The Regulation and Quality Improvement Authority

Inspection Report

10 January – 14 February 2023

Shannon Clinic

Type of Service: Medium Secure Forensic Inpatient Unit
Shannon Clinic
Knockbracken Healthcare Park
Saintfield Road
Belfast
BT8 8BH
Tel No: 028 9056 5656

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Belfast Health and Social Care Trust (BHSCT)	**Responsible Individual:** Dr Cathy Jack Chief Executive
Person in charge at the time of inspection: Jonathan Killough, Interim Service Manager	**Number of registered places:** 34
Categories of care: Medium Secure Forensic Inpatient Unit	**Number of patients accommodated in the wards on the days of this inspection:** 30

Brief description of the accommodation/how the service operates:

Shannon Clinic is a regional, medium secure, forensic, inpatient unit, situated on the grounds of Knockbracken Healthcare Park. Shannon Clinic provides intensive psychiatric treatment or rehabilitation in a secure therapeutic environment. There are three wards in Shannon Clinic. Each ward has its own specific function:

- Ward 1 is an admission and assessment unit for male patients.
- Ward 2 provides care and treatment to both male and female patients; female patients are admitted directly to Ward 2 and remain there until discharge.
- Ward 3 provides rehabilitation to male patients.

2.0 Inspection summary

An unannounced inspection of Shannon Clinic commenced on 10 January 2023 at 9am and concluded on 14 February 2023, with feedback to the Trust's Senior Management Team and representatives of the multidisciplinary team. The inspection team comprised care inspectors, a senior inspector, an assistant director and administration staff.

The inspection focused on the following ten key themes; environment; incident management and adult safeguarding (ASG); staffing; physical health; restrictive practices; patient experience; governance; patient flow; medicines management; and mental health.

Intelligence received by RQIA since the last inspection related to concerns about staff and patient safety, low staff morale, and staffing levels. These concerns were reviewed during this inspection and further detail is available in sections 5.2.2 and 5.2.3.

The previous inspection of Shannon Clinic on 14 December 2020 resulted in a serious concerns meeting. Twelve areas for improvement (AFI) were identified. These AFIs were reviewed during this inspection; five were assessed as met; five were assessed as partially met; and two were assessed as not met.

Taking into consideration the outcome of this inspection we determine Shannon Clinic does not require to remain in serious concerns. The Trust were informed of this decision during feedback and this was confirmed in writing following the inspection.

Eleven areas for improvement were identified in relation to; the environment; incident management (grading of incidents and post incident debrief); staffing; physical health; mental health; and governance. These will be managed through a quality improvement plan (QIP) which details the actions required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

We observed staff doing their best to deliver safe, effective and compassionate care whilst also managing complex patient needs. Areas of good practice were noted in relation to adult safeguarding and medicines management.

3.0 How we inspect

RQIA has a statutory responsibility under the Mental Health (Northern Ireland) Order 1986 to make inquiry into any case of ill-treatment, deficiency in care and treatment, improper detention, and/or loss or damage to property. Care and Treatment is measured using the Quality Standards (2006) for Health and Social Care to ensure that services are safe, of high quality, and up to standard.

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

4.0 What people told us about the service

Posters and easy read leaflets were placed throughout the wards inviting staff and patients to speak with inspectors and feedback on their views and experiences.

We spoke with a number of patients and staff, and also the Carers' Advocate. There were no patient or staff questionnaires returned.

Patients who spoke to us indicated they were satisfied with the care and treatment they received and gave positive feedback about the staff delivering it.

The majority of staff spoke positively about the ward, the standard of care delivered to the patients, and ward management. Staff raised some concerns about the level of support available to them following incidents.

The Carers' Advocate reflected positive feedback from relatives. Issues raised include mixed gender wards, and limited rehabilitation prior to discharge. Some relatives had made suggestions in relation to the gym and the ward shop.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection to Shannon Clinic was undertaken on 14 December 2020; 12 areas for improvement were identified.

Areas for improvement from the last inspection on 14 December 2020		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).		**Validation of compliance**
Area for Improvement 1 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1)(a)(d)(f) **Stated:** Third time **To be completed by:** 22 February 2021	The Belfast Health and Social Care Trust shall ensure that the ongoing variation in practice in relation to recording, reviewing and updating information in PQC and associated risk assessments is addressed. Consideration should be given to: • An agreed suite of PQC and associated risk assessment • A standardised approach to the review and updating of PQC and associated risk assessments that detail the frequency of reviews, the responsibility for updating the chronology of events and the level of detail that is required • A consistent and agreed approach, amongst all members of the MDT, as to the storage of PQC and associated risk assessments • Evidencing that the PQC and associated risk assessments are being used to inform care and treatment plans • Evidencing regular audit of PQC and associated risk assessments to ensure they are completed in line with the Department of Health's (DoH) Good Practice Guidance on the Assessment and Management of Risk	**Partially met**

	in Mental Health and Learning Disability Services.	
	Action taken as confirmed during the inspection: The majority of PQC risk assessments were reviewed three monthly. Standardised documents were in use; however, there continues to be disparity in the recording and storage of the documents. This area for improvement has been partially met and will be subsumed into a new area for improvement relating to recording and storage of documentation.	
Area for Improvement 2 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1)(f) **Stated:** Third time **To be completed by:** 22 February 2021	The Belfast Health and Social Care Trust shall ensure that the ongoing variation in practice in relation to recording medical reviews is addressed. Consideration should be given to: • An agreed format to be used • A standardised approach to the review and updating of the records that details the frequency of reviews and the level of detail that is required • A consistent and agreed approach, amongst all members of the MDT, as to the storage of medical review records • Evidencing that the medical reviews are being used to inform care and treatment plans	**Partially met**
	Action taken as confirmed during the inspection: Standardised documents were in use; however, there continues to be disparity in the recording and storage of the documents. Care plans were updated following medical reviews. This area for improvement has been partially met and will be subsumed into a new area for improvement relating to recording and storage of documentation.	

Area for Improvement 3 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1)(f) **Stated:** Fourth time **To be completed by:** 22 February 2021	The Belfast Health and Social Care Trust shall undertake a review of clinical leadership roles and responsibilities in the context of the needs of Shannon Clinic. The review should take account of: • The current arrangements for weekly ward rounds with a view to seeking opportunities for better streamlining of this work • The strategic direction of Shannon Clinic in the context of a regional forensic service • The number and range of meetings to ensure that each meeting has a clear purpose and that minutes of each meeting accurately reflect the progress, decisions made, and action updates between meetings • Clear lines of accountability across both the clinical and managerial teams • Ongoing and future work streams to ensure they are aligned to the operational and strategic direction of Shannon Clinic and have been developed and prioritised in agreement with the both clinical and managerial leadership teams.	**Met**
	Action taken as confirmed during the inspection: There is a new clinical leadership structure in place. Each Consultant Psychiatrist holds weekly patient review meetings with minutes recorded, including actions agreed. The strategic direction of Shannon Clinic was discussed with representatives from the Trust and the Department of Health, and confirmation given for the future plans of Shannon Clinic as the regional, medium secure, forensic inpatient unit. This area for improvement has been met.	

Area for Improvement 4 **Ref**: Standard 6.1 Criteria 6.3 (6.3.1) **Stated:** First time **To be completed by:** 22 February 2021	The Belfast Health and Social Care Trust shall communicate with Shannon Clinic SMT, patients, staff and carers regarding the rationale of downgrading the business case for the provision for a de-escalation suite and separate accommodation for female patients.	**Not met**
	Action taken as confirmed during the inspection: This area for improvement has not been met and will be revised to reflect changes made to the business case.	
Area for Improvement 5 **Ref**: Standard 4.1 Criteria 4.3 (i)(j)(n) **Stated:** First time **To be completed by:** 22 March 2021	The Belfast Health and Social Care Trust shall revisit the staffing review in the context of patient needs. The review should take account of: • Levels and skill mix at night in all three wards • Staff and patient safety in the event of an emergency situation • Staffing levels to accommodate patient outings, appointments and leave • Staff knowledge of the Telford Model and how it is used to determine skill mix and staffing levels. • Managerial oversight of staff bank hours • Managerial oversight of social work and allied health professionals input into wards with regard to meeting patient needs • Roles and responsibilities of SMT when alerted to staff shortages and agree arrangements to obtain cover.	**Met**
	Action taken as confirmed during the inspection: Staffing has been reviewed using the Telford model. A procedure outlining the roles of staff, including SMT, when addressing staffing shortages was available. All three wards had appropriate staffing levels at night, taking into consideration the requirement to respond to emergencies across the wards. Patients were, for the most part, able to engage in activities, outside of the ward, accompanied by staff as required. There	

	was evidence of allied health professional input into patient care. This area for improvement has been met.	
Area for Improvement 6 **Ref**: Standard 4.1 Criteria 4.3 (a)(g)(j)(l)(m) **Stated:** Third time **To be completed by:** 22 March 2021	The Belfast Health and Social Care Trust shall ensure that issues with respect to ongoing monitoring of mandatory training are addressed. The work should: • Detail the mandatory training required by staff across Shannon Clinic relevant to their specific roles and responsibilities • Ensure there is robust governance and oversight of mandatory training both at individual ward level and across Shannon Clinic • Ensure there is a mechanism in place to alert staff when mandatory training is about to expire • Address the identified deficits with respect to IPC and ASG training • Ensure training is embedded in practice and where necessary address any practice issues that highlight noncompliance with training received.	**Partially met**
	Action taken as confirmed during the inspection: Arrangements were in place for the oversight of staff training records by ward managers and members of senior management. A colour coded alert system had been implemented to notify staff when training was due to expire. Staff compliance with mandatory training was discussed at staff meetings. Training records highlighted some gaps in mandatory training, including continued deficits in Infection Prevention and Control, and Adult Safeguarding training. This area for improvement has been partially met and will be subsumed into a new area for improvement relating to staff training.	

Area for Improvement 7 **Ref**: Standard 5.1 Criteria 5.3 (5.3.2) **Stated:** Third time **To be completed by:** 22 April 2021	The Belfast Health and Social Care Trust shall undertake a review of incident management. The Trust must: • Undertake an urgent review of information recorded in the Trust's Datix system, to ensure that they understand the nature and extent of risks captured in the system; • Take action to address and mitigate specific patient safety risks (individual themes and/or trends) identified as part of the above review and ensure these risks are appropriately addressed in a timely manner; • Assure themselves that staff across Shannon Clinic have sufficient knowledge, awareness and understanding of adverse incidents and near misses, so that they (incidents and/or near misses) are appropriately recognised and accurately recorded in the Trust's Datix system. The grading of adverse incidents and near misses must be based on the risk inherent in each event and not on the outcome reported for the event in question; • Ensure there are appropriate structures in place to review, approve, and escalate all incidents, adverse incidents and near misses captured in the Trust's Datix system, and demonstrate that mechanisms for assuring this dynamic process are sufficiently robust; • Design and implement processes to ensure that (i) they are regularly updated on the spectrum of adverse incidents and near misses occurring across Shannon Clinic, (ii) all incidents and near misses are graded on inherent risk, (iii) appropriate mitigating actions have been identified and progressed in relation to risks identified, and (iv) learning arising from incidents and near misses has been identified and shared with all relevant staff.	**Met**
	Action taken as confirmed during the inspection: A review of incident management was undertaken at senior management level. Learning from this review had been shared	

	with ward managers who implemented learning at ward level. Staff spoke confidently about the management of incidents on the wards and the mechanisms employed to prevent further recurrence. Staff demonstrated improved knowledge and recognition of what constitutes an adult safeguarding referral following an incident. The Designated Adult Protection Officer (DAPO) has implemented robust systems for the oversight and management of incidents and adult safeguarding referrals. These included trend analysis and identified learning following incidents. This area for improvement has been met.	

Area for Improvement 8 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** First time **To be completed by:** Immediately	The Belfast Health and Social Care Trust shall undertake a review of adult safeguarding. The review should take account of and ensure: Staff at all levels and across all disciplines have a sufficient working knowledge of identifying, managing, reporting and escalating adult safeguarding incident Safeguarding procedures are followed in line with regional guidance; Adult Safeguarding: Prevention and Protection in Partnership Policy (2015) and the Trust's policy • ASP1 forms should be completed in full and contain information outlining any immediate protection plans required • Recording of incidents on the Datix system and progress notes should state when ASP1's are made • There is timely review and screening of ASP1's and that the system alerts ward managers and DAPO's of any referrals that require screening • There is regular review, audit and analysis of safeguarding incidents to identify trends and themes emerging and this should inform patients, staff, visitors to the ward, and ward performance reports • There is an adult safeguarding champion identified for Shannon Clinic.	**Met**
	Action taken as confirmed during the inspection: Significant improvement has been made in relation to incident management and adult safeguarding. Staff were knowledgeable about adult safeguarding identification, escalation and reporting processes. The Designated Adult Protection Officer (DAPO) has implemented robust systems for the oversight and management of incidents and adult safeguarding referrals. These include trend analysis and identified learning following incidents.	

	Each ward had displayed information about the adult safeguarding champion and the regional policy and procedure. This area for improvement has been met.	
Area for Improvement 9 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) (e) **Stated:** First time **To be completed by:** 22 February 2021	The Belfast Health and Social Care Trust shall undertake a review of environmental risk in the context of fire safety. The review should take account of and ensure: • There are fire wardens available on each shift; • Practical fire drills are completed annually; • Items requiring action arising from the fire risk assessment action plans should identify action owner and timescale for completion; • Appropriate governance structures are in place to monitor items are actioned.	**Partially met**
	Action taken as confirmed during the inspection: Trust staff had completed practical fire drills and fire wardens were identified on each shift. An up to date fire risk assessment was available; however, it did not provide timescales for the completion of actions nor what had been actioned. There were deficits in staff mandatory fire training. This area for improvement has been partially met and will be revised to include areas not met.	

Area for Improvement 10 **Ref**: Standard 8.1 Criteria 8.3(b)(c)(d)(h)(i) **Stated:** First time **To be completed by:** 22 February 2021	The Belfast Health and Social Care Trust shall ensure that the ongoing variation and deficits in relation to managing records is addressed. Consideration should be given to: • Ensuring there is an agreement between all staff and disciplines where records should be stored and saved; • Ensuring records are updated following any significant change in circumstances, incidents or status to reflect changes in treatment plans or risk assessments; • Ensuring regular audits on record keeping are completed.	**Not met**
	Action taken as confirmed during the inspection: This area for improvement has not been met and will be subsumed into a new area for improvement relating to the management of records. See AFI 1 & 2 above.	
Area for Improvement 11 **Ref**: Standard 8.1 Criteria 8.3 (k) **Stated:** First time **To be completed by:** 22 February 2021	The Belfast Health and Social Care Trust shall undertake a review of complaints management. The review should take account of and ensure: • All staff have sufficient working knowledge of managing Complaints; • A record is kept at ward level of any local/informal complaints and this should detail; actions taken to resolve the complaint; who is responsible for managing it; and the outcome of the actions and whether or not the complainant is satisfied with the outcome; • Where appropriate, the resolution of complaints evidence improvement in service delivery and/or the patient experience. This should be documented and included in ward performance reports.	**Partially met**

	Action taken as confirmed during the inspection: Literature pertaining to complaints was available at ward level. Staff were knowledgeable about the complaints process. Records of complaints and their outcomes were not available at ward level. This area for improvement has been partially met and will be revised to include areas not met.	
Area for Improvement 12 **Ref**: Standard 4.1 Criteria 4.3 **Stated:** First time **To be completed by:** 22 February 2021	The Belfast Health and Social Care Trust shall undertake a review of organisational and clinical governance. The review should take account of and ensure: • All staff have a clear understanding of the organisational and clinical governance structure and escalation processes within the Shannon Clinic and directorate; • There are clearly assigned governance oversight responsibilities for SMT members who are accountable for monitoring standards and driving improvement; • Improvement work is prioritised and all members of the MDT are informed of and involved in Quality Improvement initiatives; • Data sets for Shannon Clinic are separate to that of mental health acute inpatient facilities which inform the directorate and corporate governance reports**.**	**Met**
	Action taken as confirmed during the inspection: Organisational and clinical leadership has been reviewed and changes made. Staff described the new organisational structure and escalation process. SMT have clear governance oversight responsibilities and are driving improvement throughout Shannon Clinic.	

	Data sets for Shannon Clinic are now separate from those for acute mental health inpatient facilities which means that management can utilise specific information regarding the clinic effectively. This area for improvement has been met.	

5.2 Inspection findings

5.2.1 Environment

All three wards within Shannon Clinic have locked doors which patients can enter and exit with staff assistance. Patients are accommodated in single occupancy en-suite bedrooms and can lock and unlock their bedroom door as they wish.

The ward environments were bright and spacious. Patients were observed to move freely around the ward spaces, and had choice of different areas in which to spend their time. The wards require some redecoration, namely, painted areas need refreshed and some small items of décor require replacement. The furniture was in a good state of repair and appropriate for a medium secure environment. Communal areas between the wards were well maintained. The standard of cleaning throughout was good and there were no malodours.

A fire risk assessment, containing an action plan, was available and up to date; however, time frames for completion of work were not included, and completed actions were not easily identified. There was poor oversight and review of the fire risk assessment, which increases risk for patients, staff, and visitors.

A number of ligature risks were observed throughout the wards. A Ligature Risk Assessment was available, however, a number of actions had not been completed and not all ligature risks had been identified. These issues were raised immediately with ward managers and members of the SMT. The Trust gave assurances the issues identified would be addressed immediately, and the necessary action was taken during the inspection.

Damaged items of décor were accessible to patients in the wards and had the potential to be used, or be fashioned to be used, as weapons. These were highlighted to ward staff who took immediate action.

Environmental visits and oversight are an essential component of patient and staff safety; however, there was no evidence of environmental visits or audits by members of ward staff or the SMT. A new visiting programme, called a visiting pyramid, scheduled for implementation later in the year, will capture managerial visits at all levels. We recommend the findings from this inspection are reflected within it.

Areas for improvement will be made in relation to fire risk assessment, ligature risk, and environmental audit.

5.2.2 Incident Management and Adult Safeguarding

The Adult Safeguarding (ASG) arrangements for the wards were reviewed. ASG is the term used for actions which prevent harm from taking place and protects adults at risk (where harm has occurred or is likely to occur without intervention).

Significant improvement had been made in relation to incident management and adult safeguarding, which were areas of serious concern at the last inspection in December 2020.

Staff at ward level displayed good knowledge of ASG processes and what constituted an ASG incident. A number of staff had not completed ASG mandatory training or incident management training within the specified time frames. An area for improvement was identified - see Section 5.2.3.

An ASG Champion was identified for all three wards. ASG information was available throughout the wards and included process flow charts and contact details. ASG referrals had been made appropriately for the majority of incidents which met the ASG threshold. Protection plans were in place for all patients with open ASG investigations.

Shannon Clinic has an aligned Designated Adult Protection Officer (DAPO) who visits the wards regularly and is present at the monthly Multi-Disciplinary Team (MDT) governance meetings. The DAPO has oversight of all ASG referrals from the wards and displayed a good working knowledge of all ASG open investigations. Systems were in place for the oversight and governance of ASG investigations and the DAPO had implemented safety mechanisms to ensure ASG processes were not reliant on one individual. These were areas of good practice which could be shared across the Trust.

The recording of incidents on the Trusts electronic management system are known as Datix. Datix incidents from 1 June 2022 to 10 January 2023 were reviewed. There has been a high number of reported patient on staff assaults. Staff reported incident debrief was available if requested; however, it was not standard practice following an incident. Incident debrief is essential for staff learning and development, and enables staff to improve outcomes for patients. This has the potential to impact staffing retention, staffing levels, and staff morale, all of which impact patient care.

All staff within Shannon clinic wear an alarm system which they can use to call for assistance. During this inspection the alarms had been checked at the start of each shift to ensure that they were fully functioning and it was noted that staff responded appropriately when these alarms were triggered. However, staff reported that on occasion the alarms failed to activate when triggered. This is a significant risk for staff and patients. This was discussed with senior staff who informed us that the estates department were addressing alarm issues with the service provider. The Trust must expedite this issue and be assured that a fit for purpose staff alarm system is available at all times for staff and patient safety.

The Trust grading of risk process did not recognise incidents for escalation to senior management level until the risk was graded above insignificant. Patient assaults on staff had been consistently graded as insignificant, which did not accurately reflect the cumulative or potential impact on staff, or in some cases the serious injuries sustained. It is recommended that the grading of risk is reviewed and mechanisms are implemented to ensure cumulative risk is escalated.

A trauma informed support approach is one that recognises that trauma has been experienced and seeks to understand and respond to the impact the trauma has had. A limited psychology resource was available for patients and staff, both of whom spoke very positively about the impact of psychological support. The Trust must ensure there is an adequate psychology resource to effectively meet the needs of both patients and staff.

Areas for improvement will be made in relation to incident grading, incident debrief and trauma informed support for staff.

5.2.3 Staffing

The staffing arrangements in Shannon Clinic were reviewed through the analysis of staffing rotas, discussions with staff, observation of staff on shift and review of the staffing model. Staffing levels across the Clinic have been determined using the Telford model, which is a tool to assist staff in ensuring appropriate staffing levels are in place, based on patient acuity.

Staffing across the wards was based on a 60% registrant / 40% non-registrant ratio. This is not in keeping with the skill mix recommended in *Delivering Care, Phase 5A*, which is a ratio of 80% registrant / 20% non-registrant. Whilst a regional shortage of nurse registrants is acknowledged, the Trust should continue to aspire to achieve the recommended staffing ratio.

Shannon Clinic operates within an MDT model of care with a number of allied healthcare professionals (AHP) contributing to the MDT. These include Consultant Psychiatrists, Occupational Therapy staff, Clinical Psychology staff, and a number of Social Workers who are aligned to individual patients.

Staffing rotas reflected occasional shortages. Staffing levels were improved since the last inspection, including an increased staffing compliment at night. Agency and bank staff are being utilised to cover staffing deficits due to a number of staff absent from work. An improved support framework, detailing the escalation process and contact information for senior management, was in place when staffing deficits did occur.

Newly qualified substantive staff were allocated the nurse in charge of a shift role, despite more experienced agency staff being available. This practice is concerning and was discussed with members of Shannon Clinic senior management during inspection feedback. The Trust must ensure the most suitably experienced staff are allocated appropriate responsibility on each shift.

A detailed staff induction booklet had been developed and was available for review. It included information for staff working in a medium secure forensic unit and also provided advice and guidance on matters specific to Shannon Clinic. Staff training records highlighted some gaps in mandatory training, some of which required urgent attention. This was discussed during inspection feedback and assurances were provided this would be addressed as a priority. Specific forensic training should also be made available to all staff working in Shannon Clinic.

Areas for improvement will be made in relation to mandatory training, the allocation of nurse in charge, and specific forensic training for all staff.

5.2.4 Physical health

Patients physical healthcare needs were reviewed in accordance with*, The National Confidential Enquiry into Patient Outcome and Death: A Picture of Health? 2022*. This report reviews the quality of physical healthcare provided to adult patients admitted to a mental health inpatient setting.

Patients' physical healthcare needs were met, in the main, by an on-site General Practitioner (GP). There was evidence of blood testing, medication reviews, anti-biotic therapy, and anti-psychotic blood monitoring. Appropriate physical health risk assessments such as Malnutrition Universal Screen Tool (MUST) and National Early Warning Score (NEWS) risk assessments were in place for each patient. Physical health needs beyond the remit of a GP were sourced via referral to the appropriate specialism.

Patients requiring food and fluid modification had been assessed by a Speech and Language Therapist (SALT). Assessment outcomes were not readily available to all staff requiring the information, including catering staff. This issue was raised with ward management immediately and rectified by the following day, including revised care plans for patients with modified dietary needs.

Staff training records reflected that staff had not completed dysphagia training, despite this being recommended as mandatory training from May 2022. This recommendation followed the RQIA review of the implementation of recommendations to prevent choking incidents across Northern Ireland. Additionally, the Public Health Authority issued Mealtimes Matter in November 2022. Members of the SMT gave assurances, during feedback, that this would be explored and implemented as mandatory training for all staff.

Areas for improvement will be made in relation to information pertaining to patients modified dietary requirements, and staff mandatory training.

5.2.5 Restrictive Practice

Shannon Clinic is a medium secure forensic facility, and as such has necessary restrictions in place for patient, staff, and public safety. We observed staff delivering care in the least restrictive manner, considerate of the environment and patient needs.

Some patients had specific restrictions imposed as a result of their sentencing and offending behaviours. It was positive to note MDT discussion and decision making to enable patients to maximise their time off the ward, with support from ward staff and allied health professionals.

The Trust operates a site wide no smoking policy. Patients were not able to smoke within the hospital grounds. Patients told us that they chose to go out for a walk with staff, to avail of the opportunity to smoke, rather than engage in planned activities. At times staffing resources and ward priorities do not lend to staff leaving the ward to accompany patients for a walk; this has the potential to cause patients to become frustrated as they do not get the opportunity to smoke. The subject of smoking on the Trust site is a sensitive one and one that requires further discussion with appropriate patient advocate representation.

5.2.6 Patient Experience

The ward environment provided adequate space for patients to sit together, or avail of quiet time as they wished. There were facilities available within the wards for patients to complete their own laundry, cook and heat simple meals, or make hot beverages, all with staff assistance and/or supervision.

Patients spoke positively about the care they received and about the staff delivering it. They described staff as caring and respectful. We observed staff deliver care in a caring and professional manner, and patients were noted to be comfortable engaging with all staff. Patients told us they attend a weekly MDT meeting and stated they felt involved in discussions and decision making about their care.

Staff supported patients to partake in ward based activities and also accompanied them in activities outside the ward. Allied health professionals encouraged patients to engage in planned activities; however, patients frequently chose to spend their time walking outside with staff (see section 5.2.5).

The meal time experience for patients was relaxed and the food presented was appetising. Patients reported they had a reasonable variety of food to choose from, and could also request some items that were not on the standard menu. Snacks and treats were available for purchase in the tuckshop style facility located within Shannon Clinic.

There is an identified patient advocate who visits the wards on an ad-hoc basis, or when requested to by a patient. The patient advocate is available to support patients at MDT meetings, Promoting Quality Care (PQC) meetings, and is also on request to support patients attending Mental Health Tribunal Hearings.

We spoke to a Carers' Advocate who has regular contact with a number of relatives of patients within Shannon Clinic. Relatives have not expressed any direct care and treatment related concerns through this forum. Relatives have raised some concerns about the limited rehabilitation work available to patients prior to discharge, the patient mixed gender in one ward, and the length of stay for some patients. They also made some suggestions in relation to gym availability, and choice of goods at the tuckshop.

Literature pertaining to Shannon Clinic, the Mental Health Order (including detention), and the Mental Health Review Tribunal was available throughout the Clinic.

5.2.7 Governance

It is important to recognise there have been significant changes to the management structures within the Trust, and in particular across the Knockbracken site. These changes require time to embed and consideration should be given for staff to become established in their new roles.

Good improvement has been noted since the last inspection in December 2020. The Trust submitted an action plan, and subsequent updates, by way of providing assurances for the concerns identified during the last inspection.

A business case had previously been raised to address the ongoing issues in relation to the mixed gender on one ward and the lack of a seclusion facility within Shannon Clinic. We had been advised that this business case had been downgraded and there had been no further progress in relation to the two issues. It was positive to note that this has been revisited and a revised business case has been drafted to address the mixed gender issue; the lack of seclusion has not been included in the revised case. RQIA will monitor the progress of this work.

Data sets for Shannon Clinic were available and informed the Directorate and Corporate Governance reports. This information should be used to improve outcomes for patients and will ensure data specific to Shannon Clinic is discussed at senior management level.

Weekly MDT meetings are held with representation from all disciplines invited. The minutes of these meetings recorded clear and detailed action plans.

A review of records and documentation showed disparity amongst disciplines in terms of recording and storing of information. These disparities led to difficulties in locating records, including patient information. It is important that all staff can easily access the information that is relevant for them and that staff complete and store records in line with Trust policy. The Trust should ensure all disciplines are aware of, and compliant with, the Trust's policy and procedure for the management of records.

Staff had sufficient working knowledge of complaints management. Local / informal complaints records were not available at ward level. Ward staff did not have immediate access to action taken to resolve complaints or the outcome for the complainant. The Trust should undertake a review of the management of complaints and the accessibility of records at ward level.

Areas for improvement will be made in relation to separate accommodation for female patients, and complaints management.

5.2.8 Patient Flow

Delayed discharges happened for various reasons and there was evidence that significant delays in discharge had a negative impact on patient's mental health and wellbeing. Some patients who had been ready to transition into the community became unwell while they were waiting, requiring a period of assessment and / or treatment in another ward within the Clinic.

It is acknowledged that securing appropriate community placements for patients leaving Shannon Clinic can be problematic. This is reflected in the high average length of stay of patients, some of whom are ready to move once suitable accommodation in the community has been secured.

A number of patients have remained in Shannon Clinic for long periods of time, throughout which they have required active care and treatment. Some patients have had periods of trial leave that were unsuccessful resulting in their return to the Clinic.

Weekly bed management meetings take place with representation from Shannon Clinic MDT, Trust senior managers, representatives from other Trusts, Department of Health Strategic Planning and Performance Group, and South Eastern Health and Social Care Trust Prison Healthcare staff. These meetings have proven effective for the oversight and management of patient movement across the region.

5.2.9 Medicines Management

There was evidence that satisfactory systems were in place for medicines management on all wards. Medicines were being managed safely and patients were being administered their medicines as prescribed.

Systems were in place to review and monitor the stock control of medicines to ensure that medicines supplies were not depleted. Nurses demonstrated a good knowledge of critical medicines and the need for their timely administration.

Medicine kardexes were maintained in a satisfactory manner on each ward. The medicine administration records were completed to a high standard. The records indicated that patients were administered their medicines as prescribed.

Robust arrangements were in place for the management of controlled drugs.

Arrangements were in place for the safe management of medicines during the patient admission processes. In order to transition a patient's discharge to the community there was a phased process to facilitate the self-administration of medicines, including provision of advice on their medicines.

At the weekly patient case conferences, the multidisciplinary team consider medication changes, the use of "when required" medicines and additional information, such as blood tests, physical health checks and the use of high dose antipsychotics.

On all wards there were clear parameters specified on the medicine kardexes to direct the administration of medicines prescribed on a "when required" basis as part of a behavioural management strategy. On each ward, the reason for and outcome of administration was evidenced in the patient progress notes. Nurses confirmed that the frequency of a patient's use of medicines for rapid tranquillisation was monitored and reviewed at the daily staff briefing meetings and at the weekly multidisciplinary patient case conferences.

Clozapine was supplied on a named patient basis. Running balances were maintained of clozapine stocks; this is good practice. Arrangements were in place for the regular review and monitoring of clozapine treatments, including blood monitoring.

5.2.10 Mental Health

All patients were detained under the Mental Health Order part (ii), or part (iii). Patients' detention forms were available for review within their care records.

Patients' mental health needs were assessed on admission. Care plans detailing mental health needs, psychological functioning, support, and alcohol / substance misuse were available for review.

RAID (Reinforce Appropriate Implode Disruptive behaviours) training has been completed for the majority of staff in one ward. The RAID model advocates a philosophy of care where professionals "play down disruptive behaviours as far as safety allows, and concentrate on recognising and reinforcing appropriate behaviour, so that it gradually displaces the disruptive behaviour". This has proven successful and beneficial for staff and patients. Further dissemination of this training has been planned for the other two wards.

Promoting Quality Care (PQC) risk assessments were reviewed three monthly, for the majority of patients. A small number of patients PQC were reviewed monthly as indicated in their risk assessment. Following PQC reviews care plans were updated accordingly.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

	Standards
Total number of Areas for Improvement	11

Areas for improvement and details of the Quality Improvement Plan were discussed with the SMT, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).	
Area for improvement 1 **Ref:** Standard 6.1 Criteria 6.3 **Stated:** Second time	The Belfast Health and Social Care Trust should inform patients staff and carers of the current position with respect to the business case for separation of the mixed gender ward and keep them appraised of progress. Ref: 5.1 / 5.2.7
To be completed by: 31 August 2023	**Response by registered person detailing the actions taken**: Business cases will be a standing item on the Monthly Shannon Clinic Operational Meeting. Updates will be cascaded through the minutes of the meeting and displayed on staff notice boards. The Carer and Service user reps will update patients and carers at their forums.

Area for improvement 2 **Ref:** Standard 5.1 Criteria 5.3 **Stated:** First time **To be completed by:** 30 June 2023	The Belfast Health and Social Care Trust should ensure fire risk assessments provide details of timescales for the completion of actions. Governance structures should be in place to monitor and record the completion of actions. Ref: 5.2.1 **Response by registered person detailing the actions taken:** Fire risk assessment compliance will be a standing agenda item on Shannon Clinic's operational meeting. Ward Managers will be required to provide a monthly update with timescales. Areas outside the Ward Managers control will be escalated to the Service Manager who will seek relevant information from the responsible body.
Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3 **Stated:** First time **To be completed by:** Immediate	The Belfast Health and Social Care Trust should undertake a review of ligature risk in Shannon Clinic and ensure the Ligature Risk Assessment is updated accordingly. Ref: 5.2.1 **Response by registered person detailing the actions taken:** The BHSCT Health and Safety Team has updated the ligature survey documentation across the Trust and the process of how the survey is completed. Shannon Clinic's survey was completed on 15 August 2023. The recommendations will be actioned and the risk assessment will be updated.
Area for improvement 4 **Ref:** Standard 5.1 Criteria: 5.3 **Stated:** First time **To be completed by:** 30 June 2023	The Belfast Health and Social Care Trust should undertake a review of governance arrangements in relation to environmental audits. A programme of environmental audits, with particular focus on patient and staff safety, should be developed. Ref: 5.2.1 **Response by registered person detailing the actions taken:** Quarterly environmental audits with a focus on patient and staff safety will be led by the Shannon Clinic Security nurse. Any outcomes and identified actions will be escalated to the Ward Manager and reviewed as part of the monthly Security Meeting.
Area for improvement 5 **Ref:** Standard 5.1 Criteria: 5.3	The Belfast Health and Social Care Trust should ensure the grading of incidents, in relation to patient on staff assaults, takes into consideration the cumulative impact of the assaults on staff. Staff responsible for incident management and post incident

Stated: First time **To be completed by:** 31 May 2023	grading of risk must ensure cumulative risk is graded appropriately and escalated as required. Ref: 5.2.2
	Response by registered person detailing the actions taken: Shannon Clinic's weekly safety and governance meeting template has been updated to capture incidents that staff have been assaulted/ targeted by patients with what action has been taken. Cumulative risk will be graded appropriately and escalated as required.
Area for improvement 6 **Ref:** Standard 5.1 Criteria: 5.3 **Stated:** First time **To be completed by:** 31 August 2023	The Belfast Health and Social Care Trust should undertake a review of Incident Management, and ensure post incident debrief is completed, as standard, following all incidents. The Trust must ensure adequate, trauma informed, support is available to staff at Shannon Clinic. Ref: 5.2.2
	Response by registered person detailing the actions taken: The Mental Health Division has invested in debrief training for Band 6 and Band 7 nursing staff. Incident debrief is part of the culture in Shannon Clinic and will be incorporated into the Trust Datix form. Any staff member involved in an incident in Shannon will have access to Psychology (within Shannon or through occupational health
Area for improvement 7 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 30 April 2023	The Belfast Health and Social Care Trust should ensure roles and responsibilities, including Nurse in Charge, are delegated to the most suitably experienced staff on shift. Ref: 5.2.3
	Response by registered person detailing the actions taken: The Ward Manager of each ward will delegate the Nurse in Charge role to the most suitably experienced staff. Junior staff will have an opportunity to take charge with a more senior nurse providing a mentoring role. Nurse in charge and mentor will be clearly identified in the roster
Area for improvement 8 **Ref:** Standard 4.1	The Belfast Health and Social Care Trust should ensure all staff complete all mandatory training required for their role and responsibilities, including Dysphagia training for all staff.

Criteria 4.3 **Stated:** First time **To be completed by:** 30 June 2023	The Belfast Health and Social Care Trust shall ensure specific Forensic Training is made available to all staff working in Shannon Clinic and that mechanisms are in place for the oversight and governance of mandatory training. Ref:5.2.3 / 5.2.4
	Response by registered person detailing the actions taken: Training matrixes will be presented at Shannon Clinic operational meetings. The Forensic Care Network is updating the New to Forensic course- new title is Foundations in Forensic. This training is due to be available from January 2024. All staff in Shannon will be completing this training once available.

Area for improvement 9 **Ref:** Standard 5.1 Criteria: 5.3 **Stated:** First time **To be completed by:** Immediate	The Belfast Health and Social Care Trust should ensure accurate information pertaining to patients modified dietary requirements is available to all staff involved in the patient's care, including ancillary staff. Ref: 5.2.4
	Response by registered person detailing the actions taken: Shannon clinic have a SALT board in every kitchen. Patient SALT individual plans will be available on these boards. This is available for all staff.
Area for improvement 10 **Ref:** Standard 5.1 Criteria 5.3 **Stated:** First time **To be completed by:** 31 August 2023	The Belfast Health and Social Care Trust should ensure that regular audits of patient records are completed. Records must be easily retrievable and completed in line with Trust policy. Deficits identified in records management must be addressed in a timely manner. Ref: 5.2.7
	Response by registered person detailing the actions taken: Shannon Clinic's lead nurse will complete quarterly audits and present findings at the operational meeting. Deficits will be addressed with the individual practitioner and the responsible lead. Any learning will be shared with the wider team.
Area for improvement 11 **Ref:** Standard: 8.1 Criteria:8.3 **Stated:** First time **To be completed by:** 31 August 2023	The Belfast Health and Social Care Trust should ensure a record is kept at ward level of any local/informal complaints, to include detail on; actions taken to resolve the complaint; the outcome of the actions; and whether or not the complainant was satisfied with the outcome. Ref: 5.2.7
	Response by registered person detailing the actions taken: All Wards have a complaints folder with information regarding all local and formal complaints. The folder will contain all current complaints and will be updated at each stage of the complaint process through to the completion of the complaint.

Please ensure this document is completed in full and returned via the Web Portal

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