Unannounced Follow Up Inspection Report
8 – 10 January 2018

Shannon Clinic

Medium Secure
Knockbracken Healthcare Park
Saintfield Road,
Belfast
BT8 8BH

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Assurance, Challenge and Improvement in Health and Social Care

Core Inspection Team

The following table contains the names of each member of the inspection team.

Name	Inspection Role
Wendy McGregor	Lead Inspector
Audrey McLellan	Inspector
Alan Guthrie	Inspector
Cairn Magill	Inspector
Dr Brian Fleming	Sessional Medical Officer
Dr John Simpson	Sessional Medical Officer
Patrick Convery	Head of Programme
Hannah Morton	Administrative support

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

1.0 What we look for

2.0 Profile of service

Shannon Clinic is a regional medium secure, forensic, inpatient unit situated on the grounds of the Knockbracken Healthcare Park. The clinic provides intensive psychiatric treatment or rehabilitation in a secure therapeutic environment. There are three wards in the 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. There are 34 beds in the Shannon clinic. On the days of the inspection there were 12 patients in Ward 1, 12 patients in Ward 2 and 9 patients in Ward 3. 33 patients were detained appropriately and in accordance with the Mental Health (Northern Ireland) Order 1986. One patient had been regraded to voluntary and was waiting on a community placement. There were two patients whose discharge was delayed.

3.0 Service details

Responsible person: Martin Dillon
Operational manager: David Martin
Ward Managers: Ward 1 – Ann McDonald Ward 2 – Damien Murdock Ward 3 – Una Maguire

4.0 Inspection summary

An unannounced follow-up inspection took place over three days on 8 – 10 January 2018.

The inspection sought to assess progress with findings for improvement identified from the last unannounced inspection on 30 August – 2 September 2016.

Inspectors noted that the clinic had made improvements from the previous inspection.

- Environmental risk assessments were up to date.
- Patient risk assessments were completed by the multidisciplinary team (MDT) with involvement from medical staff.
- The person with overall responsibility for the implementation of the risk management plans was recorded.
- Patient information provided from prison was evidenced as good.

- A record was completed of who attended each patient's MDT meeting.
- The six consultant psychiatrists working in the Shannon Clinic were providing a more consistent approach in completing medical reviews.
- The psychology service had increased with the appointment of a second forensic psychologist.
- All patients assessed as requiring psychological interventions had access to same.
- An external audit of records management had been commissioned and carried out by the information governance group in February 2017.
- MDT assessments were comprehensive, reviewed regularly and up to date.
- Outcomes of weekly MDT reviews were comprehensively recorded on the patient electronic recording system (PARIS).
- MDT care plans had improved and were goal specific.
- Nursing care plans were reviewed and updated regularly.
- Staff were consistent with their approach to the Smoke Free Policy.
- Staff working in the clinic said they felt well supported by their peers and management.
- Reflective practice sessions were available for staff every week.

Inspectors followed up on a recommendation made following a Serious Adverse Incident on 5 December 2016 in relation to patients' leave information. Inspectors noted that patients leave information had been updated and the recommendation had been met.

Good practice was evident in relation to governance oversight of incidents and accidents. It was noted that the number of incidents requiring physical intervention was low in comparison with the other inpatient facilities in the Belfast Trust.

Inspectors observed that care in the Shannon Clinic was patient centred and the environment was calm. Inspectors also observed that staff appeared to have a good relationship with patients.

Inspectors acknowledged that the Trust has set up mechanisms to address the areas for improvement made during the last inspection. A clinical lead has been appointed and this should continue to promote a more consistent approach in relation to practice, reporting and recording in the Shannon Clinic.

During the inspection a number of areas for improvement were assessed as either partially met or not met.

Patients' risk assessments were documented on several templates which made locating up to date information difficult.

There was an inconsistent approach to reviewing and updating patient risk assessments and up to date management plans were not always in place to direct staff on how to manage risks associated with each patient.

Records completed by the consultant psychiatrists varied in content. Some records were very comprehensively completed and others lacked detail. It was not consistently recorded if a patient had or had not attended their MDT meeting or how information from the meeting was shared with the patient.

The transfer of patients from between the three wards is still affected by the delayed discharge of some patients and the management of mixed gender population in Ward 2. The business case to develop a de-escalation suite and separate accommodation for female patients has been sent to Belfast Senior Management Team but there was no further action at the time of the inspection.

There has been an increase in the number of staff working in the clinic, however Ward 3 rarely achieved its required staffing levels for each shift.

Inspectors could not confirm if all staff working in the Shannon Clinic had received up to date mandatory training as there was an inconsistent approach to collating this information.

There was limited evidence in relation to sharing learning from incidents and accidents in Ward 3.

Three out of seven trust policies had not been updated since the last inspection.

There was a decrease in the pharmacy service. This has resulted in a number of patients not being able to progress towards self- administration of medication which is an essential aspect of rehabilitative care and preparation for discharge.

RQIA have requested that the Trust forward the following information by 1 March 2018:

- Confirmation that all required staff have attended training on HCR-20 risk assessments.
- The Promoting Quality Care audit.
- The work force analysis.

(HCR-20 risk assessments are designed to support patients with a mental health problem and forensic history).

Patients Views

The inspectors spoke to 11 patients in the Shannon Clinic. Patients were complimentary about the care and treatment they were receiving. Patients confirmed they knew who to speak to if they were unhappy and that staff were always available for them to talk to. Patients stated they felt safe on the ward.

Some patients said there weren't enough activities, particularly during the evening and weekends. Inspectors discussed this with staff who attended inspection feedback. Staff agreed to review the availability of activities in the clinic.

Patients advised that staff treat them with dignity and respect. Patients stated they attend their MDT meetings each week and get the opportunity to contribute to these meetings.

Patients made the following comments;

"All staff treat meet me with dignity and respect and listen to my views. Dr X is very approachable…the kitchen is open so we can make tea when we like" (patient from Ward 2).

"This is a calm ward and I always feel safe….staff have explained my rights to me….I have supervised ground leave…..all staff are very helpful and caring on the ward….my family have

been invited to meetings….I feel better now than when I was admitted onto the ward….when my medication was changed the reasons were explained to me…. staff gave me a leaflet…this is a very well run ward, there are enough staff and they all know what they are doing….I have now given up smoking since been on this ward and I was given lots of help".(patient Ward 2)

Relative's views

Feedback was received from three relatives. Relatives were generally satisfied with the care and treatment their family member was receiving. All three relatives indicated that they were satisfied to very satisfied that care was safe, two relatives indicated that they were satisfied to very satisfied that care was compassionate and the clinic was well led. Two relatives were neither satisfied or not satisfied in relation to effective care.

Relatives made the following comments:

"As xxx parents we are very impressed by the care and support they have received. Staff are excellent and I can't praise them enough."

Staff Views

The inspector spoke to 24 members of the MDT. Staff stated the clinic was very busy but they enjoyed working there and felt well supported. They advised the MDT was effective and all staff supported each other. Staff members from Ward 2 stated that they felt the mix of very unwell female patients and male patients whose mental health is stable can be challenging. For example male patients may have less restriction in place due to the decreased level of risk and can access leave off the ward and female patients find this difficult to understand. Staff members working on Ward 3 raised concerns about reduced staffing levels and the challenges with organising patient leave from the ward. Staff from Ward 3 also raised concerns about responding to the emergency alarm if activated on another ward during the night as they stated they are expected to respond. This leaves one staff member on the Ward 3.

The findings of this report will provide the Trust with the necessary information to assist them to fulfil their responsibilities, enhance practice and service user experience.

4.1 Inspection outcome

Total number of areas for improvement	8

The total number of areas for improvement comprise of;

- Seven areas for improvement restated for a second time.
- One area for improvement restated for a third time.

These are detailed in the Quality Improvement Plan (QIP).

Areas for improvement and details of the QIP were discussed with senior trust representatives, members of the multi-disciplinary team, the ward managers and ward staff as part of the inspection process. The timescales for completion commenced from the date of inspection.

5.0 How we inspect

The inspection was underpinned by:

- 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.

The following areas were examined during the inspection:

- Psychology and social work service.
- Care Documentation in relation to nine patients.
- Risk assessments and management plans in relation to nine patients.
- Ward environment.
- Governance arrangements in relation to incidents and accidents.
- Audits of care documentation.
- Duty rotas.
- Environmental risk assessments.
- Mandatory training records.
- Trust policies and procedures.
- Shannon clinic operational policy.
- Minutes from medical meetings, bed management meetings, peer review meetings, Safety Quality Service Development (SQSD) meetings, operational team meeting.

6.0 The inspection

6.1 Review of areas for improvement from the last unannounced inspection 30 August – 2 September 2016

The most recent inspection of the Shannon Clinic was an unannounced inspection. The completed QIP was returned and approved by the responsible inspector. The QIP was validated by inspectors during this inspection.

Areas for Improvement

Area for Improvement No. 1 **Stated:** First time **Ref:** Standard 5.3.1 (e)	Environmental risk assessments.	
	Action taken as confirmed during the inspection: Inspectors reviewed the environmental risk assessments. The Safety Quality Service Development meeting held on 22nd September 2017 confirmed that the environmental risk assessments were up to date. The yearly ligature risk assessment was up to date (completed July 2017). A capital bid was submitted on 21 June 2017 for ligatures identified in the three assisted bathrooms. The cost for this work is £49,500. A risk management plan was in place to manage these risks in mean time. The annual fire risk assessment was up to date and an action plan was completed. The Belfast Trust Risk register included specific risks associated with the Shannon Clinic. This area has been assessed as met.	**Met**
Area for Improvement No. 2 **Stated:** First time **Ref:** Standard 5.3.1 (a)	Patient Promoting Quality Care (PQC) risk assessments/ associated risk assessments.	
	Action taken as confirmed during the inspection: An external audit of records management was commissioned and completed by an information governance team in February 2017. Following the audit the Shannon Clinic Information Governance Group team reviewed the areas for improvement along with the previous RQIA findings. The minutes of the meetings highlighted the following in relation to the management of patient risk assessments. • A variation in practice. • Lack of structured assessment of progress. • Duplication of documentation between disciplines. • Poor recording onto PARIS. • Every patient should have a HCR-20 or other specialist risk assessment completed within three months of admission. • The HCR-20 or specialist risk assessment should be updated at minimum six months and should be appended to the PQC review documentation (unless there is a version in PARIS that can be completed. • Formulations from specialist risk assessments could	**Partially met**

be pasted into the overall Comprehensive Risk Assessment (CRA) formulation.
- An audit of Promoting Quality Care risk assessments needs to be completed.

One of the recommendations from this audit was in relation to staff training on the completion of HCR -20 risk assessments. Inspectors were informed by the acting operational manager that this training will be completed by the end of February 2018. Training will be delivered to three groups of staff. Group one includes consultant psychiatrists and clinical psychologists. Group two includes senior nursing staff and social workers and group three involves awareness training for the remaining staff. RQIA will request confirmation that all required staff have attended this training by 1 March 2018.

Inspectors were informed that an audit of PQC was completed May 2017. However the outcome from this audit was not available during the inspection.

RQIA request the outcome of this audit by 1 March 2018.

Inspectors reviewed risk assessments in relation to nine patients admitted to the Shannon Clinic. Risk assessments were individualised and comprehensive. Improvements were noted as risk assessments were completed by the multi-disciplinary team with involvement from medical staff. The person with overall responsibility for the implementation of the risk management plans was recorded.

In the nine risk assessments and management plans reviewed, inspectors noted a variation in practice in relation to recording, reviewing and updating information. Inspectors found locating information in relation to risk assessments was difficult. The information was recorded on several templates and stored in three different locations. The patient electronic recording system (PARIS), T-drive and in a hard copy. Staff confirmed that they knew where to access the information. However it is the view of RQIA that would be difficult for a staff member who was not familiar with the recording systems (for example agency staff, bank staff completing occasional shifts, locum medical staff etc.) to access the information.
Several assessments were used to record and manage patient risk. These included individual management plans, CRA assessments, HCR -20 assessments and Promoting Quality Care (PQC) review assessments. There was evidence that when a PQC meeting was held the CRA was

	updated. However the inspectors were concerned that there was no overall management plan in place to direct staff on how best to manage patients whilst they are in the Shannon clinic. A number of management plans were not completed in the CRA assessment and a number stated "see care and treatment plan' or 'see individual management plan' however these plans did not detail the level of risk associated with each patient and how the MDT plan to manage these risks. These were overall plans in relation to patients care and treatment and not specific to the level of risk each patient presented. They did not detail the interventions agreed by the MDT to manage these risks. Staff reported that information in relation to risks provided from prison was good. Information from Trusts needed to be followed up at times. Due to the inconsistent approach to the management, recording, reviewing and storage of patient risk assessments this area for improvement has been assessed as partially met and will be restated a second time.	
Area for Improvement No. 3 **Stated:** Second time **Ref**: Standard 5.3.1 (a)	Care documentation.	
	Action taken as confirmed during the inspection: An external audit of records management was commissioned and completed by an information governance team in February 2017. Inspectors reviewed the care documentation in relation to nine patients from the three wards. There was evidence of improvement in this area. <u>MDT meetings</u> Inspectors noted a record was completed to confirm which member of the MDT attended each patient's MDT meeting. <u>Assessments</u> Inspectors noted that the MDT had signed the assessments for seven out of nine patients. However on review of the minutes of the Information Governance Meeting the Trust were aware of this issue and senior management confirmed that the Information Governance Group will continue to review and monitor this. The Clinic was waiting on agreement for one version of care and treatment plans. This area has been assessed as met. RQIA will continue to	**Met**

	review care documentation through inspection processes.	
Area for Improvement No. 4 **Stated:** First time **Ref**: Standard 5.3.1 (a)	Medical reviews.	
	Action taken as confirmed during the inspection: A clinical lead for the Shannon Clinic was appointed in August 2017. There are six consultant psychiatrists in the Shannon Clinic (representing each of the five trusts). There could be up to six MDT meetings every week on each ward. Inspectors noted a significant improvement regarding how often each consultant psychiatrist reviewed each patient. However, it was noted there were inconsistencies with the recording of medical reviews. For example not all consultants were recording their review in the 'Consultant Note' section in the PARIS record. Inspectors noted that it was not consistently recorded if a patient had or had not attended their MDT meeting. If a patient did not attend it was not recorded how the information from the MDT meeting was shared with the patient after meeting. There were no patients receiving a course of Electroconvulsive Treatment at the time of the inspection. Due to the inconsistency of recording patient reviews and information about patient attendance at their MDT meetings this area for improvement has been assessed as partially met and will be restated a second time.	**Partially met**
Area for Improvement No. 5 **Stated:** Second time **Ref**: Standard 6.3.1 (f)	Psychology Service.	
	Action taken as confirmed during the inspection: Psychology input has improved significantly. The clinical psychology service has increased from 0.5 whole time equivalent (wte) to 1.3 wte with the employment of a second forensic psychologist. This is above the Quality Network standards of 1.0 wte. Staff informed inspectors that psychology input was available when required. Patients also have access to a psychotherapist. There was also evidence of in reach work from a community	**Met**

psychologist.

A specialist nurse therapist was now in post. The nurse delivers psychological interventions and receives supervision from the consultant psychologist and psychotherapist.

Six members of the MDT have been trained in Dialectical Behaviour Therapy (DBT) and had received appropriate supervision from the clinical psychologist. A plan was also in place to train further nursing staff in psychotherapeutic interventions.

It was positive to note that the Trust have recently made links with Cardiff university. A student will be attending the clinic three days every week on a trainee placement.

The psychology service is currently providing 1:1 interventions with 14 patients in the Shannon Clinic. The service is also helping to facilitate a number of groups.

- Violence reduction programme due to start 2nd March 2018 to run for 6-9 months, 10 participants, 1 day a week for 2 hours. Participants will also receive individual sessions on the ward from nursing staff.
- A DBT skill group which continues to run 1 day a week every 6 months.
- A further group for DBT is due to commence in May 2018.

One of the clinical psychologists also provides Eye Movement Desensitization and Reprocessing (EMDR) psychotherapy treatment to four patients.

The service finished a good thinking skills group in December 2017.

The clinical psychologists said they are not able to attend all MDT reviews due to lack of resources however they do attend the three monthly review meetings for all patients.

The psychotherapist continues to offer reflective practice sessions every week for staff and facilities the “working well and living well together” sessions for Ward 3 patients and staff.

Although the Trust acknowledged that this service is still under resourced in accordance with best practice guidance. It was good to note that patients identified as requiring a psychological intervention were in receipt of same.

	The clinical psychologist stated that they hope to work towards a model where each patient has a named psychologist. This area has been assessed as met.	
Area for Improvement No. 6 **Stated:** Second time **Ref**: Standard 5.3.1 (a)	Multidisciplinary assessments and care plans.	
	Action taken as confirmed during the inspection: An external audit of records management was commissioned and carried out by the information governance group in February 2017. The aim of this audit was to identify best practice work so that it can be replicated across the clinic and to promote a more consistent approach in relation MDT recording. Improvement was noted in relation to ensuring that MDT care plans were goal specific. Ten of the eleven care and treatment plans reviewed evidenced that goals had been set and reviewed regularly with new goals set following the review. Nursing care plans were comprehensive, reviewed and updated regularly. This area has been assessed as met.	**Met**
Area for Improvement No. 7 **Stated:** First time **Ref**: Standard 5.3.1 (f)	The management of the Smoke Free policy and procedure.	
	Action taken as confirmed during the inspection: Inspectors spoke to staff in relation to the Smoke Free Policy. Staff stated there were ongoing difficulties with the management of the policy. Patients who smoke have access to Nicotine Replacement Therapy and smoking cessation programmes. Patient non- adherence to the Smoke Free policy was highlighted at the weekly bed management meeting, staff meetings and discussed at patient meetings. Staff stated they were concerned that patients continue to bring smoking materials into the wards when returning from leave or use other means for ignition. These items are often concealed and this behaviour increases the risk to health and safety of patients and staff. Staff also said that patients have reported that they see	**Met**

	patients on other wards on the Knockbracken site smoking and this has also caused tension. There have some incidents where staff have detected a smoke odour on the wards. Staff stated they report this as an incident on the incident recording system (DATIX). All staff stated they were committed to ensuring that the Human Rights of patients are considered at all times when adhering to the policy. All staff confirmed that there is a consistent approach to the Smoke Free policy although there are clearly concerns. Due to consistency in the approach by staff RQIA have assessed this area for improvement as met. RQIA recommend that the Shannon Clinic reviews the application of the Smoke Free Policy in accordance with Belfast Trust guidance on the "Therapeutic Management of Incidence of Patients Smoking".	
Area for Improvement No. 8 **Stated:** Second time **Ref:** Standard 8.3	Clinical management.	
	Action taken as confirmed during the inspection: Inspectors spoke to the MDT and reviewed care documentation. A clinical lead for medical staff was appointed in August 2017. Processes for improvement are now in place with regard to convergence of consultant practice. There were five governance work streams that are reviewing practice across the Shannon Clinic. These are information governance forum, safety quality service development, research and quality therapeutic co-ordination group and training in education group. Staff from the Shannon Clinic attend a criminal justice integration meeting as part of the Forensic Managed Care Network. This meeting is attended by all staff / agencies who work in the criminal justice system. Variance in recording is being addressed through the information governance group. Inspectors noted some improvement with a more consistent approach from medical staff with completing patient care and treatment documentation. However there was evidence that further	**Partially met**

	improvement work is required. There is a Shannon Clinic medical meeting that convenes every month attended by consultants. Standing items on the agenda include updates from the different governance forums/groups. Inspectors were informed by the clinical lead and acting operational manager that there are plans to move towards a common treatment care plan. Inspectors were also informed that there is a proposal to reduce the number from six consultants per ward to two and appoint a staff grade doctor. This would significantly reduce the number of ward rounds and team meetings and would likely drive a more consistent approach to care and treatment across the clinic. RQIA acknowledge that the Trust has made progress in relation to this area for improvement. However RQIA have assessed this area as partially met as further improvements are required to promote a consistent approach from the medical team. Inspectors were informed by the senior management team that these areas will continue to be reviewed and monitored through the various governance work streams. This area for improvement will be restated a second time.	
Area for Improvement No. 9 **Stated:** First time **Ref:** Standard 4.3	Function of the clinic.	
	Action taken as confirmed during the inspection: The transfer of patients to Ward 2 or Ward 3 is still affected by delayed discharges and the difficulties with the management of mixed gender population in Ward 2. Staff on Ward 2 have put measures in place to manage the gender mix on the ward. Female patients have use of a female only area to protect their privacy. The needs of the patients in Ward 3 are unchanged since the last inspection. There are still a number of patients on Ward 3 who require escorted leave. However the required staffing levels had not changed. Subsequently, there were challenges in supporting patients requiring/requesting supervised time off the ward. The business case to develop a de-escalation suite and separate accommodation for female patients has been sent to Belfast Senior Management Team but there was no	**Partially met**

	further action evidenced at the time of the inspection. There were four patients on the wait for an admission to the Shannon Clinic at the time of the inspection. Inspectors were informed that a workforce analysis was completed October / November 2017. The outcome from this analysis was not available during the inspection. RQIA request this information by 1 March 2018. This area for improvement has been assessed as partially met. The workforce analysis was not available during the inspection and there was limited evidence that staffing levels on Ward 3 had been reviewed. This area for improvement will be restated a second time.	
Area for Improvement No. 10 **Stated:** First time **Ref:** Standard 6.3.1 (f)	Multidisciplinary team	
	Action taken as confirmed during the inspection: Since the last inspection, there has been an increase in the clinical psychology service from 0.5 wte to 1.3 wte. The Trust have looked at other models for the delivery of psychological therapies and have appointed a nurse therapist band 7 who is dual qualified as a substance misuse nurse. There are six staff who are trained to deliver dialectic behavioural therapy (DBT). Staff delivering psychological therapies receive their clinical supervision by the clinical psychologist. A psychotherapist also continues to attend the clinic. The social work team has increased. There is one social work team lead, one full time social worker in post and one social worker who will be returning this month after a period of absence. At the time of the inspection there were no gaps in the MDT team. This area has been assessed as met.	**Met**
Area for Improvement No. 11 **Stated:** First time **Ref:** Standard 4.3	Staffing levels	
	Action taken as confirmed during the inspection: Since the last inspection the nursing staff compliment has increased with the recruitment of fifteen nursing staff. There was 86 nursing staff, with 51 registered nurses at the	**Partially met**

	time of the inspection. The level of nursing staff per shift working in Ward 1, Ward 2 and Ward 3 is different because of the assessed needs of the patients on each ward. Inspectors reviewed the nursing staff compliment required for the clinic and assessed if the required number of staff for each shift was achieved. There was evidence that Ward 1 and Ward 2 achieved the required number of staff per shift with the use of bank staff. The number of staff required per shift on Ward 3 to attend to an incident was rarely achieved. Inspectors noted that patients admitted to Ward 3 continue to require escorted grounds / community leave. The level of escort can vary with some patients requiring two staff. The staff numbers per shift did not always meet this demand. Staff continue to be flexible and the duty rota is reviewed and amended on a daily basis to ensure that patients get their leave. Inspectors noted from the off duty that staff have shown flexibility and willingness to cover bank shifts. On review of Ward 3's duty rota it was noted that there were two staff required on night duty. Although this number was achieved staff stated that one staff was required to leave the ward when the emergency alarm was activated to attend to an incident on another ward. This meant that during those times there was only one member of staff on Ward 3. This area has been assessed as partially met. Although there has been an increase in the number of staff working in the Shannon Clinic, there were still concerns in relation to the reduced staff levels in Ward 3 and the challenges in relation to managing patient's leave. This area for improvement will be restated a second time.	
Area for Improvement No. 12 **Stated:** First time **Ref:** Standard 4.3	Mandatory training	
	Action taken as confirmed during the inspection: The inspectors noted that there was an inconsistent approach in the clinic to the overall monitoring of staff attendance at mandatory training. Inspectors could not confirm if mandatory training was up to date for all staff working in the Shannon Clinic. The approach to the overview and monitoring of staff mandatory	**Not met**

	training was inconsistent between Ward 1, Ward 2 and Ward 3. Staff from Ward 3 reported to inspectors that they could not be released to attend a core skills training week on 2-6 October 2017 and that they find it difficult to get time of the ward to attend mandatory training. Inspectors were informed that the clinic will be receiving additional support in relation to monitoring attendance at mandatory training. The acting operational manager said that this support will provide a consistent approach across the clinic in the collating of this information. Due to the unavailability of mandatory training records in Ward 3 and additional confirmation from Ward 3 staff that not all staff had not received up to date mandatory training. This area for improvement has been assessed as not met and will be restated for a second time.	
Area for Improvement No. 13 **Stated:** First time **Ref:** Standard 4.3	Staff support	
	Action taken as confirmed during the inspection: Inspectors noted that reflective practice sessions were available every week for all staff. The sessions were rotated between the three wards. Attendance is voluntary. Attendance at the sessions was noted to be good.	**Met**
Area for Improvement No. 14 **Stated:** First time **Ref:** Standard 5.3.2	Incidents and accidents	
	Action taken as confirmed during the inspection: Inspectors reviewed the mechanisms in place to discuss/evaluate/disseminate learning from incidents. There was a good governance mechanism in place to review and analyse incidents and accidents. For example the Trust collated the number of times an incident has resulted in a restrictive practice such as physical intervention. A formal process was in place to discuss/evaluate and disseminate learning from incidents and accidents. Ward managers are invited to the governance meetings. Ward managers meet every Monday to discuss issues on the wards. There was a weekly bed management meeting held to discuss all incidents and accidents. Staff could select a feedback option when they record an incident on the incident / accident electronic recording system (DATIX).	**Partially met**

	However there was an inconsistent approach in relation to sharing learning from incidents with staff working at ward level. In Ward 1 and Ward 2 learning from incidents was discussed at regular staff meetings and also available in a file on the ward. Staff on Ward 1 and Ward 2 did not raise any concerns and confirmed learning from incidents was shared with staff. Staff on Ward 3 stated that incidents and accidents that occur on the ward were discussed amongst staff and during the de-brief post incident. However, inspectors were informed by Ward 3 staff that there have not been any regular or recent team meetings. There was limited evidence available to confirm that staff working in Ward 3 were provided with information in relation to learning from incidents. This area for improvement has been assessed as partially met as there was an inconsistent approach to disseminating learning from incidents and limited evidence that learning was shared with staff working on Ward 3. This area will be restated a second time.	
Area for Improvement No. 15 **Stated:** First time **Ref:** Standard 4.3	Policies and procedures	
	Action taken as confirmed during the inspection: Inspectors reviewed the policies highlighted as requiring review during the last inspection and noted that three out of seven policies were not up to date. RQIA noted that these are Trust policies. This was discussed at feedback with Trust senior management who agreed to raise this with Trust governance team. As these are Trust policies and procedures and not directly Shannon Clinic policies RQIA will not restate this area for improvement.	**Met**
Area for Improvement No. 16 **Stated:** First time **Ref:** Standard 5.3.1	Pharmacy input	
	Action taken as confirmed during the inspection Staff informed inspectors that the pharmacy service is commissioned for five hours a week. Inspectors were informed that there has been decrease in the availability of the pharmacy service. This has resulted in	**Not met**

	patients who have been assessed as ready to progress to self-administration of their medication cannot progress. During the inspection there were three patients waiting to progress to self-administration. This area for improvement has been assessed as not met due to the reduction in pharmacy service in the Shannon Clinic and will be restated a second time.	

7.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with senior trust representatives, members of the multi-disciplinary team, ward managers, and ward staff as part of the inspection process. The timescales commence from the date of inspection.

The responsible person must ensure that all areas for improvement identified within the QIP are addressed within the specified timescales. The responsible person should note that failure to comply with the findings of this inspection may lead to escalation action being taken.

7.1 Actions to be taken by the service

The QIP should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed provider compliance via the RQIA web portal by 7 March 2018**.**

Quality Improvement Plan

The responsible person must ensure the following findings are addressed:

Area for Improvement No. 1 **Stated: Second time** **Ref: Standard 5.3.1 (a)** **To be completed by:** 10 July 2018	Patient Promoting Quality Care risk assessments/ associated risk assessments. **Response by responsible individual detailing the actions taken:** A HONoS assessment is completed for each individual admitted into Shannon Clinic. Shannon Clinic are currently looking at a number of other best practice models which will be implemented within the inspector's timescale. An audit regarding the completion of HCR20 risk assessment tools and other specialist risk assessment tools is currently being undertaken by the Specialist Registrar based within Shannon Clinic. Any issue will be addressed with the author(s) of the risk assessment. This will be completed within the inspector's timescale. A rolling programme of training in relation to HCR20 assessments has been put in place for all relevant staff. The audit completed in May 2017 will be sent to the Inspector in a separate email as requested. All patients within Shannon Clinic have a treatment and care plan in place; work regarding the uniformity of these is ongoing. Consideration is also being given to wording that will better evidence the connection between this document and the PQC risk assessment. This will be completed within the inspector's timescale.
Area for Improvement No. 2 **Stated: Second time** **Ref: Standard 5.3.1 (a)** **To be completed by:** 10 July 2018	Medical reviews. **Response by responsible individual detailing the actions taken:** All Consultant Psychiatrists are now recording their reviews under Consultant case note on the PARIS system. Nursing staff will now record whether a patient has attended their mdt meeting or not. If the patient has not attended a record will be made of how the information from the meeting is shared with the patient.
Area for Improvement No. 3	Clinical management. **Response by responsible individual detailing the actions taken:**

Stated: Third time **Ref: Standard 8.3** **To be completed by:** 10 July 2018	As stated in the report, there are a number of governance work streams ongoing within Shannon Clinic. All Consultant Psychiatrists are now recording their reviews under Consultant case note on the PARIS system. Work is also ongoing regarding the uniformity of treatment and care plans within the Unit.
Area for Improvement No. 4 **Stated: Second time** **Ref: Standard 4.3** **To be completed by:** 10 July 2018	Function of the clinic **Response by responsible individual detailing the actions taken:** The business case in relation to the de-escalation suite is now with the Co-Director of Mental Health Services to take forward. There are no longer four patients on the waiting list for admission to Shannon Clinic. The Delivering Safe Staffing document has not yet been endorsed by the Expert Reference Group or ratified by the Chief Nursing Officer. At Shannon Clinic's inception to the nurse to bed ratio for Ward 3 was 2:1 in keeping with national standards. The national average is nearer to 1:8
Area for Improvement No. 5 **Stated: Second time** **Ref: Standard 4.3** **To be completed by:** 10 July 2018	Staffing levels **Response by responsible individual detailing the actions taken:** As stated in the report the nursing staff compliment has increased in Shannon Clinic with the recruitment of fifteen nursing staff. The Delivering Safe Staffing document has not yet been endorsed by the Expert Reference Group or ratified by the Chief Nursing Officer. At Shannon Clinic's inception to the nurse to bed ratio for Ward 3 was 2:1 in keeping with national standards. The national average is nearer to 1:8
Area for Improvement No. 6 **Stated: Second time** **Ref: Standard 4.3** **To be completed by:** 10 April 2018	Mandatory training **Response by responsible individual detailing the actions taken:** Training is facilitated for staff as necessary. The Ward Managers' administration assistant now updates the unit's training matrix on a monthly basis. This can be provided on request.

Area for Improvement No. 7 **Stated: Second time** **Ref: Standard 5.3.2** **To be completed by:** 10 April 2018	Incidents and accidents
	Response by responsible individual detailing the actions taken: All staff have access to the minutes of the Bed Management meeting which discusses incidents over the previous week. They also have access to shared learning from accidents, incidents and complaints on the T drive. Regular staff meetings have now been put in place for Ward 3 where learning from incidents/accidents is discussed.
Area for Improvement No. 8 **Stated: Second time** **Ref: Standard 5.3.1** **To be completed by:** 10 April 2018	Pharmacy input
	Response by responsible individual detailing the actions taken: Clinical Lead, Shannon Clinic will escalate this issue to Co-Director for Mental Health Services to address.

Name of person (s) completing the QIP	Barney McNeany, Co-Director, Mental Health Services Dr. Richard Bunn, Clinical Lead, Shannon Clinic Davy Martin, Operations Manager, Shannon Clinic Ann McDonald, Ward Sister, Ward 1, Shannon Clinic Jillian Neville, Ward Sister, Ward 3, Shannon Clinic Patricia Minnis, Quality and Information Manager		
Signature of person (s) completing the QIP		**Date completed**	26/02/2018
Name of responsible person approving the QIP	Martin Dillon, Chief Executive		
Signature of responsible person approving the QIP		**Date approved**	26/02/2018
Name of RQIA inspector assessing response	Wendy McGregor		
Signature of RQIA inspector assessing response	Wendy McGregor	**Date approved**	12 March 2018

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

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