Regional Medium Secure Inpatient Unit
Inspection Report
30 August – 2 September 2016

Shannon Clinic

Knockbracken Healthcare Park
Saintfield Road,
Belfast
BT8 8BH

Tel No: 02890 565656

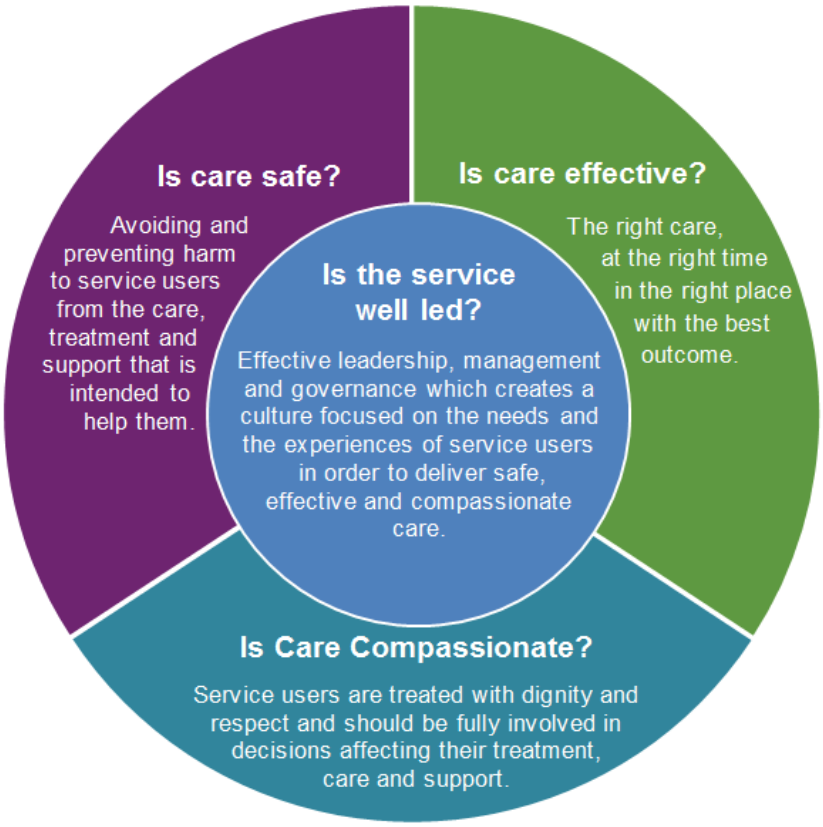
www.rqia.org.uk
Assurance, Challenge and Improvement in Health and Social Care

Inspection Team

Name	Inspection Role
Elizabeth Colgan	Senior Inspector
Wendy McGregor	Inspector
Audrey McLellan	Inspector
Alan Guthrie	Inspector
Dr Brian Fleming	Sessional Medical Officer
Dr Oscar Daly	Sessional Medical Officer
Dr John Simpson	Sessional Medical Officer
Dr Nichola Rooney	Sessional Psychologist
Frances Gault	Pharmacy Inspector
Moira Scanlon	Peer Reviewer – Occupational Therapist
Dougie Seath	Peer Reviewer – Scottish Mental Health Commission
Richard Moore	Administrative support

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we Look For



2.0 Profile of Service

Shannon Clinic is a regional medium secure inpatient unit situated on the grounds of the Knockbracken Healthcare Park. The clinic provides psychiatric treatment for patients with a forensic history and rehabilitation in a secure therapeutic environment. There are three wards in the Shannon clinic. Each ward has its own function:

Ward 1 is an admission and assessment unit for male patients.

Ward 2 provides care and treatment to both male and female patients. Female patients are admitted directly to Ward 2 and remain there until discharge. Male patients transition after their assessment on Ward 1 to commence treatment in Ward 2.

Ward 3 provides rehabilitation for male patients.

There are 34 beds in total in the Shannon clinic. On the days of the inspection there were 12 patients in Ward 1, 11 patients in Ward 2 and 9 patients in Ward 3. All patients were detained appropriately in accordance with the Mental Health (Northern Ireland) Order 1986.

3.0 Service Details

Responsible person: Martin Dillon	**Position:** Deputy Chief Executive
Operational manager: David Martin	
Ward managers : Ward 1 – Anne McDonald Ward 2 – Damien Murdock Ward 3 – Linda Taylor	

4.0 Inspection Summary

An unannounced inspection took place over four days from 30 August to 2 September 2016.

This inspection focused on the theme of Person Centred Care. This means that patients are treated as individuals, and the care and treatment provided to them is based around their specific needs and choices.

We assessed if the Shannon Clinic was delivering, safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to patient involvement in decisions about care and treatment, the safe administration of medication, the range of activities available for patients and the quality of nurse leadership.

Areas requiring improvement were identified in relation to environmental risk assessments, patient risk assessments, the lack of consistency in the approach amongst the medical team and the limited psychology service. Other identified areas for improvement were in relation to the lack of revision of policies and procedures, lack of clarity regarding the aims and objectives and the function of the clinic, reduced staffing issues in Ward 2 and Ward 3 and the recording of incidents and accidents.

Inspectors were particularly concerned that there was no clinical management lead. There were six consultant psychiatrists providing care and treatment to patients admitted to the clinic. The consultants were from the five health and social care trusts. The consultants were not full time members of staff in the clinic and their role was to support and follow their patients from admission to discharge. Although this should give more consistency regarding care and treatment, there were different practices noted among the medical team as follows;

- Attendance at ward rounds.
- An inconsistent approach to the management of multidisciplinary team (MDT) meetings.

- An inconsistent approach with the regularity of seeing patients.
- An inconsistent approach to recording.
- Gaps in the completion of care and treatment plans.
- Gaps in the timely completion of risk assessments, and subsequent updates.

Patients said they felt safe and secure in the clinic. Patients confirmed that they were involved in decisions about their care and treatment and staff regularly told them how they were progressing. All patients stated that being in the clinic was helping them with their recovery. Patients were complimentary about staff and said that care was compassionate as staff listened and took their views into account. Staff were observed responding compassionately when help was needed and were noted to be supportive and helpful. Patients stated that staff gave them an explanation and sought permission before supporting them with care and treatment. All patients confirmed that there was a good level of activities in the clinic.

Patients stated they had limited access to the clinic's psychology service. Patients were waiting on psychological interventions following assessment by the Consultant Psychologist. Patients also complained of the inconsistent responses being provided to patients who were found smoking. Patients stated that some staff ignore smoking, whilst others were more "punitive" and restricted their access to the garden areas for 48 hours after a smoking incident. Patients confirmed that they had been offered help with nicotine replacement therapy.

Patients said:

"*The ward has really helped me."*
"I have no complaints at all."
"The staff are friendly and helpful….I haven't a bad word to say about them."
"I have really improved since I got here."
"I think the food is great."
"The nurses are very person centred."
"Staff always ask about my feelings and how it's going for me."
"I am not happy about the smoking ban….what's that about?"

The findings of this report will provide the service with the necessary information to enhance practice and service user experience.

4.1 Inspection Outcome

Total number of areas for improvement	16

Findings from the inspection were discussed with clinic staff, and trust senior management as part of the inspection process and can be found in the main body of the report.

Escalation action did not result from the findings of this inspection.

5.0 How we Inspect

Prior to inspection we reviewed a range of information relevant to the service. This included the following records:

- The operational policy and statement of purpose for the clinic.
- Incidents and accidents.
- Safeguarding vulnerable adults.
- Complaints.
- Health and safety assessments and associated action plans.
- Information in relation to governance, meetings, organisational management structure and lines of accountability.
- Details of staff supervision and appraisal records.
- Policies and procedures.

Inspectors received completed questionnaires from 21 patients, and one relative.

The following records were examined during the inspection:

- Care documentation in relation to 12 patients.
- Documentation in relation to the prescription and administration of medication.
- Staff duty rotas.
- Bamford specialist support group minutes.
- Mental Health Service Group Information Dashboard – June 2016.
- Audit of referrals, preadmission assessments and admissions to Shannon 2014, 2015 and 2016.
- Regional Forensic Sub Group minutes 2016.
- Operational team meeting minutes 2016.
- MDT records.
- Clinical room records.
- Mandatory training records.
- Records relating to the monitoring of incidents, accidents and serious adverse incidents.
- Records relating to adherence to statutory requirements of mental health legislation.
- Minutes of patient forum meetings.
- Minutes of staff meetings.
- Minutes of a number of different governance meetings and senior staff meetings.

During the inspection four focus groups were held with the following groups of staff:

- Band 5 and 6 nurses, healthcare assistants and the Consultant Psychologist.
- Senior managers including heads of service and lead nurses.
- Support Staff, medical secretaries and administrative staff.
- Medical staff including consultants and junior doctors.

We found that all staff who took part in these groups to be open and transparent and willing to discuss both the positives and challenges within their area of work.

The findings from the focus groups are included in Appendix 1.

During the inspection inspectors observed staff working practices and interactions with patients using a Quality of Interaction Schedule Tool (QUIS).

We reviewed the recommendations made from the last inspections of Ward 1, Ward 2 and Ward 3. An assessment of compliance in relation to previous recommendations was recorded as met/ partially met/ not met.

The preliminary findings of the inspection were discussed at feedback to the service managers and staff at the conclusion of the inspection.

6.0 The Inspection

6.1 Review of Areas for Improvement / Recommendations from the Most Recent Inspections.

The most recent inspections of the Shannon clinic were unannounced. An inspection had been completed on each ward as follows;

Ward 1 – 9 February 2016
Ward 2 – 30 June 2015
Ward 3 - 23 to 27 November 2015

The completed Quality Improvement Plan (QIP) for each inspection was returned from each ward and approved by the responsible inspector. The QIP's were validated by the inspectors during this inspection.

Any recommendations required to be restated have been included in the areas for improvement.

6.2 Review of Recommendations from the last inspections of Ward 1, Ward 2 and Ward 3.

The responsible person must ensure that following areas for improvement are addressed.

Areas for Improvement **Ward 1**		**Validation of Compliance**
Number 1 **Ref**: Standard	Patient records are appropriately ordered and maintained.	**Not Met**

5.3.1(f) **Stated:** First Time	**Confirmed during the inspection**: There has been no improvement noted in this area. Findings in relation to this are included in this report. This finding requires to be restated for a second time.	
Number 2 **Ref**: Standard 5.3.3(d) **Stated:** First Time	Patients can access the support of a clinical psychologist in accordance to best practice standards. (Royal College of Psychiatrists 1st Edition CRTU 044 (2006).	**Not Met**
	Confirmed during the inspection: There has been no improvement noted in this area. Findings in relation to this are included in this report. This finding requires to be restated for a second time.	
Number 3 **Ref**: Standard 5.3.3(d) **Stated:** First Time	Patients can access 1:1 evidenced based psychological therapies in accordance with their assessed needs.	**Not Met**
	Confirmed during the inspection: There has been no improvement noted in this area. Findings in relation to this are included in this report. This finding requires to be restated for a second time.	
Number 4 **Ref**: Standard 5.3.3(d) **Stated:** First Time	Patients can access group therapies in accordance with their assessed needs.	**Partially Met**
	Action taken as confirmed during the inspection: Some improvement has been made in relation to recovery focused care plans. Please see main findings in this report. This finding requires to be restated for a second time.	

Areas for Improvement **Ward 2**		Validation of Compliance
	There was no Quality Improvement Plan for Ward 2 as a result of the previous inspection.	**Not applicable**

Areas for Improvement **Ward 3**		Validation of Compliance
Number 1 **Ref**: Standard 6.3.1 (a) **Stated:** First Time	Concerns raised by patients and staff in relation to the length of time it took to access community leave.	**Met**
	Confirmed during the inspection: None of the patients or staff who were interviewed during the inspection raised any concerns about accessing community leave. However, due to staff shortages and the changes in the needs of patients in Ward 3, community leave was rescheduled on some occasions. The inspectors noted that as a result of committed staff and careful scheduling / rescheduling of the duty rota that patients leave was not cancelled. Six out of nine patients on Ward 3, during the inspection, required escorted leave. On review of the staff duty rota there were days when there were only two staff on duty. An area for improvement has been made in relation to this.	
Number 2 **Ref**: Standard 5.3.1 (a) **Stated:** First Time	Patient goals for recovery were not clearly recorded in three out of four nursing care plans or in the four multidisciplinary care plans reviewed.	**Partially Met**
	Confirmed during the inspection: Some improvement has been made in relation to recovery focused care plans. Please see main findings in this report. This finding requires to be restated for a second time.	

Number 3 **Ref**: Standard 5.3.1 (a) **Stated:** First Time	There was an inconsistent approach to MDT meetings.	**Not Met**
	Confirmed during the inspection: There has been no improvement noted in this area. Findings in relation to this are included in the findings in this report. This finding requires to be restated for a second time	
Number 4 **Ref**: Standard 5.3.1 (a) **Stated:** First Time	Care documentation was confusing. There was a multidisciplinary care plan and a nursing care plan for each patient. The multidisciplinary care plan was not comprehensive and not up to date.	**Not Met**
	Confirmed during the inspection: There has been no improvement with this finding. Findings in relation to this area are included in this report. This finding requires to be restated for a second time.	
Number 5 **Ref**: Standard 5.3.1 (a) **Stated:** First Time	Patients had limited access to clinical psychology services. The clinical psychologist was available 2.5 days per week.	**Not Met**
	Confirmed during the inspection: There has been no improvement noted with this finding. Findings in relation to this area are included in the report. This finding requires to be restated for a second time.	

7.0 Review of Findings

Findings are presented as reflected across all three wards within the clinic. Findings specific to a particular ward are discussed in the context of that ward.

7.1 Is Care Safe?

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

Areas of Good Practice

Patients were actively involved in designing and managing their risk assessments.

Risk assessments were individualised and based on the assessed needs of each patient.

Each patient had a comprehensive risk assessment completed by the MDT and when necessary a general risk assessment form as required by management of Health and Safety Regulations 2000.

The environmental health and safety assessment was up to date.

All staff interviewed and observed during the inspection demonstrated a high level of skill and knowledge regarding their role and understanding of the needs of each patient.

Staff who met with inspectors reflected positively about their experience of the training that they had received.

All staff who spoke with the inspectors stated they knew who to raise concerns with in relation to patient safety.

There were no concerns in relation to the management of detention processes, patients' rights, capacity to consent and complaints.

There were clear protocols in place in relation to all occupational therapy activities attended by patients. The occupational therapists (OTs) were noted to take a positive approach to risk management in order to maximise the opportunities for meaningful activity.

Systems were in place to manage the ordering of medicines to ensure adequate supplies were available and to prevent wastage.

Patients who had been diagnosed with diabetes were well supported on the ward.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. Medicine refrigerators were checked at regular intervals and the temperature was maintained within the recommended range.

There was good support provided to patients prior to their transfer to the community in helping them access medical services.

Areas for Improvement

1. Environmental risk assessments

The Belfast Trust Mental Health Register did not relate directly to the Shannon clinic. Specific risks relating to the Shannon clinic were not reflected.

The Belfast Risk Audit and Assessment Tool (BRAAT) was up to date. However, the documentation was not completed in full; ratings were "scored out" or incomplete and the evidence was not consistently recorded.

The fire risk assessment was up to date but not completed in full. The "date action" section was incomplete.

The ligature risk assessment was up to date. The risks identified were recorded as managed locally on each of the wards. However the action plan detailed a number of environmental changes required. It was unclear when these changes would be actioned.

2. Patient Promoting Quality Care risk assessments/ associated risk assessments

Patient care documentation was stored in three separate locations and accessing this information was complex and confusing. The electronic patient record system (PARIS) was not user friendly.

Patients' risk assessments were not reviewed in accordance with "Promoting Quality Care; Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services; May 2010" (PQC).

Risk assessments when updated included a record of events but no comment on whether the risks were increasing or decreasing. There was no record of a change in two patients' risk management intervention plans since their admission several years previously.

There was no evidence in patients' PQC documentation of who had overall responsibility for the implementation of the risk management plans.

A separate review of risk for each patient was held every three months. This was referred to as a PQC review. However, this did not review the PQC comprehensive risk assessment or management plan. Subsequently there were two separate processes in place to manage each patient's individual risk.

Nursing, social work and occupational therapy all submitted separate reports for the three monthly PQC review but these were not used to update the risk assessment and management

plan, so that a “live” comprehensive risk assessment was in place. There was no specific input from medical staff in this process.

Assessments indicated that other risk assessments were required such as HCR-20, SARA etc., however there was no evidence to support that these had been completed.

Staff stated they often had to retype the comprehensive risk assessment if a patient was transferred from another trust. In some instances staff had recorded “refer to previous assessment”. As stated earlier the risk assessment was therefore not a “live” document in keeping with the PQC guidance.

Number of areas for improvement	2

7.2 Is Care Effective?

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

Areas of Good Practice

Overall there was evidence that patients were involved in decisions in relation to their care and treatment plans.

Patients’ needs were comprehensively assessed.

Nursing staff assessed each patient on a daily basis and documented this in the progress notes.

Nursing staff completed a progress report every week, in preparation for the weekly MDT meeting. Nursing care plans were noted to be holistic, person centred, easily understood by patients, goal focused, measurable and reviewed and updated.

The wards were comfortable, clean and tidy.

Restrictive practices were used as a last resort and were proportionate and necessary to the risks identified. Other than smoking free policy adherence there were no issues in relation to restrictive practices.

Patients had access to a range of meaningful activities that were specific to their individual needs and were person centred.

Appropriate and recognised individual assessments were completed with all new patients.

Occupational therapy focussed treatment options were planned and delivered in line with: current evidence based guidance, defined care pathways, best practice standards and legislative requirements.

Person-centred goals were drawn up collaboratively with each patient and the OT.

Occupational therapy goals are rehabilitation and recovery based and discharge planning is evident from early assessment.

Staff maintain a daily audit on the prescription and administration of clozapine.

A record of the registered nurses who have a specific responsibility for the medicine keys each day was maintained.

The use of rapid tranquilisation was discussed with one nurse who advised that this was discussed with the patient to ensure that they know how and when it may be used. The treatment is also based, where possible, on the patients preference as to the medicine used in the process.

Areas for Improvement

3. Care documentation

With the exception of nursing, care records were often not signed by the MDT.

A record of who attended a patient's multidisciplinary meetings was not always completed.

4. Medical reviews

There was variability in the regularity of medical reviews.

Consultant psychiatrists did not always document when they had reviewed a patient in either the case note section on PARIS or in the paper records.

In some cases there was no evidence that patients were reviewed regularly by the medical team.

There were very few records of a mental state review for a patient who was nearing the end of a course of Electro Convulsive Treatment (ECT). This would not be in keeping with ECT Accreditation Service, Standards for the administration of ECT, April 2016, Section 7.

5. Psychology Service

There was one 0.5 whole time equivalent (wte) Consultant Psychologist for the clinic.

The limited psychology service did not meet the identified psychological needs of the patients.

There was limited access to psychological assessment (e.g. neuropsychology/cognitive). There was no criminogenic needs/ assessment or interventions and no therapeutic work in relation to index offences/recidivism. There were limited evidence based practice interventions in relation to sexual assault work, drug and alcohol misuse and trauma.

There was a lack of capacity to train and supervise staff.

6. Multidisciplinary assessments and care plans

Multidisciplinary care plans were not goal specific, reviewed or updated to reflect patient progress and current presentation.

Multidisciplinary assessments and care plans were not reviewed consistently. Goals and interventions remained the same from admission.

Number of areas for improvement	4

7.3 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.

Areas of Good Practice

Patients stated they were treated with dignity and respect, and that staff were considerate and responded compassionately when help was needed.

All staff observations / patient interactions were noted to be positive.

Staff sought consent before supporting patients with care and treatment.

Restrictive practices were explained to patients.

Overall patients were complimentary and were satisfied with their care and treatment.

There was evidence of a collaborative approach between patients and staff to the assessment process and goal planning.

There was a comprehensive patient information / welcome booklet.

Activity information was provided in an accessible manner wen required.

Appropriate arrangements were in place to facilitate patients responsible for self-administration of medicines. This wasa phased process with patients moving from supervised administration to holding up to a two week supply of their medication. There were systems in place to monitor this process.

The administration of medicines was completed in a caring manner. Patients were given time to take their medicine and medicines were administered individually either at the hatch in the clinical room (Ward 1) or in the clinical room (Ward 2 and Ward 3) as discreetly as possible. The nurses were observed talking to patients about their medicines and patients' questions were answered in a language which was easily understood.

Smoking cessation interventions were available for use by patients. A choice of different products were available.

Areas for Improvement

7. Management of the Smoke Free policy and procedure

Staff and patients were concerned about the smoke free policy and the implications for patients if they breach the policy. The implications seemed restrictive and could potentially impact on the rights of patients.

An inconsistent approach across the clinic was evident in applying the Smoke Free policy and procedure.

Number of areas for improvement	1

7.4 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

Areas of Good Practice

Staff working on the ward understood their roles and responsibilities in relation to concerns.

There were systems in place to collect and analyse patient and carer views. Patient forum meetings were offered every week and the advocate took a lead in the “have your say” meetings every month. Patients could attend the food users group, which is a group that met to review menus and meal choices. There were community meetings for patients and staff every morning.

Nursing staff in all three wards felt the nursing management within the ward was effective and supportive.

All staff had received up to date supervision and appraisals.

Complaints and compliments had been managed in accordance with trust policy and procedure.

The ward managers shared information from governance meetings to ward based staff at the team meetings.

All staff confirmed good working relationships between the MDT members.

Staff knew the organisational and management structure and the lines of accountability.

All OTs used a regionally agreed, standardised model for occupational therapy which covers: initial interview, assessment, intervention and outcomes. The Model of Human Occupation (MOHO) and the range of MOHO assessments were used appropriately.

Robust systems were in place for the management of medicines.

Staff stated that a pharmacist would check the controlled drugs every few months but there was no other clinical pharmacy input into the wards.

The clinic received a review from the Forensic Quality Network for Forensic Mental Health Services (in February 2016). The clinic met 93% of medium secure standards and 100% of criteria in five areas including Relational Security, Safeguarding, Patient Focus, Family and Friends and Environment and Facilities.

Areas for Improvement

8. Clinical management

There were six consultants providing support to patients admitted to the clinic. However there was no clinical management lead. There were different practices among the medical team in relation to attendance at ward rounds. In addition to this there was: an inconsistent approach to MDT meetings; differences in the regularity of seeing patients, a lack of proper recording and evidence of a lack of timely completion of risk assessments and subsequent updates. This was a serious concern for the inspection team.

9. Function of the clinic

There has been no review of the function of the clinic and agreed staffing compliment since the clinic opened in 2006. There has been no work force analysis to ensure that agreed staffing levels are sufficient to maintain the current service delivery.

The needs of patients particularly in Ward 3 have changed, i.e. six patients who were now admitted to Ward 3 required escorted grounds / community leave. The level of escort varied with some patients requiring two staff. The staffing compliment had not changed to meet this demand.

The transfer of patients from Ward 1 to Ward 2 or Ward 3 was affected by a number of challenges. This included the delayed discharge and reintegration of patients from Ward 3 back to the community and the difficulties with the management of the mixed gender population within Ward 2. Due to these factors it was not always possible to transfer a patient to another ward as required and within a specified time frame.

A business case to develop a de-escalation suite and separate accommodation for female patients was completed and submitted, however there was no agreement on progressing any of the options suggested in the proposal.

10. Multidisciplinary team

The MDT for the clinic has been agreed; however there were vacancies in psychology and social work services.

11. Staffing levels

There were significant staff shortages in Ward 2 and Ward 3 which were not always covered. 25% of the staff on Ward 3 were off on sick leave.

There were days where there were only two staff on duty in Ward 3; one qualified member of staff and one health care assistant, adding to the staffing pressures (see above for implications for escorted leave). This was a concern for the inspection team.

Staff in Ward 3 were committed and ensured patients accessed their activities and leave requirements. As a result staff worked additional hours. There was evidence that the staff duty rota on Ward 3 was rearranged on a daily basis to meet the needs of the patients. This also added to the work load of nursing staff, who were required to reschedule this rota continually.

Staffing shortages in Ward 2 and Ward 3 also impacted on releasing staff for mandatory training and in the frequency of staff meetings.

12. Mandatory Training

There were a number of staff who had not received up to date mandatory training in Ward 2 and Ward 3 in the following training. .

Immediate Life Support.
Fire Safety.
Infection Prevention.
Manual Handling.
Workplace safety.
Promoting Quality Care.
Medical devices.

13. Staff support

The reflective practice sessions were mainly attended by nursing staff with limited involvement of the wider multidisciplinary team.

14. Incidents and accidents

There were no formal meetings to discuss/evaluate/disseminate learning from incidents.

There was no evidence that learning was shared with staff working at ward level.

Staff were not always updated on the outcomes of incidents or concerns.

15. Policies and procedures

Seven policies and procedures required to be reviewed these included:

- Fire Safety and Procedural Arrangements.
- Manual Handling Policy and Procedural Arrangements.
- Policy and Procedure for Crash Call.
- Roles and Responsibilities of Staff in Relation to Environmental Cleanliness and Cleanliness of Equipment.
- Environmental Cleanliness policy and escalation policy.
- BHSCT Occupational Therapy Supervision protocol.
- Rapid tranquilisation guidelines for the immediate pharmacological management of violent and aggressive behaviours in adult sand adolescent patients in the Belfast trust.

16. Pharmacy input

There was no ward pharmacist to facilitate effective integrated medicines management. A nurse advised that a clinical input would be useful to ensure that all medicines were appropriately prescribed and that the risk of polypharmacy was minimised. The Head of Pharmacy and Medicines Management at BHSCT advised that it was not possible to provide a clinical service to the wards solely due to the limited resources available.

Number of areas for improvement	9

8.0 Provider Compliance Plan

Areas for improvement identified during this inspection are detailed in the provider compliance plan. Details of the provider compliance plan was discussed at feedback, as part of the inspection process. The timescales commence from the date of inspection. The responsible person should note that failure to comply with the findings of this inspection may lead to further /escalation action being taken. It is the responsibility of the responsible person to ensure that all areas identified for improvement within the provider compliance plan are addressed within the specified timescales.

8.1 Areas for Improvement

This section outlines recommended actions, to address the areas for improvement identified. These are based on The Quality Care Standards for Health and Social Care (DHSSPSNI) March 2006, the Mental Health (Northern Ireland) Order 1986 and relevant evidenced based practice.

8.2 Actions to be taken by the Service

The provider compliance plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed provider compliance plan by 23 December 2016.

Provider Compliance Plan Shannon clinic	
The responsible person must address the following findings for improvement.	
Area for Improvement No. 1 **Stated:** First time **Ref:** Standard 5.3.1 (e) **To be completed by:** 1 June 2017	Environmental risk assessments.
	Response by responsible person detailing the actions taken: Mental Health Services Risk Register is reviewed on a quarterly basis by the Senior Management Team. It is the responsibility of the Operations Manager, Shannon Clinic to escalate the need for inclusion of any risk pertaining to Shannon Clinic on the aforementioned risk register to the Service Manager, Acute Mental Health Services for consideration. BRAAT for each ward will be reviewed and updated as necessary. Fire risk assessments for each ward have been reviewed and updated. A capital bid will be placed for completion of work to address issues highlighted on the Unit's ligature risk assessment.
Area for Improvement No. 2 **Stated:** First time **Ref:** Standard 5.3.1 (a) **To be completed by:** 1 June 2017	Patient Promoting Quality Care risk assessments/ associated risk assessments.
	Response by responsible person detailing the actions taken: Each patient has a Comprehensive Risk Assessment on admission. A working group is being convened to review the Trust's procedure in relation to the PQC guidance to ensure compliance. The group will be Co-Chaired by the Clinical Lead for Shannon and the Operations Manager and membership will include the leads for Psychology, Social Work, Occupational Therapy, Nursing and the Patient Advocate. Membership will be extended to the regional Community Forensic Team Leads. The Co-Chairs will report on progress at the monthly Operational Team Meeting with final report and recommendations by 31st May 2017.
Area for Improvement No. 3 **Stated:** Second time **Ref**: Standard 5.3.1 (a)	Care documentation.
	Response by responsible person detailing the actions taken: An audit of care documentation will be undertaken in conjunction with the Trust's Information Governance Team on the 14th February 2017 and the resulting action plan taken forward by the Information

To be completed by: 1 June 2017	Governance Group within Shannon Clinic. Audit records and outcomes will be forwarded to RQIA as requested by Mid March 2017.

Area for Improvement No. 4 **Stated:** First time **Ref**: Standard 5.3.1 (a) **To be completed by:** 1 June 2017	Medical reviews.
	Response by responsible person detailing the actions taken: Patients are seen weekly by medical staff in adherence to Quality Network for Forensic Unit standards. The Service Manager and Associate Medical Director will write to Medical Staff in Shannon to remind them of the requirement to record patient reviews in the patient's records. The Trust will also address the recording and variability of the reviews to include variability in the MDT meetings through a review which will be led by the Clinical Lead and will be concluded with appropriate actions implemented by June 1st 2017 The Trust accepts that mental state review should be carried out on patients nearing the end of a course of ECT and will implement the ECTAS standards in Shannon. This process has now commenced. The service will carry out an audit of compliance with the standards yearly (If ECT Treatment has occurred in the year)
Area for Improvement No. 5 **Stated:** Second time **Ref**: Standard 6.3.1 (f) **To be completed by:** 1 June 2017	Psychology Service.
	Response by responsible person detailing the actions taken: A Band 8b Clinical Psychologist providing 0.8 WTE to Shannon Clinic has recently been appointed for Shannon Clinic subject to references. However, the Trust acknowledges that this still does not meet required Psychology levels within a medium secure unit setting which is 1.0 WTE Psychologist to 12 patients. The Head of Psychology Services for the Trust is currently preparing a new business case to be submitted to the Health and Social Care Board for consideration in relation to additional Psychology in order to meet these standards.
Area for Improvement No. 6 **Stated:** Second time **Ref**: Standard 5.3.1 (a) **To be completed by:** 1 June 2017	Multidisciplinary assessments and care plans.
	Response by responsible person detailing the actions taken: An audit of care documentation will be undertaken in conjunction with the Trust's Information Governance Team at the end of January 2017 and the resulting action plan taken forward by the Information Governance Group within Shannon Clinic. Audit records and outcomes will be forwarded to RQIA as requested by Mid March 2017
Area for Improvement No. 7 **Stated:** First time **Ref**: Standard 5.3.1 (f) **To be completed by:** 1 June 2017	The management of the Smoke Free policy and procedure.
	Response by responsible individual detailing the actions taken: Shannon Clinic staff take a consistent approach to the implementation of the smoke free policy however the difficulties and associated risks of implementing the above within mental health wards has been raised by the Service Manager, Acute Mental Health Services with the Chair of the Trust's Smoke Free Steering Group. This has also been added onto the Mental Health Risk Register. Staff have also been reminded to report all instances of unauthorised smoking on the DATIX system.

Area for Improvement No. 8 **Stated:** Second time **Ref:** Standard 8.3 **To be completed by:** 1 June 2017	Clinical management
	Response by responsible person detailing the actions taken:
	The Trust endeavours to ensure continuity of care for patients by having the local Trust Community Forensic Consultant being the RMO. While this may lead to some inconsistency in practices these are not significant and the benefit of continuity of care outweigh the challenges of consistent MDT meetings. The recruitment process for a Clinical Lead for Shannon Clinic has commenced with an appointment expected in early 2017. As indicted in No. 4 The Trust will address the recording and variability of the reviews to include variability in the MDT meetings through a review which will be led by the Clinical Lead and will be concluded with appropriate actions implemented by June 1st 2017
Area for Improvement No. 9 **Stated:** First time **Ref:** Standard 4.3 **To be completed by:** 1 December 2017	Function of the clinic.
	Response by responsible person detailing the actions taken: The Trust does not believe a formal review of the "function" of Shannon Clinic is required. The Unit is a medium secure unit and benchmarks its performance with all other similar units in the UK and Ireland and compares favourably with its peers. A workforce review will commence at the beginning of 2017. A capital bid has been placed in relation to Shannon Clinic's de-escalation suite and female only accommodation and will be taken forward to the next Trust Capital Bid Meeting. The Service Manager will chair a multidisciplinary work force review which will include a review of the patient profile and patient pathway within the facility. The review will consider best practice guidance for medium secure units. The Chair will report back with findings and recommendations by November 30th 2017.
Area for Improvement No. 10 **Stated:** First time **Ref:** Standard 6.3.1 (f) **To be completed by:** 1 June 2017	Multidisciplinary team
	Response by responsible person detailing the actions taken: A Band 8b Clinical Psychologist providing 0.8 WTE to Shannon Clinic has recently been appointed for Shannon Clinic subject to references. However, the Trust acknowledges that this still does not meet required Psychology levels within a medium secure unit setting which is 1.0 WTE Psychologist to 12 patients. The Head of Psychology Services for the Trust is currently preparing a new business case to be submitted to the Health and Social Care Board for consideration in relation to additional Psychology in order to meet these standards. A Social Worker has recently been appointed for Shannon Clinic and it is hoped that they will commence post in the New Year.
Area for Improvement	Staffing levels

No. 11 **Stated:** First time **Ref:** Standard 4.3 **To be completed by:** 1 June 2017	**Response by responsible person detailing the actions taken:** Additional Nursing Staff have been recruited to Wards 2 and 3 and the recruitment process is ongoing. The Service Manager will chair a multidisciplinary workforce review which will include a review of the patient profile and patient pathway within the facility. The review will consider best practice guidance for medium secure units . The Chair will report back with findings and recommendations by November 30th 2017 and a copy of the report will be forwarded to RQIA

Area for Improvement No. 12 **Stated:** First time **Ref:** Standard 4.3 **To be completed by:** 1 June 2017	Mandatory training
	Response by responsible person detailing the actions taken: Additional Nursing Staff have been recruited since the inspection and Ward Managers will prioritise outstanding mandatory training for staff to ensure staff have met the requirements by end of March 2017.

Area for Improvement No. 13 **Stated:** First time **Ref:** Standard 4.3 **To be completed by:** 1 June 2017	Staff support
	Response by responsible person detailing the actions taken: Reflective practice sessions take place regularly within Shannon Clinic to which all disciplines are invited. However, it should be noted that these sessions are not compulsory. Practitioners are also given the opportunity to reflect on their practice during supervision sessions and in any post incident review.
Area for Improvement No. 14 **Stated:** First time **Ref:** Standard 5.3.2 **To be completed by:** 1 June 2017	Incidents and accidents
	Response by responsible person detailing the actions taken: Incidents are discussed at the weekly Bed Management meeting. All incidents are currently reviewed by Band 7s within Shannon Clinic. It is expected that they take any learning arising from the incident and discuss with staff both during staff meetings and supervision. Shared Learning Boards are now in situ in each ward where Trust learning letters are displayed. A risk governance forum for Shannon Clinic being led by a Consultant Psychiatrist is being convened; this will include the Operations Manager, Heads of Discipline and medical staff. This meeting will look to discuss/evaluate and disseminate learning from incidents at a local level. Band 6 nursing staff will receive training from the Trust's Risk Governance Department to enable them to scrutinise the DATIX system more closely to assist with the evaluation process.
Area for Improvement No. 15 **Stated:** First time **Ref:** Standard 4.3 **To be completed by:** 1 June 2017	Policies and procedures
	Response by responsible person detailing the actions taken: The manual handling policy and procedural arrangements is not due for review until November 2017 and remains within date. The Trust's Fire Safety Policy was approved by the Executive Team on 07 December 2016 and will be available for staff in the coming weeks. A working group is being convened to review the Trust's procedure in relation to the PQC guidance. The BHSCT Occupational Therapy Supervision Policy is currently being reviewed. The other policies and procedures mentioned are Trust policies and this issue has been highlighted by the Senior Manager for Service Improvement and Governance at the Trust's Standards and Guidelines Committee.
Area for Improvement No. 16 **Stated:** First time	Pharmacy input
	Response by responsible person detailing the actions taken: Shannon Clinic is currently provided with 5 hours of pharmacy input as per the budget. Additional input by pharmacy services will be

Ref: Standard 5.3.1 **To be completed by:** 1 June 2017	considered when undertaking the workforce analysis within Shannon Clinic.

Name of person completing the provider compliance plan	Mel Carney Noel McDonald Davy Martin		
Signature of person completing the provider compliance plan		**Date completed**	15/02/2017
Name of responsible person approving the provider compliance plan	Martin Dillon		
Signature of responsible person approving the provider compliance plan		**Date approved**	15/02/2017
Name of RQIA inspector assessing response	Wendy McGregor		
Signature of RQIA inspector assessing response		**Date approved**	23/02/2017

Appendix 1

Focus Groups Shannon Clinic

Key Findings Focus Groups

On days two and three of the inspection four focus groups were held with the following groups of staff:

- Band 5 and 6 nurses, healthcare assistants and the Consultant Psychologist.
- Senior managers including, heads of service and lead nurses.
- Support staff, medical secretaries and administrative staff.
- Medical staff including consultants and junior doctors.

We found that all staff who took part in these groups to be open and transparent and willing to discuss both positive and challenges within their area of work.

Senior Manager Focus Group

The group spoke about their current challenges which included bed availability, waiting lists and the flow of patients through the clinic. The lack of available facilities and placements for returning patients to their community was also discussed. The delayed of a patient's discharge made it difficult to access a bed in emergency situations. Challenges were also mentioned regarding voluntary patients who could not be discharged due to the lack of suitable placements. Senior managers stated that the lack of prison healthcare inpatient beds within the Northern Ireland Prison Service placed extra pressure on the Shannon wards.

The lack of a lead clinician for the group of six consultants was discussed. The new Clinical Director advised that they had recently been given this additional role and a meeting had been arranged with consultants and the service manager. The Director stated that their intention was to develop closer working relationships with the medical team.

The group was asked about Serious Adverse Incidents (SAI) and incident reporting. Whilst investigation and feedback from SAI's was shared, there was only data analysis of incidents for the mental health directorate as a whole and not specifically for Shannon clinic. This was an area that needs to be developed to ensure any learning from incident trends and patterns are identified and shared with staff on the wards. The group spoke about the need to progress the Mental Health services electronic information dashboard to report on key performance indicators.

The group raised concerns regarding the lack of a de-escalation seclusion suite and separate accommodation for female patients. Senior managers advised that the business case is almost complete but some costs in relation to revenue were causing delay.

Senior managers stated that the interface with the courts was difficult. The lack of an appropriate diversion scheme meant that some people were coming into custody and being sent straight to prison instead of going for assessment and treatment.

The group discussed the issues related to community treatment/hospital orders. Medical staff raised a problem in identifying the designated trust officer responsible to confirm the acceptance of patients to an available bed following a Hospital Order. Senior Managers advised that the Director of Mental Health has responsibility for this and it was delegated to the senior management team.

Senior staff have been invited to attend a workshop to explore the introduction of a Regional Forensic Managed Clinical Network. Staff stated that this would be a useful network for connecting the clinic with prisons and the wider criminal justice sector and standardising practice.

Senior managers spoke about the implementation of the no smoking policy and the practicalities and realities of trying to implement it. Inspectors stated that staff had told them that the smoking ban is impacting on their therapeutic relationship with patients as they were required to police the ban and enforce restrictions without sufficient guidance. Staff told inspectors that this can include withdrawal of freedom of movement.

Senior management advised that there was excellent support in place for staff looking to attend courses. Senior manager training was reported as being up to date with Leadership Model Training.

The group were asked about recent improvements or initiatives that had been introduced to improve the quality of care for patients and service delivery.

A new substance abuse treatment pilot programme is to commence. Screening is available but not all patients have been screened.

An audit has commenced to develop and measure outcomes for patients with a forensic history, a part time nurse has been appointed to take this work forward. There has been vocational training and courses to help integrate patients back into the community. This initiative had been shortlisted for an award in the Belfast Trust. Work by OTs in Shannon was described as effective. Staff stated that services stop when a patient is discharged as there was no community provision. A target for reduction in violence has been set by the trust and will be monitored by senior management.

The current difficulties and risks regarding the recording of patient care on three systems was discussed with managers. The new electronic patient recording information system (PARIS) was also discussed. Senior managers advised that the new system had “teething problems” but this area was being reviewed as a wider trust issue.

Nursing Focus Group

The group spoke about their concerns regarding staffing levels in both nursing and psychology. Concerns were also raised as to how the function of the wards had changed and the consequences of the lack of psychology input.

Staff spoke about the difficulties caused by the lack of a lead medic. They stated that this caused inconsistent decisions and delays in discharge. They discussed the OT's role and nursing staff stated it would be easier if an OT was attached to a ward rather than a consultant.

Staff stated that Ward 1 staffing levels were generally satisfactory. At times when wards were unsettled, it was difficult to get staff to take on extra shifts, which resulted in staff from remaining two wards having to help out. Staff stated that a significant number of staff had left and had not yet been replaced. This had led to difficulties in Ward 3 where there were more patients requiring to be escorted.

The staff from Ward 3 spoke about their difficulties with moving patients out into the community. They stated there were various reasons for this. These include the lack of appropriate placements, limited networking with prison healthcare and the need for a better diversion service.

Ward 2 staff spoke about their concerns and difficulties in having a mixed gender ward. They stated that they believe this had caused some patients admitted from Ward 1 to deteriorate. The lack of staff had led to gym time being cancelled and that this could impact on behavioural problems.

Problems were discussed by staff about working in a secure environment and dangers compared to other wards. Staff stated the patient group and associated aggressive incidents produced challenges. Unplanned interventions were difficult and unpredictable and there was a need for a de-escalation suite. They also stated that feedback and shared learning from incidents could be improved.

Staff voiced their frustration about the introduction by the trust of a non-smoking policy for this patient group. They stated that it was causing arguments and a breakdown in relationships between staff and patients. Staff stated that other wards on site were not strictly enforcing it and patients were aware of this.

Staff stated that mandatory training was up to date including MAPA and life support. Staff advised that management were good at allowing and encouraging them to attend external training and all staff stated they had good support from their managers.

Staff stated they had no concerns about their ability to deliver care for the patients as all staff worked well together and helped each other when needed. They stated that the reflective practice group was very good and appreciated by the nursing staff.

However nurses stated that they are the only ones who use this group even though it was available to the wider multidisciplinary team.

Staff stated that team work has improved and nursing staff considered that there had been a softer culture developed from a therapeutic viewpoint. Staff felt they also had become better at de-escalating situations.

Staff spoke about what they thought could improve care. They stated that they would like to see more movement in the introduction of the regional personality disorder strategy. A second form of transport would be useful as there currently is only one people carrier between the three wards. Other improvements suggested were a bigger gym and a store for bicycles used by patients

Staff spoke about the difficulties caused by the lack of a medical lead. They stated that this caused decision making begin inconsistent and delays in discharge.

Support Services Group

Staff told us that a number of full time administrative staff have left over the last year and not replaced. They did say that staffing levels had improved recently. However, the new staff employed were agency staff rather than permanent. These vacancies were not being filled with permanent staff and the agency staff are constantly changing leading to difficulties with training. Staff stated that agency staff have not been given the corporate induction even though they have been in the agency position for some time. The staff all stated that they felt part of the team and clinic but were not always consulted or involved with change apart from issues that directly relate to them.

The PARIS system has been updated and was described as ‘not user friendly’. Staff stated it could be simpler. Medical secretaries spoke about the difficulties to provide cover for each other as each consultant works differently.

Continuing staff training had been difficult due to vacant posts and the high turnover of agency staff. New staff are taken through a checklist specific to Shannon Clinic. Staff stated that fire training has recently been updated and a date agreed for breakaway skills. Previously they had attended training on records management, IT security and equality but no refresher training has been given. Staff advised that they had no issues gaining support from their line manager to attend external training course relevant to their roles.

Difficulties were raised about ensuring reception is covered as it can be complex in relation to security and alarms. Agency or new staff do not feel completely confident.

Staff informed RQIA that they would welcome more visible contact with their manager and that staff meeting should be started again to ensure that relevant information is passed on. However staff stated they felt supported and could discuss with their line manager when needed.

Staff stated that they have issues with lack of some essential equipment. Currently there is no colour printer and one old photocopier for the whole unit. When trust IT engineers are contacted the response is usually slow.

Medical staff focus group

Staff stated that the working environment was good for consultants. Patients have the same consultant from admission to discharge and stated that this model was best for continuity of care and was particularly effective in reducing the length of stay. Staff acknowledged that working with six different consultants does present some difficulties for nurses. They were open to exploring possible solutions.

Staff stated there were challenges recruiting multidisciplinary staff to the unit. In relation to junior doctors, there were more training places available than were taken up. They had raised this with the Northern Ireland Medical and Dental Training Agency (NIMDTA). Junior doctors reported that the unit provided a high quality training environment.

Staff stated there was a weekly meeting of all senior clinical staff in the unit. Although it is a business/bed management meeting, all incident reports were discussed and acted upon where necessary. However, staff felt that there was a general disconnect between the unit staff and higher levels of clinical governance staff within the trust.

Staff stated the monthly senior staff team meeting was useful. However, it was noted that there was no mechanism regarding consultant leadership within the unit, particularly if a consensus could not be achieved. Staff stated meetings had not been held regularly with their previous clinical director. Medical staff were in the process of setting up regular meetings with the new interim Clinical Director. Consultant cover for the clinic was described as ad-hoc. Consultants seemed to be very flexible in covering each other. Written handover, debrief and plans were in place for longer absences. Consultants were always contactable if they were off site. There were no issues raised by nursing staff regarding access to consultants.

Staff stated that working networks across the trusts were good but very informal and a more structured plan was needed, but there was no lead to take this forward. They stated that this could be better facilitated by the trust. Staff stated that a regional forensic team or managed clinical network connecting the unit with prisons and the justice system would be of great benefit.

Staff stated there were a number of improvement initiatives. The clinic was the first secure ward in the UK to have an ATM. The main improvement initiative was the ongoing development of a new build which would provide a ward for female patients as well as de-escalation facilities. Funding has been awarded from the Guidelines and Audit Implementation Network (GAIN) to measure the outcome of the development of the de-escalation suite.

Staff confirmed that annual reviews were undertaken whereby the unit was benchmarked against other similar secure units in the UK. Their comparisons were favourable, with improvements in standards showing year on year.

Staff were complimentary about the role of the OTs who had introduced a number of quality improvement initiatives to the clinic.

Staff stated that the network could be improved between the trust and Prison Healthcare. Patient flow back into prisons was not as good as it could be. A closer relationship between prison consultants and the consultants in the clinic was seen as a priority issue. They stated it was important to note that the clinic was just one part of the forensic service.

There was discussion about the lack of a court diversion scheme compared to the rest of the UK. Medical staff stated that the care and treatment needs of patients were not being identified at an early enough stage.

Staff agreed that there was a pressing need for more forensic psychology input both into the clinic and regionally.

Medical staff, similar to nursing staff, also raised concerns about no officer being designated to represent the trust in court if a judge wants to make a Hospital Order. There was no formal trust representative to confirm the acceptance of the patient into a free bed. Medical staff also raised other issues such as the slow progress of developing the de-escalation building. The lack of specialised training courses in Northern Ireland regarding violence risk assessments. Concerns were also expressed regarding some patients being transferred from the Shannon clinic to Clare ward as Clare Ward's function seemed to be unclear.

Key points requiring review and action by the BHSCT

The trust should review the issues relating to bed availability, waiting lists, patient flow through the clinic, community placements and access to a bed in emergency situations

There should be greater liaison with Prison Healthcare to review and discuss solutions to ease the extra pressure on Shannon wards

The clinical director and the service manager should work with consultants to address the disconnect between the unit and higher levels of clinical governance within the trust and issues with variations in approach and clinical leadership within the clinic.

The trust should introduce a system that ensures learning from incident trends and patterns are identified and shared with staff.

Continued work is required to identify key performance indicators for the clinic to assist in the development of a Mental Health dashboard.

The business case for a de-escalation seclusion suite and separate accommodation for female patients should be prioritised.

The trust should liaise with the wider criminal justice sector to identify the most appropriate model to support all-stages diversion of vulnerable individuals coming into contact with the Criminal Justice System.

Strong consideration and support should be provided to progress the introduction of a Regional Forensic Managed Clinical Network to improve the informal working network between trusts.

The trust should review the clinic policy to ensure that set restrictions do not compromise freedom of movement and also consider the potential impact on the human rights of the patients.

Management should review the potential risks regarding the recording of patient documentation in three separate locations and the learning from the early implementation of PARIS.

The trust should undertake a work force analysis to ensure that agreed staffing levels are sufficient to maintain the current service delivery.

Management within the clinic should encourage involvement of the multidisciplinary team in the reflective practice group.

The trust should progress the recommendations set out in the Regional Personality Disorder Strategy.

Management within the clinic should review the provision of transport and storage of equipment.

OT staff, nurses and management within the clinic should meet to discuss the adequacy of provision of ward based OT services.

Management should provide more visible contact with administrative and secretarial staff, introduce staff meetings and discuss training requirements.

The trust should ensure that equipment needed to ensure effective service delivery is provided.

The trust should work with NIMDTA to improve the uptake of training places for junior doctors.

Management should work with consultant psychiatrists to ensure the ad-hoc arrangements in place provide sufficient cover.

The trust should discuss the need for specialised training courses with relevant staff regarding violence risk assessments.

The function of Clare Ward should be more clearly defined.

Wendy McGregor
14 November 2016

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews