The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Shannon Clinic Ward 1

Knockbracken Healthcare Park

Belfast Health & Social Care Trust

16 & 17 February 2015

npm national preventive mechanism

informing and improving health and social care
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Contents

1.0 General Information

Ward Name	Shannon Clinic Ward 1
Trust	Belfast Health & Social Care Trust
Hospital Address	Knockbracken Healthcare Park Saintfield Road Belfast BT8 8BH
Ward Telephone number	028 9056 5656 / 028 9504 2032
Ward Manager	Ann McDonald
Email address	annt.mcdonald@belfasttrust.hscni.net
Person in charge on day of inspection	Ann McDonald
Category of Care	Mental Health
Date of last inspection and inspection type	28 May 2014, Patient Experience Interviews
Name of inspector	Wendy McGregor

2.0 Ward profile

Shannon ward 1 is a regional medium secure, forensic, inpatient unit set within Shannon Clinic. The clinic is situated on the grounds of the Knockbracken Healthcare Park.

Shannon ward 1 is an admission and assessment unit, which provides in-patient treatment and care to male patients over the age of 18 years.

All patients admitted to Shannon ward 1 are detained in accordance with the Mental Health (Northern Ireland) Order 1986. On the days of the inspection there were twelve patients on the ward. Eight patients were detained in accordance with Part Three of the Mental Health (Northern Ireland) Order 1986 and four patients were detained in accordance with Part Two of the Mental Health (Northern Ireland) Order 1986.

Patients are referred to Shannon ward 1 from various sources including, court, prison and community. Referrals were assessed by the multi-disciplinary team to establish if the referral meets the criteria of a medium secure unit and the needs of the patient can be met appropriately.

Security on the ward was prioritised and there are strict protocols for entering and leaving the ward and clinic. The patients on the ward are subject to a number of restrictions in accordance with the nature of a medium secure unit.

Care and treatment on the ward is provided by the multi-disciplinary team, made up of medical, nursing, social work, psychology and occupational therapy. The patients have access to a GP who visited the ward two times per week and a Health and Wellbeing nurse weekly.

Access to other primary health care services such as podiatry is through referral.

There was two independent advocacy services available to patients and their carers and are integrated into the overall running of the ward.

The ward had a designated manager, and the majority of the staff compliment was made up of nursing registrants. The ward provided a placement for student nurses.

Shannon 1 shares a number of communal areas with Shannon 2 and 3. These are a gym, café, vending machines, shop, ATM machine, library, phone facilities, music room, woodwork room and a therapy room. There was also a large conference room with video conferencing facilities.

Shannon 1 was noted to be bright and clean. Patients have access to an open plan TV area, dining room, TV room and a resource room. Within the resource room patients can store restricted personal possessions such as mobile phones, razor's etc in individualised secure compartments. All patients have single bedrooms with en suite facilities and these are located along two corridors within the ward. The rooms contain personalised items and where appropriate, patients can bring in their own TV's, radios, DVD players. There was a washing machine and tumble dryer on the ward and patients are encouraged to do their own laundry. There was also a kitchen for patient use.

The patients have access to enclosed garden areas with shelters and seating to facilitate smoking. There is also a hen coop, and patients are responsible for the care of the hens. Within each ward there are storage areas, additional toilet facilities, bathroom, nursing office, clinical room and interview rooms.

3.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Northern Ireland's health and social care services. RQIA was established under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to drive improvements for everyone using health and social care services. Additionally, RQIA is designated as one of the four Northern Ireland bodies that form part of the UK's National Preventive Mechanism (NPM). RQIA undertake a programme

of regular visits to places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment, upholding the organisation's commitment to the United Nations Optional Protocol to the Convention Against Torture (OPCAT).

3.1 Purpose and Aim of the Inspection

The purpose of the inspection was to ensure that the service was compliant with relevant legislation, minimum standards and good practice indicators and to consider whether the service provided was in accordance with the patients' assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

The aim of the inspection was to examine the policies, procedures, practices and monitoring arrangements for the provision of care and treatment, and to determine the ward's compliance with the following:

- The Mental Health (Northern Ireland) Order 1986;
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006
- The Human Rights Act 1998;
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003;
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

Other published standards which guide best practice may also be referenced during the inspection process.

3.2 Methodology

RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the inspection standards.

Prior to the inspection RQIA forwarded the associated inspection documentation to the Trust, which allowed the ward the opportunity to demonstrate its ability to deliver a service against best practice indicators. This included the assessment of the Trust's performance against an RQIA Compliance Scale, as outlined in Section 6.

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.

Specific methods/processes used in this inspection include the following:

- analysis of pre-inspection information;
- discussion with patients and/or representatives;
- discussion with multi-disciplinary staff and managers;
- examination of records;

- consultation with stakeholders;
- file audit; and
- evaluation and feedback.

Any other information received by RQIA about this service and the service delivery has also been considered by the inspector in preparing for this inspection.

The recommendations made during previous inspections were also assessed during this inspection to determine the Trust's progress towards compliance. A summary of these findings are included in section 4.0, and full details of these findings are included in Appendix 1.

An overall summary of the ward's performance against the human rights theme of Autonomy is in Section 5.0 and full details of the inspection findings are included in Appendix 2.

The inspector would like to thank the patients, staff and relatives for their cooperation throughout the inspection process.

4.0 Review of action plans/progress

An unannounced inspection of Shannon Clinic Ward 1 was undertaken on 16 & 17 February 2015.

4.1 Review of action plans/progress to address outcomes from the previous announced inspection

The recommendations made following the last announced inspection on 13 & 14 January 2014 were evaluated. The inspector was pleased to note that all of the recommendations had been fully met.

4.2 Review of action plans/progress to address outcomes from the previous finance inspection

The recommendation made following the finance inspection on 30 December 2013 was evaluated. The inspector was pleased to note the recommendation had been fully met.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection it was good to note that all the recommendations made following the last announced inspection had been fully met.

The inspector observed staff using effective communication skills to promote therapeutic engagement with patients. Staff were observed treating patients with dignity and respect.

Patients were kept fully informed of what was happening in their day through the daily community meetings. The inspector noted the mechanisms in place to support staff e.g. reflective practice, staff meetings and staff supervision.

The following is a summary of the inspection findings in relation to the Human Rights indicator of Autonomy and represents the position on the ward on the days of the inspection.

Information in relation to capacity and consent, including Department of Health guidance was available for staff. Capacity to consent was assessed on admission. Patients and where appropriate their relatives were involved in their assessments, care and treatment plans, risk assessments, risk management plans and subsequent reviews. Patients had been consulted in decision making processes in relation to their care and treatment. The right to refuse care and treatment was respected. Consent to care and treatment had been obtained prior to care delivery. A reason was recorded when a patient did not consent. Staff had knowledge of capacity and consent, respected patient's wishes and made reasonable adjustments to ensure that patients' understood their care and treatment plans in order to give informed

consent. Staff had knowledge of the procedure to follow when a patient was assessed as incapable.

Patients were involved in their Promoting Quality Care (PQC) risk assessments and management plans and were invited to attend their PQC meetings. Patients were offered either a copy of the minutes of the meeting and/or their PQC report.

Patients were involved in any decisions about proposed changes to their care and treatment plans. The independent advocate attended weekly multidisciplinary and PQC meetings at the patients' request.

Patients were invited to attend their weekly multi-disciplinary meetings. Patients had the opportunity to meet daily on a 1:1 basis, with an allocated member of staff and at least weekly with their named nurse. The content and outcomes of the meetings was discussed with the patients prior and after the meetings. Patients' views in relation to their care and treatment plans were also discussed and recorded.

All care documentation was completed electronically. There was a continuous record completed by all members of the multi-disciplinary team involved in the patients care. A paper copy of essential care documents was held on the ward, which could be used in the event of a technical difficulty and the need to access this information in an emergency.

Assessments, care plans, risk assessments and risk management plans were individualised, person centred and holistic. Patients also had an Individual Approach plan completed. Care plans promoted patients involvement. Patients identified what their needs were, how staff could best support them and how staff would know if what they were doing to support the patient was helpful. Patients had agreed/disagreed and signed their care plans. Each assessed need had a care plan developed. Care and treatment plans were reviewed and updated weekly or earlier if required. Patients care documentation was audited weekly by a member of the staff team and this audit was then reviewed by the ward sister.

A G.P visited the clinic twice a week to address physical health concerns. Shannon Clinic also had a Health and Well-being Nurse one day per week to support patients with physical health needs and deliver health promotion. Communication needs were assessed on admission. Patients had access to an interpretation service when required.

Patients had the opportunity to take part in both recreational and therapeutic activities within the Shannon Clinic. Patients have access to occupational therapy and psychology. All patients were referred to occupational therapy on admission. Patients had an individualised occupational therapy assessment. This detailed patient likes and dislikes, and past, present and future recreational activities. There was evidence of patient involvement in the assessments. Patients were involved in the development of their

individualised therapeutic and recreational activity plans. Patient participation or otherwise was recorded in the patients daily progress notes by both nursing and occupational therapy staff. Patients also received weekly one to one time with a member from the occupational therapy team. Each occupational therapist is aligned with the patients' consultant to ensure consistency of care as patients move from ward 1 to ward 2 or 3.

The following therapies were available for patients; Dialectical Behaviour Therapy (DBT), Psycho- education, Coping with Mental Illness, Good Thinking Skills and other psychological therapies, woodwork, horticulture and the gym. A ward activity schedule was displayed in the patient communal area.
Some of the recreational activities offered to patients included, current affairs, ward art, hen duty, football, rackets club and a music group.
Activities of Daily Living (ADL) related activities were offered to patients, to promote independence and develop skills. The inspector observed patients making pancakes during the inspection in the ADL kitchen. All activities were delivered by both nursing and occupational therapy. Patients in Shannon 1, due to their presenting needs, cannot access activities outside of the Shannon clinic.

The following facilities were available within the clinic, indoor sports hall and a gym, library, tuck shop, coffee shop, garden and hen keeping. Patients are also provided with a daily selection of newspapers as agreed at the community meetings.

A new "inside out" project is scheduled to commence in April 2015, this has been developed with Extern and aims to support patients to develop "a work ready attitude, promote community integration, improve future employability, endorse health and well-being, explore meaningful activities, develop vocational skills and assist with resettlement". Patients will be offered the opportunity to develop essential skills and ICT, upholstery and catering with the goal of obtaining a vocational qualification.

A therapeutic co-ordination group meeting was convened once a month. The group were responsible for coordinating the development and maintenance of the therapeutic programme in Shannon clinic. Membership of the group comprised of the independent advocate, nursing, medical, social work and O.T staff. Minutes of the group meeting were available on the ward.

Patients had received a Shannon Clinic information booklet which informed patients of their rights. Patients had been informed of how to raise a concern and make a formal complaint; this information was also displayed in the ward communal areas. Patients were also aware of how to access independent advocacy services.

A full time independent advocate was available. A timetable was available on the ward to inform patients of the date and time of the advocate visits and included the dates of the patient forum meetings. The independent advocate facilitated both the weekly "Have Your Say" and monthly "Shannon for Us"

patient forum meetings. The independent advocate was part of the operational team and attended weekly bed management and operational meetings. The advocate attended multi-disciplinary meetings on request from the patient.

Information in relation to local complaints was shared with the patients and included the action taken to resolve the complaint. Patients who had been detained in accordance with part 2 of the Mental Health (Northern Ireland) Order 1986 had been informed of their right to appeal to the Mental Health Review Tribunal. Staff knew how to access and effectively use advocacy services. A carers advocate was available. There was a visitor feedback card in reception that asked visitors to provide comment on the Shannon clinic and to suggest on any improvements.

Shannon Clinic had a number of restrictive practices in accordance with the requirements of a medium secure unit. Access and exit from the unit is through several locked doors, there was a list of banned and restricted items, visitors and patients are subject to searches in line with trust policy; patients' bedrooms may also be routinely searched. Information in relation to these restrictions and the rationale was included in the Shannon Clinic information booklet which was given to patients on admission.

Patients had access to the garden and smoking area. A lighter was available in the gardens.

Patients had an Individual Approach plan completed using the stair case model, this identified why a person responds in an aggressive and violent manner, the triggers for aggression, the aim of staff intervention, the goals staff want the individual to achieve and what alternative coping mechanisms staff could teach the patient. The plan included patients presentation when calm, tense, using non-verbal aggression, verbal aggression and the critical moment. Proactive and reactive strategies were documented. Patients were involved in the development of their Individual Approach plans.

Patients were informed of the potential use of restrictive practices, such as physical interventions and the rationale for their use. When physical interventions were used, this was as a last resort and only after proactive strategies and de-escalation techniques were used and were ineffective. When implemented, physical interventions were proportionate to the risk. All incidents resulting in the use of restrictive practices were discussed at the weekly bed management meeting and at the patients' weekly multi-disciplinary meetings. All documentation was completed in line with trust policy and Promoting Quality Care guidance. Training records reviewed evidenced that all staff working on the ward had received up to date training in the use of physical interventions. Staff were committed to using restrictive practices as a last resort. All incidents resulting in the use of restrictive practices were discussed at the weekly bed management meeting.

Patients' discharge plans were discussed on admission. Patients on Shannon ward 1 move to either Shannon ward 2 or ward 3 for further care, treatment and rehabilitation when assessed as requiring a less restrictive environment. When assessed as medically fit patients were either discharged to independent accommodation, supported housing or returned to prison. Patients' Promoting Quality Care risk assessment and risk management plans identify risks and the supports the patient will require on discharge. There were no patients whose discharge was delayed during the days of the inspection.

There was evidence that patients' Human Rights Article 3, the right to be free from inhuman or degrading treatment/punishment, Article 5 the right to liberty and security of person, Article 8 the right to respect for private and family life and Article 14 the right to be free from discrimination were considered and documented in the patients care plans.

Staff demonstrated an understanding of how being a patient in Shannon ward 1 could impinge on the following patients' Human Rights; article 3 the right to be free from inhuman or degrading treatment/punishment, Article 5 the right to liberty and security of person, Article 8 the right to respect for private and family life and Article 14 the right to be free from discrimination.

Details of the above findings are included in Appendix 2.

On this occasion Shannon ward 1 has achieved an overall compliance level of **Compliant** in relation to the Human Rights inspection theme of "Autonomy".

6.0 Consultation processes

During the course of the inspection, the inspector was able to meet with:

Patients	**Four**
Ward Staff	**Two**
Relatives	**None**
Other Ward Professionals	**Four**
Advocates	**Two**

Patients

Patients knew why they had been admitted to Shannon ward 1. Patients confirmed they had been given the Shannon Clinic information booklet and were informed of their rights and the restrictive environment. Patients stated they were involved in their care and treatment plans. Patients also stated when a physical intervention had been used that they were informed of the reason for this. Patients knew how to raise concerns and how to access independent advocacy services. Overall patients stated they were satisfied with their quality of their care and treatment in Shannon ward 1.

Relatives/Carers

The inspection was unannounced. There were no relatives/carer available on the days of the inspection.

Ward Staff

Ward staff stated they were well supported by their peers and the ward sister. Staff commented that team work was good on the ward. Staff placed value on the reflective practice sessions. Staff stated they were encouraged to develop their knowledge and skills through practice development. Staff stated that working with this group of patients was challenging, however they promoted a culture of openness and honesty between patients and staff. Staff stated they kept patients fully involved in their care and treatment plans.

Other Ward Professionals

The occupational therapist, consultant psychiatrists and social worker all confirmed that the multi-disciplinary team work on the ward was excellent. They acknowledged that caring for patients on Shannon ward 1 had its challenges. Staff all worked to high standard.

Advocates

Both the patient advocate and carer advocate stated that staff provide a high standard of care to the patients. Both advocates stated they are part of the team and staff know how to effectively access and utilise the service.

Questionnaires were issued to staff, relatives/carers and other ward professionals in advance of the inspection. The responses from the questionnaires were used to inform the inspection process, and are included in inspection findings.

Questionnaires issued to	Number issued	Number returned
Ward Staff	20	6
Other Ward Professionals	5	0
Relatives/carers	12	2

Ward Staff

Four out of six staff had received training in capacity and consent and human rights. Staff were aware of Deprivation of Liberty Safeguards (DOLS) – interim guidance (2010). Staff were aware of restrictive practices on the ward. Staff had received training in restrictive practices. Staff were aware of alternative methods of communication and confirmed the ward had processes in place to meet patient's individual communication needs. Staff stated patients were informed of their rights. Staff stated patients on the ward had access to therapeutic and recreational activities and all activities were individually tailored.

Relatives/carers

Relatives rated the care their family member had received on the ward from good to excellent. Relatives did not express any concerns about their family members capacity to consent. Relatives had the opportunity to be involved in care and treatment plans. Relatives confirmed that an individual assessment had been completed in relation to therapeutic and recreational activities and their family member took part in activities. Relatives stated their family member did not require an assessment of their communication need. Relatives confirmed that their family member knew why they were in hospital and had been informed of their rights.

Relative quotes

"We find the staff pleasant, helpful, both verbally on visit and telephone conversation. Staff are friendly during visits and always ask us to feedback on our family members progress i.e. how do we feel they are getting on etc. Any concerns etc. The staff make us welcome and feel at ease keeping us informed of how they feel our family member is progressing etc. We

appreciate the warm welcome and the work we feel they are providing, staff are very experienced."

"I feel our family member has been well looked after and has improved immensely while being in Shannon. They have addressed their medical problems and hopefully they will once again be able to live in the community. It is the first time in 20 years they have been observed and assessed for a long time, which was what was badly needed."

7.0 Additional matters examined/additional concerns noted

Complaints

Prior to the inspection the ward submitted to RQIA the details of two complaints received from 1 April 2013 and 31 March 2014. The inspector reviewed complaints records and noted that both complaints had been managed in accordance with trust policy and procedure.

8.0 RQIA Compliance Scale Guidance

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable	Compliance with this criterion does not apply to this ward.	A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant	Compliance will not be demonstrated by the date of the inspection.	A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the inspection year.	In most situations this will result in a recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a recommendation, being made within the Inspection Report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and being made within the inspection report.

No requirements or recommendations resulted from the unannounced inspection of **Shannon Clinic Ward 1, Knockbracken Health Care Park** which was undertaken on **16 & 17 February 2015** and I agree with the content of the report.

Please provide any additional comments or observations you may wish to make below:

NAME OF REGISTERED MANAGER COMPLETING	Ann Mc Donald
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING	Martin Dillon, Deputy Chief Executive

Approved by:	**Date**
Wendy McGregor	26 March 2015

Appendix 1 – Follow up on Previous Recommendations

The details of follow up on previously made recommendations contained within this report are an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Appendix 2 – Inspection Findings

The Inspection Findings contained within this report is an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Contact Details
Telephone: 028 90517500
Email: Team.MentalHealth@rqia.org.uk

Appendix 1

Follow-up on recommendations made following the announced inspection on 13 and 14 January 2014

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	Document Number: 19 11.1	It is recommended the trust review their safeguarding vulnerable adult procedures to ensure they are in line with regional guidelines.	1	The inspector received correspondence from the trust on 22 September 2014 and confirmed with the designated officer and ward sister during the inspection that only staff who are trained, as per regional guidelines, screened all safeguarding vulnerable adult referrals.	Fully met
2	Document Number: 19 16.8	It is recommended the trust develops and implements a formal system to; identify the number of referrals, alert the designated officer to multiple referrals in relation to victims or perpetrators and this is included in the trust safeguarding vulnerable adult procedures.	1	The inspector reviewed the system for referring Safeguarding Vulnerable Adult concerns. All referrals were sent to the Designated Officer electronically via the PARIS system. The PARIS system was noted to identify the number of referrals, and alert the designated officer to multiple referrals in relation to victims, and perpetrators. There was also a record in the patients' electronic file, which enabled quick access to the number and the detail of the Safeguarding Vulnerable adult referrals. All Safeguarding Vulnerable Adult referrals were discussed at the weekly bed management meetings attended by the ward managers, operational manager, designated officer and independent advocate.	Fully met

3	Document Number: 17 8.3 k	It is recommended that the ward manager ensures a record of local complaints, the action taken and the outcomes is maintained on the ward.	1	The inspector reviewed records in relation to local complaints. There was a record of the complaint and the action taken. Information in relation to all local complaints was collated weekly and a written report shared with the patients on the ward.	Fully met
4	Document Number: 17 6.3.2	It is recommended the trust review and reduces the length of time of three months between menu ordering and the food delivery. This review and reduction should consider the specific requests addressed by the patient forum meetings and food users group.	1	The inspector reviewed the minutes from the food users group. Liaison between ward staff and hospitality staff was evident. There is now agreement if patients do not want the food on the menu they can order an alternative. Patients can also access the kitchen to make toast, cereal and eggs for their breakfast. The ward manager stated that patients receive £6 allowance from the trust to purchase a takeaway of their choice on Fridays. The inspector spoke with the advocate who stated that issues in relation to food have not been raised as a concern at the patient forum meetings. The advocate represents the patients from Shannon ward 1 at the food users group.	Fully met
5	Document Number:17 4.2	It is recommended the trust should ensure the ward manager has protected time to fulfil their ward managerial tasks / role	1	The inspector spoke to the ward sister. The ward sister has reviewed this recommendation. The ward sister stated this is no longer an issue and that they set time aside to fulfil managerial tasks.	Fully met

Appendix 1

Follow-up on recommendations made following the patient experience interview inspection on 28 May 2014

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1		N/A	N/A	

Follow-up on recommendations made at the finance inspection on 30 December 2013

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensures that a record of staff who access the key to the Bisley drawer, and the reason for access, is maintained.	The inspector reviewed documentation in relation to patients' finances. A record of staff who access the key to the Bisley drawer was maintained and included a reason for access**.**	Fully met

Ward Self-Assessment

Statement 1: Capacity & Consent • **Patients' capacity to consent to care and treatment is monitored and re-evaluated regularly throughout admission to hospital.** • **Patients are allowed adequate time and resources to optimise their understanding of the implications of their care and treatment.** • **Where a patient has been assessed as not having the capacity to make a decision there are robust arrangements in place in relation to decision making processes that are managed in accordance with DHSSPS guidance.** • **Patients' Article 8 rights to respect for private and family life & Article 14 right to be free from discrimination have been considered**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Patient needs and risks are identified during the pre-admission assessment, on admission, and recorded on their Comprehensive Risk Assessment. A person centred treatment plan is developed to address the patient's needs and reviewed at the weekly case conference. A Promoting Quality Care meeting also takes place for each patient every three months. The patient and their relatives/carers (where appropriate) are fully involved in the development and review of their treatment plans. A patient will be deemed to have capacity unless otherwise identified. Discussions will take place within the multidisciplinary team as to a patient's capacity where concerns arise. Should the patient be deemed incapable, decisions will be taken by the multidisciplinary team (in conjunction with the patient and their relatives/carers (where appropriate) as to their future treatment plan - the patient and their relatives/carers (where appropriate) can be represented by the patient's Advocate or other representative if preferred. Anyone deemed not to have capacity will have this regularly reviewed by their Consultant Psychiatrist. It is acknowledged that capacity to consent to treatment can fluctuate throughout admission to hospital. Patients' consent is requested for all care and treatment offered. Patients are given an information booklet on admission. This contains information on the ward routine and the complaints process. This booklet is discussed with the patient by a member of staff or if preferred by the patient's advocate/representative. Information on the patient's rights if detained will also be given to the patient both in written and verbal formats. A more user friendly format of explaining a patient's rights is currently being explored with the Service User Consultant for Mental Health Services. A booklet for Carers is also available for the patient's relatives/carers.	Moving towards compliance

Carers will also be contacted by the Carer Advocate aligned to Shannon Clinic (CAUSE) who will offer to meet with them. As stated above patients and their relatives/carers (where appropriate) are fully involved in their person centred treatment plan and risk management plan. All patients are invited to their weekly multidisciplinary team meetings. Should a patient decline to attend, their views and requests will be obtained by a member of staff prior to the meeting (or by the Patient's Advocate if preferred). Feedback regarding the outcome of the meeting is given to the patient and their relatives/carers (where appropriate) afterwards. A record of this is made in the patient's records and patients are asked to sign their nursing care plans to evidence their agreement with this. Where a patient doesn't wish to sign their care plan, a record of the reason for this will be documented. Patients and their relatives/carers (where appropriate) can request to meet at any time with their Consultant Psychiatrist. 1:1 time with a member of nursing staff is allocated daily and the Named/Associate Nurse meets with their patient regularly. There are daily patient community meetings and monthly meetings chaired by the Patients Advocate. Advocacy Services are in place for both patients and their relatives/carers (where appropriate) should they wish to avail of them. Advocacy is an integral part of ensuring that patients and their relatives/carers (where appropriate) have adequate time and resources to optimise their understanding of their treatment and care. Patient Advocacy Services within Shannon Clinic are offered by Mindwise - Shannon has a full time Patient Advocate who facilitates "Shannon for Us" meetings (patient meeting) and is part of its Operational Team. The Patient's Advocate represents the Patient where requested and can attend their multidisciplinary team meetings and discharge meetings if required. They address specific individual patient concerns with ward staff and any more generalised patient concerns at the Operational Team Meeting. Carers Advocacy is provided by CAUSE. Belfast Mental Health Services has a history of good working relationships with its Patient and Carers Advocates and has representation on both its governance committee and senior management team. This allows their representation at all levels throughout. Human rights including Articles 8 and 14 are considered during the development of the patient's person centred treatment plan. There are 12 ensuite bedrooms within Ward 1 in which patients keep their property and to ensure patient's privacy. Patients have their own key for their room unless risk assessment dictates otherwise. Where a patient doesn't have their own key they can request staff to open/lock door as necessary. Patients are discouraged from bringing large amounts of money or expensive items into the Unit. Any large amounts of money/expensive items will go to the on site Patients Bank. Staff in Ward 1 work to the Trust's Patient Finance Policy. As part of the recovery ethos, patients are encouraged to spend time with their family either within the Unit or as per pass arrangements. A private room is available for relatives to visit the patient in the Unit - all visits are planned and	

supervised as per Shannon Clinic's Visiting Policy. Visits outside set visiting times will be facilitated if necessary The Unit's Social Worker will meet with the patient's relatives/carers on the patient's admission to advise them of the visiting policy in place. Patients have access to a GP whilst in Shannon Clinic.	
Inspection Findings: FOR RQIA INSPECTORS USE Only	
Information in relation to capacity and consent including Department of Health guidance was available for staff. The inspector interviewed four patients. Patients stated they had been involved in the development of their care and treatment plans and had been consulted in decision making processes. Patients stated their consent to care and treatment had been obtained prior to care delivery. Patients confirmed when they had not agreed to care and treatment this was respected. The inspector interviewed two staff working on the ward. Both staff demonstrated their knowledge of capacity and consent. Staff stated they respected patient's wishes and explained what reasonable adjustments they would make to ensure the patient understood their care and treatment in order to give informed consent. Staff also stated, that when a patient was assessed as incapable, decisions in relation to best interests would be taken by the multi-disciplinary team as per trust policy and procedure and department of health guidance. The inspector reviewed care documentation in relation to four patients. There was evidence that capacity was assessed on admission. There was evidence that care and treatment plans had been discussed with the patients and all care plans had been agreed and signed by the patients. Promoting Quality Care risk assessments and management plans had been discussed with each of the four patients and had been agreed and signed by the patients. Three out of the four patients had a Promoting Quality Care meeting (One patient was a new admission and therefore was not due a meeting). Prior to the patients Promoting Quality Care meeting, a letter had been sent to each patient informing the patient of the meeting inviting them to attend. The letter included a questionnaire asking the patient the following questions; • Are you aware of the contents of your current care plan? • Do you agree with your entire care plan? • Is there anything you would like to change / add to you care plan?	Compliant

• Have you any goals that you feel the forensic Mental Health Team can help you achieve? • Please write down any comments about the mental health care you receive/ • Do you know who to make contact with and get help from services if an urgent mental health problem arises • Do you consent to your care plans begin shared with xxxxxx? • Will you be attending your review? It was also noted that when patients had consented, a letter was sent to their next of kin inviting them to attend the Promoting Quality Care meeting with a similar questionnaire as above. Patients were also given the choice of whether they wanted the minutes from the meeting or their full Promoting Quality Care report. There was evidence in the patients daily progress notes reviewed that all staff sought consent before care and treatment delivery. It was also documented when patients had not consented and the reason for this. The four sets of care documentation reviewed evidenced that staff had provided the patients with all the necessary information in relation to the care and treatment and documented if the patient had understood and was in agreement. There was evidence in the care documentation that patients were involved in decisions about proposed changes to their treatment plans e.g. patients were informed of changes to their medication, which included giving the relevant information required in relation to the treatment. The inspector spoke with the independent advocate who confirmed that they attend weekly multidisciplinary and Promoting Quality Care meetings at the patients' request. There was evidence the Human Rights Article 8, the right to respect for private and family life and Article 14 the right to be free from discrimination had been considered in patients care documentation. Staff interviewed also demonstrated their knowledge of how they actively consider the patients Human Rights. Staff promoted ongoing family engagement. A carer's advocate was also available.	

Ward Self-Assessment

Statement 2: Individualised assessment and management of need and risk • **Patients and/or their representatives are involved in holistic needs assessment and in development of related individualised, person-centred care plans and risk management plans** • **Patients with communication needs have their communication needs assessed and there are appropriate arrangements in place to promote the patient's ability to meaningfully engage in the assessment of their needs, planning and agreeing care and treatment plans and in the review of their needs and services.** • **Assessment of need is a continuous process and plans are revised regularly with the involvement of the patient and/or their representative and in accordance with any changes to assessed needs.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Patients and their relatives/carers (if appropriate) are fully involved in the development and review of their person centred treatment plan and risk management plan - these address the physical, psychological and therapeutic needs of the patient. Human rights including Article 8 are considered when developing the patient's person centred treatment plan and risk management plan. Staff adhere to the Code of Practice 1992 pertaining to the Mental Health (NI) Order 1986. As stated above all patients are invited to their weekly multidisciplinary team meetings. Should a patient decline to attend, their views and requests will be obtained by a member of staff prior to the meeting (or by the Patient's Advocate if preferred). Feedback of the outcome of the meeting will be given to the patient and their relatives/carers (where appropriate) afterwards. A record of this is made in the patient's records and patients are asked to sign their nursing care plans to evidence their agreement with this. Where a patient doesn't wish to sign their care plan, a record of the reason for this will be documented. Advocacy Services are in place for both patients and their relatives/carers (where appropriate) should they wish to avail of them. Patient Advocacy is provided by Mindwise and Carers Advocacy by CAUSE. Any patient's communication issues will be addressed during their initial assessment on admission to the ward. The	Moving towards compliance

Belfast Trust has an established process in place to access interpreters. Staff will access an interpreter who can address the communication issue a person presents with. This is to enable the patient and their relatives/carers (if appropriate) to continue to input into their treatment and care. This also allows staff to meet the patient's spiritual or cultural needs. There are 12 ensuite bedrooms within Ward 1 in which patients will keep their property and to ensure patient's privacy. Patients have their own key for their room unless risk assessment dictates otherwise. Where a patient doesn't have their own key they can request staff to open/lock door as necessary. Patients are discouraged from bringing large amounts of money or expensive items into the Unit. Any large amounts of money/expensive items will go to the on site Patients Bank. Staff in Ward 1 work to the Trust's Patient Finance Policy. As part of the recovery ethos, patients are encouraged to spend time with their family either within the Unit or as per pass arrangements. A private room is available for relatives to visit the patient in the Unit - all visits are planned and supervised as per Shannon Clinic's Visiting Policy. Visits outside set visiting times will be facilitated if necessary The Unit's Social Worker will meet with the patient's relatives/carers on the patient's admission to advise them of the visiting policy in place. Staff have access to Equality Training via e-learning. This training provides an overview of the key legislative and policy requirements relating to both Employment Equality and Section 75, Good Relations and Human Rights. This ensures that staff are made aware of the key concepts of equality and diversity, are provided with an overview of the main legislation and its practical implications and are familiar with the Trust's equality policies and their responsibilities. Staff are aware that they can access these policies on the Trust's "Hub".	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The four patients spoken to during the inspection all confirmed that they had been involved in their assessments, care plans, risk assessments, risk management plans and subsequent reviews. Patients confirmed they were invited to attend their weekly multi-disciplinary meetings and Promoting Quality Care Reviews. Patients stated they had the opportunity to meet daily on a 1:1 basis with an allocated member of staff and at least weekly with their named nurse. The inspector reviewed documentation in relation to four patients. All care documentation was completed electronically. There was a continuous record completed by all members of the multi-disciplinary team involved in the patients care. A paper copy of essential care documents was held on the ward, which could be used in the event of a technical difficulty with the information technology systems and the need to access this information in an emergency. Assessments, care plans, risk assessments and risk management plans were	Compliant

individualised, person centred and holistic. Patients also had a Developing an Individual Approach plan completed. There was evidence of patient attendance at their multi-disciplinary reviews and Promoting Quality Care review meetings and evidence of discussions with the patient prior to and after the meetings. Patients views in relation to their care and treatment plans were also discussed and recorded. The template used for patients care plans ensured that they were person centred and promoted patient involvement. Patients identified what their own needs were, what staff could do to help and how staff would know what they were doing was helpful. Each set of care plans reviewed by the inspector evidenced that patients had been involved, had agreed and had signed the documentation. The inspector noted that a care plan had been completed for every need identified in the patients' assessment. Care plans were holistic and addressed the following; • Mental Health Needs • Medication • Psychological Functioning • Physical Health • Supports (family, emotional, professional, social) • Placement (inpatient, level of security) • Alcohol/substance misuse intervention • Child care/Child protection /Vulnerable adults • Financial • Occupation/Leisure/Education • Activities of Daily Living (ADL) • Cultural/Spiritual Needs • There was evidence that care and treatment plans were reviewed and updated weekly or earlier if required. The inspector noted that patients care documentation was audited weekly by a member of staff and this audit was then reviewed by the ward sister. A G.P visited the clinic twice weekly. Shannon Clinic also had a Health and Well-being Nurse one day per week to support patients with physical health needs and health promotion. There was evidence that patients' Human Rights Article 3 the right to be free from inhuman or degrading	

treatment/punishment, Article 5 the right to liberty and security of person, Article 8 the right to respect for private and family life and Article 14 the right to be free from discrimination were considered and documented in the patients care plans. Communication needs were assessed on admission. The inspector was informed that there were no patients on the ward who required support with communication . Staff interviewed informed the inspector how to access the interpretation service when required. Two relative questionnaires returned confirmed that where appropriate they had been involved in their relatives care and treatment plans. Both relatives stated their family member did not require an assessment of their communication needs.	

Ward Self-Assessment

Statement 3: Therapeutic & recreational activity • **Patients have the opportunity to be involved in agreeing to and participating in therapeutic and recreational activity programmes relevant to their identified needs. This includes access to off the ward activities.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
All patients have an individualised activity programme and an overarching programme. Both programmes are developed by multidisciplinary staff in partnership with patients. A patient's individual programme is based on the needs and risks they present and will address therapeutic, occupational and psychological needs. Evidence based activities include DBT, psycho-education, woodwork, complimentary therapies, literacy skills etc. A new Band 7 OT has recently been recruited who co-ordinates the activities within the unit. The Occupational Therapist is part of the multidisciplinary Team. They document all therapeutic input onto the Trust's Community Information System. There are 12 ensuite bedrooms within Ward 1 in which patients will keep their property and to ensure patient's privacy. Patients have their own key for their room unless risk assessment dictates otherwise. Where a patient doesn't have their own key they can request staff to open/lock door as necessary. Patients are discouraged from bringing large amounts of money or expensive items into the Unit. Any large amounts of money/expensive items will go to the on site Patients Bank. Staff in Ward 1 work to the Trust's Patient Finance Policy. As part of the recovery ethos, patients are encouraged to spend time with their family either within the Unit or as per pass arrangements. A private room is available for relatives to visit the patient in the Unit - all visits are planned and supervised as per Shannon Clinic's Visiting Policy. Visits outside set visiting times will be facilitated if necessary The Unit's Social Worker meets with the patient's relatives/carers on the patient's admission to advise them of the visiting policy in place.	Moving towards compliance
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

The four patients interviewed by the inspector stated they had the opportunity to take part in both recreational and therapeutic activities within the Shannon Clinic. The inspector spoke with the occupational therapist. Shannon Clinic receives input from four full time occupational therapists, and one full time occupational therapy assistant. The clinic also has one full time technical instructor for woodwork and the support from three Nursing care assistants three days per week for recreational activities. The inspector reviewed care documentation in relation to four patients on the ward and noted the following; • Each patient had an appropriate occupational therapy completed. There was evidence of patient involvement in the assessments. • Each patient was involved the development of an individualised therapeutic and recreational activity plan. • Patient participation or otherwise was recorded in the patients daily progress notes by both nursing and occupational therapy staff. • Patients also received weekly one to one time with a member from the Occupational Therapy team. • There was evidence of evaluation of improved patient outcomes. Each occupational therapist is aligned with the patients' consultant to ensure consistency of care as patients move from ward 1 to ward 2 or 3. The following therapeutic and recreational activities were available for patients; Dialectical Behaviour Therapy (DBT), Psycho- education, Coping with Mental Illness, Good Thinking Skills and other psychological therapies, woodwork, horticulture and the gym. A ward group activity schedule was displayed in the patient communal area. Some of the recreational activities offered to patients included, current affairs, ward art, hen duty, football, rackets club and a music group. Activities of living related activities were offered to patients e.g. cooking and laundry and the inspector observed patients making pancakes during the inspection in the ADL kitchen. All activities were delivered by both nursing and occupational therapy. Patients in Shannon 1 due to their presenting needs cannot access activities outside of the Shannon clinic.	Compliant

The following facilities were available within the clinic, indoor sports hall and a gym, library, tuck shop, coffee shop, garden and hen keeping. Patients are also provided with a daily selection of Newspapers as agreed at the community meetings. A new “inside out” project is scheduled to commence in April 2015, this has been developed with Extern and aims to support patients to develop “a work ready attitude, promote community integration, improve future employability, endorse health and well-being explore meaningful activities, develop vocational skills and assist with resettlement”. Patients will be offered the opportunity to develop essential skills and ICT, upholstery and catering with the goal of obtaining a vocational qualification. The inspector noted that monthly therapeutic co-ordination group meeting was convened monthly. The group were responsible for coordinating the development and subsequent maintenance of the therapeutic programme in Shannon clinic. Membership of the group comprised of the independent advocate, nursing, medical, social work and O.T staff. Minutes of the group meeting were available on the ward. There was evidence of consideration to patients Human Rights Article 8 the right to respect for private and family life. Both relative questionnaires returned stated their family member took part in therapeutic and recreational activities.	

Ward Self-Assessment

Statement 4: Information about rights • **Patients have been informed about their rights in a format suitable to their individual needs and access to the communication method of his/her choice. This includes the right to refuse care and treatment, information in relation to detention processes, information about the Mental Health Review Tribunal, referral to the Mental Health Review Tribunal, making a complaint, and access to independent advocacy services.** • **Patients' Article 5 rights to liberty and security of person, Article 8 rights to respect for private and family life and Article 14 right to be free from discrimination have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Patients are given an admission booklet at the time of admission. This contains information on the detention process, making a complaint and access to advocacy services. This is discussed with the patient by a member of staff or if preferred by the patient's advocate/representative. A more user friendly format of explaining a patient's rights is currently being explored with the Service User Consultant for Mental Health Services. A booklet for Carers is also available for the patient's relatives/carers. Carers are contacted by the Carer Advocate aligned to Shannon Clinic (CAUSE) who will offer to meet with them. An interpreter is requested if required. There is a full time Patients' Advocate within Shannon Clinic. He facilitates "Shannon for Us" meetings (patient meeting) and is part of its Operational Team. The Patient's Advocate will represent the Patient where requested and can attend their multidisciplinary team meetings and discharge meetings if required. They address specific individual patient concerns with ward staff and any more generalised patient concerns at the Operational Team Meeting. Carers Advocacy is provided by CAUSE. Belfast Mental Health Services has a history of good working relationships with its Patient and Carers Advocates and has representation on both its governance committee and senior management team. This allows their representation at all levels throughout. There are 12 ensuite bedrooms within Ward 1 in which patients will keep their property and to ensure patient's privacy. Patients have their own key for their room unless risk assessment dictates otherwise. Where a patient doesn't have their own key they can request staff to open/lock door as necessary. Patients are discouraged from bringing large amounts of money or expensive items into the Unit. Any large amounts of money/expensive items will go to the on site Patients Bank. Staff in Ward 1 work to the Trust's Patient Finance Policy. As part of the recovery ethos, patients are encouraged to spend time with their family either within the Unit or as per pass	Moving towards compliance

arrangements. A private room is available for relatives to visit the patient in the Unit - all visits are planned and supervised as per Shannon Clinic's Visiting Policy. Visits outside set visiting times will be facilitated if necessary. The Unit's Social Worker will meet with the patient's relatives/carers on the patient's admission to advise them of the visiting policy in place.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The four patients interviewed confirmed that they had been given the Shannon Clinic patients information booklet. The information booklet contained the following information; • Patients right to confidentiality • Multi-disciplinary team • Advocacy services • Mental Health N.I Order (1986) • Personal mail and parcels and protocols • Restricted and banned items • Complaints • RQIA • Information on outside agencies that may support the patient with a complaint or concerns • Protocol for substance misuse on the ward Patients interviewed stated they knew how to raise a concern and make a formal complaint, were aware of advocacy services and had been informed of their rights. Information on how to make a complaint and accessing advocacy services was displayed in the patients' communal area. A full time independent advocate was available. A timetable was available on the ward to inform patients of the date and time of the advocate visits and the schedule of the patient forum meetings they facilitate. The inspector spoke to the independent advocate who confirmed they facilitated both the weekly "Have Your Say" and monthly "Shannon for Us" patient forum meetings. The independent advocate stated they were part of the operational team and attended weekly bed management and operational meetings. The advocate also confirmed they attended multi-disciplinary meetings on request from the patient. The inspector reviewed feedback from local complaints raised by patients. This information was available for patients and discussed at the community meetings. Issues raised and action taken was documented. Issues such as the provision of towels, blankets, and food preferences were among some of the issues raised. Actions	Compliant

taken were noted to be appropriate. The inspector reviewed documentation relating to four patients. Patients who were detained in accordance with part 2 of the Mental Health (Northern Ireland) Order 1986 had been informed of their right to appeal to the Mental Health Review Tribunal. Staff interviewed informed the inspector how to access and effectively use advocacy services. The inspector spoke to the carers advocate. The advocate informed the inspector of the support they provide to patients carers through carers' forums. There was a visitor feedback card in reception that asked visitors to provide comment on the Shannon clinic and to suggest on any improvements. One of the two relative questionnaires returned stated their family member had received information in relation to their rights. One questionnaire stated they did not know as their family member did not talk about "those matters" however they assumed their family member had been told as they could explain and understood why they had been admitted to Shannon clinic.	

Ward Self-Assessment

Statement 5: Restriction and Deprivation of Liberty • **Patients do not experience "blanket" restrictions or deprivation of liberty.** • **Any use of restrictive practice is individually assessed with a clearly recorded rationale for the use of and level of restriction.** • **Any restrictive practice is used as a last resort, proportionate to the level of assessed risk and is the least restrictive measure required to keep patients and/or others safe.** • **Any use of restrictive practice and the need for and appropriateness of the restriction is regularly reviewed.** • **Patients' Article 3 rights to be free from torture, inhuman or degrading treatment or punishment, Article 5 rights to liberty and security of person, Article 8 rights to respect for private & family life and Article 14 right to be free from discrimination have been considered.**	**COMPLIANCE LEVEL**
Shannon Clinic is a Medium Secure Unit, providing in-patient services for people with mental illness who require intensive psychiatric treatment and rehabilitation within a structured, secure and therapeutic environment. It's a regional service linking mental health services throughout Northern Ireland. Security is of fundamental importance and a number of restrictive practices are in place due to its nature. This includes a list of banned/restricted items, locked door policy, routine searches etc. Blanket restrictions and the rationale for these are explained in the patient's booklet. Any other restriction will be considered on a case by case basis and addressed within the patient's treatment plan. The rationale for these restrictions will be fully explained to the patient and their relatives/carers (where appropriate). Any such restriction will be reviewed regularly in keeping with both Trust and Regional Guidance to ensure the least restrictive practice is imposed on patients. Restrictive practices are proportionate to the level of risk posed by the patient and will be reviewed regularly. All staff within the Unit have received mandatory MAPA training. Agency staff are not used within the unit and any bank staff have up to date MAPA training as per Shannon Clinic's requirements. A record is made of any restraint. These are reviewed at the patient's multidisciplinary team meeting. Restraints within mental health services in the Belfast Trust are also audited by the Resource Nurse for Mental Health and Learning Disability on a monthly basis. The results are shared with both management and staff to inform training.	Moving towards compliance

There are 12 ensuite bedrooms within Ward 1 in which patients will keep their property and to ensure patient's privacy. Patients have their own key for their room unless risk assessment dictates otherwise. Where a patient doesn't have their own key they can request staff to open/lock door as necessary. Patients are discouraged from bringing large amounts of money or expensive items into the Unit. Any large amounts of money/expensive items will go to the on site Patients Bank. Staff in Ward 1 work to the Trust's Patient Finance Policy. As part of the recovery ethos, patients are encouraged to spend time with their family either within the Unit or as per pass arrangements. A private room is available for relatives to visit the patient in the Unit - all visits are planned and supervised as per Shannon Clinic's Visiting Policy. Visits outside set visiting times will be facilitated if necessary. The Unit's Social Worker will meet with the patient's relatives/carers on the patient's admission to advise them of the visiting policy in place.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Shannon Clinic had a number of restrictive practices in accordance with the requirements of a medium secure unit. Access and exit from the unit is through several locked doors, there was a list of banned / restricted items, visitors and patients are subject to searches in line with trust policy; patients may also be subject to routine searches, this included their bedrooms. Information in relation to these restrictions and the rationale was included in the Shannon Clinic information booklet which was given to patients on admission. Patients had access to the garden and smoking area. A lighter was out in the gardens. Bedrooms were not locked on the days of the inspection. The inspector reviewed documentation in relation to four patients. Each patient had an Individual Approach plan completed using the stair case model, this identified why a person responds in an aggressive and violent manner, the triggers for aggression, the aim of staff intervention, the goals staff want the individual to achieve and what alternative coping mechanisms staff could teach the patient. The plan included patients presentation when calm, tense, using non-verbal aggression, verbal aggression and the critical moment. Proactive strategies were documented. There was evidence of patient involvement in the plans. There was evidence in the documentation that patients had been fully informed of the potential use of restrictive practices such as physical interventions and the rationale for their use. The inspector noted it was documented when physical interventions were implemented this was as a last resort and only after proactive strategies and de-escalation techniques were used and were not effective. Physical interventions were noted to be proportionate to the risk. A low stimulus room was available on the ward. The inspector noted the infrequent use of the low stimulus	Compliant

room. All incidents resulting in the use of restrictive practices were discussed at the weekly bed management meeting and at the patients' weekly multi-disciplinary meetings. All documentation was completed in line with trust policy and Promoting Quality Care guidance. Training records reviewed evidenced that all staff working on the ward had received up to date training in the use of physical interventions. Staff interviewed demonstrated their commitment to only using restrictive practices as a last resort and informed the inspector of the strategies they implement to reduce the likelihood of crisis situations. The inspector noted evidence that restrictive practices were reviewed at the monthly staff meetings. It was noted in the four sets of care documentation that consideration was given to patients Human Rights Articles 3 the right to be free from torture, Article 8 the right to respect and family life, and Article 14 the right to be free from discrimination. One of the two relative questionnaires returned stated they were aware of restrictive practices on the ward. The other relative questionnaire returned did not answer the question.	

Ward Self-Assessment

Statement 6: Discharge planning • **Patients and/or their representatives are involved in discharge planning at the earliest opportunity.** • **Patients are discharged home with appropriate support or to an appropriate community setting within seven days of the patient being assessed as medically fit for discharge.** • **Delayed discharges are reported to the Health and Social Care Board.** • **Patients' Article 8 rights to respect for private and family life have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Patients and their relatives/carers (where appropriate) are invited to contribute to all aspects of their treatment and care including discharge planning. Work towards discharge commences on the patient's admission. Any patient discharged from Shannon Clinic will be subject to Enhanced Discharge as per the Promoting Quality Care Guidance. Consideration is given to any support/care package needed to allow a safe discharge from Shannon Clinic be it to independent accommodation, supported housing or back to prison. Any patient discharged from Shannon Clinic into the community will receive input from the Community Forensic Mental Health Team. Discharge plans are person centred and take into consideration the patient's human rights. The date and time of discharge is communicated with the patient and their relatives/carers (as appropriate) prior to discharge. Pending discharges are discussed at the weekly bed management meeting. Any delayed discharges are reported to the Health and Social Care Board.	Moving towards compliance
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
The inspector reviewed documentation in relation to four patients. Plans for discharge were discussed on admission. Patients on Shannon ward 1 move to either Shannon ward 2 or ward 3 for further care, treatment and rehabilitation when assessed as requiring a less restrictive environment. When assessed as medically fit for discharge patients were then discharged to independent accommodation, supported housing or returned to prison. Although discharge was discussed on admission the ward sister stated due to the needs of the patients on	Compliant

admission and the restrictive environment, it was difficult to confirm plans for discharge during this stage. The patients Promoting Quality Care risk assessment and risk management plans identify risks and supports the patient will require on discharge. Discharge plans were noted to be person centred and evidenced patient involvement. There were no patients whose discharge was delayed during the days of the inspection.	

Ward Manager's overall assessment of the ward's compliance level against the statements assessed	**COMPLIANCE LEVEL**
	Moving towards compliance

Inspector's overall assessment of the ward's compliance level against the statements assessed	**COMPLIANCE LEVEL**
	Compliant

SUPPLEMENTARY INFORMATION

For information or incidents within the last 12 months, this is interpreted as being from the date of the inspection.

Within the last 12 months, please confirm the number of Under 18 admissions to the ward and the age, gender and length of stay for each placement.							
Admission number	Age	Gender	Length of Stay (days)	Admission number	Age	Gender	Length of Stay (days)
1				8			
2				9			
3				10			
4				11			
5				12			
6				13			
7				14			

Within the last 12 months, please confirm the number of investigations undertaken on the ward and their outcomes.			
Adult Protection Investigations		**Child Protection Investigations**	
Substantiated Allegations	15	Substantiated Allegations	n/a
Unsubstantiated Allegations	34	Unsubstantiated Allegations	n/a
On-going Allegations	0	On-going Allegations	n/a
Total	49	Total	0

Please confirm the names of the following contacts for safeguarding children and vulnerable adults.	
The wards Nominated Manager for Safeguarding Vulnerable Adults	Mark Johnston