and noted that they would be beneficial for medical staff that may be required to review the patient out of hours. We were advised that this work will continue to be completed across all wards on the site and a system was being built to ensure that any changes in staffing would easily identify the ongoing physical health needs (the general population and patient specific screening programmes) of the hospital's patients.

Review of the patient care records confirmed that patients who were prescribed antipsychotic medication were receiving the required monitoring in accordance with the hospital's antipsychotic monitoring policy. We observed from care records that one patient's daily fluid balance was being monitored and we found that this was completed regularly and in good detail.

As previously stated, the PIpA model has been introduced across the hospital and staff across the MAH spoke positively regarding the benefits it provided. This included more contact with the MDT which provided a more robust decision making process and promoted a culture of shared responsibility; which was welcomed by staff. We established that the multi-disciplinary nature of the PIpA model of care was working well and this enabled all staff to deliver effective care and learn collaboratively as a team.

However, we noted that its introduction had also presented some challenges on certain wards in relation to poor documentation about attendees at the PIpA reviews and also in relation to risk and management plans. One ward's documentation gave the impression that daily PIpA meetings were occurring daily, but on speaking with staff they reported that PIpA reviews were only occurring three days per week. Whilst we were not able to identify any direct impact on patient care, evidence of recent patient weights, monthly physical checks and blood sugars being completed or even offered to patients could not easily be found. We found the recording of this information was not standardised across the hospital and was not easily accessible. Staff told us this information is sometimes stored in a patient's daily progress notes which is not satisfactory and does not lend itself well to auditing for trend analysis. We established that other methods of capturing this patient information were included in the patient's nursing assessment on PARIS or on paper charts which were both more appropriate. In addition, we noted from review of care records that on some occasions when health checks are declined by patients, this is not recorded and there is no evidence to demonstrate that staff have returned at a later date to engage further with the patient in an attempt to encourage the patient to have the test completed.

An area for improvement was made in relation to improving and standardising the documentation used for recording monthly physical health checks across the hospital. A further area for improvement was made in relation to documenting when health checks are declined and ensuring that that there is ongoing collaborative engagement of patients to have health checks completed.

6.3.6 Discharge Planning

We reviewed the arrangements in relation to discharge planning for patients. We spoke with staff and reviewed care documentation relating to patients who had completed their care and treatment and were assessed as delayed in awaiting discharge. Staff informed us that they had access to required detailed information regarding each patient in relation to their discharge plan and assessed needs. Staff were aware of the resources and availability of services in the community which enabled them to ensure that appropriate placements for patients were found and then recorded in the patient's discharge care plans.

6.3.7 Hospital Planning

We reviewed the hospital's forward plan and found that all staff who spoke with us told us that the new management team's style was open, transparent and conducive to staff listening to and supporting one another. Staff reported that they felt supported by the current leadership and management structures.

Staff informed us that they were aware that a comprehensive forward plan for MAH was in development and that this would be communicated to staff, once available.

We were informed by the SMT that the aims and objectives for the hospital's PICU were being developed and this will be disseminated to frontline nursing staff so that there is clarity regarding both the current position of the unit and the staff positions. In the meantime PICU remains closed to its previous use but is repurposed as a low stimulus area. The previous area for improvement was met as all staff were aware that PICU was no longer being used in the way it previously would have been and were aware of its current purpose.

6.3.8 Hospital Governance

We assessed the progress made in relation to strengthening the hospital's governance arrangements. We were encouraged by the improvements in the governance arrangements which were in part, due to better sharing of information on a multi-disciplinary level which had greatly improved since the previous inspections. This was evident in the daily and weekly SITREP, live governance meetings, significant event audits (SEA's), MDT meetings and clinical improvement groups. In addition we found that the hospital governance structure was further strengthened by the strong clinical and managerial leadership team currently on site.

We found that the new interim management team confirmed the Trust's commitment to provide support to the staff and patients on the site. Their style of management was found to be open and transparent and was conducive to staff listening to and supporting one another. Staff feedback to us was positive about the current management team, with all staff confirming that they feel supported by the current leadership and new management structures. We acknowledged the speed and ease with which the majority of documentation or information requested by us was supplied to our inspection team.

Front line staff reported to us that communication across the site from senior management had greatly improved. Staff who spoke with us were knowledgeable about the purpose of the various governance committees and meetings to support leadership and understood the need to provide information for them. Staff told us that they felt involved in the daily and weekly SITREP; live governance meetings; significant event audits (SEA); MDT meetings; and clinical improvement groups.

The daily safety huddle (at ward level) was observed to be taking place on each ward. We found staff were knowledgeable about the benefits of the safety huddle and the additional level of communication it provided. Staff told us that the weekly safety pause (hospital level) meetings were scheduled in to the weekly timetable which provided us with assurance that these meetings were valued and embedded into the overall governance framework of the hospital.

We saw evidence that reporting of SEA's had increased and were being used by the MDT as a learning tool. This was further evidence of the strengthening of the governance arrangements in the hospital and the systems being used in a meaningful way to support staff in the delivery of patient care.

We established that the implementation of the Deprivation of Liberty (DoLS) safeguards process had begun. DoLS ensures people who cannot consent to their care arrangements in a hospital setting are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary and in the person's best interests. Representation and the right to challenge a deprivation are other safeguards that are part of DoLS. We found that the hospital had identified and prioritised those patients who were eligible for safeguards to be implemented under the under DoLS and a lead person had been appointed to undertake this task.

We found that quality improvement had been integrated well into the current governance systems. We noted that through a review of their systems and processes the staff and management teams had created space for themselves to have more opportunities for learning and development. We spoke with the Clinical Director, two consultants, two staff grades and a trainee separately and were told about plans to launch an improvement project next month in relation to reducing violence by patients towards both other patients and staff within the site.

We continue to have concerns regarding the regional work to review and refresh the model for learning disability patients in Northern Ireland, including the resources and availability of services in the community. It was acknowledged that whilst regional infrastructure work was ongoing, it's pace and focus was slow and impacted negatively on the flow of patients both into and out of hospital. The region's understanding of the arrangements relating to patients with severe learning disabilities who need admission to hospital remains a concern. Senior management in RQIA confirmed that we would be happy to advise; assist and support the Trust's management team with these ongoing challenges.

We discussed the interim management arrangements implemented by the Trust. We highlighted the need for a planned and staged approach to the withdrawal of the current interim management team and highlighted the potential negative impact this could have across the hospital if it was not effectively managed.

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 on 16 December 2019 as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

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 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

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 to **BSU.Admin@rqia.org.uk** for assessment by the inspector by **18 August 2020**.

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">Action required to ensure compliance with the DHSSPSNI Quality Standards for Health and Social Care (March 2006)</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 5.1
Criteria 5.3 (5.3.1)

Stated: Third time

To be completed by:
1 October 2020</td><td>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.

Ref: 6.3.1</td></tr>
<tr><td>Response by the Trust detailing the actions taken:
1. A CCTV Working Group has been set up (this includes representation from ward staff, safeguarding staff, management, governance, litigation and staff unions) to review the current use of CCTV within the hospital. The group are finalising letters of explanation and surveys to family, carers, and patient advocates to capture their views on the current and future use of CCTV within the hospital. Letters and surveys have also been prepared for all staff. This process will further inform a further review of the CCTV Policy and feedback is being sought from patients with support from the Speech and Language Therapy Team.</td></tr>
</table>

	(a) The most up to date draft policy has been made available to all staff, including the procedures they should follow. A further review of this policy is currently taking place which will also take into consideration the survey feedback from staff, family, carers and patient advocates. (b) There are agreed procedures in place for the monitoring and management of CCTV images, the relevant templates have been updated and improved following feedback from the Contemporaneous CCTV Viewing Team and from staff. A business case was agreed and actioned in relation to replacing some aspects of the CCTV system in order to be able to retain footage. 2. The CCTV policy has been reviewed and updated to include previous addendums into the main body of the policy. This draft will be presented to the CCTV Working Group for comment following results of the survey mentioned in point 1 above. The updated draft policy now includes a broadened use of CCTV to incorporate training and reflection, support for transition teams in understanding patient support needs, etc. The policy will be presented to the Trust's Standards and Guidelines Committee in December 2020.
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. **Ref**: **6.1**
	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. On the 1 March 2020 Muckamore Abbey Hospital pharmacist hours were increased from 0.5wte to 0.8wte on a temporary basis until 31 December 2020. This will be reviewed in December 2020 to establish if the increased pharmacy hours is more appropriate for the site or if there is still a requirement for the recruitment of a Pharmacy Technician. 2. The Site Pharmacist has developed and carried out a full site audit to include omitted does of medicine and standards of completion of administration records. The findings from this audit have been

	communicated to Ward Managers. This audit will form part of a medication audit schedule going forward. The management team are working with the ward pharmacist to agree standards for the use of "when required medicines" utilised to manage agitation to enable an appropriate audit to be taken forward to monitor the effectiveness and appropriateness of its use as part of a de-escalation strategy. As part of medication monitoring, the site participated in the Prescribing Observatory for Mental Health (POMH) audit of monitoring of ID patients prescribed an antipsychotic and the results were received in August 2020. The Clinical Director for Intellectual Disability Services and the Trust Senior Pharmacist will co-present these results in October 2020. The results will be reviewed for learning and an action plan developed to progress any recommendations. 3. The Wards on site use the Trust's approved recording sheet for refrigeration monitoring daily checks. The site pharmacist is presently reviewing the last two months records for all wards as part of her medications audit.
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 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. **Ref: 6.3.2**
	Response by the Trust detailing the actions taken: A monthly audit takes place reviewing all periods of seclusion and voluntary confinement that have taken place the previous month across all wards. Episodes of seclusion are discussed at PIpa meetings and MDT meetings. Seclusion episodes are detailed at PIpa, Live Governance and a separate MDT meeting is convened if required. Seclusion levels are reported in both the weekly Safety Report and reviewed bi-monthly at the Governance Committee to provide assurance and oversight to the hospital management team and the collective leadership. A Restrictive Practices Working Group had been set up to have oversight of all restrictive practices used within the hospital including the use of seclusion. The group was stood down during the initial months of the pandemic but will recommence in October 2020 as part of the site's recovery and rebuild plan. The Group will be led by the new Co-Director for Learning Disability services. The Restrictive Practice Working Group will agree a format and timescale of a review of how seclusion is provided on site including environmental assessment taking into account the safety of both patients and staff.

	This review will include a scoping exercise of best practice guidance and ensure that the dignity of our patients is at the centre of any decisions.
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. **Ref: 6.3.3**
	Response by the Trust detailing the actions taken: The Restrictive Practice Working Group will develop a statement of purpose for the use of PICU as a "Low Stimulus Area" – during this exercise the group will take account of the required standards and best practice guidance and ensure the safety of patient and staff.
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. **Ref: 6.3.5**
	Response by the Trust detailing the actions taken: A GP role has been recruited to the hospital to focus on physical health checks for all patients. There are 3 SHO positions within the hospital which are made up of one GP trainee and 2 psychiatry trainees. A lookback exercise has taken place to gather all physical information for each patient including family history were available. This information is now stored on one template which is available on the PARIS system and in a physical health folder kept on each ward. All patient physical health information is stored on one template providing assurance that historical check information, family history and planned checks are available to all relevant staff. This provides assurance that all relevant checks have taken place or planned within the required timeframe.
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. **Ref: 6.3.5**
	Response by the Trust detailing the actions taken: When patients decline physical health checks this is documented as "R" in red on the Visual Control Board (VCB) at PIPA with regular revisits (under bloods). If a patient refuses to have bloods done each incident is recorded on a form within the Physical Health Check folder, which tracks the number of times the patient has declined.

	The urgency of bloods / procedures is assessed (usually low), discussions are recorded on the patient notes and PARIS. The MDT consider various strategies with advice from Behaviour Therapists / psychology as to how to encourage this to happen. Ward staff use Social Stories to help patients understand the reason why the procedure is needed and how it happens. This also applies to dental procedures.

Name of person (s) completing the QIP	Gillian Traub		
Signature of person (s) completing the QIP	Gillian Traub	**Date completed**	25.09.20
Name of person approving the QIP	Gillian Traub		
Signature of person approving the QIP	Gillian Traub	**Date approved**	25.09.20
Name of RQIA inspector assessing response	Wendy McGregor		
Signature of RQIA inspector assessing response	Wendy McGregor	**Date approved**	29 September 2020

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