The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Shannon Clinic Ward 2

Knockbracken Healthcare Park

Belfast Health and Social Care Trust

11 & 12 November 2014

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1.0 General Information

Ward Name	Shannon Clinic Ward 2
Trust	Belfast Health and Social Care Trust
Hospital Address	Knockbracken Healthcare Park Saintfield Road Belfast BT8 8BH
Ward Telephone number	028 9504 2037/38
Ward Manager	Damien Murdock
Email address	damian.murdock@belfasttrust.hscni.net
Person in charge on day of inspection	Damien Murdock
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 2 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 2 provides inpatient care and treatment to male and female patients over the age of 18 years with forensic mental health problems, who require intensive psychiatric treatment or rehabilitation in a secure therapeutic environment. Male patients are transferred from Shannon 1 following a period of assessment. Female patients are admitted directly to Shannon 2 and remain there until discharge.

On the days of the inspection there were seven male and five female patients on the ward.

All patients in Shannon 2 were detained in accordance with the Mental Health (Northern Ireland) Order 1986. Seven patients were detained in accordance with Part Three of the Mental Health (Northern Ireland) Order 1988, three patients were detained in accordance with Part Two of the Mental Health

(Northern Ireland) Order 1986 and two patients were detained under Part two and Part three of the Mental Health (Northern Ireland) Order 1986.

Female patients are referred to Shannon 2 from various sources including, court, prison and community. Referrals are 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 were strict protocols for entering and leaving the ward and clinic. The patients on the ward were 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 Shannon clinic two times per week and a Health and Wellbeing nurse once every two weeks. 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. The ward provides a placement for student nurses.

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

Shannon 2 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. Female and male sleeping areas were segregated. Bedrooms 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. Females had access to a female only sitting room.

The patients had access to enclosed garden areas with shelters and seating to facilitate smokers. A lighter was available in the garden. Male and female smoking areas were segregated. The exit door to the garden was open. There was also a hen coop, and patients were responsible for the care of the hens. Within each ward there were storage areas, additional toilet facilities, bathrooms, a 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 Ward 2 was undertaken on 11 and 12 November 2014.

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

The recommendations made following the last announced inspection on 10 & 11 March 2014 were evaluated. The inspector was pleased to note that all of the eighteen recommendations had been fully met and compliance had been achieved in the following areas:

- All staff working on the ward had received up to date training in Safeguarding Vulnerable Adults
- The trust had developed and implemented a formal system to; identify the number of referrals and alert the designated officer to multiple referrals in relation to victims or perpetrators and this was included in the trust safeguarding vulnerable adult procedures.
- All care documentation is transferred with patients when moved from Shannon 1.
- The integrated care pathways were consistently completed by all relevant members of the multi-disciplinary team.
- A paper copy of each patients Absence without Leave form was available in the patients care documentation and available if required.
- All staff working on the ward were adequately trained and competent in following the policy and procedure in relation to the timely completion of vulnerable adult referrals
- All staff on the ward had received supervision as per trust policy.
- Up to date records in relation to staff fire safety training were available on the ward.
- All staff on the ward had received up to date training in child protection.
- All patients are informed daily of their allocated member of staff for their 1:1 time.
- A record of local complaints, the action taken and the outcomes was maintained on the ward as per trust policy.
- The patient advocate ensured that the patients were aware of and understood the purpose of patient advocacy and the advocate made themselves available and met with patients on the ward on a weekly basis.
- All members of the multi-disciplinary team had consistently documented their interventions into the appropriate multi-disciplinary care documentation.
- The practice of retaining paper copies of patients care documentation held on the ward was reviewed and the contents were consistent, accessible, up to date and relevant and in line with BHSCT records management policy and procedure

- The ward manager ensured that all staff on duty were present in communal patient areas and were available to meet with and support patients on the ward.
- The trust had reviewed the length of time of three months between menu ordering and food delivery. This review considered the specific requests addressed by the patient forum meetings and food users group.
- The trust had reviewed the patient daily milk allowance and ensured patients access to milk was not limited. This review considered the specific requests addressed by the patient forum meetings.
- The smoking area was within general hygiene standards.

4.2 Review of action plans/progress to address outcomes from the patient experience interview inspection

The recommendations made following the patient experience interview inspection on 28 May 2014 were evaluated. The inspector was pleased to note that all two recommendations had been fully met and compliance had been achieved in the following areas:

- All patients' personal items and clothing were marked in to ward admission documentation in accordance with Trust policy.
- The environment where clothing and personal items for patients who have restricted access are stored was reviewed.

4.3 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 that the recommendation had been fully met and compliance had been achieved in the following area:

- A record of staff who accessed the key to the Bisley drawer, and the reason for this access, was maintained.

4.4 Review of implementation of any recommendations made following the investigation of a Serious Adverse Incident

A serious adverse incident had occurred on this ward on 9 October 2011. Relevant recommendations made by the review team who investigated the incident were evaluated during this inspection. It was good to note that compliance had been achieved in relation to:

- The Belfast Health & Social care trust Mental Health Services AWOL Policy had been reviewed and included action to be taken by the escorting nurse when a patient absconds from them.

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 of the recommendations made from the previous announced, patient experience, finance inspections and the recommendation made following a serious adverse incident had been fully met.

The inspector was pleased see the high level of therapeutic and recreational activities available for the patients and it was good to note that new female orientated activities were now available.

It was good to note the good multi-disciplinary team work on the ward with good communication mechanisms in place and that the independent advocate had an integral role within the team. The inspector was pleased that the availability of the advocate had improved.

The inspector noted evidence of patient involvement in their care and treatment plans and also in decisions in relation to the ward environment, food, activities. Patients were also kept informed of what was happening on the ward on a day to day basis via the daily community meetings convened in the mornings.

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.

The Department of Health guidance and trust policy and procedure in relation to capacity and consent was available for staff. Patients' capacity to consent was assessed on admission. Staff working on the ward demonstrated their knowledge of capacity and consent and this was reflected in the patients care documentation. There was evidence of patient involvement and patients were given time and opportunity to discuss their care and treatment plans. Patients' capacity to manage their own financial affairs had been completed and signed by the consultant psychiatrist. Capacity was assessed both on a daily basis and weekly at the multi-disciplinary meeting. Patients are invited to attend their multi-disciplinary meeting.

Care plans included seeking consent using language such has "seek agreement from the patient" prior to care and treatment. The daily progress notes stated patients were involved and either agreed or disagreed to episodes of care and treatment. Where appropriate there was evidence of relative involvement in decisions in relation to the patient consent.

The inspector noted patients had an individualised and holistic assessment completed and care and treatment plans were person centred and addressed all the assessed needs of each patient. There was evidence of patient and family (where appropriate) involvement. Care plans were signed by the patient. Care and treatment plans were discussed and reviewed at the patients weekly multi-disciplinary meetings with patient involvement and updated when required.

Each patient had a person centred risk assessment and associated risk management plan completed and reviewed in accordance with Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services DHSSPS (2010). Adverse incidents, incidents requiring the use of a restrictive practice and vulnerable adult concerns were recorded in the patients risk assessment. Patients' communication needs were noted to be assessed on admission.

Shannon Clinic receives input from three full time Occupational Therapists, and one full time Occupational Therapist 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. Patients had an individualised Occupational Therapy assessment appropriate to their needs completed. This detailed patient likes and dislikes and past, present, and future recreational activities. Each patient was involved in 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.

Patients were offered the following therapeutic and recreational activities; 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. Activities offered to patients included, current affairs, ward art, hen duty, football, rackets club, monthly film club, music group, walking group, lunch cookery. All activities were delivered by both the nursing and occupational therapy team. Some patients on the ward had the opportunity to work in the shop.

A female specific forum "Womans Way" had been established, where the ladies suggested and agreed on female orientated activities; the ladies were offered a choice of female activities such as; a ladies lunch where discussions were held about women's mental and physical health, "pamper sessions", craft work such as candle making, sugar craft, jewellery making, and a ladies only film club.

The inspector was informed by the charge nurse that input from Psychology services was two days per week; on review of the care documentation and discussion with the charge nurse this input was not conducive to the needs of the patient population in Shannon Clinic, e.g there were patients on the ward with a diagnosed personality disorder. The charge nurse informed the inspector this has been raised at the operational meeting and a proposal for an increase in psychology services has been completed. This was addressed with the operational manager who stated that a proposal to increase psychology services was completed. A recommendation has been made in relation to this.

Due to the nature of the medium secure unit, Shannon clinic as a visiting policy where all visits are planned and supervised. A private room was

available for visits. There was evidence in the patients care documentation of family contact either on the ward or out on pass.

A Shannon Clinic information booklet was available for patients on admission, the booklet contained information in relation to patients' rights. Information on how to make a complaint was also displayed in the patient communal area. It was also documented in the patients care documentation that staff had informed patients of their rights.

Information on independent advocacy services was displayed in the patients' communal area and included the date and time of the advocate visit. The advocate worked full time in Shannon Clinic and visited the ward weekly and when required. The advocate facilitated the weekly "Have Your Say" and monthly "Shannon for Us" patient forum meetings. Staff were aware of how to access and effectively utilise independent advocacy services.

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, and this may have included the patients' 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.
All restrictive practices were documented and included a clear rationale for the restriction that was proportionate to the risk. Risk assessments and restrictive practices were reviewed weekly and when required. Episodes of physical intervention and enhanced observations were documented and reviewed in accordance with trust policy. It was also documented that patients' was informed of the reason for the physical Intervention and enhanced observations. The inspector noted evidence that restrictive practices were reviewed at the monthly staff meetings. All staff working in Shannon 2 had received up to date training in Physical interventions.

The inspector was informed by the charge nurse that there were no delayed discharges on the ward. There was a pathway for discharge planning as follows; planning for discharge was discussed with the patient and documented following admission. Risks were identified for discharge planning on the risk assessment and risk management plan and detailed the support and care package needed to allow for a discharge into the community. There was documented evidence of liaison through discharge planning meetings between the multi-disciplinary team and the appropriate community team with patient involvement and family involvement (where appropriate). Potential placements were identified and discussed with the patient.
There was evidence of liaison and discussions through discharge planning meetings with specialist team's e.g community forensic teams. There was documented evidence of liaison through discharge planning meetings

between the multi-disciplinary team and other appropriate agencies such as the Northern Ireland Housing Executive with patient and family involvement (where appropriate). Discharge care plans were completed in two out of the three sets of care documentation reviewed. A recommendation has been completed in relation to this. Pending discharges were discussed at the weekly bed management meetings. All delayed discharges were reported to the Health and Social Care Board.

The inspector noted that consideration was given and documented in all of the care documentation reviewed on the days of the inspection to patients Human Rights Articles 3 the right to be free from torture; Article 5, the right to liberty and security of person; Article 8, the right to respect and family life; and Article 14 the right to be free from discrimination. Staff also demonstrated their knowledge of patients Human Rights.

Details of the above findings are included in Appendix 2.

On this occasion Shannon ward 2 has achieved an overall compliance level of **substantially 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	**2**
Ward Staff	**2**
Relatives	**0**
Other Ward Professionals	**2**
Advocates	**1**

Patients

The inspector met with two of twelve patients on the ward. One patient stated they were dissatisfied with the lack of service from a Psychologist. Both patients stated they had been involved in their care and treatment plans and attended their ward round meetings. Both patients knew who to speak to if they were unhappy about their care and treatment.

One patient quoted; "*the care is good, this is the best hospital, the doctors, nurses and occupational therapists are all good - they are the best*."

Relatives/Carers

The inspection was unannounced; there were no relatives available to speak with on the days of the inspection.

Ward Staff

The inspector met with two of five nursing staff on the days of the inspection. The nursing staff stated they felt well supported by the charge nurse. Both staff demonstrated their competence in the policies and procedures relating to Safeguarding Vulnerable Adults, adverse incidents, and capacity to consent. Both staff demonstrated their knowledge of Human Rights and how they considered these when providing care and treatment. Both staff indicated that there was good team work on the ward.

Other Ward Professionals

The inspector met with the ward Occupational Therapist and the ward doctor. Both staff indicated that the team work on the ward was good. Both staff stated that patients are always involved in their care and treatment plans and were always given choices.

Advocates

The inspector met with the independent advocate. The advocate stated that staff are approachable. The advocate stated they update the patients of their availability on a timetable displayed in the patients' communal area. The advocate stated they notify the staff of any changes to the scheduled visits and staff amend the timetable. The advocate stated they facilitate the monthly "Shannon for Us" and weekly "Have Your Say" patients' forum meetings, attend the weekly bed management meetings and patients ward rounds on request. The advocate stated they have no concerns at present about patients care and treatment on Shannon 2 ward.

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	3
Other Ward Professionals	5	0
Relatives/carers	12	0

Ward Staff

Three questionnaires were returned by nursing staff. Two out of three questionnaires returned indicated that staff had received training in Capacity to Consent, Human Rights and they were aware of Deprivation of Liberty Safeguards (DOLS) – interim guidance (2010).
Two questionnaires indicated that staff were aware of restrictive practices on the ward, the third staff had not answered this question. Two questionnaires indicated they had received training on meeting the needs of patients who require support with communication. Three questionnaires indicated that patients' communication needs were recorded in their assessment and care plan and they were aware of alternative methods of communication and the ward had processes in place to meet patients' individual communication needs. Three questionnaires stated that the ward had information in a format that met individual needs in relation to patients' rights under the Mental Health Order, how to make a complaint and how to access advocacy services. Three questionnaires stated that patients on the ward had access to therapeutic and recreational activities that met the patients' needs. One staff quoted;

"every effort is made to ensure compassionate patient centred nursing care. We welcome all help and guidance to direct progress of our ability to safely meet the nursing and complex needs of all our stake holders in Shannon Clinic including patients, family, staff and management. We welcome RQIA guidance to support the development and maintaining of compassionate

mental health and well-being recovery programmes of care in Shannon Clinic."

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Other Ward Professionals

There were no questionnaires returned by other ward professionals.

Relatives/carers

There were no questionnaires returned by relatives or carers professionals.

7.0 Additional matters examined/additional concerns noted

Complaints

Prior to the inspection RQIA requested a record of the number of complaints received between 1 April 2013 and 31 March 2014. The ward had forwarded the detail of one complaint. The inspector reviewed records in relation to complaints and confirmed that there was one complaint that had been managed in accordance with Policy and Procedure.

Additional concerns

The inspector was informed by the charge nurse and operational manager of the challenges of managing the dynamics of a mixed sex ward. This challenge was also confirmed by the independent advocate. The inspector was informed by the operational manager that they had completed a positioning paper to review this, with the proposal to establish a single sex environment.

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.

Appendix 1

Follow-up on recommendations made following the announced inspection on 10 and 11 March 2014

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	Document Number:17 4.3 j	It is recommended the ward manager ensures that all staff working on the ward have received up to date training in Safeguarding Vulnerable Adults	2	The inspector reviewed the training records for the 26 staff working on Shannon ward 2. Training records show that all staff working on the ward had received up to date training in Safeguarding Vulnerable Adults.	**Fully met**
2	Document Number:17 4.3 b	It is recommended the trust develops and implements a formal system to; identify the number of referrals and 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 concern. 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 h	It is recommended the ward manager ensures that all care documentation is transferred with patients when moved from Shannon 1.	1	The inspector reviewed care documentation relating to three of twelve patients on the ward. It was noted that one of the patients had transferred from Shannon ward 1. All documentation had been transferred with the patient. Records within the three sets of patients' notes were consistent. The inspector noted there has been two file audits since the last inspection and noted the mechanism for raising any deficits with the patients' named nurse. The ward manager informed the inspector that at present file audits are planned every 6 weeks with the overall aim of moving to quarterly audits.	**Fully met**

4	Document Number:17 5.3.1 f	It is recommended the ward manager ensures that the integrated care pathways are consistently completed by all relevant members of the multi-disciplinary team.	1	The inspector reviewed care documentation relating to three of twelve patients on the ward. The inspector noted that integrated care pathways had been completed by the multi-disciplinary team. The inspector noted that the completion and update of Integrated Care Pathways was included in the file audits.	**Fully met**
5	Document Number:17 8.3 d	It is recommended the ward manager ensures there is a paper copy of each patients Absence without Leave form available in the patients care documentation and always available if required.	1	The inspector reviewed care documentation relating to three of twelve patients on the ward. The inspector noted that a paper copy of the Absence Without Leave (AWOL) form was available in the three files reviewed. The inspector noted that the completion and availability of AWOL forms was included in the file audits.	**Fully met**
6	Document Number: 17 5.2 f	It is recommended the ward manager ensures that all staff working on the ward are adequately trained and competent in following the policy and procedure in relation to the timely completion of vulnerable adult referrals	1	The inspector reviewed the training records for the 26 staff working on Shannon ward 2. Training records show that all staff working on the ward had received up to date training in Safeguarding Vulnerable Adults. The inspector interviewed two of the five staff working on the ward on the days of the inspection. Both staff stated they had received up to date training on Safeguarding Vulnerable Adults and demonstrated their competency in relation to following the procedure in relation to the timely completion of vulnerable referrals	**Fully met**
7	Document Number: 17 4.3 l	It is recommended the ward manager ensures that all staff on the ward have received supervision as per trust policy.	1	The inspector reviewed the records in relation to staff supervision and noted that all staff had received up to date supervision.	**Fully met**
8	Document Number: 17 4.3 J	It is recommended the ward manager ensures that up to date records in relation to staff fire safety training are available on the ward.	1	Fire safety training records in relation to the twenty six staff working on the ward were available on the days of the inspection. The inspector noted that all staff working on the ward had up to date training in relation to fire safety.	**Fully met**
9	Document Number: 17	It is recommended the ward manager ensures that all staff on the ward have received up to	1	The inspector reviewed the training records for the 26 staff working on Shannon ward 2 and noted that all staff working on the ward had received up to date training in Child	**Fully met**

	4.3 J	date training in child protection.		protection.	
10	Document Number: 17 5.3.3	It is recommended the ward manager ensures all patients are informed daily of their allocated member of staff for their 1:1 time.	1	The inspector noted on the days of the inspection that up to date information was displayed in the patient communal area informing patients who their allocated member of staff was for their 1:1 time each day.	**Fully met**
11	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 as per trust policy.	1	The inspector reviewed records in relation to local complaints. A record of local complaints, the action taken and the outcomes had been maintained. The inspector noted that any issues raised via the patients' forum meetings and the outcomes were also included in the complaints records.	**Fully met**
12	Document Number: 17 6.3.2.a	It is recommended the patient advocate ensures that the patients are aware of and understand the purpose of patient advocacy and that the advocate makes themselves available to meet with patients on the ward on a weekly basis.	1	The inspector noted that information in relation to independent advocacy services was available in the patients' communal area. This included a schedule of the advocates' weekly visits to the ward. The inspector noted the process followed when there is a change in the advocates schedule and patients and ward staff were informed in a timely manner. The inspector spoke with two of the twelve patients on the ward who confirmed the advocate visits weekly.	**Fully met**
13	Document Number: 17 5.3.1 f	It is recommended the ward manager ensures that all members of the multi-disciplinary team consistently document their interventions into the appropriate multi-disciplinary care documentation.	1	The inspector reviewed multi-disciplinary care documentation relating to three of twelve patients on the ward for October 2014. The inspector noted that the multi-disciplinary team had consistently documented their interventions into the multi-disciplinary care documentation.	**Fully met**
14	Document Number: 17 8.3	It is recommended the ward manager reviews the practice of retaining paper copies of patients care documentation held on the ward to ensure the contents are consistent, accessible, up to date and relevant and in line with BHSCT records management	1	The inspector noted the charge nurse had completed two file audits. An agreement was noted of what should be retained in the paper copy of patients' files. The inspector reviewed files relating to three of twelve patients on the ward and noted that the contents were consistent, accessible, up to date and relevant. The ward manager informed the inspector that presently file audits will be completed every six weeks, with the future	**Fully met**

		policy and procedure		proposed plan that audits will be conducted quarterly.	
15	Document Number: 17 5.3.1	It is recommended the ward manager ensures that all staff on duty are present in communal patient areas and available to meet with and support patients on the ward.	1	The inspector observed that staff were present at all times in the patient communal area. The inspector spoke with two of the twelve patients who confirmed that staff were always available in the patient communal area.	**Fully met**
16	Document Number: 17 6.3.2	It is recommended the trust reviews 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 ADL kitchen to cook a meal; this is planned at the morning meetings. Fresh fruit and yoghurts are available at all times. 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 was informed by the charge nurse that food can be served on the ward at whatever time the patients wish. 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.	**Fully met**
17	Document Number: 17 6.3.2	It is recommended the trust review the patient daily milk allowance to ensure patients access to milk is not limited. This review should consider the specific requests addressed by the patient forum meetings.	1	The inspector was informed the patient daily milk allowance was reviewed and increased. Following the review there was an excessive amount of milk on the ward. The milk allowance has returned to its original compliment. The advocate stated patients have not raised any concerns in relation to milk allowance at the patient forum meetings.	**Fully met**
18	Document Number: 17 5.3.1	It is recommended the ward manager reviews the frequency of cleaning and disposal of smoking debris in the garden	1	The inspector observed the smoking area and noted it to be adequately clean and within general hygiene standards.	**Fully met**

		area to ensure the smoking area is within general hygiene standards.			

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

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	6.3.2	It is recommended that the ward manager ensures that all patients' personal items and clothing are marked in to ward admission documentation in accordance with Trust policy.	1	The inspector reviewed the process and documentation completed in relation to patients personal items. It was noted patient personal items were marked into a patient property book and a duplicate copy given to the patient in accordance with trust policy.	**Fully met**
2	6.3.2	It is recommended the ward manager reviews the environment where clothing and personal items for patients who have restricted access are stored.	1	The inspector noted that additional lockable storage has been purchased for patients who have excessive personal belongings or where they have restricted access their personal items.	**Fully met**

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 the records in relation to patient finances. A record of staff who access the Bisley drawer and the reason for access was maintained.	**Fully met**

Appendix 1

Follow up on the implementation of any recommendations made following the investigation of a Serious Adverse Incident

No.	SAI No	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	BHSCT/SAI11/70	AWOL Policy --The Belfast Health & Social care trust Mental Health Services AWOL Policy to be reviewed to include action to be taken by the escorting nurse when a patient absconds from them.	The inspector noted the Belfast Health and Social Care Trust Mental Health Services AWOL policy had been reviewed and completed in MAY 2013 and due review in March 2016. The inspector noted the procedure to be followed in relation to a patient going AWOL. The inspector noted in the three sets of care documentation that patients had a risk assessment completed each time they left the ward in accordance with the trust policy.	**Fully met**

Quality Improvement Plan

Unannounced Inspection

Shannon Clinic Ward 2

Knockbracken Healthcare Park

Belfast Health & Social Care Trust

11 & 12 November 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with the Operational Manager, Charge Nurse, Deputy Ward Sister, Quality Co-ordinator, Assistant Director of Mental health Services, Senior Nurse Manager and the Independent Advocate on the day of the inspection visit.

It is the responsibility of the Trust to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	6.3.1 (a)	It is recommended the trust review the provision of Psychology services within the Shannon Clinic to ensure that patients who are assessed as requiring clinical psychological interventions have access to this service.	1	10 February 2015	A Specialist Clinical Psychology Post (Band 8a)has been advertised, closing date 11/12/14. This post will be interviewed in early 2015. It will provide 1.0wte additionality into Shannon.
2	5.3.1 (a)	It is recommended that the charge nurse ensures that all patients have a person centred discharge plan completed.	1	10 January 2015	As stated in the inspector's report not all patients had a person centred discharge plan completed. The Named Nurses within the ward have been reminded of the importance of ensuring this information is up to date as per their duties outlined in the Trust's Named Nurse Policy. Notes are audited by the Deputy Charge Nurse and Deputy Ward Sister on a routine basis to ensure that necessary documentation including a Discharge Plan are in place. Any issues arising from this audit will be discussed with the staff member by the Charge Nurse and addressed with the MDT if necessary.

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

NAME OF WARD MANAGER COMPLETING QIP	Damian Murdock
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Michael McBride, chief Executive

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	✓		Wendy McGregor	**18 December 2014**
B.	Further information requested from provider				

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:	
Ward 2 is a 12 bedded ward (7 Male & 5 Female beds) with a designated female only area. The ward caters for patients with continuing care mental health needs and provides care for female patients with intensive care needs. Female Patients needs and risks are identified during the pre-admission assessment, on admission, and recorded on their Comprehensive Risk Assessment. Male patients would already have gone through this process when they were admitted to Ward 1. Male patients who have made progress are transferred to Ward 2 following discussions at their MDT meetings and Bed Management and when a male patient bed becomes available in Ward 2. 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.	Moving towards compliance

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. 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 (7 Male & Female) within Ward 2 in which patients keep their property and to ensure patient's privacy. Patients can 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 2 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	
Department of Health guidance and trust policy and procedure in relation to capacity and consent was available for staff. Two out of the three staff questionnaires returned stated they had received training in relation to capacity and consent. The inspector reviewed care documentation in relation to three of the twelve patients on the ward. The inspector noted the following in all of the documentation; On admission patients capacity was assessed and recorded as either capable or incapable on the Integrated Care Pathway (ICP). The three patients whose care documentation was reviewed had been assessed as capable. Capacity to manage own financial affairs had been completed and signed by the consultant psychiatrist. Capacity was assessed on a daily basis and recorded in the patients daily progress notes Patients had been given time to understand their care and treatment plans. Care and treatment plans are revisited during the weekly 1:1 time with the patients named nurse and daily where required with their allocated 1:1 team member. Care and treatment plans were discussed weekly at the patient multi-disciplinary meeting with a record of patient attendance. Patients had signed their care documentation. Care plans included seeking consent using language such has “seek agreement from the patient” prior to care	Compliant

and treatment. The daily progress notes stated patients were involved and either agreed or disagreed to episodes of care and treatment. Care documentation considered patients Human Rights Articles 8; to respect the right to family and private life and Article 14; the right to be free from discrimination. Where appropriate there was evidence of relative involvement in decisions in relation to patient consent The inspector spoke to two of the twelve patients on the ward; patients indicated they had attended their multi-disciplinary meetings and had been involved in decisions relating to their care and treatment. The inspector spoke to two of the five nursing staff working on the ward on the days of the inspection. Staff demonstrated their knowledge of capacity and consent, staff informed the inspector of the process they would follow if a patient refused care or any invasive procedures. Staff informed the inspector that they would respect the patients right to refuse and detailed what they would do in this event e.g establish the reasons the patient had refused and work with these by giving the patient all the related information in relation to the care and treatment. Staff informed the inspector where a patient was assessed as not having capacity; the multi-disciplinary team would complete a best interest pathway. The inspector noted during the inspection that one patient was refusing to have their blood taken for medication monitoring, staff respected the patients' right to refuse but on further enquiry it was established that the patient wanted the doctor to take their blood, and this was arranged. Staff demonstrated their knowledge of Human Rights and informed the inspector that they promote patient privacy and encourage contact and family visits by making reasonable adjustments to support this.	

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.	Moving towards compliance

Any patient's communication issues will be addressed during their initial assessment on admission to the ward. The 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 (7 Male & 5 Female) within Ward 2 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 2 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 inspector reviewed care documentation in relation to three of the twelve patients on the ward and noted the following; Each patient had an individualised and holistic assessment completed. Care and treatment plans were person centred and addressed all the assessed needs of each patient. Care plans in relation to Mental Health, Medication, psychological functioning, financial, family support, level of security, alcohol / substance misuse, child care/vulnerable adults/protection and occupational/leisure/education; Activity of Daily Living Skills, Cultural and Spiritual, Criminogenic needs, Legal (Mental Health Order, Human Rights, Department of Justice) were completed. Care plans detailed restrictive practices and deprivation of liberty, physical interventions and enhanced observations (when appropriate).	Compliant

Care and treatment plans were discussed at the patients weekly multi-disciplinary meetings with patient involvement. Changes to the patients' needs were detailed in the minutes of the multi-disciplinary meeting and care plans were noted to be updated. All of the care plans had been signed by the patients. There was evidence of family involvement where appropriated and if the patients consented – e.g there was evidence in one set of care documentation of a relative questionnaire that asked the following questions: Are you aware of your relatives care plan? Do you agree with the care plan? Is there anything you would like to change? Do you know who to make contact with if you need any help? Do you wish to attend the review of the care plan? Do you want a carers assessment? Each patient had a person centred risk assessment and associated risk management plan completed. Risk assessment and management plans were completed in accordance with Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services DHSSPS 2010. Changes to risk assessments and management plans were discussed at the weekly multi-disciplinary meeting with patient involvement. Adverse incidents, incidents requiring the use of a restrictive practice and vulnerable adult concerns were recorded in the patients risk assessment. Risk assessments and risk management plans were reviewed when required (at times daily depending on the changing needs of the patient) and at the three monthly Promoting Quality Care meeting. Patient signatures were evident in all of the risk assessment and risk management plans. Communication needs were noted to be assessed on admission. The inspector was informed of one patient on the ward who spoke limited English. The patient was provided with an interpreter when required. There was also an easy access interpretation service via the phone for staff when needed. The inspector was informed at present there wasn't any difficulties communicating with the patient as both them and the staff could make their needs known. The inspector spoke to two of the twelve patients on the ward. Both patients indicated they had been involved in the development and review of their care and treatment plans, during their multi-disciplinary meetings, daily one to one time with their allocated nurse and weekly one to one time with primary nurse. .	

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 (7 Male & 5 Females) within Ward 2 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 2 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 at the earliest opportunity 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 inspector spoke with the Occupational Therapist for the ward. Shannon Clinic receives input from three full time Occupational Therapists, and one full time Occupational Therapist 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 three of the twelve patients on the ward and noted the following; • Each patient had an individualised occupational therapy assessment appropriate to their needs completed e.g. each patient had Model of Human Occupancy completed which detailed patient likes and dislikes, and past, present and future recreational activities. 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. 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. Activities offered to patients included, current affairs, ward art, hen duty, football, rackets club, monthly film club, music group, walking group, lunch cookery. All activities were delivered by both nursing and occupational therapy. Patients on the ward had the opportunity to work in the shop. A female specific forum “womans way” had been established, where the ladies suggested and agreed on female activities; the ladies were offered a choice of female orientated activities such as; a ladies lunch where discussions were held about women’s mental and physical health, “pamper sessions”, craft work such as candle making, sugar craft, jewellery making, and a ladies only film club. The inspector was informed by the charge nurse that input from psychology services was two days per week; on review of the care documentation and discussion with the charge nurse this input was not conducive to the needs of the patient population in Shannon Clinic, e.g there were patients on the ward with a diagnosed personality disorder. The charge nurse informed the inspector this has been raised at the operational meeting and a proposal for an increase in psychology services has been completed. A recommendation has been made in relation to this. This was addressed with the operational manager who stated that a proposal to	Substantially Compliant

increase psychology services was completed. A recommendation has been made in relation to this. There was evidence that consideration was given to patients' Human Rights Article 8 respect for private and family life. Due to the nature of the medium secure unit, Shannon clinic as a visiting policy where all visits are planned and supervised. A private room was available for visits. There was evidence in the patients care documentation of family contact either on the ward or out on pass.	

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 a patient information 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 (7 Males & 5 Females) within Ward 2 in which patients will keep their property and to ensure patient's privacy. Patients can 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.	Moving towards compliance

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	
A Shannon Clinic information booklet was available for patients on admission, the booklet contained the following information; • Rights under the Mental Health (Northern Ireland) Order 1986 • The right to be treated with dignity courtesy and respect with attention to religious and cultural beliefs • The right to have your care co-ordinated by a named nurse • The right to your care delivered based on assessment of need and consulted (as far as possible) when care is being planned • You will be shown your treatment plan weekly and asked to sign this, you may decline this opportunity • The right to have a complaint properly dealt with Information on outside agencies who address complaints was also detailed in the booklet. Information on the role and function of Regulation and Quality Improvement Authority was included in the booklet. Information on how to make a complaint and accessing advocacy services was included in the booklet. The inspector spoke with two of the twelve patients on the ward who confirmed they had been given the information as above. Information on how to make a complaint was also displayed in the patient communal area. The inspector reviewed documentation relating to three of twelve patients and noted that it was documented that patients had been informed of their rights in relation to; the Mental Health Review Tribunal and accepting /refusing care and treatment. Information on independent advocacy services was displayed in the patients' communal area and included the date and time of the advocate visit. The inspector spoke with the independent advocate. The advocate worked full time in Shannon Clinic. The advocate confirmed they visited the ward weekly and when required. The advocate gave the ward notice if there are any changes to their planned visit. The advocate facilitated the weekly "Have your say" and monthly "Shannon for us" patient forum meetings. The inspector spoke to two of five staff working on the ward, both staff were aware of how to access and effectively utilise independent advocacy services.	Compliant

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 person centred 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	Moving towards compliance

Disability on a monthly basis. The results are shared with both management and staff to inform training. There are 12 ensuite bedrooms (7 Males & 5 Females) within Ward 2 in which patients will keep their property and to ensure patient's privacy. Patients can 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 2 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 at the earliest opportunity following 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. On the days of the inspection there was one patient on enhanced observations. The inspector was informed the last physical intervention used was 7 November 2014. The inspector reviewed care documentation in relation to three of twelve patients and noted that all restrictive practices were documented and included a clear rationale for the restriction that was proportionate to the risk. Risk assessments and restrictive practices were reviewed weekly and when required. The inspector noted that episodes of physical intervention and enhanced observations were documented and reviewed in accordance with trust policy. It was also documented that the patients were informed of the reason for the physical Intervention and enhanced observations. The inspector noted evidence that restrictive practices were reviewed at the monthly staff meetings. It was noted in the three 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.	Compliant

Training records reviewed showed that all staff working in Shannon 2 had received up to date training in Physical interventions.	

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 was informed by the charge nurse that there were no delayed discharges on the ward. The inspector reviewed care documentation in relation to three of twelve patients on the ward. The inspector noted the pathway for discharge planning as follows; • Planning for discharge was discussed with the patient and documented following admission. • Risks were identified for discharge planning on the risk assessment and risk management plan and detailed the support and care package needed to allow for a discharge into the community.	Substantially compliant

• There was documented evidence of liaison through discharge planning meetings between the multi-disciplinary team and the appropriate community team with patient involvement and family involvement (where appropriate). Potential placements were identified and discussed with the patient. • There was evidence of liaison and discussions through discharge planning meetings with specialist team's e.g community forensic teams. • There was documented evidence of liaison through discharge planning meetings between the multi-disciplinary team and other appropriate agencies such as the Northern Ireland Housing Executive with patient and family involvement (where appropriate). Discharge care plans were completed in two out of the three sets of care documentation reviewed. A recommendation has been completed in relation to this. The inspector was informed by the charge nurse that pending discharges were discussed at the weekly bed management meetings. The inspector was informed by the operational manager that all delayed discharges were reported to the health and Social Care Board.	

Ward Manager's overall assessment of the ward's compliance level against the	**COMPLIANCE LEVEL**

statements assessed	Moving towards compliance

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