Unannounced Inspection Report
26, 27 & 28 February 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, standards and best practice.

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 67 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 three days commencing on 26 February 2019 and concluding on 28 February 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).
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

We noted some measures which had recently been introduced to improve staff well-being, additional pharmacist input to wards had been secured and day care staff were in reaching into the wards. We were unable to determine that these measures were having the desired impact on patient care and treatment.

We identified both a structural and a psychological disconnect in relation to communication between clinical/ward based staff and hospital management. We noted the significant impact the recent abuse allegations, the ongoing police investigation and staff suspensions were having on staff, leading to poor morale amongst the staff groups in each of the wards we visited.

Overall we observed a reactive and crisis approach to management. We did not find effective arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to patients and proactive identification of issues in relation to the safety and quality of some aspects of care.

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).

During this inspection we identified six areas of significant concern in relation to the following overarching themes emergent:

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

We provided feedback to BHSCT senior management team on 1 March 2019. At this meeting we informed BHSCT that RQIA had serious concerns in relation to the care, treatment and services as provided for patients in MAH in respect of the emergent themes.

In response to our ongoing concerns we invited the Chief Executive and up to four BHSCT colleagues to attend a meeting at RQIA on 7 March 2019 as it was our intention to serve six Improvement Notices to BHSCT in respect of MAH.

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 our serious concerns in relation to care, treatment and services provided for patients at MAH and 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.

At our Intention to serve six Improvement Notices meeting on 7 March 2019, representatives from three of the HSC Trusts who have patients receiving care and treatment at MAH were provided with an opportunity to outline and discuss evidence/information relating to each of the six areas of concern identified. After thorough consideration of BHSCT representation at our meeting on 7 March 2019 and of the additional information provided by BHSCT to RQIA on 8 March 2019, we determined not to serve Improvement Notices to BHSCT at this 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 advised that we will seek evidence of improvement resulting from the actions/measures BHSCT is now progressing as the main provider of care in MAH and/or in conjunction with other providers, in particular with NHSCT and SEHSCT.

Following our determination not to serve Improvement Notices to BHSCT we also wrote to the Department of Health (DoH) on 14 March 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 update them about our determination. At this time we advised that our recommendation that the DoH agrees and implements a special measure for BHSCT in relation to MAH remained valid.

4.1 Inspection outcome

Total number of areas for improvement	11

We identified 11 areas for improvement in relation to the six emergent themes arising from this inspection. These relate to:

- Staffing
- Safeguarding
- Close Circuit Television (CCTV)
- Restrictive practices (seclusion)
- Patient observations
- Management of medicines

- Patients' physical health care needs
- Discharge planning
- Strategic planning & communication
- Hospital governance
- Financial governance

Detailed findings of this unannounced inspection were shared with the BHSCT senior management team during a feedback session held on 1 March 2019. At this meeting we advised that RQIA had serious concerns in relation to care, treatment and services as provided for patients in MAH in respect of the emergent themes.

In response to our ongoing concerns we invited the Chief Executive and up to four 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 thorough 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 this 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. At this time we advised that our recommendation that the DoH agrees and implements a special measure for BHSCT in relation to MAH remained valid.

The Quality Improvement Plan (QIP) should be completed and detail the actions taken to address the areas for improvement identified. The timescales for implementation of these improvements commence from the date of this inspection.

4.2 Action/enforcement taken following our most recent inspections

The most recent inspections of the wards were as detailed:

Erne Ward: No further actions were required following the most recent unannounced inspection on 24 October 2017.
Donegore: No further actions were required following the most recent unannounced inspection on 17 and 18 May 2017.
Killead: No further actions were required following the most recent unannounced inspection from 2 October to 4 October 2017.
Cranfield PICU: Cranfield PICU was closed temporarily on 21 December 2018 and has remained closed since.
Cranfield One: No further actions were required following the most recent inspection on 22 November 2018.
Cranfield Two: No further actions were required following the most recent inspection on 9 and 10 July 2018.

N.B. RQIA were notified on 7 December 2018 that the BHSCT had restructured Killead and Donegore wards and amalgamated the staff team into one ward. The new ward was renamed Ardmore.

Other than those actions detailed in the QIP's no further actions were required to be taken.

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

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.

Questionnaires were provided to patients during the inspection by the lay assessor on behalf of RQIA. Returned completed patient questionnaires were analysed following the inspection.

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 inspections

Erne Ward: The most recent inspection was an unannounced inspection on 24 October 2017. There were no areas for improvement identified as a result of that inspection.

Donegore and Killead amalgamated on 7 December 2018 to become Ardmore ward. Prior to amalgamation they were inspected individually.

Donegore: The most recent inspection was an unannounced inspection on 17 and 18 May 2017. There were no areas for improvement identified as a result of that inspection.

Killead: The most recent inspection was an unannounced inspection from 2 October 2017 to 4 October 2017. Seven areas for improvement were identified as a result of that inspection. These areas related to speech & language therapy recommendations, ligature risk assessment, complaints management, fire safety, environment, care plan management and lack of clinical pharmacy support. These areas of improvement were reviewed as part of this inspection.

PICU: Was closed temporarily on 21 December 2018 and has remained closed since.

Cranfield One: The most recent inspection was an unannounced inspection on 22 November 2018. Four areas for improvement were identified as a result of that inspection. These areas related to the management of patient observations and the management of patients physical health care. These areas were reviewed as part of this inspection.

Cranfield Two: The most recent inspection was an unannounced inspection from 9 to 10 July 2018. Four areas for improvement were identified as a result of that inspection. These areas related to the management of patients physical health care and were reviewed as part of this inspection.

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

6.3.1 Staffing

We observed that nursing staff throughout the wards were responsive to patient requests and managed them in a caring manner. Staff described the multidisciplinary team (MDT) within each of the wards as being patient centred and safety focused.

We reviewed patient care records and evidenced that patient progress and safety was being monitored and regularly reviewed by nursing staff. It was noted that each patient's care pathway/plan was reviewed on a weekly basis.

Discussions with staff and a review of duty rotas evidenced that the nursing staff complement for MAH for the week commencing 26 February 2019 was subject to significant deficits. This was as a result of a combination of long-term sickness absence, precautionary suspensions, maternity leaves and unfilled vacant posts.

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 three 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.

We noted good evidence of psychology assessments and positive behaviour support (PBS) plans for patients who presented with challenging behaviour. These plans were being regularly reviewed and adapted to meet patients' needs. However, there was limited evidence that PBS plans were being incorporated into care plans and interventions undertaken by nursing staff. Inspectors noted that specialist behavioural nurses were rostered to general duties on wards. This was having a significant impact upon the availability of support to implement patients' PBS plans. We noted that this was having a detrimental effect for patients and staff.

Staff informed us that they were unable to attend training due to low numbers of staff available at ward level.

We determined that staff morale was low and has been particularly impacted by events at MAH over the last 18 months. We highlighted that the impact of psychological trauma experienced by staff was significant.

We highlighted that the insufficient staffing at ward level had the potential to impact on patient safety and the safety of staff that are at risk from the challenging behaviour of patients who present as unwell. We noted from the minutes of a recent MAH live governance meeting that high levels of adverse incidents involving staff injuries in Ardmore and Cranfield One had been discussed.

We noted that almost all wards were in a cycle of continuous crisis management which was impacting on the quality, safety and effectiveness of care delivered.

We highlighted our concerns regarding the large number of vacancies that exist and which greatly exceed the number of additional staff recently recruited or in the process of being recruited. BHSCT Senior Management informed us of an on-going recruitment campaign for nurse staffing.

A day care coordinator had recently been appointed to support all wards and day care staff are now in-reaching to wards. Ward managers confirmed that this has been introduced as a measure to reduce the risk associated with staff having to leave a ward to support a patient attending MAH's day care facility.

We highlighted that staff currently in the hospital (both front-line and managerial) have displayed enormous resilience, they are to be commended for their dedicated service to the patients in MAH, however they now require additional support and resources in order to continue to provide safe care.

An area for improvement in relation to staffing has been made.

6.3.2 Management of Incidents

Policies and procedures in relation to incident/risk management were reviewed and found to be up to date and incidents were being recorded, reviewed and approved on the Datix incident system.

We determined that incident reports were being completed in accordance to the required policies and staff were able to effectively describe the processes to report incidents. We could not evidence how the learning from incidents was shared or how it resulted in changes to practice. There was no evidence of analysis of incidents to determine patterns or trend data and information coming from incidents was not being shared with frontline ward staff.

Members of the senior management team informed us that incidents and risk management issues are being reviewed on a weekly basis at the recently established site situation report (SITREP) and MAH live governance meetings. Having reviewed the information feeding into the SITREP and MAH live governance meetings we were unable to determine that incident/risk management processes were sufficiently integrated within the overall MAH governance system or intelligent enough to consistently feed risk information to BHSCT management/Board. We highlighted that this was necessary in order to assure the safety and effectiveness of care.

We were concerned to find that a number of adverse incidents involving glass in Ardmore had been reported but that this issue or an action plan to address it was not detailed on the risk register.

An area for improvement in relation to strengthening of the governance arrangements, (into which management of incidents will feed), in MAH has been detailed under the "Is the service well led?" domain.

6.3.3 Safeguarding Practices

MAH adult safeguarding guidance was reviewed and found to be up to date and in accordance with the regional safeguarding policy.

We noted a high number of frequently reported safeguarding referrals for individual patients as a result of the same issue (physical abuse, assault or violence). We were unable to evidence any change in outcome or learning from these incidents and there was no evidence of how these incidents resulted in changes to practice.

Staff advised us that there was a process to review and screen incidents out of the safeguarding process at ward level. We were unable to evidence that incidents screened out at ward level were being audited to confirm and assure this screening process.

There was evidence that some information in relation to safeguarding referrals was being reported into governing arrangements for MAH but there was no evidence that learning was identified and shared back out to front line ward staff.

We highlighted the need for learning to be shared in a meaningful way with frontline ward staff. We acknowledged that this was also made difficult due to the challenges with staffing levels on wards.

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.

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 structural disconnect between various groups of professional staff was evident within the current safeguarding arrangements.

<u>Close Circuit Television (CCTV)</u>

The inspection team was clear that staff across the site were fearful. 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 some confusion with respect to how CCTV is being used and the associated operational parameters of its use.

The Senior Management Team must develop policies and associated operational procedures to clearly define how CCTV is being used at the MAH site.

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.

An area for improvement in relation to safeguarding has been made. An area for improvement regarding the management and monitoring of CCTV has also been made.

6.3.4 Restrictive Practices (Seclusion)

The only purpose built seclusion room, which meets with relevant best practice guidance in terms of a seclusion environment, on the MAH site, is located in the PICU. In December 2018, BHSCT made a decision to temporarily close PICU and relocate the six patients to other wards across the hospital site. Two patients had been relocated to Ardmore, one patient to Cranfield One, two patients to Cranfield Two and one patient to Six Mile. We reviewed the care and treatment of these patients as part of our inspection focus.

The use of seclusion across the MAH site was also reviewed. We found that seclusion of patients as an appropriate and managed therapeutic intervention was taking place across the hospital site. In the main staff were found to be managing the practice well with evidence of de-escalation measures in use and required documentation in place.

The MAH seclusion policy and procedure provided to the inspection team was dated November 2016 and did not reflect the changes which had been introduced following the temporary closure of the PICU in December 2018.

Cranfield Two which had previously been an open ward was found to be locked. We were unable to locate evidence of the decision making process with regards to this change. Staff told us that patients who had been risk assessed as being safe to leave the ward knew how to do so. We observed this to be the case but found no evidence that care plans of individual patients had been updated to reflect these risk assessments.

We highlighted concerns that following the closure of PICU, the physical environments utilised for seclusion across a number of wards in MAH do not meet best practice guidelines. We observed that ward MDTs were implementing local arrangements to facilitate seclusion for patients in the absence of a clearly defined policy and following the closure of PICU. These arrangements were being provided in rooms that did not meet best practice guidelines for seclusion. In addition, various practices such as; seclusion; self-seclusion; de-escalation or practice agreed as part of a patient's management/care plan were being described across the wards. In the absence of a clearly defined policy it was difficult to determine what information was being reported into the SITREP or MAH's weekly live governance meetings.

The inspection team highlighted the need for the use of restrictive practices (seclusion) to be closely monitored. We could not find evidence of seclusion practices being audited and trends monitored over time. There was no evidence of robust assurance arrangements with respect to restrictive practices (seclusion).

We recognised that this issue is complex and will be challenging to address and suggested the BHSCT obtain ongoing expert support to ensure clear definitions and practices in relation to use of seclusion, self-seclusion, de-escalation and patient care planning.

BHSCT senior managers advised that they have recently sought support from the East London and Mersey Care NHS Foundation Trusts to assist with a review of restrictive practices in general and seclusion specifically.

An area for improvement has been made to ensure that the use of restrictive practices (seclusion) is reviewed across the MAH site in line with the following best practice guidance:

- Challenging Behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges; NICE guideline NG11 (2015);
- Nice Clinical Guidance NG-54 Mental Health Problems in people with learning difficulties: prevention, assessment and management DoH (NI) (2016) and
- Guidance: Isolation in detention; National Preventive Mechanism (2017)

The review should include daily discussion and MDT review at ward level and as a core component of MAH's weekly live governance meeting.

The BHSCT seclusion policy should also be reviewed and updated in line with these best practice guidelines and should include involvement of patients' families, staff and advocacy organisations.

6.3.5 Patient Observations

We reviewed the arrangements in place for the management of prescribed patient observations. We reviewed patient numbers, supervision ratios and the number of patients receiving enhanced one to one care.

Samples of patient observation records were reviewed and we noted that patients' observations were prescribed as required but were not always completed. Staff informed us that due to current nurse staffing they were unable to meet patients prescribed observations levels.

We observed that nurse staffing shortages were having a detrimental impact on patient behaviour and ward routine.

There was no evidence of audits of observations being carried out at ward level. We recommended that there should be engagement with ward managers and frontline nursing staff to implement a regular programme of audits of patient observations across the wards in MAH. An area for improvement in relation to this has been made.

6.3.6 Management of Medicines

We reviewed the arrangements in place for the management of medicines within MAH to ensure that medicines are safely, securely and effectively managed in compliance with legislative requirements, professional standards and guidelines. We evidenced that an up to date Medicines Code was in place.

There was evidence of satisfactory systems in place for medicines management. Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were observed to be clean, tidy and organised.

Pharmacist input is provided across the hospital site for 18.75 hours each week. The pharmacist input includes provision of medicines reconciliation at admission and discharge, review of prescribing and monitoring of stock levels.

We found a number of examples of medicines which had been prescribed for on-going treatment for several long-stay patients as having been ordered "urgently" on supplementary

requisition sheets. This evidenced that stock management and effective anticipatory ordering was not consistent.

There was no Pharmacy Technician support. We highlighted that this would be beneficial in supporting/reducing pressure on nursing staff, releasing the pharmacist time to concentrate upon patient facing activities and to support stock management and address deficiencies (stock levels/ordering/expiry date checking).

We reviewed patient kardexes and found that they were well maintained overall. We noted the good practice of highlighting dates for medicines prescribed at intervals.

A review of administration records highlighted a number of unexplained missing nursing staff signatures and we identified four examples of medicines being unavailable for administration. We did not see evidence of these areas being audited at ward level, except in Erne where some evidence of medication audit was found.

In relation to anxiolytic and antipsychotic medicines prescribed on a 'when required' basis e.g. to manage agitation, there were clear parameters to direct administration of these medicines on the patient's kardex. This included the indication for the medicine, the minimum frequency intervals and the maximum daily dose. Details of first line and second line (and occasionally third line) treatment were clearly recorded.

Samples of case notes (on the PARIS system) were reviewed and the rationale for any administration within a strategy for de-escalation was detailed; however, the assessment of effectiveness of the administration of these medicines was not consistently recorded. Staff advised us that the incidence of use was monitored and reviewed as part of patient reviews/ward rounds.

A range of audits should be completed to include: omitted doses, completion of administration records and effectiveness and appropriateness of 'when required' medicines be undertaken to improve medicines assurance.

Staff advised us of a regular review of stock to ensure that the medicine trolley only contained medicines for patients currently in the ward. However, we found some expired medicines including an anaphylaxis kit in Ardmore. We highlighted these to staff for removal (none of these medicines were in use) and advised that they ensure the immediate replacement of the anaphylaxis kit.

In relation to medicines requiring refrigeration we found a number of medicines which had expired or which did not require refrigeration. These were subsequently removed. We noted that refrigerator temperature was not being consistently recorded in Ardmore. The minimum and maximum medicine refrigerator temperatures should be recorded in all wards.

It was not always clear that therapeutic blood monitoring/other monitoring of physical health parameters associated with antipsychotic prescribing was being systematically undertaken or followed up to ensure that it was completed at required intervals (in accordance with the hospital's antipsychotic monitoring protocol). To remind staff when these are due for completion staff advised us that the required intervals would be recorded in the nurse's diary.

An area for improvement has been made regarding medication management.

6.3.7 Environment

Ardmore and Erne were the specific focus of the environmental inspection parameters; however, all five wards were visited over the course of the three day inspection.

Ardmore

The environment was observed to be clean and appropriately maintained.

We observed that when patients are in the dining room/communal area the noise echoes throughout both sides of the ward and creates a noise reverberation which can be very distracting and unpleasant.

Ward staff informed us that they have tried to encourage patients to access other parts of the ward. We found that there are a number of rooms in the ward which patients can avail of which are very pleasant.

We noted that patients tended to congregate in the large open dining room/communal area as the nurses' station is located there and it appears to be the hub of the ward.

Patients with hearing impairments, sensory problems and autism may find this area very distressing due to the high ceiling creating vibrating sounds. We suggested consideration of a possible review of furnishings/layout to try and absorb noise and reduce the echo effect.

Erne

The environment was observed to be clean, clutter free and well maintained.
There was good ventilation, large lounge areas and neutral odours.

We observed that the ward was undergoing renovation work. We noted that this was being well managed.

Ward furnishings were observed to be well maintained and comfortable.

The ward is of an older design and has a number of areas, annexes and rooms with some limitation to sight lines.

Cranfield One and Two

The Cranfield wards were observed to be similar in design to Ardmore.

Number of areas for improvement	**6**

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome

6.4.1 Care Pathways & Plans

There were 67 patients receiving care and treatment in MAH at the time of the inspection.

We reviewed a sample of patient care plans. There was evidence of an up to date mental health needs review of each patient, as well as records of decision making by the MDT involved in delivery of the patient's care.

We noted that MAH operates a dual records system. Patient care documentation was available on the PARIS electronic patient information system and in hard copy. Core care records were centrally located on the PARIS system and we observed that staff are familiar with the system. We found that continuing care records were difficult to track and locate.

Staff demonstrated good understanding of individual patient needs. We noted that nursing staff also demonstrated a high level of skill when supporting patients who presented with challenging behaviour. Effective use of de-escalation techniques with patients was observed throughout the duration of the inspection.

We found that there were good psychological formulations recommended for individual patients but they were not being fully implemented. Staff informed us that this was because they were complex in nature and staff did not have the time required to implement them. Staff reported that the deficit of positive intervention was impacting patient behaviour adversely.

BHSCT senior managers informed us that they were trying to resolve this issue by each ward having dedicated support from psychology staff to assist ward staff with the implementation of patients' positive behaviour support plans.

We found that the management and recovery of patients was being adversely affected by the mix of patients present in wards and delays in the discharge of patients who no longer required treatment. Acutely unwell patients were being admitted whilst patients' whose assessment and treatment had been completed were experiencing delays in their discharge. We were told that this combination was contributing to deterioration in patient behaviour.

We highlighted that other key expected activities including the audit of prescribed observations and the provision of nurse led ward based activities for patients were not being undertaken as nursing staff had prioritised the primary care needs of patients.

An area for improvement in relation to audit of patient observations has been detailed under the "Is care safe?" domain.

6.4.2 Physical Health Care Needs

We reviewed patient care records and ward procedures and processes for the management of patients' physical health care needs.

We found evidence of reactive measures for patients in respect of their physical health. No evidence of annual physical health checks or monitoring of co-existing physical health conditions was found.

Ward staff were observed to respond quickly to patients if they became ill or suffered injury as a result of a fall or from the effects of a seizure. We were told that patients could access out of hours general practitioner services as required.

Senior managers informed us that they had recently advertised for a general practitioner to facilitate in hours clinical sessions on the hospital site. They told us about the development of a physical health checklist which was to be piloted. Whilst we welcomed this development we highlighted that this approach may assist with addressing local ward arrangements but will not introduce a sustainable system level solution.

Reviews of patient care records evidenced that patients did not have their physical health appropriately monitored. We found they did not access health or population screening appropriate to their gender and/or age, and did not have appropriate access to primary care services. We noted that this placed them at a disadvantage when compared to their peers living in the community.

We found that there were no regular audits of patients' physical health care records being undertaken at ward level. We also found that some patients who were prescribed antipsychotic medications did not experience appropriate monitoring of related parameters of physical health as required in accordance to MAH's antipsychotic monitoring protocol.

Dental screening was in place but we found that this was not consistent across the hospital.

MAH must develop an appropriate system to ensure that the range of patients' physical health care needs are robustly addressed and monitored. An area for improvement has been made.

6.4.3 Discharge Planning

We did not find robust systems in place to ensure that agreed discharge arrangements are recorded and co-ordinated with all services that are involved in the patient's on-going care.

We were informed by BHSCT senior managers that they are continuing to progress a collaborative regional approach to ensure the hospital functions as an assessment and treatment hospital. They highlighted 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).

Discharge planning arrangements were reviewed. We found that 32 patients no longer required treatment and were experiencing a delay in their discharge from hospital.

During discussions with ward staff we were told that they often did not have up to date information about the plans for patients who have completed their active assessment and treatment and are awaiting discharge. Staff told us about the challenges that this presents as patients, family members/carers seek their advice in relation to possible discharge options. We

did not find evidence of clear communication with families taking place. We could not find detailed or up to date information in relation to proactive discharge planning for patients who are delayed in leaving the hospital.

An area for improvement has been made to ensure that ward staff have access to the most up to date information regarding patients who are awaiting discharge from MAH.

We acknowledged that wider systemic issues were negatively impacting on the hospital's ability to discharge patients. We noted a lack of appropriate community infrastructure had resulted in the delayed discharge of a number of patients.

Senior managers advised they recognise that urgent action is needed to facilitate reintegration back into the community of those patients who no longer require hospital treatment. They told us that they had set a priority for all patients to have a discharge address and plan and for this to be developed using a co-production model.

6.4.4 Strategic Planning and Communication

Following discussions with senior managers and reviewing minutes of meetings we found that BHSCT had a number of priorities in relation to re-modelling services in MAH. These priorities include review of admission criteria so that admission to MAH will only be for mental ill health or severe behavioural concerns that require hospital intervention, development of a clinical assessment unit and a target that use of seclusion would be reduced to zero.

Discussions with a wide range of staff across the whole MAH site identified that a large number were not aware of the plans for the hospital. We highlighted an issue relating to how the hospital's management team communicated plans to staff.

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.

We advised that stated aims and objectives for the hospital's PICU should be developed and disseminated to frontline staff so that there is clarity regarding both the unit and staff aligned to this service.

We noted that the poor understanding of the of hospital plans was symptomatic of this disconnect between what the management team were trying to achieve and what staff actually understood.
We found that this disconnect was common across several areas

An area for improvement has been made regarding the provision of a forward plan for MAH to include stated aims and objectives for the PICU.

Number of areas for improvement	**3**

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

6.5.1 Person centred care

Compassionate and positive interactions between staff and patients were observed throughout the inspection.

We observed staff treating patients with dignity and respect and responding compassionately to patients presenting with physical and/or emotional distress.

We found that nursing staff had good knowledge and understanding of the specific needs of individual patients they were caring for.

All staff described the MDT teams within each ward as patient centred, inclusive and supportive. We noted that MDTs included the range of professionals necessary to provide the required care and treatment to patients.

6.5.2 Patient Engagement

We reviewed how MAH engages with patients and/or their representatives.

We found that when appropriate and in accordance with each individual's presenting needs and health, patients were given the opportunity to be involved in any meetings where decisions about their care and treatment were being made.

We evidenced that care and treatment options were discussed with patients and their relatives.

During the inspection the Lay Assessor met with five patients from three wards, namely, Ardmore, Erne and Cranfield One. Patient staff interactions observed by the Lay Assessor were positive. Patients remained relaxed and at ease throughout the inspection. The Lay Assessor noted that when a patient became unsettled or agitated staff intervened quickly in a sensitive, supportive and caring manner.

One patient reported that their relationship with staff was good and they knew who to talk to if they were unhappy or had a concern. The Lay Assessor observed that ward staff were familiar with this particular patient's care needs and that the patient and staff had a close informal relationship. Two patients described the ward they were on as being clean and tidy. Both patients stated that there were not always enough activities to keep them busy at nights and at weekends. Both patients stated that when they had a concern or difficulty regarding their care they could discuss this with their named nurse. Patients told inspectors that they knew who was involved in their care and who to talk to if they were not happy or they were upset.

The Lay Assessor was also provided with feedback in relation to the impact of delays in obtaining a suitable community placement. One patient stated that they had been on the ward for three years and there was no suitable community placement available for them. Another patient informed the Lay Assessor that they had no concerns regarding the care provided however, the patient expressed frustration at having to remain in hospital as they wanted to be

in their own home. The Lay Assessor was informed that there was no community placement currently available for this patient.

A third patient discussed their concerns and frustrations in relation to their discharge from the ward being delayed. The patient explained that they understood why their discharge had been delayed and the reasons for this.

BHSCT senior management informed us that it plans to appoint a Carers' Consultant to enhance family/carer experience and to influence and shape services from a holistic perspective.

Number of areas for improvement	0

6.6 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

6.6.1 Planning and oversight of staffing levels

We reviewed the staffing arrangements in MAH. The multidisciplinary team (MDT) for each ward included nursing, occupational therapy, psychiatry, clinical psychology, behavioural support and social work professionals. In addition there is forensic psychology and specialist nurse practitioner support available. Independent advocacy services also visit the wards in MAH.

Senior managers told us that they had implemented nurse staffing planning measures and escalation arrangements to support ward managers. We were advised that bank and agency staff had been employed and that staffing levels on each ward were being monitored daily.

Wards were staffed using a mix of BHSCT, bank and agency staff. Staff told us that this mix did not always contain the required knowledge and skills to meet the complex needs of the patients currently receiving care and treatment in MAH. Staff told us that the BHSCT policy of agency staff not being permitted to take charge of the wards was creating difficulty in getting BHSCT only staff in charge to cover the wards.

Staff reported their experiences which indicated that morale was poor. Staff told us they had been significantly affected by the recent abuse allegations, the ongoing police investigation and staff suspensions. Staff told us that they could not complete the required level of observations, that they frequently had to cancel therapeutic and leisure activities and that they continually had to spend time inducting new members of agency staff. They informed us that this inability to fulfil their responsibilities is a further source of anxiety. We noted that it is impacting on the quality of care that staff are providing.

We were told that frequent changes of staff and increased use of agency staff was negatively impacting patients and their behaviour due to unfamiliarity. We highlighted the importance of continuity of staffing for patients with learning disabilities. Ward managers told us that they did not feel supported to address the daily workforce shortfall.

The monitoring and escalation arrangements in relation to staff shortages were reviewed. We found they did not accurately identify the impact the nurse staffing shortages were having on the care and treatment experienced by patients on some wards.

We found no evidence of an overarching forward plan for staffing in MAH which details how the BHSCT is going to find, retain and support staff.

The importance of the BHSCT engaging with colleagues from NHSCT and SEHSCT to seek necessary staff resources to facilitate adequate nurse staffing cover in MAH was discussed. It was noted that the BHSCT is experiencing difficulty in recruiting sufficient numbers of learning disability trained nurses because of the low numbers of nurses available within Northern Ireland.

An area for improvement in relation to planning arrangements for nurse staffing at MAH has previously been made in the "Is care safe?" domain.

This area of improvement has been made to ensure:

- A model to determine safe levels of ward staffing (including registrant and non-registrant staff) is defined. The model should be based on the assessed needs of the current patient population and incorporate flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements; and
- An effective process for oversight and escalation of challenges relating to staffing across the hospital site is implemented.

Senior managers informed us that they had recently introduced a number of arrangements to improve staff support. These included facilitating staff information/update sessions, access to one to one meetings with occupational health staff, information and support regarding the management of personal and professional issues, a keeping in touch system for absent staff and a Health and Wellbeing strategy.

Staff told us that they do not feel empowered, that they are fearful and that they are not engaged with the support measures.

We advised of the need for monitoring of the effectiveness of these arrangements after adequate time has been allowed for staff engagement and reflection. This is included in the area for improvement.

6.6.2 Hospital Governance

We reviewed the arrangements in place to support hospital governance.

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

We found that a BHSCT Assurance Committee covering the Learning Disability Division and chaired by the Chair of Division and Clinical Director has recently been established.

Hospital Services meetings were operating on a monthly basis. We found that they are chaired by the hospital services manager and are attended by ward managers and MDT staff. A review of sampled minutes illustrated that items discussed included staffing, patient discharges, site updates and Datix incidents.

MDT staff told us that weekly consultant led MDT meetings were taking place. We were told that Leadership Walk Arounds with a safety and quality focus are undertaken on a monthly basis by senior managers from both within and outside the division.

Staff informed us that they were unclear about the functions and operational purpose of the committees, meetings and walk arounds. Staff could not describe how these arrangements were supporting them to discharge their responsibilities. We highlighted that in view of psychological trauma experienced by staff it is important that there is clear communication about any new arrangements introduced. We also advised that the BHSCT should avoid implementing too many new arrangements at once so that staff do not feel overwhelmed.

We noted and welcomed that the BHSCT had introduced new approaches to review and strengthen governance arrangements including; introduction of a SITREP tool, weekly safety pause meeting and a weekly MAH live risk management/governance meeting. We observed both types of meetings during the inspection and found them to have been effectively chaired. There was limited evidence that the SITREP tool was used to escalate issues of concern to the service managers or BHSCT more widely. We highlighted that the tool may require some revision in order to be sensitive to pertinent issues, such as finance and pharmacy, and to be utilised to its' full potential.

The benefit of the weekly safety pause meeting becoming embedded within the overall governance system was discussed.

Ward managers advised us that they meet on a weekly basis and that a ward based morning safety briefing (huddle) is being piloted in two wards (Cranfield One and Two). We observed briefings and noted that they were attended by the MDT. We found them to be open, inclusive and effective particularly with regard to the sharing of patient information and providing updates on patient progress. We noted that the outputs from these meetings would also help to improve decision making with respect to appropriate escalation of issues.

The benefit of the daily safety huddle becoming embedded across all the wards in MAH was discussed.

Erne was observed as being well led. Local governance arrangements and effective auditing were noted as having been implemented by the ward manager. Supervision and appraisals were evidenced as being up to date. We noted that a programme of audit of case records, safeguarding referrals and incident reports was being undertaken. Nursing staff were visible and approachable and there was evidence of effective leadership. Patients and relatives who met with inspectors reflected positive experiences and reported a good standard of care and treatment being provided by the ward's MDT.

We acknowledged that the new governance system arrangements were at an early stage and would take time to become fully embedded throughout the hospital. Current arrangements were not sensitive enough to identify risks so as to consistently feed them to management. We highlighted that this development will be necessary in order to provide assurance to BHSCT that all operational aspects of MAH are robust.

We advised that the governance system requires further strengthening to ensure it is robust and supports collection and analysis of governance data at both ward and management level.

An area for improvement has been made relating to comprehensive implementation of robust governance arrangements at ward and hospital level.

6.6.3 Financial Governance

We assessed how the BHSCT discharged its' responsibilities in accordance with Articles 116 and 107 of the Mental Health (Northern Ireland) Order 1986 (MHO). This legislation sets outs the requirements for the Trust in managing monies and valuables on behalf of patients and the conditions for referring a patient to The Office of Care of Protection (OCP) to enable appropriate financial decisions to be made.

We noted a number of cases where monies was held in excess of 20K and where neither consent has been obtained by RQIA or referral had been made to The Office of Care and Protection to enable a controller to be appointed. We advised that the necessary steps should be taken to ensure that the Trust is compliant with its responsibilities.

We were informed that the MAH site manager acts as appointee for 13 patients but found related documentation for only six of these patients. We noted that none of the 13 patients' files were fully complete, entirely clear or contained evidence of an overarching financial plan. We were not assured that the designated appointee had sufficient knowledge and understanding of the individual patients for whom they had been appointed to enable fully informed best interest decisions to be made.

We noted that ward level ledgers, used for recording routine transitions were in place. However, we found these were sometimes inaccurately completed and that weekly checks by ward managers or monthly checks by senior managers were not being undertaken consistently.

We reviewed a sample of three sets of patient finance records. We found no evidence of discussions with patients regarding their choices or evidence of support being provided for decisions relating to spending. We found records of expenditure which were not supported by accompanying receipts. We identified a case where a safeguarding referral had not been made when there was some indication of potential financial abuse. Ward staff reviewed the patient's circumstances and a safeguarding referral was completed and forwarded to the responsible Adult Safeguarding Team.

We reviewed a sample of patients' property records and identified that three patients did not have an accurate record of their personal property and that one patient's record was last completed in June 2016.

The ward procedure for maintaining property records was discussed with two members of staff. We were informed by one member of staff that property records are not routinely maintained following a patient's admission to the ward and that items deposited for safekeeping were not recorded. We were advised by the second member of staff that property is recorded on admission and discharge only. We were told that items acquired and disposed of during the patient's stay are not recorded.

We determined these findings reflected a lack of understanding by ward managers and other ward staff, of their responsibilities for patient finances and we recommended this be urgently addressed. We also highlighted the need for improvement in the consistency and accuracy of completion of weekly and monthly ledger checks.

The BHSCT Patient Finances policy was reviewed and we noted it was only in draft form. We did not find evidence of regular financial audits being completed in MAH. An audit had been last completed in 2015. We recommended that the Patient Finances policy be updated and then an audit of its' operational use be undertaken to assure it full implementation.

We advised that there is a need for BHSCT to implement a programme of regular audits of compliance with its financial procedures across all wards in MAH to ensure a robust system approach to oversight and governance.

An area for improvement with respect to financial governance has been made and incorporates all of the concerns outlined.

6.6.4 Quality Assurance

We found evidence of active quality improvement initiatives with respect to violence reduction (Ardmore) and improving physical health (Cranfield Two).

Weekly incident audits and audits of the use and cost of bank and agency staff were evidenced as being undertaken and subsequently reviewed at the weekly SITREP meeting.

We were informed by BHSCT Senior Management Team that feedback and learning from a workshop undertaken on 30 January 2019 in relation to the purpose of MAH as an Assessment and Treatment unit, the patient pathway and desired outcomes would be utilised for future quality improvement initiatives. We were told that the learning would also be used for improving communication with frontline staff and remodelling of service provision.

BHSCT Senior Management Team informed us that they will be participating in NHS Benchmarking for Learning Disability Services. We recognised this was an opportunity for appropriate service data to be collected and analysed and also for local peer comparator review.

We welcomed these elements as signs of early development of an improvement culture in MAH and encouraged their progression moving forward.

Number of areas for improvement	**2**

6.7 Staff views

No staff questionnaires were received by RQIA.

Inspectors met formally and informally with staff from various professions during the inspection.

Structured staff interviews were undertaken with two members of junior medical staff, one member of agency nursing staff, one hospital social worker and a ward deputy manager. Focus groups with senior management staff, allied health professionals (social work, occupational therapy and psychology) and support staff were also held.

All staff interviewed highlighted issues with nurse staffing. The nursing staff who spoke with the inspection team told us about the impact of the increased use of agency staff and the challenge of seeking additional staff on a daily basis. They highlighted the impact of this upon the safety of staff and patients. Staff discussed the challenges of ensuring that there was an appropriate number of trained nursing staff available to cover each shift. This was noted as being particularly challenging during nightshifts.

All staff interviewed indicated that they felt patient care was compassionate. They highlighted an approach of continuous assessment and of patient focused MDT working.

We were told by staff that the effectiveness of care would be improved by appropriate placements being available in the community.

Staff experience of management support was mixed. One staff member described their manager as someone who was approachable and always listened. The staff member reflected that they felt valued. Another staff member told inspectors that staff job plans changed continually and there was uncertainty regarding the future and purpose of some wards.

A number of staff commented on the hospitals inconsistent approach and the completion of patient medical reviews. Staff stated that medical reviews were completed as required and that there was no system to ensure continuous routine patient medical reviews.

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.
Strategic Planning & Communication	
Area for improvement No. 9 **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 disseminated to frontline nursing staff so that there is clarity regarding both the unit and staff positions.

To be completed by: 14 May 2019	**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.
Hospital Governance	
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	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.
	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. 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	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

Ref: Standard 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	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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