Unannounced Inspection Report
15 & 16 April 2019

Belfast Health and Social Care Trust

Muckamore Abbey Hospital

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Assurance, Challenge and Improvement in Health and Social Care

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Abbreviations

AHP	Allied Health Professionals
BHSCT	Belfast Health and Social Care Trust
DoH	Department of Health
MAH	Muckamore Abbey Hospital
MDT	Multi-disciplinary Team
MHO	Mental Health(Northern Ireland) Order 1986
NHSCT	Northern Health and Social Care Trust
OCP	Office of Care and Protection
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 from their responsibility for maintaining compliance with legislation,

1.0 What we look for

2.0 Profile of the 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.

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) had temporarily closed on 21 December 2018 and has remained closed since.

At the time of the inspection there were five wards 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.

On the days of the inspection there were 63 patients receiving care and treatment in MAH.

3.0 Service details

Responsible person: Mr Martin Dillon Belfast Health and Social Care Trust (BHSCT)	**Position:** Chief Executive Officer
Category of care: Acute Mental Health & Learning Disability	**Number of beds:** 83
Person in charge at the time of inspection: Mairead Mitchell, Interim Co- Director, Learning Disability Services, Adult Social and Primary Care Directorate, BHSCT.	

4.0 Inspection summary

We undertook an unannounced inspection to MAH over two days commencing on 15 April 2019 and concluding on 16 April 2019. All five wards were visited over the course of the inspection.

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).

The focus of this unannounced inspection was to assess the progress made by BHSCT to address the areas of significant concern in relation to six overarching themes emergent during our inspection to MAH from 26 to 28 February 2019:

- Staffing;
- Patients' physical health care needs;
- Financial governance;
- Safeguarding;
- Restrictive practices (seclusion); and
- Hospital governance.

We employed a multidisciplinary inspection methodology during this inspection. The multidisciplinary inspection team examined a number of aspects of the hospital, from front line care and practices, to management and oversight of governance across the organisation. We met with individual staff members and various staff groups, patients and a small number of relatives, observed care practice and reviewed relevant records and documentation to support the governance and assurance systems.

Key Findings

Overall we evidenced limited progress in relation to the 10 areas for improvement and the six areas of significant concern previously identified.

We identified that staffing levels had not improved and there continued to be a lack of support for ward managers when they experienced challenges in relation to staffing. We did not find effective escalation arrangements in relation to staffing and we remain concerned that there is a lack of evidence that staffing at ward level and across the site is managed and assured on the basis of assessed patient need.

We did not find evidence of any mechanisms/tools in use by the BHSCT to determine the staffing model required. We were not able to demonstrate that current planning arrangements were achieving consistency across the site and assurance in respect of the delivery of safe and effective care.

Staff morale was observed to still be significantly impacted. The staff well-being measures recently introduced were not found to have led to the desired improvements in staff health and well-being.

We again identified a structural disconnect between professional staff in relation to the current safeguarding arrangements for the hospital. We noted that the approach to safeguarding practices was process driven. There was no improvement in integration of social care staff and frontline nursing/ward staff. It was concerning to note that safeguarding incidents were being reviewed in isolation and ward(s) MDT's were not being appropriately utilised to improve debriefing and learning between staff groups.

We noted that the BHSCT CCTV policy was a generic BHSCT wide policy. The CCTV policy had not been updated to support the use of CCTV within the MAH site.

Improvements in appropriate recording and monitoring of restrictive practices (seclusion) were noted. We found that the overall use of seclusion had reduced since the February 2019 inspection but we remain concerned regarding the environments currently used for seclusion across the hospital site.

We found that patient observations were being carried out as required, however we found no evidence of a regular programme of audits of patient observations being completed at ward level.

We noted some improvements in relation to patients' physical health care needs including the completion of annual checks for most patients in the hospital. Appropriate monitoring of physical health parameters of patients receiving antipsychotic medications in accordance with the hospital protocol was evidenced. We did not, however, find effective arrangements in place to support robust assessment and/or planning to ensure patients are included in appropriate population screening programmes.

We found limited progress had been made to ensure that agreed discharge arrangements were recorded and co-ordinated with all services involved with patients' on-going care.

The inspection team determined that the governance systems were not working effectively to assure the Senior Management and Executive Teams that the care provided at MAH is safe, effective and compassionate. We did not find that arrangements to improve hospital governance were having the required impact on patient safety or improving integration and communication with staff groups.

Limited progress was evidenced in relation to financial governance. We did not find robust arrangements in place to monitor, audit and review the effectiveness of financial oversight or that the BHSCT was discharging its' responsibilities in accordance with Articles 116 and 107 of the MHO.

We provided feedback to BHSCT Senior and Executive Management Teams on 17 April 2019. At this meeting we informed BHSCT that RQIA continued to have significant concerns in relation to the care, treatment and services as provided for patients in MAH in respect of the emergent themes.

Following the inspection RQIA wrote to the Chief Medical Officer on 30 April 2019 in accordance with the provision of Articles 4 and 35 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inform him of RQIA's continuing serious concerns in relation to care, treatment and services as currently provided for patients in Muckamore Abbey Hospital. In this letter we recommended the establishment of two taskforces:

(i) a taskforce to stabilise the hospital site, in support of patients currently receiving care and of staff delivering that care and
(ii) a taskforce to manage, deliver and govern a programme to relocate patients who are delayed in their discharge from MAH to the community.

We also wrote to the Department of Health (DoH) in accordance with the provision of Articles 4 and 35 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. We advised the DoH of RQIA's continuing serious concerns in relation to care, treatment and services as currently provided for patients in MAH. We recommended that the DoH agrees and implements a special measure for BHSCT in relation to MAH. The recommendation was made with a view to supporting BHSCT (and the other two HSC Trusts served by MAH), to improve care and treatment of patients currently in MAH, to ensure appropriate governance systems/arrangements are in place, and to ensure appropriate planning for patients who have completed their active assessment/treatment and who will relocate out of MAH to accommodation in the community over the coming months.

4.1 Inspection outcome

Total number of areas for improvement	11

As outlined previously the focus of this inspection was the six emergent themes and 11 areas for improvement arising from our inspection to MAH (26 to 28 February 2019). The area for improvement in relation to medications management identified during the last inspection was not reviewed during this inspection. This area will be carried forward for review at the next inspection

We identified ten areas for improvement from this inspection. These relate to:

- Staffing
- Safeguarding
- Close Circuit Television (CCTV)
- Restrictive practices (seclusion)
- Patient observations
- Patients' physical health care needs
- Discharge planning
- Strategic planning & communication
- Hospital governance
- Financial governance

Detailed findings of this unannounced inspection were shared with Dr Cathy Jack, Deputy Chief Executive & Medical Director, BHSCT Senior and Executive Management Teams and ward staff during the feedback session on 17 April 2019 held at the conclusion of the inspection.

4.2 Action/enforcement taken following our most recent inspections

The most recent inspection of MAH was an unannounced inspection commencing on 26 February 2019 and concluding on 28 February 2019. Following this inspection we continue to engage with BHSCT and the DoH to secure improvements across the hospital site.

Ongoing enforcement action resulted from the findings of this inspection.

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

https://www.rqia.or.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.

In response to our ongoing concerns we invited the Chief Executive and BHSCT colleagues to attend an Intention to Serve six Improvement Notices meeting at RQIA on 7 March 2019. We also wrote to DoH recommending the implementation of a special measure for BHSCT in respect of MAH.

After consideration of BHSCT representation at our meeting on 7 March 2019 and of the additional information provided by the BHSCT to RQIA (8 March 2019), we determined not to serve Improvement Notices to BHSCT at that point in time. We advised BHSCT that we will continue to closely monitor each of the six areas of concern and the quality of care and treatment delivered to patients in MAH. We also wrote to the DoH to update them about our determination.

5.0 How we inspect

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

- Previous inspection reports
- Serious Adverse Incident notifications
- Information on Concerns
- Information on Complaints
- Other relevant intelligence received by RQIA
- BHSCT action plan for MAH received by RQIA on 8 March 2019

Each ward is assessed using an inspection framework. The methodology underpinning our inspections includes; discussion with patients and relatives, observation of practice, focus groups with staff involved in all functions from across the hospital and review of documentation. Records examined during the inspection include; nursing records, medical records, senior management and governance reports, minutes of meetings, duty rotas and training records.

We invited staff to complete an electronic questionnaire during this 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 on 26, 27 & 28 February 2019

Areas for improvement		Validation of compliance
Staffing		
Area for improvement No.1 **Ref**: Standards 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1, 5.3.3) **Stated:** First time	The Belfast Health and Social Care Trust must: 1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at MAH, which; a) is based on the assessed needs of the current patient population; and a) 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 to senior management and the executive team when challenges in nurse staffing arise. 3. Implement an effective assurance mechanism to provide oversight of the implementation of the model and escalation measures. 4. Engage the support of the other key stakeholders, including the commissioner in defining the model to determine safe levels of nurse staffing.	**Not met**
	Action taken as confirmed during the inspection: Inspectors evidenced significant staffing deficits in each of the wards. Evidence of robust plans and allocation of nurse staffing, including registrant and non-registrant staff, on the basis of assessed patient need was not demonstrated. We could not accurately confirm nursing staff requirements as compared to nursing staff provision across the hospital. We were unable to evidence any mechanisms/tools in use by the BHSCT to determine the staffing	

	model required. Site managers described escalation arrangements in the context of staffing challenges. We found these arrangements were unclear and we were not assured that they were working effectively. Frontline staff told us they were not receiving adequate support from senior managers when they escalated staff shortages. We found that to date additional nursing staff had not been secured through collaborative working arrangements with the NHSCT and SEHSCT.	

Safeguarding		
Area for improvement No. 2 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** First time	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for adult safeguarding at MAH 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 are improved. 2. Implement an effective process for oversight and escalation of matters relating to adult safeguarding across the hospital site; this should include ward managers, hospital managers, BHSCT 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.	**Not met**
	Action taken as confirmed during the inspection: As in our previous inspection, we did not find evidence of implementation of learning from safeguarding investigations or that he outcomes from safeguarding investigations were positively impacting patient well-being. Due to the complexity and mix of patients in some wards and staffing levels, we noted that	

	meaningful implementation of protection plans was a significant challenge. A structural disconnect between professional staff was again evident within the current safeguarding arrangements for the hospital.	
CCTV		
Area for improvement No. 3 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** First time	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.	**Not met**
	Action taken as confirmed during the inspection: We noted that the BHSCT CCTV policy was a generic BHSCT wide policy. The CCTV policy had not been updated to support the use of CCTV within the MAH site. Staff told us that they were not clear as to how and when CCTV was used. A MAH CCTV policy had not been implemented and that they had not received any further update since the February 2019 inspection. We found no evidence of a CCTV images monitoring system to support staff to deliver care and learn collaboratively.	

<table>
<tr><th colspan="3">Restrictive Practices</th></tr>
<tr><td rowspan="2">Area for improvement No. 4

Ref: Standard 5.1 Criteria 5.3 (5.3.1, 5.3.3)

Stated: First 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.

Review and update BHSCT restrictive practices policy and ensure the policy is in keeping with best practice guidelines.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The overall use of seclusion had reduced. However we remained concerned about the environments being used for seclusion across the hospital site as they did not meet the required standards.

We remained concerned that MAH site managers did not appear to appreciate the considerable distance between arrangements and practices as outlined in the Trust’s updated seclusion policy and practices as currently implemented in the hospital.

Our inspection team noted that staff involved in managing patients with challenging behaviours did not appear to be supported through structured debriefing and there were limited opportunities to identify and share learning in a meaningful way.</td></tr>
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<table>
<tr><th colspan="3">Patient Observations</th></tr>
<tr><td rowspan="2">Area for improvement No. 5

Ref: Standard 5.1 Criteria 5.3 (5.3.3)

Stated: First time</td><td>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.</td><td rowspan="2">Partially met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
We found that patient observations were being carried out as required.

We found no evidence of a regular programme of audits of patient observations being completed at ward level.

We found no evidence that an effective system was in place for assessing and managing patient observation practices, which is multi-disciplinary in nature.</td></tr>
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<tr><th colspan="3">Management of Medicines</th></tr>
<tr><td rowspan="2">Area for improvement No. 6

Ref: Standard 5.1 Criteria 5.3 (5.3.1(f))

Stated: First time</td><td>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.</td><td rowspan="2">Not Reviewed</td></tr>
<tr><td>Action taken as confirmed during the inspection:
This area for improvement was not reviewed during this inspection and will be carried forward for review during the next inspection.</td></tr>
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Physical Health Care Needs		
Area for improvement No. 7 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** First 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 here is an appropriate number of suitability qualified staff to oversee 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. A system of assurance in respect of delivery of physical healthcare.	
	Action taken as confirmed during the inspection: We noted improvements since our previous inspection in regards to annual physical health checks for patients and monitoring of physical health parameters of patients receiving antipsychotic medication. However we did not find evidence of robust assessment and/or planning to ensure patients were included in appropriate population screening programmes.	**Not met**

<table>
<tr><th colspan="3">Discharge Planning</th></tr>
<tr><td rowspan="2">Area for improvement No. 8

Ref: Standard 5.1 Criteria 5.3 (5.3.3(b))

Stated: First time</td><td>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.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Ward staff told us that they did not have up to date information for all patients who had completed their active assessment and treatment and were awaiting discharge.

We found limited progress had been made to ensure that agreed discharge arrangements were recorded and co-ordinated with all services involved in patients’ on-going care.</td></tr>
<tr><th colspan="3">Strategic Planning & Communication</th></tr>
<tr><td rowspan="2">Area for improvement No. 9

Ref: Standards 4.1 & 8.1 Criteria 4.3 (b, d and e), 8.3 (b)

Stated: First time</td><td>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 disseminated to frontline nursing staff so that there is clarity regarding both the unit and staff positions.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection
A forward plan for MAH had not been developed.

We were unable evidence a clear strategic direction and robust planning regarding staffing, safeguarding, management of patients’ physical health care, discharge planning and financial governance

Staff were not clear about the plans for the future of the hospital. This was due to a combination of factors relating to a cessation of patient admissions, delayed discharges, the inability to safely staff the hospital, and uncertainty about the hospital’s PICU.</td></tr>
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<tr><th colspan="3">Hospital Governance</th></tr>
<tr><td rowspan="2">Area for improvement No. 10

Ref: Standards 4.1 & 5.1 Criteria 4.3 (a) and 5.3.1.(f)

Stated: First time</td><td>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.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Frontline staff informed us that they were unclear about the role and functions of the various meetings and arrangements.

Our inspection team could not clearly determine the linkages between the constituent parts of the governance system. We noted discrepancies in information reported through various parts of the hospital’s operating and governing systems.

We could not evidence that the hospitals governance arrangements were having the required impact on safety and effectiveness of care for patients or on the health and well-being of staff.</td></tr>
<tr><th colspan="3">Financial Governance</th></tr>
<tr><td>Area for improvement No. 11

Ref: Standard 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1)

Stated: First time</td><td>The Belfast Health and Social Care Trust must ensure:
1. That the BHSCT 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 BHSCT 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</td><td></td></tr>
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	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 BHSCT 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 BHSCT policy; d) that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in MAH.	**Not met**
	Action taken as confirmed during the inspection: We could not evidence appropriate documentation relating to appointee-ship arrangements for six of 13 patients, we could not identify improvements in completion of patient property records or in completion of ledgers at ward level. Monthly monitoring of ward finances by senior site managers was inconsistently completed, and when completed lacked evidence of appropriate assurance. The inspection team could not evidence work relating to the Trust's planned audit of financial procedures across the site, to be undertaken during April 2019 as advised in the Trust's action plan.	

6.2 Inspection Findings

Staffing

We reviewed the staffing arrangements in MAH against the BHSCT action plan and new information/assurances provided to us on 7 March 2019. We found limited progress in relation to staffing. Significant deficits in staffing levels on all of the wards had continued since the previous inspection.

As part of the assurance provided to RQIA on the 7 March 2019 in respect of the safety of the site, the Trust Chief Executive had advised that seven additional nurse registrants had been recruited, inducted and would begin work on the site in the week commencing 11 March. The inspection team noted on this inspection that the seven additional nursing registrants had not in fact been in post since 11 March. Over the two days of the inspection, conflicting information in respect of the actual numbers of new staff recruited and in post was given to inspectors. However RQIA was eventually able to ascertain that four additional nursing registrants were in post and that these are all agency staff.

We were informed that five experienced Band 7 nurses and two other senior staff would move from their roles/posts in MAH in the near future.

We reviewed the data provided by the MAH senior nursing office and detailed in the minutes of hospital situation report (SITREP) meetings for numbers of staff in post, vacancies, sick or maternity leaves, precautionary suspensions and also the numbers of agency staff for each ward. We examined staff rotas and spoke to ward managers when reviewing staffing levels and applicable ward data.

There was evidence of insufficient staffing at ward level to meet patients' prescribed level of observation, to implement and execute appropriate therapeutic care plans for patients, or to appropriately manage patients' physical health care needs. We evidenced insufficient staffing at ward level on each day of the two day inspection visit. Staff of all grades throughout the hospital site informed us there was insufficient staffing at ward level. Due to staff shortages at ward level, staff are at times unable to appropriately fulfil their responsibilities and this is impacting on the quality and assurance of care delivered and is in itself a source of anxiety for staff. Frontline ward staff told us that activities are frequently cancelled or re-scheduled causing frustration for patients.

Considerable difficulty was experienced with regards to accurately confirming nursing staff requirements as compared to nursing staff provision across the hospital. We were unable to accurately confirm the BHSCT determination of this.

We found that checks of the numbers of nursing staff in the wards were being undertaken. We highlighted that the issue was not in relation to numbers of staff but rather the requirements to achieve consistency across the site. Evidence of robust planning and allocation of nurse staffing, including registrant and non-registrant staff, on the basis of assessed patient need was not demonstrated. We were unable to evidence any mechanisms/tools in use by the BHSCT to determine the staffing model required.

Site managers described escalation arrangements in the context of staffing challenges. We found these arrangements were unclear and we were not assured that they were working effectively so as to appropriately support frontline ward staff when they experience challenges in relation to staffing. Frontline staff told us they were receiving poor support from senior managers and that they could not escalate staff shortages as in practice the responsibility to address the staffing deficits is retained with them.

We noted a mismatch between information supplied by site managers and that supplied by ward staff/managers with regards to nursing staff provision across the site.

We found that to date additional nursing staff had not been secured through collaborative working arrangements with the NHSCT and SEHSCT. We could not evidence a plan for permanent recruitment.

Concerns regarding the skill mix and appropriate deployment of staff were shared with the inspection team.

Specialist behavioural nurses continued to be rostered to cover general duties on wards. We were unable to evidence the commencement of improvement work to develop the roles of AHPs in MAH.

We acknowledged that front line staff continue to display enormous resilience and they are to be commended for their dedicated service to the patients in MAH and their families.

Safeguarding Practices

We reviewed the safeguarding arrangements in MAH against the BHSCT action plan and new information/assurances provided to us on 7 March 2019.

From an analysis of information provided our inspection team did not find evidence of effective deployment of safeguarding referrals, of implementation of learning arising through safeguarding investigations or that the outcomes from safeguarding investigations were positively impacting patient well-being. A continued structural disconnect between various groups of professional staff was evident within the current safeguarding arrangements

We noted that the approach to safeguarding practices was process driven. There was no improvement in integration of social care staff and frontline nursing/ward staff. We again evidenced that safeguarding incidents were being reviewed in isolation. We observed that MDTs were not being optimally utilised to improve debriefing, learning and connection between staff groups. We did not find evidence of any implementation of learning arising from safeguarding investigations. There was no evidence that outcomes from safeguarding investigations were positively impacting patients' care.

Figures for current adult safeguarding incidents and referrals, including the time period for referrals received by the designated adult protection officer (DAPO), were found to be collated by ward and type and reported at the weekly SITREP meetings.

Due to the complexity and mix of patients in some wards and with current staffing levels, it was again noted that meaningful implementation of protection plans was a significant challenge. We recommended that safeguarding incidents or allegations are assessed by a multidisciplinary team to determine the best action and outcome for the patient(s) and staff member(s). We advised that this approach would assist with addressing potential root causes giving rise to and/or influencing repeated referrals.

BHSCT senior managers informed us that the discharge of patients from MAH is a factor strongly influencing the implementation of effective safeguarding arrangements. We noted that the number of patients being looked after in MAH since the February 2019 inspection has largely remained static.

It was positive to note that following commencement of a recent Quality Improvement project there had been a 10% reduction in violence and that there were plans to introduce activity boxes to each ward.

Overall we found that arrangements for reviewing, risk assessing and recommending safeguarding measures were not robust.

CCTV

The inspection team was clear that staff across the site remained fearful of the use and implications of CCTV. The inspection team found a number of examples where staff had allowed themselves to be struck by patients because they feared the consequences of using legitimate intervention techniques in which they had been trained, to support patient's behaviour. The use of CCTV on site has contributed to this fear, with many staff unable to articulate to the inspection team their understanding of how and why CCTV was used. We determined that there was continued confusion with respect to how CCTV is being used and the associated operational parameters of its use.

Policies and associated operational procedures to clearly define how CCTV is being used at the MAH site were not in place. Staff told us that MAH did not have a CCTV policy and that they had not received any further update since the February 2019 inspection with regards to purpose and operational parameters of use.

Once defined staff must be supported to develop their understanding of CCTV use and the MDT team must be utilised as a safe environment for staff to learn how CCTV use can assist them in their practice. We again highlighted the impact upon staff and the importance of clear communication with them regarding this issue.

Restrictive Practices (Seclusion)

It was positive to note that overall use of seclusion had reduced since the February 2019 inspection. We evidenced that care staff were appropriately recording and monitoring when seclusion was used. We found that staff were trying to reduce the number of areas that patients were secluded to. Seclusion was evidenced as being 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

We observed that staff involved in managing patients with challenging behaviour (in particular patients for whom restraint and/or seclusion may be required) did not appear to be supported through structured debriefing. Additionally, there appeared to be limited opportunities to identify and share learning in a meaningful way.

There was no change in respect of the environments used for seclusion since the February 2019 inspection. We again highlighted our concerns regarding patient safety and comfort.

We noted that the PICU remains closed with the consequence that the environments currently used for seclusion did not meet required standards.

We found that Site Managers did not appear to appreciate the considerable distance between arrangements and practices as outlined in the BHSCT updated Seclusion Policy and the actual operational practices implemented in the hospital.

We noted that the BHSCT had recently updated its' Seclusion Policy and that it was out for review/comment. However, we were unable to evidence any plan which the BHSCT had for implementation of its' refreshed Seclusion Policy. There were also no details regarding how the BHSCT intends to move from the current operational practices in relation to seclusion of patients in MAH to the position stated in the Policy.

Whilst we welcomed the stated commitment of the BHSCT to seek expert input/support from both East London and Mersey Care NHS Foundation Trusts, we were unable to evidence the level of engagement or the impact to date.

Patient Observations

We reviewed the arrangements in place for the management of prescribed patient observations in each ward. We noted patient numbers, supervision ratios and the number of patients receiving enhanced one to one care. Four of the five wards we visited continued to experience staffing shortages. Despite this inspectors found that patient observations were being carried out as required and that day care and in reach services were ongoing on the site. Staff were challenged in taking breaks and leaving on time after their shifts. It was noted that the Behaviour Nurses were not always operating in this capacity and that this was not helpful in respect of the therapeutic interventions that would improve patient outcomes.

Patient observation records reviewed by inspectors evidenced that patients' observations were prescribed as required. We observed that nurse staffing shortages in each ward, with the exception of Erne, continued to have a detrimental impact on patient behaviour and ward routine.

We found no evidence of audits of observations being carried out at ward level.

Physical Health Care Needs

The inspection team found evidence of appropriate monitoring of physical health parameters of patients receiving antipsychotic medications in accordance with MAH's protocol. Inspectors noted that an audit of antipsychotic monitoring had been completed since the previous inspection in February 2019.

We also evidenced that annual checks of physical health had been completed for most patients in the hospital (52 patients checks completed). We noted that eleven patients had not received a physical health check (3 patients on leave and 8 patients declined). Whilst we welcomed that this work had been undertaken we noted that the medical staff deployment was on a short-term basis. We did not find evidence of a plan to ensure the completion of checks for patients on leave or a rolling programme for managing patients' physical health checks going forward.

The hospital situation report (SITREP) dated 04 April, 2019 was reviewed and found to state that physical health checks for all patients were complete. We found that this was not an accurate reflection of our findings.

Arrangements to support robust assessment and/or planning to ensure patients are included in appropriate population screening programmes (breast, cervical, abdominal aortic aneurysm (AAA) and/or diabetic retinopathy screening) were not found to be in operation.

We found evidence of some consideration of how many patients might need a particular screening test ((eg) mammography) but we could not evidence a hospital-wide system to identify, arrange and assure appropriate participation of patients in population screening programmes relevant to their age and gender.

In hours general practitioner (GP) clinical sessions are not provided on the MAH site. We found that there was no local partnership/service level agreement arrangement in place with any of the local GP practices to address this requirement. We noted that this disadvantages patients in MAH when compared to their peers living in the community.

Discharge Planning

We found limited progress for those patients experiencing a delay in the discharge. Ward staff told us that they did not have up to date information for all patients who had completed their active assessment and treatment and were awaiting discharge. Inspectors met with several patients who were experiencing a delay in their discharge from MAH. Patients and staff discussed the challenges that this presents as patients, family members/carers continued to seek advice and support in relation to possible discharge options.

Staff of all grades and professions highlighted the ongoing difficult in securing appropriate community based resources to support patients upon their discharge from hospital. BHSCT continued to progress a collaborative regional approach to ensure the hospital functions as an assessment and treatment hospital. The MAH management team advised us that a Supported Living Service was being developed close to the hospital site. The service will provide accommodation for up to twelve individuals and was in the process of registering with RQIA.

It was positive to note continued multi-agency involvement with all stakeholders including other Trusts, the Health and Social Care Board (HSCB), the Public Health Agency (PHA) and the Department of Health (DoH). However, we found limited progress had been made to ensure that agreed discharge arrangements were recorded and co-ordinated with all services involved in patients' on-going care.

Discharge planning arrangements were reviewed. We found that a high percentage of patients no longer required treatment and were experiencing a delay in their discharge from hospital.

Strategic Planning and Communication

Following the most recent inspection of MAH BHSCT had introduced a number of priorities to support the re-modelling of services within MAH. At the time of the inspection the hospital was not accepting new admissions and patients requiring acute care were being redirected to facilities in other Trusts.

MAH admission criteria had been reviewed to ensure that only those patients presenting with mental ill health or severe behavioural concerns would be admitted to the hospital going forward.

Despite the introduction of new arrangements we remained concerned about the hospital's strategic planning. We did not evidence a clear strategic direction and robust planning regarding staffing, safeguarding, management of patients' physical health care, discharge planning and financial governance.

Discussions with a wide range of staff across the whole MAH site identified that a large number were not aware of the future plans for the hospital.

Staff told us that they were unclear as to the role and function of the hospital's PICU. During discussions some staff advised us that they were in temporary positions whilst PICU was closed for a short time; whilst others who had been relocated from PICU believed that they had been moved permanently to other wards.

Ward MDT's continued to implement local arrangements to facilitate seclusion for patients as they were unable to access the purpose built seclusion room located within the PICU. These arrangements were being provided in rooms that did not meet the required standards and best practice guidelines for seclusion.

Hospital Governance

MAH governance arrangements and documentation was discussed with BHSCT senior managers, senior nursing managers, ward managers and members of the MDT.

We welcomed that a BHSCT Assurance Committee has been established and that daily, weekly and monthly governance meetings were also occurring at ward/hospital level. We found that the Deputy Chief Executive/Medical Director chairs a weekly assurance meeting. We noted that SITREP meetings included a weekly governance review section during which staffing, service continuity, incidents, seclusion, complaints, risk register issues and updates regarding on-going CCTV monitoring are reported. Whilst these metrics are useful we highlighted that the tool may require some revision in order to be fully sensitive to all pertinent issues and to be utilised to its' full potential. We did not find that exploration of alternative safety measurement and monitoring frameworks had been undertaken.

Governance arrangements were found to be insufficiently developed to be capable of providing assurance to BHSCT that services in MAH are safe and well led. We suggested that additional resources and external support was required. This is necessary to provide robust assurance of the quality and safety of care provided in the hospital, to ensure appropriate planning for transition of identified patients from the hospital to suitable community placements and to define the hospital's overall purpose within the wider HSC system (current and future).

Frontline staff again informed us that they were unclear about the role and functions of the various meetings and arrangements. We were unable to clearly determine the linkages between the constituent parts of the governance system.

We noted discrepancies in information reported through various parts of the hospital's operating and governing systems.

We were concerned to find that incidents meeting the threshold for Serious Adverse Incident (SAI) review were not being robustly reviewed, assessed and progressed through the system. An incident in which a patient had threatened to self-harm using glass and then subsequently threatened staff was noted. We were concerned that it appeared that the categorisation of the incident had been on the basis of outcome (no significant injury occurred) rather than the potential for a catastrophic injury.

A review of the minutes of SITREP of 04 March 2019 indicated that a member of the medical staff team was "conducting serious event audit review". We found frontline staff were unclear whether this was focusing solely upon the incident in Ardmore or involved a review of a different incident/number of serious adverse incidents.

BHSCT senior managers informed us that on-site presence and leadership had been refreshed.

We spoke to a wide range of staff from across the hospital a large number of who told us that they did not feel appropriately supported. We were informed that there was only two middle management staff on site when the complement should be four. Staff told us that this was causing them significant pressure and contributing to them being unsupported. Staff experiences shared with us evidenced that morale continued to be poor. It remained a significant cause for concern. Staff told us that they were often subject to a lot of assaults by patients. They reported that there was no formal debrief following an incident but they instead accessed support from within the immediate team or their peers.

We were told that debriefs post incident usually only occur when staff who have been off sick return to work or when there is a serious incident. We observed that nursing staff continue to experience enormous challenges and may not be able to avail of comfort breaks or finish their working hours on time due to the demands of providing care in these complex and challenging circumstances. Staff also told us that they have had to carry over a lot of annual leave and feel at risk of burnout.

The inspection team noted that a BHSCT survey of MAH staff in relation to the question "How safe did you feel in work today?" was reported at the weekly SITREP meeting on 18 March 2019. The results indicated that 60% of (150 staff) reported that they felt very unsafe.

We again could not evidence that the local governance arrangements or the support measures were having the required impact on safety and effectiveness of care for patients or on the health and well-being of staff.

Financial Governance

We confirmed that the outstanding safeguarding referral in relation to one patient identified during the previous inspection had been completed. We were unable to evidence progress in relation to the other aspects of financial oversight and governance.

We reviewed a sample of patient property records and ward ledgers and were unable to identify improvements in the standard of their completion. The documentation and knowledge deficiencies with respect to the appointee-ship arrangements for 13 patients identified during the previous inspection in February 2019 were not found to have been comprehensively addressed.

We found that monthly monitoring of ward finances by senior site managers was inconsistently completed. The records we reviewed highlighted a lack of evidence of appropriate assurance.

The report of a previous financial audit undertaken in 2015 by the internal audit team was reviewed. We noted that many of the priority one and two recommendations in this report were similar to those identified during this inspection and also the previous inspection in February 2019. We highlighted the timeline of this audit report (>3 years old) in the context of a need for more recent audit and assurance. We were unable to evidence that BHSCT had undertaken an audit of its' financial procedures across all wards in the MAH site during April 2019.

Overall we were not assured that implementation of and compliance with financial procedures was consistent across all wards in order to provide assurance of robust financial governance.

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 Deputy Chief Executive & Medical Director, BHSCT Senior and Executive Management Team and ward staff as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

BHSCT should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further action. It is the responsibility of BHSCT 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 Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to meet the areas for improvement identified. The BHSCT 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 5 March 2020.

Quality Improvement Plan	
The Trust must ensure the following findings are addressed:	
Staffing	
Area for improvement No. 1 **Ref**: Standards 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1, 5.3.3) **Stated:** Second time **To be completed by:** Before 14 May 2019	The Belfast Health and Social Care Trust must: 1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at MAH, 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 to senior management and the executive team when challenges in nurse staffing arise. 3. Implement an effective assurance mechanism to provide oversight of the implementation of the model and escalation measures. 4. Engage the support of the other key stakeholders, including the commissioner in defining the model to determine safe levels of nurse staffing.
	Response by the Trust detailing the actions taken: 1. a. Work progressed to determine safe staffing levels through an assessment of the current patient population's acuity and dependency. Acuity and dependency was determined using the current level of observation employed by the staff to safely care for patients, and using Telford to determine the registrant levels. This triangulated approach has resulted in a nursing model, which is in use to describe safe staffing levels. b. The model is in use by the ward managers and reviewed regularly to respond to temporary or unplanned variations in patient assessed needs and/or service requirements. 2. Ward staffing levels are reviewed on a daily basis Monday to Friday and at the weekly Ward Managers meeting (Friday) for the weekend. ASMs are on site Monday to Friday and review the requirements daily. An OoH co-ordinator also reviews staffing levels on site in the OoH period. Any issues of concern are raised by the wards to the ASM/OoH Co-Ordinator to Service manager and then to Collective leadership team. In the OoH there is a senior manager on call rota in place to provide additional support to staff OoH. 3. The Model was developed with engagement from the ward managers and ASMs in the first instance to ensure buy in. the Divisional Nurse worked closely with the ward Managers and ASMS to determine the current patients' needs on site in order to inform the model. Also a Telford

	exercise was undertaken with each of the ward managers. Once the model was developed the DN met with each of the Ward managers and ASMS to implement. Assurances are sought at the weekly ward managers meeting that the model is in use. When there are any issues Ward managers and ASMS are able to contact and talk it through with the DN if that support is required. The pathway used to escalate issues is Ward Manager to ASM to SM and then to the Collective Leadership team. 4. The nursing model has been developed by the senior team in MAH (in conjunction with the ward managers and ASMs) and approved by the Executive Director of Nursing and the Expert Nurse Advisor, DoH, and it has been presented to and supported by RQIA.
Safeguarding	
Area for improvement No. 2 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for adult safeguarding at MAH 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 are 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, BHSCT 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.
	Response by the Trust detailing the actions taken: A detailed action plan was developed by the ASG and management team at MAH. There are 37 actions in place to ensure that the key 3 areas outlined in the QIP are

	achieved. At present 34 of these actions have been completed, the remaining 3 actions are currently on hold following advice from the PSNI not to proceed whilst the investigation is ongoing. There are plans in place to meet with the PSNI to discuss further. There are currently monthly ASG audits taking place on site to provide assurance that the changes implemented through the action planned are still in place and compliant.
CCTV	
Area for improvement No. 3 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	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.
	Response by the Trust detailing the actions taken: The CCTV policy has been reviewed, included update to forms included within the policy, the policy is currently with the Trust's Standard and Guidelines Committee for tabling. All staff have access to the initial policy approved in MAH. Further policy review and update is planned to improve the use of CCTV for safety monitoring. This is being progressed with the CCTV working Group and will be shared with staff when fully approved. There are agreed procedures within the hospital for monitoring and managing CCTV images, the template for requesting a download of footage has been updated. Work is required to improve the robustness, monitoring and functionality of the CCTV system on site. The Co-Director is awaiting quotes from Estate Services/ RadioContact and a business case will be developed. A CCTV working group has been set up (this includes a representation from ward staff, safeguarding staff, management, litigation and unions) to review the current use of use and the development of use within the hospital. Feedback surveys and processes have been developed to gather feedback on the current use and developed use of CCTV for safety monitoring within the hospital.

	Feedback is being sought from staff, families, carers, advocates and patients.
Restrictive Practices (Seclusion)	
Area for improvement No. 4 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1, 5.3.3) **Stated:** Second time **To be completed by:** 14 May 2019	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 keeping with best practice guidelines.
	Response by the Trust detailing the actions taken: MAH have implemented a suite of reports including a weekly patient safety report and a monthly governance report to ensure a clear statistical position for the use of restrictive practice is available for each setting. Reports are shared at both Executive Team and Trust Board. To date the use of seclusion and physical intervention have greatly decreased in the hospital. Audits have been implemented for the use of seclusion and patient observations, they are carried out on a monthly basis. The finding and actions from the audits are discussed at Pipa meetings and at the monthly Governance Committee. Restrictive Practices usage is discussed at a range of meetings, a Live Governance Call takes place each week when ward staff discuss the use of seclusion, Physical Intervention and use of PRN medication at patient level. The use of restrictive practice is included in the weekly Patient Safety Report and reviewed at the monthly Governance Committee. A Restrictive Practice Working group has been set up to provide a strategic overview of the use of and future use of Restrictive Practices within the hospital. The group has presentation of medical staff, ward staff, management, Safeguarding Staff, Governance, PBS and pharmacy. The suite of Restrictive Practice policies have been reviewed by an MDT within the hospital, an overarching Restrictive Practice Policy has been developed in line with best practice across the UK.

	MAH have formed a 'critical friend' relationship East London NHS Foundation Trust to act as critical friend to provide support and challenge in respect of all restrictive practices
Patient Observations	
Area for improvement No. 5 **Ref:** Standard 5.1 Criteria 5.3 (5.3.3) **Stated:** Second time **To be completed by:** 14 May 2019	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.
	Response by the Trust detailing the actions taken: A monthly audit process has been embedded across the hospital. The audit looks at the use of observations and reports compliance or non-compliance with the policy. The outcome of each audit is circulated to the management team, discussed at PiPa and reviewed at the Governance Committee meeting. Assessing and management of patient observation practices are reviewed through PiPa meeting with a MDT approach.
Management of Medicines	
Area for improvement No. 6 **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.
	Response by the Trust detailing the actions taken: 1. The existing registered pharmacist has agreed to increase hours from 0.5wte to 0.8 wte from the beginning of April 2020. The pharmacy technician post is in the early stages of recruitment. 2. The pharmacist reviews the kardexes for omitted does and completion of administration records at the

	PIPA meetings and any omissions or areas of concern raised at that time. With the increase in the Pharmacy hours, a more formalised approach can now be developed. A POMH audit on antipsychotic prescribing in ID patients, led by the Trust Pharmacy team will commence by the end of March 2020. 3. Each ward sister is responsible to ensuring that refrigerator temperature monitoring recording (Actual/Minimum & Maximum) is in place on their ward. This will be placed on the safety brief for daily checking. In addition the Pharmacist will audit the temperature monitoring when the Controlled drug audits are being undertaken.
Physical Health Care Needs	
Area for improvement No. 7 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	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 suitability 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.
	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. There is an out of hours GP available on site from 7pm-11pm each day with all other hours are covered by the onsite GP, the 3 SHOs and the psychiatry team for physical health care and queries. A lookback exercise has taken place to gather all physical health 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. Patients who meet the guidelines set out by Northern Ireland screening programmes have had their screening completed and added to the registers to ensure they are called appropriately with the general population. (Cervical cancer,

	Bowel screening, mammograms, AAA and diabetic eye. Each relevant patient now has an annual Chronic Health Condition review (Eye exams, asthma review, epilepsy review, hypertension review, testicular exams, breast exams and cervical screening. A review of all patients' health checks in regards to antipsychotic medication has been carried out. Each patient has an anti-psychotic monitoring chart which is reviewed by both a medical professional and a pharmacist. Six monthly (March & September) checks in line with Maudsley Guidelines is carried out, this includes bloods, ECG and all other relevant physical checks. All patient physical check 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. 1. All patients receive a physical examination within 24 hours of admission (ward trainee/on call trainee and nursing staff observations). We have ECG machines, physical observation equipment and venepuncture facilities available on site. 2. Past medical history and medicines reconciliation are confirmed within the first week (ward trainee/pharmacist) 3. Any initial concerns about physical health are followed up accordingly (ward trainee) 4. Longer term conditions and screening are managed by or GP locum doctor who also offers advice to trainees where required 5. For non-urgent physical concerns on the ward, the ward trainee is called 6. For urgent physical concerns, we have a duty bleep system for our site doctors and staff are aware to also contact NIAS in emergencies (as we have limited resuscitation facilities on site). Mandatory training for staff includes Life Support Training (at various levels depending on the grade/role of staff) accessed via the Trust HRPTS system 7. PIpA Visual Control Boards on each ward include prompts regarding physical healthcare, screening and antipsychotic monitoring. 8. We operate daily ward rounds (PIpA model) with focus days, one of which per week is about health promotion 9. All material pertaining to physical healthcare concerns are kept in manual files on the wards for

	easy access at PIpA and for out of hours doctors 10. Antipsychotic monitoring is performed as required and routinely every six months (March and September) now by our GP locum doctor and ward nursing staff. An audit of this across the site was carried out in December 11. Current completion of the POMH audit: Antipsychotic prescribing in people with a learning disability under the care of mental health services (4/2-27/3/20 period, all inpatients and a sample of community patients). To compare with previous audit findings 12. We have the facility to refer to podiatry, dietetics, SALT, physio, OT on site and to our visiting dentist. 13. We have close links with and advice from the lead AMH pharmacist. We also have a part time pharmacist on site. 14. Future plans to develop the role of our locum GP colleague in the 'ID Physician' model to bridge the knowledge gap between primary and secondary care and improve the quality of physical healthcare assessment for our patients with complex co morbidities
Discharge Planning	
Area for improvement No. 8 **Ref**: Standard 5.1 Criteria 5.3 (5.3.3(b)) **Stated:** Second time **To be completed by:** 14 May 2019	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.
	Response by the Trust detailing the actions taken: Patient level assessment and discharge information and plans are discussed at weekly PiPa meetings at ward level. Information from these meetings is shared appropriately at ward level by the ward representatives at Pipa. Patient transition plans are shared at ward level and there is an MDT approach for transition planning. The Transition team attend the ward managers meetings and the ASM meetings when there are updates to patient resettlement plans. A Quality Improvement project has been initiated involving staff from across the hospital to focus on standardising and improving the transition processes for patients resettling from hospital.

<table>
<tr><th colspan="2">Strategic Planning & Communication</th></tr>
<tr><td rowspan="2">Area for improvement No. 9

Ref: Standards 4.1 & 8.1 Criteria 4.3 (b, d and e), 8.3 (b)

Stated: Second time

To be completed by:
14 May 2019</td><td>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 disseminated to frontline nursing staff so that there is clarity regarding both the unit and staff positions.</td></tr>
<tr><td>Response by the Trust detailing the actions taken:
A workshop (invite open to all MAH staff) is planned for the 26 Mar 2020 to discuss plans and development for the future of the hospital site.
Monthly staff briefing meetings have been embedded within the hospital, these meetings aim to share information with staff across the site and respond to any questions.
A weekly newsletter is distributed to all staff across the hospital, providing information updates and sharing news.
The PICU is no longer in use and will not be restored to its previous function, this information has been communicated to staff. The workshop planned for March and future planning meetings will include discussion around the future use of the PICU space.</td></tr>
<tr><th colspan="2">Hospital Governance</th></tr>
<tr><td rowspan="2">Area for improvement No. 10

Ref: Standards 4.1 and 5.1 Criteria 4.3 (a) and 5.3.1.(f)

Stated: Second time

To be completed by:
14 May 2019</td><td>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.</td></tr>
<tr><td>Response by the Trust detailing the actions taken:
A governance framework has been developed within the hospital, this consists of a hierarchy of meetings which provide the space for discussion, challenge, review and assurance. There have been a suite of reports developed to provide statistics, analysis and oversight of key governance areas within the hospital.
The governance meeting and reports framework has been illustrated in a flow chart and provided to staff to assist with understanding of the reports and meetings within / about the hospital.</td></tr>
</table>

	The daily safety huddle now takes place on a daily basis within each ward. A weekly live governance call has been embedded within the hospital, this meeting has multi-disciplinary representation and is led by ward level information. The assurance framework has been embedded, this has been built from ward level reports and meetings building into Hospital management meetings which feed into Executive and Trust Board level meetings.
Financial Governance	
Area for improvement No. 11 **Ref**: Standard 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must ensure: 1. That the BHSCT 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 BHSCT 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 BHSCT 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 BHSCT policy; d) that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in MAH.
	Response by the Trust detailing the actions taken: A comprehensive action plan has been developed by the finance team and management team at MAH. The plan consists of 18 actions (8 completed, 9 in progress and 1 no longer applicable). The appointment of a Finance Liaison Officer has been very successful and enabled individual financial plans to be produced. The Trust has recently received a response from RQIA to our request to hold balances over £20k for 4 patients and we are currently addressing the questions raised and remain confident that the Trust is best placed to manage these monies on patient's behalf. The Trust has sought and received appropriate documentation including benefit entitlement for all patients

	we are appointee for with the exception of one patient that transferred to MAH from a Trust supported living accommodation – the documentation for this one patient is currently being followed up. The Trust Policy has been extensively reviewed and updated a number of times since the inspection and training has been delivered to all relevant staff. Although the current version of the Policy has been issued to staff it continues to be reviewed and updated in light of in-house monitoring findings. The BSO Internal Audit has now taken place and the Trust is due to meet with auditors on 25th March to discuss findings.

Name of person (s) completing the QIP	Gillian Traub		
Signature of person (s) completing the QIP	Gillian Traub	**Date completed**	12 March 2020
Name of Responsible Person approving the QIP	Gillian Traub		
Signature of Responsible Person approving the QIP	Gillian Traub	**Date approved**	18 September 2020
Name of RQIA Inspector assessing response	Wendy McGregor		
Signature of RQIA Inspector assessing response	Wendy McGregor	**Date approved**	18 September 2020

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