The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Shannon Clinic Ward 3

Knockbracken Healthcare Park

Belfast Health & Social Care Trust

11 & 12 March 2015

npm national preventive mechanism

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Contents

1.0 General Information

Ward Name	Shannon Clinic Ward 3
Trust	Belfast Health & Social Care Trust
Hospital Address	Knockbracken Healthcare Park Saintfield Road Belfast BT8 8BH
Ward Telephone number	028 9056 5656
Ward Manager	Una Maguire
Email address	una.maguire@belfasttrust.hscni.net
Person in charge on day of inspection	Una Maguire
Category of Care	Mental Health
Date of last inspection and inspection type	29 May 2014, Patient Experience Interviews
Name of inspector	Wendy McGregor

2.0 Ward profile

Shannon ward 3 is a regional medium secure, forensic, inpatient unit set within Shannon Clinic. The clinic is situated on the grounds of the Knockbracken Healthcare Park.

Shannon ward 3 is a rehabilitation unit, which provides in-patient treatment and care to male patients over the age of 18 years.

Shannon ward 3 has occupancy for ten patients. On the days of the inspection there were ten patients on the ward. Nine patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986. Five patients were detained in accordance with part three and four patients were detained in accordance with part two of the Mental Health Order. One patient was voluntary.

Patients transfer to Shannon ward 3 when assessed by the multi-disciplinary team as requiring rehabilitation in a less restrictive environment.

Security in Shannon clinic is prioritised and there are strict protocols for entering and leaving the ward and clinic. The patients on the ward are subject

to a number of restrictions in accordance with the nature of a medium secure unit.

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

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

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

The ward has a designated manager, and the majority of the staff compliment are made up of nursing registrants. The ward provides a placement for student nurses.

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

Shannon ward 3 was noted to be bright and clean. Patients have access to an open plan TV area, dining room, TV room and a resource room. Within the resource room patients can store restricted personal possessions such as mobile phones, razor's etc in individualised secure compartments. All patients have single bedrooms with en suite facilities and these are located along two corridors within the ward. The rooms contain personalised items and where appropriate, patients can bring in their own TV's, radios, DVD players. There was a washing machine and tumble dryer on the ward and patients are encouraged to do their own laundry. Patients have unrestricted access to the kitchen.

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

3.0 Introduction

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

cruel, inhuman or degrading treatment or punishment, upholding the organisation's commitment to the United Nations Optional Protocol to the Convention Against Torture (OPCAT)**.**

3.1 Purpose and Aim of the Inspection

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

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

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

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

3.2 Methodology

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

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

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

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

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

- evaluation and feedback.

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

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

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

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

4.0 Review of action plans/progress

An unannounced inspection of Shannon Clinic Ward 3 was undertaken on 11 & 12 March 2015.

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

The recommendations made following the last announced inspection on 27 & 28 January 2014 were evaluated. The inspector was pleased to note that all of the recommendations had been fully met.

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

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

5.0 Inspection Summary

Since the last inspection it was good to note that all the recommendations made following the last announced inspection had been fully met.
The inspector observed patients accessing a range of therapeutic and recreational activities both within the ward and in the community.

The inspector observed patient and staff engagement to be therapeutic. Patients were treated with dignity and respect. Staff were observed to be courteous to patients.

Patients were kept fully informed of what was happening in their day through the daily community meetings.

The inspector was pleased to note the mechanisms in place to support staff e.g. reflective practice, staff meetings and staff supervision.

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

Information in relation to capacity and consent including Department of Health guidance was available for staff.

Patients in Shannon ward 3 have been assessed as requiring rehabilitation and are progressing towards discharge. The ward manager stated that all patients in Shannon ward 3 had capacity to consent.

Patients were involved in the development of their care and treatment plans and had been consulted in decision making processes. Staff had sought consent prior to care and treatment delivery.

Promoting Quality Care (PQC) risk assessments and management plans were discussed with patients. Staff recorded the reason why patients had not signed their risk assessment. Patients were invited to attend Promoting Quality Care reviews. Patients were offered the option of receiving the minutes from the meetings or the full PQC report. Relatives were invited with patient consent.

The independent advocate confirmed that they attend weekly multidisciplinary and Promoting Quality Care meetings at the patients' request.

Care documentation was completed electronically and there was a continuous record completed by all members of the multi-disciplinary team involved in the patients' care. A paper copy of essential care documents was held on the ward. These could be used in the event of a technical difficulty with the information technology systems and if staff needed to access this information in an emergency.

Patients were involved in their assessments, care plans, risk assessments and risk management plans. Care documentation was individualised, personal and holistic. Patients were invited to attend their weekly multi-disciplinary meetings. Staff discussed care and treatment plans and risk assessments with patients prior to and after every multi-disciplinary meeting. Patients' views in relation to their care and treatment plans were also discussed and recorded.

Patients had the opportunity to meet daily on a 1:1 basis with an allocated member of staff and at least once a week with their named nurse.

Care plans had been completed for every need identified in the patients' assessment.

Care and treatment plans were reviewed and updated every week or earlier if required.

Communication needs were assessed on admission to ward 1. Patients for whom English was not their first language were supported by an interpreter for case conferences, explanation of rights and meetings with the consultant psychiatrist. Staff knew how to access the interpretation service when required.

Patients had the opportunity to take part in both recreational and therapeutic activities within the Shannon Clinic.

Shannon ward 3 received input from four full time occupational therapists, and one full time occupational therapy assistant. There was one full time technical instructor for woodwork and support from three nursing care assistants three days per week for recreational activities.

All patients were referred to occupational therapy and were involved in completing an occupational therapy assessment. Patients also had one to one time with a member from the occupational therapy team once a week.

Patients had a personal therapeutic and recreational activity plan. Patient participation in activities was monitored, recorded and evaluated weekly. Each occupational therapist was aligned with the patients' consultant to ensure consistency of care as patients move from ward 1 to ward 2 or 3.

A comprehensive therapeutic and recreational activity programme was offered to patients. The programme was displayed in the patient communal area. This was delivered by occupational therapy and nursing. Activities to support rehabilitation were on offer e.g. cooking, laundry, integrating and engaging with the community and shopping.

On the days of the inspection patients on Shannon ward 3 had been assessed as requiring rehabilitation in a less restrictive environment. Patients were therefore progressing toward discharge. Patients had more access to both escorted and unescorted walks in the hospital grounds, community leave and attended community activities provided by external agencies.

Patients had unrestricted access to the kitchen to prepare meals of their choice.

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

The inspector was informed by the ward manager that monthly therapeutic co-ordination group meetings were convened. Members of the group comprised of the independent advocate, nursing, medical, social work and O.T staff. The group were responsible for coordinating the development and subsequent maintenance of the therapeutic programmes in Shannon clinic. Minutes of the group meetings were available on the ward.

A Shannon clinic information booklet was available for patients. The information was comprehensive and informed patients of their rights and detailed the restrictions in the clinic.

Patients knew how to raise a concern, make a formal complaint, were aware of advocacy services and had been informed of their rights. Information on how to make a complaint and accessing advocacy services was displayed in the patients' communal area.

A full time independent advocate was available. A timetable was displayed on the ward to inform patients of the date and time the advocate visits and the

schedule of the patient forum meetings they facilitate. The independent advocate facilitated both the weekly “Have Your Say” and monthly “Shannon for Us” patient forum meetings. The independent advocate was part of the operational team and attended weekly bed management and operational meetings. The advocate also attended multi-disciplinary meetings when requested by patient. Staff knew how to access and effectively use advocacy services. A carers advocate was also available.

A record of local complaints was maintained and accessible to patients. Issues raised, actions taken and outcomes were discussed with patients at the daily community meetings.

Patients who were detained in accordance with part 2 of the Mental Health (Northern Ireland) Order 1986 had been informed of their right to appeal to the Mental Health Review Tribunal.

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

Shannon Clinic had a number of restrictive practices in accordance with the requirements of a medium secure unit. Access and exit from the unit was 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 available in the garden for patient to access..

Bedrooms were not locked on the days of the inspection. Patients had an individual approach plan completed using the stair case model, this identified why a person responds in an aggressive and violent manner, the triggers for aggression, the aim of staff intervention, the goals staff want the individual to achieve and what alternative coping mechanisms staff could teach the patient. The plan included patients presentation when calm, tense, using non-verbal aggression, verbal aggression and critical moments. Proactive strategies were documented and there was evidence of patients’ involvement in these plans. The patients’ documentation evidenced that patients had been fully informed of the potential use of restrictive practices such as physical interventions. The rationale for using these interventions had been explained to patients. The inspector was informed by the ward manager that there have been no incidents requiring physical intervention in two years. The ethos of the ward is that if a patient requires that level of intervention care in rehabilitation is inappropriate.

All incidents resulting in the use of restrictive practices were discussed and reviewed at the weekly bed management meeting, patients' weekly multi-disciplinary meetings and the monthly staff meetings. All documentation was completed in line with Trust policy and Promoting Quality Care guidance.

All staff working on the ward had received up to date training in the use of physical interventions.

Patients transfer to Shannon ward 3 from Shannon ward 2 when assessed as requiring rehabilitation in a less restrictive environment. Patients were involved in their plans for discharge. Discharge plans were noted to be person centred and evidenced patient involvement. Staff had recorded how they support patients with preparation for discharge. Staff helped patients prepare for discharge by supporting them through a self-medication programme. When assessed as medically fit for discharge patients are discharged to independent accommodation, supported housing or return to prison.

Patient's Promoting Quality Care risk assessment and risk management plans were updated prior to discharge and identify risks and supports the patients required on discharge.

There were two patients whose discharge was delayed during the days of the inspection. This was due to the lack of appropriate supports in the community for one patient and the other patient was waiting on a panel meeting to assess for potential accommodation. Both patients had been kept fully informed of updates in relation to their discharge. One patient had submitted a formal complaint to their home Trust in relation to delay in sourcing suitable support in the community. There was evidence that the ward manager and clinic senior social worker had actively liaised with both patients' care manager and community teams in relation to their discharge arrangements.

Details of the above findings are included in Appendix 2.

On this occasion Shannon ward 3 has achieved an overall compliance level of **Compliant** in relation to the Human Rights inspection theme of "Autonomy".

6.0 Consultation processes

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

Patients	Three
Ward Staff	One
Relatives	None
Other Ward Professionals	None
Advocates	None

Patients

All three patients who met with the inspector stated they were overall satisfied with their care and treatment in Shannon ward 3. Patients did not raise any concerns about the ward. Patients stated the staff were caring. Patients stated how receiving care and treatment in Shannon clinic had improved their mental health.

Two patients stated they were frustrated with the delay in their discharge and stated this was due to the lack of appropriate community support. Patients stated they knew it wasn't the fault of the staff on the ward. They stated they had been kept up to date and fully informed and that staff were actively liaising with their home trusts. One patient had completed a formal complaint to their home trust in relation to the delay in their discharge. The inspector informed the other that they had the right to make a formal complaint and advised them to talk to the independent advocate.

Relatives/Carers

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

Ward Staff

The inspector spoke with one staff member. This staff member stated they were well supported in their role. They stated they had attended training relevant to their role of delivering care in a forensic ward.

Other Ward Professionals

Ward professionals were not available during the inspection. However the inspector spoke to a number of ward professionals on a previous inspection on Shannon ward 1. Comments made by other ward professionals were reflective of Shannon clinic. The occupational therapist, consultant

psychiatrists and social worker all confirmed that the multi-disciplinary team work on the ward was excellent and all staff provided a high standard of care.

Advocates

The advocates were not available during the inspection.

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	14	2
Other Ward Professionals	5	0
Relatives/carers	10	0

Ward Staff

Two questionnaires were returned by ward staff. One staff member stated they had not received training on capacity and consent or Human Rights. Both staff were aware of Deprivation of Liberty Safeguard (DOLS) – interim guidance (2010) and restrictive practices on the ward. Both staff stated they had received training in restrictive practices. Both staff stated that patients' communication needs were recorded in their assessment and care plan. Staff indicated they were aware of alternative methods of communication. One staff referenced when an interpretation service was used. They both stated information in relation to rights was available for patients. One staff member stated that not all patients access therapeutic and recreational activities. Both staff stated that patients have access to recreational therapeutic activity programmes that met individual needs.

Other Ward Professionals

No questionnaires were returned by other ward professionals.

Relatives/carers

No questionnaires were returned by relatives / carers.

7.0 Additional matters examined/additional concerns noted

Complaints

Prior to the inspection the ward submitted to RQIA the details of two complaints received from 1 April 2013 and 31 March 2014. The inspector reviewed complaints records and noted that there were no formal complaints within this time period. However one patient informed the inspector that they had completed a formal compliant to their home trust about their delayed

discharge and the lack of community resources. The patient was waiting on a response. The patient stated the independent advocate and staff on the ward had supported them to write the complaint.

8.0 RQIA Compliance Scale Guidance

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

No requirements or recommendations resulted from the unannounced inspection of **Shannon Clinic Ward 3, Knockbracken Healthcare Park** which was undertaken on **11 & 12 March 2015** and I agree with the content of the report.

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

NAME OF REGISTERED MANAGER COMPLETING	Una Maguire
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING	Martin Dillon, Deputy Chief Executive

Approved by:	**Date**
Wendy McGregor	18 May 2015

Appendix 1 – Follow up on Previous Recommendations

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

Appendix 2 – Inspection Findings

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

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

Follow-up on recommendations made following the announced inspection on 27 & 28 January 2014

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	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 concerns. All referrals were sent to the Designated Officer electronically via the PARIS system. The PARIS system was noted to identify the number of referrals, and alert the designated officer to multiple referrals in relation to victims, and perpetrators. The inspector reviewed one patient's electronic file. There was a record in this patient's electronic file, which enabled quick access to the number and detail of the safeguarding vulnerable adult referrals. The inspector was informed by the ward manager and designated officer that 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
2	It is recommended the ward manager ensures that all staff working on the ward have received up to date training in Safeguarding Vulnerable Adults. (1)	The inspector reviewed the training records for staff working on the ward. All staff had received up to date training in safeguarding vulnerable adults.	Fully met
3	It is recommended that the ward manager ensures a record of local complaints, the action taken and the outcomes is maintained on the ward. (1)	The inspector reviewed records in relation to complaints. There was a record of local complaints, the action taken and the outcomes. These records were maintained on the ward and accessible to patients. Concerns raised were mainly in relation to environmental issues, such as	Fully met

		heating, electrical fittings and the fridge not working. The outcomes were shared with patients at the daily community meetings.	
4	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 policy and procedure. (1)	The inspector reviewed paper copies of care documentation in relation to four patients. The inspector noted that the contents were consistent, up to date and relevant and in line with BHSCT records management policy and procedure. The inspector noted that the ward manager had introduced an audit template of what should be retained in the paper copies of the patients' care documentation. The ward manager stated the audit will be completed monthly by night staff. The ward manager will review the outcomes of the audit.	Fully met
5	It is recommended the ward manager ensures that all associated members of the multi-disciplinary team consistently document their interventions into the associated multi-disciplinary care documentation. (1)	The inspector reviewed documentation that the ward manager had sent to members of the multi-disciplinary team requesting that they all complete the Integrated Care Pathway. The inspector reviewed care documentation in relation to four patients. The inspector noted that although the Integrated Care Pathway had not consistently been completed by members of the multi-disciplinary team. The team had recorded their interventions on the PARIS system. It is hoped that with the introduction of the Mental Health Core Care Pathway, information will be recorded in one place on the PARIS system.	Fully met

6	It is recommended the trust review and reduces the length of time of three months between menu ordering and the food delivery. This review and reduction should consider the specific requests addressed by the patient forum meetings and food users group. (1)	The inspector reviewed the minutes from the food users group. Liaison between ward staff and hospitality staff was evident. There is now agreement if patients do not want the food on the menu they can order an alternative. Patients have unrestricted access to the kitchen to make meals. The ward manager stated that patients receive £6 allowance from the trust to purchase a takeaway of their choice on Fridays. Patients are invited to attend the food users group.	Fully met
7	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 ward manager stated that the milk allowance was reviewed and increased. However there are times when less milk is required. The milk allowance is reviewed daily, and can be increased or decreased as required. There were no concerns raised by patients or the ward advocate in relation to the milk allowance.	Fully met
8	It is recommended the ward manager reviews the frequency of cleaning and disposal of smoking debris in the garden area to ensure the smoking area is within general hygiene standards. (1)	The ward manager had reviewed the frequency of cleaning and disposal of smoking debris. Patients are reminded to clean the smoking area on a weekly basis. The inspector observed the garden area and noted the area to be within general hygiene standards.	Fully met
9	It is recommended the ward manager ensures there are adequate staff resources to ensure patients do not miss out on their therapeutic or recreational activities. (1)	The inspector observed the therapeutic and recreational activity schedules for four patients. The inspector spoke to three patients who confirmed that their activities were occasionally cancelled. The patients stated they were informed of the reason for the cancellation.	Fully met

		The ward manager stated that activities were only cancelled in an emergency when urgent response is required from another ward.	

Follow-up on recommendations made following the patient experience interview inspection on 29 May 2014

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

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

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

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
	N/A	N/A	N/A	N/A

Ward Self-Assessment

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

Carers will also be contacted by the Carer Advocate aligned to Shannon Clinic (CAUSE) who will offer to meet with them. As stated above patients and their relatives/carers (where appropriate) are fully involved in their person centred treatment plan and risk management plan. All patients are invited to their weekly multidisciplinary team meetings. Should a patient decline to attend, their views and requests will be obtained by a member of staff prior to the meeting (or by the Patient's Advocate if preferred). Feedback regarding the outcome of the meeting is given to the patient and their relatives/carers (where appropriate) afterwards. A record of this is made in the patient's records and patients are asked to sign their nursing care plans to evidence their agreement with this. Where a patient doesn't wish to sign their care plan, a record of the reason for this will be documented. Patients and their relatives/carers (where appropriate) can request to meet at any time with their Consultant Psychiatrist. 1:1 time with a member of nursing staff is allocated daily and the Named/Associate Nurse meets with their patient regularly. There are daily patient community meetings and monthly meetings chaired by the Patients Advocate. Advocacy Services are in place for both patients and their relatives/carers (where appropriate) should they wish to avail of them. Advocacy is an integral part of ensuring that patients and their relatives/carers (where appropriate) have adequate time and resources to optimise their understanding of their treatment and care. Patient Advocacy Services within Shannon Clinic are offered by Mindwise - Shannon has a full time Patient Advocate who facilitates "Shannon for Us" meetings (patient meeting) and is part of its Operational Team. The Patient's Advocate represents the Patient where requested and can attend their multidisciplinary team meetings and discharge meetings if requested by the patient. 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 10 ensuite bedrooms within Ward 3 in which patients keep their property and to ensure patient's privacy. Patients have their own key for their room unless risk assessment dictates otherwise. Where a patient doesn't have their own key they can request staff to open/lock door as necessary. Patients are discouraged from bringing large amounts of money or expensive items into the Unit. Any large amounts of money/expensive items will go to the onsite Patients Bank. Staff in Ward 3 work to the Trust's revised Patient Finance Policy. As part of the recovery ethos, patients are encouraged to spend time with their family either within the Unit or as per pass arrangements. A private room is available for relatives to visit the patient in the Unit - all visits are planned and	

supervised as per Shannon Clinic's Visiting Policy. Visits outside set visiting times will be facilitated if necessary. The Unit's Social Worker will meet with the patient's relatives/carers on the patient's admission to advise them of the visiting policy in place. Patients have access to a GP whilst in Shannon Clinic.	
Inspection Findings: FOR RQIA INSPECTORS USE Only	
Information in relation to capacity and consent including Department of Health guidance was available for staff. The inspector interviewed three patients. Patients stated they had been involved in the development of their care and treatment plans and had been consulted in decision making processes. Patients stated their consent to care and treatment had been obtained prior to care delivery. Patients confirmed when they had not agreed to care and treatment this was respected. On the days of the inspection patients on Shannon ward 3 had been assessed as requiring rehabilitation. The inspector was informed by the ward manager that all patients on the ward had capacity to consent. The inspector reviewed care documentation in relation to four patients. There was evidence that capacity was assessed on admission. There was evidence that care and treatment plans had been discussed with the patients and all care plans had been agreed and signed by patients Promoting Quality Care risk assessments and management plans had been discussed with each of the four patients. Three patients had agreed with the assessment and had signed this document, one patient had not signed with the reason given that they 'had refused'. Prior to patients Promoting Quality Care meeting, a letter had been sent to each patient informing the patient of the meeting inviting them to attend. The letter included a questionnaire asking the patients the following questions; • Are you aware of the contents of your current care plan? • Do you agree with your entire care plan? • Is there anything you would like to change / add to you care plan? • Have you any goals that you feel the forensic Mental Health Team can help you achieve? • Please write down any comments about the mental health care you receive/ • Do you know who to make contact with and get help from services if an urgent mental health problem arises	Compliant

• Do you consent to your care plans begin shared with your relative? • Will you be attending your review? It was also noted that when patients had consented, a letter was sent to their next of kin inviting them to attend the Promoting Quality Care meeting with a similar questionnaire as above. Patients were also given the choice of whether they wanted the minutes from the meeting or their full Promoting Quality Care report. There was evidence in the patients' daily progress notes reviewed that all staff sought consent before care and treatment delivery. The independent advocate confirmed that they attend weekly multidisciplinary and Promoting Quality Care meetings at the patients' request. There was evidence the Human Rights Article 8, the right to respect for private and family life and Article 14 the right to be free from discrimination had been considered in patients' care documentation. There was evidence in the care documentation reviewed that staff had an understanding of how they consider patients' Human Rights. Staff promoted ongoing family engagement. A carer's advocate was also available.	

Ward Self-Assessment

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

Belfast Trust has an established process in place to access interpreters. Staff will access an interpreter who can address the communication issue a person presents with. This is to enable the patient and their relatives/carers (if appropriate) to continue to input into their treatment and care. This also allows staff to meet the patient's spiritual or cultural needs. There are 10 ensuite bedrooms within Ward 3 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 onsite Patients Bank. Staff in Ward 3 work to the Trust's revised 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 three patients spoken to during the inspection all confirmed that they had been involved in their assessments, care plans, risk assessments, risk management plans and subsequent reviews. Patients confirmed they were invited to attend their weekly multi-disciplinary meetings and Promoting Quality Care Reviews. Patients stated they had the opportunity to meet daily on a 1:1 basis with an allocated member of staff and at least weekly with their named nurse. The inspector reviewed documentation in relation to four patients. All care documentation was completed electronically on the. There was a continuous record completed by all members of the multi-disciplinary team	Compliant

involved in the patients' care. A paper copy of essential care documents was held on the ward, which could be used in the event of a technical difficulty with the information technology systems and the need to access this information in an emergency. Assessments, care plans, risk assessments and risk management plans were individualised, person centred and holistic. Patients also had a Developing an Individual Approach plan completed.

There was evidence of patient attendance at their multi-disciplinary reviews and Promoting Quality Care review meetings and evidence of discussions with the patient prior to and after the meetings. Patients' views in relation to their care and treatment plans were also discussed and recorded.

The template used for patients' care plans ensured that they were person centred and promoted patient involvement. Patients identified what their own needs were, what staff could do to help and how staff would know what they were doing was helpful. Each set of care plans reviewed by the inspector evidenced that patients had been involved, had agreed and had signed the documentation. The inspector noted that a care plan had been completed for every need identified in the patients' assessment.

Care plans were holistic and addressed the following;

- Mental Health Needs
- Medication
- Psychological Functioning
- Physical Health
- Supports (family, emotional, professional, social)
- Placement (inpatient, level of security)
- Alcohol/substance misuse intervention
- Child care/Child protection /Vulnerable adults
- Financial
- Occupation/Leisure/Education
- Activities of Daily Living (ADL)
- Cultural/Spiritual Needs

A template had been introduced for nursing staff to evaluate the patients' care and treatment on a weekly basis. The information was collated from the patients' daily progress notes. The information was discussed at the weekly case conference. The template addressed the following;

- Mental state (include symptoms, impact on social functioning, sleep pattern, engagement and

motivation • Medication (compliance, desired effects, side effects, any changes to treatment, psychoeducation, and attitudes to medication • Physical health • Financial • Incidents (CRA updated) • Adult safeguarding issues (protection plan / management plan) • Nursing care plan reviews and 1:1 named nurse sessions • Feedback from escorts/activities (include escorted walks, community leaves on and off ward activities and nursing input • Patient requests (include patients' wish to see consultant/attend case conference) • Nursing recommendations A G.P visited the clinic twice weekly. Shannon Clinic also had a Health and Well-being Nurse one day per week to support patients with physical health needs and health promotion. There was evidence that patients' Human Rights Article 3 the right to be free from inhuman or degrading treatment/punishment, Article 5 the right to liberty and security of person, Article 8 the right to respect for private and family life and Article 14 the right to be free from discrimination were considered and documented in the patients' care plans. Communication needs were assessed on admission. Patients for whom English was not their first language were supported by an interpreter for case conferences, explanation of rights and meetings with the consultant psychiatrist. Staff informed the inspector how to access the interpretation service when required.	

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. The Band 7 OT 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 10 ensuite bedrooms within Ward3 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 onsite Patients Bank. Staff in Ward 3 work to the Trust's revised Patient Finance Policy. As part of the recovery ethos, patients are encouraged to spend time with their family either within the Unit or as per pass arrangements. A private room is available for relatives to visit the patient in the Unit - all visits are planned and supervised as per Shannon Clinic's Visiting Policy. Visits outside set visiting times will be facilitated if necessary. The Unit's Social Worker meets with the patient's relatives/carers on the patient's admission to advise them of the visiting policy in place.	Moving toward compliance
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

The three patients interviewed by the inspector stated they had the opportunity to take part in both recreational and therapeutic activities within the Shannon Clinic. Shannon ward 3 receives input from four full time occupational therapists, and one full time occupational therapy assistant. There was also has one full time technical instructor for woodwork and the support from three nursing care assistants three days per week for recreational activities. The inspector reviewed care documentation in relation to four patients on the ward and noted the following; • Each patient had an appropriate occupational therapy assessment completed. There was evidence of patient involvement in assessment. • 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. • There was evidence of evaluation of improved patient outcomes. Each occupational therapist was aligned with the patients' consultant to ensure consistency of care as patients move from ward 1 to ward 2 or 3. The following therapeutic and recreational activities were available for patients; Dialectical Behaviour Therapy (DBT), Psycho- education, Coping with Mental Illness, Good Thinking Skills and other psychological therapies, woodwork, horticulture and the gym. A ward group activity schedule was displayed in the patient communal area. Some of the recreational activities offered to patients included, current affairs, ward art, hen duty, football, rackets club and a music group. Rehabilitation type activities were offered to patients to promote independence with activities of living e.g cooking, laundry, shopping and integrating and community engagement. All activities were delivered by both nursing and occupational therapy.	Compliant

The following facilities were available within the clinic, indoor sports hall and a gym, library, tuck shop, coffee shop, garden and hen keeping. On the days of the inspection patients on Shannon ward 3 had been assessed as requiring rehabilitation in a less restrictive environment. The inspector was informed by the ward manager that patients were progressing toward discharge and had more access to both escorted and unescorted activities. These included walks in the hospital grounds, community leave and attendance at community activities provided by external agencies. Patients had unrestricted access to the kitchen and could make their own meals. A new “inside out” project was scheduled to commence in April 2015. This has been developed with Extern and aims to support patients to develop “a work ready attitude, promote community integration, improve future employability, endorse health and well-being explore meaningful activities, develop vocational skills and assist with resettlement”. Patients will be offered the opportunity to develop essential skills and ICT, upholstery and catering with the goal of obtaining a vocational qualification. The inspector noted that monthly therapeutic co-ordination group meetings were convened. Members of the group comprised of the independent advocate, nursing, medical, social work and O.T staff. This group were responsible for coordinating the development and subsequent maintenance of the therapeutic programmes in Shannon clinic. Minutes of the group meetings were available on the ward. There was evidence of consideration to patients’ Human Rights Article 8 the right to respect for private and family life.	

Ward Self-Assessment

Statement 4: Information about rights • **Patients have been informed about their rights in a format suitable to their individual needs and access to the communication method of his/her choice. This includes the right to refuse care and treatment, information in relation to detention processes, information about the Mental Health Review Tribunal, referral to the Mental Health Review Tribunal, making a complaint, and access to independent advocacy services.** • **Patients' Article 5 rights to liberty and security of person, Article 8 rights to respect for private and family life and Article 14 right to be free from discrimination have been considered.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Patients are given an admission booklet at the time of admission. This contains information on the detention process, making a complaint and access to advocacy services. This is discussed with the patient by a member of staff or if preferred by the patient's advocate/representative. A more user friendly format of explaining a patient's rights is currently being explored with the Service User Consultant for Mental Health Services. A booklet for Carers is also available for the patient's relatives/carers. Carers are contacted by the Carer Advocate aligned to Shannon Clinic (CAUSE) who will offer to meet with them. An interpreter is requested if required. There is a full time Patients' Advocate within Shannon Clinic. He facilitates "Shannon for Us" meetings (patient meeting) and is part of its Operational Team. The Patient's Advocate will represent the Patient where requested and can attend their multidisciplinary team meetings and discharge meetings if required. They address specific individual patient concerns with ward staff and any more generalised patient concerns at the Operational Team Meeting. Carers Advocacy is provided by CAUSE. Belfast Mental Health Services has a history of good working relationships with its Patient and Carers Advocates and has representation on both its governance committee and senior management team. This allows their representation at all levels throughout. There are 10 ensuite bedrooms within Ward 3 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 onsite Patients Bank. Staff in Ward 1 work to the revised Trust's revised Patient Finance Policy. As part of the recovery ethos, patients are encouraged to spend time with their family either within the Unit or as per pass	Moving toward compliance

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

documented and shared with patients. Concerns raised were in relation to environmental issues, mainly heating, electrical fittings, fridge not working. One patient had completed a formal complaint to their home trust because there discharge was delayed. The inspector reviewed documentation relating to four patients. Patients who were detained in accordance with part 2 of the Mental Health (Northern Ireland) Order 1986 had been informed of their right to appeal to the Mental Health Review Tribunal. Staff interviewed informed the inspector how to access and effectively use advocacy services. A carer's advocate is available. There was a visitor feedback card in reception that asked visitors to provide comments on the Shannon clinic and to suggest any improvements.	

Ward Self-Assessment

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

There are 10 ensuite bedrooms within Ward 3 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 onsite Patients Bank. Staff in Ward 1 work to the Trust's revised Patient Finance Policy. As part of the recovery ethos, patients are encouraged to spend time with their family either within the Unit or as per pass arrangements. A private room is available for relatives to visit the patient in the Unit - all visits are planned and supervised as per Shannon Clinic's Visiting Policy. Visits outside set visiting times will be facilitated if necessary. The Unit's Social Worker will meet with the patient's relatives/carers on the patient's admission to advise them of the visiting policy in place.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Shannon Clinic had a number of restrictive practices in accordance with the requirements of a medium secure unit. Access and exit from the ward 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 for patient to access. Bedrooms were not locked on the days of the inspection. The inspector reviewed documentation in relation to four patients. Each patient had an individual approach plan completed using the stair case model. This identified why a person responds in an aggressive and violent manner, the triggers for aggression, the aim of staff intervention, the goals staff want the individual to achieve and what alternative coping mechanisms staff could teach the patient. The plan included patients' presentation when calm, tense, using non-verbal aggression, verbal aggression and critical moments. Proactive strategies were documented. There was evidence of patients' involvement in their plans. There was evidence in the documentation that patients had been fully informed of the potential use of restrictive practices such as physical interventions and the rationale for using these methods of intervention. The inspector was informed by the ward manager that there had been no incidents requiring physical intervention in two years. The ethos of the ward is	Compliant

that if patients require that level of intervention they should not be in a rehabilitation ward. All incidents resulting in the use of restrictive practices were discussed and reviewed at the weekly bed management meeting and at the patients' weekly multi-disciplinary meetings. All documentation was completed in line with trust policy and Promoting Quality Care guidance. Training records reviewed evidenced that all staff working on the ward had received up to date training in the use of physical interventions. The inspector noted evidence that restrictive practices were reviewed at the monthly staff meetings. It was noted in the four sets of care documentation that consideration was given to patients Human Rights Articles 3 the right to be free from torture, Article 8 the right to respect and family life, and Article 14 the right to be free from discrimination.	

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 including Article 8. 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 toward compliance
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Patients transfer to Shannon ward 3 from Shannon ward 2 when assessed as requiring rehabilitation in a less restrictive environment. The inspector reviewed documentation in relation to four patients. Plans for discharge were discussed with patients. When assessed as medically fit for discharge patients are discharged to independent accommodation, supported housing or return to prison. The patients' Promoting Quality Care risk assessment and risk management plans identify risks and supports	Compliant

that patients require on discharge. Discharge plans were noted to be person centred and evidenced patient involvement. Staff had recorded how they support patients with preparation for discharge. Staff prepare patients by supporting them through a self-medication programme, with the aim that patients will self-medicate safely as prescribed before discharge. There were two patients whose discharge was delayed during the days of the inspection. This was due to lack of appropriate supports in the community for one patient and the other patient was waiting on a panel meeting to assess for potential accommodation. The inspector had noted that both patients had been kept fully informed. One patient had submitted a formal complaint to their home Trust in relation to delay in sourcing suitable support in the community. The inspector reviewed this patient's care records and there was evidence of the ward manager actively liaised with both patient's care manager and community team in relation to this patient's delayed discharge.	

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

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

SUPPLEMENTARY INFORMATION

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

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

Within the last 12 months, please confirm the number of investigations undertaken on the ward and their outcomes.			
Adult Protection Investigations		**Child Protection Investigations**	
Substantiated Allegations	28	Substantiated Allegations	0
Unsubstantiated Allegations	29	Unsubstantiated Allegations	0
On-going Allegations	0	On-going Allegations	0
Total	57	Total	0

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