Unannounced Inspection Report
14 – 22 December 2020

Belfast Health & Social Care Trust

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

Membership of the Inspection Team

Lynn Long	Acting Deputy Director, Improvement Directorate, Regulation and Quality Improvement Authority
Wendy McGregor	Acting Assistant Director, Improvement Directorate, Regulation and Quality Improvement Authority
Cairn Magill	Acting Senior Inspector, Hospital Programme Team, Regulation and Quality Improvement Authority
Carmel Treacy	Inspector, Hospital Programme Team, Regulation and Quality Improvement Authority
Jillian Campbell	Inspector, Hospital Programme Team, Regulation and Quality Improvement Authority
Rhona Brennan	Inspector, Hospital Programme Team, Regulation and Quality Improvement Authority
Paul Nixon	Pharmacist Inspector, Regulation and Quality Improvement Authority
Gerry Lynch	Consultant Psychiatrist, Regulation and Quality Improvement Authority
Paulina Spychalska	Inspection Coordinator, Regulation and Quality Improvement Authority
Gavin Doherty	Estates Officer, Regulation and Quality Improvement Authority

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 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 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.

There are 34 beds in Shannon Clinic. On the days of the inspection there were 34 patients in Shannon Clinic. There were two patients whose discharge was delayed.

3.0 Service details

Responsible person: Dr Cathy Jack Belfast Health and Social Care Trust	**Position:** Chief Executive Officer
Category of care: Medium Secure Forensic Inpatient Unit	**Number of beds:** 34
Person in charge at the time of inspection: Acting Assistant Service Manager	

4.0 Inspection summary

An unannounced inspection was undertaken to Shannon Clinic, commencing on 14 December 2020 and concluding on 22 December 2020. All three wards were inspected and the inspection included a night time visit on 16 December 2020 commencing at 23:00 and concluding at 02:30 on 17 December 2020. Feedback from the inspection was delivered to the Trust's senior management team (SMT) on 22 December 2020.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

We undertook this inspection in response to intelligence we had received about Shannon Clinic during 2020 which we had been monitoring over a period of time. The concerns related to poor treatment of staff in the form of intimidation and bullying by management; low staff morale; inadequate staffing; a lack of managerial response when concerns are raised; the use and presence of illicit substances on the wards; high levels of patient on patient assaults; and allegations that senior management influence who and how staff share information with RQIA during inspections.

The focus of this inspection included our determination of the intelligence we held. We examined a number of areas to support our findings including staffing; adult safeguarding (ASG); mandatory training; medicines management; restrictive practices; incident management; records management; complaints management; and the organisational and clinical governance arrangements in Shannon Clinic. In addition, the areas for improvement identified in the previous Quality Improvement Plan (QIP) from 8-10 January 2018 were examined to assess if the Trust had addressed them.

We were pleased to see good practice in relation to:

- Patient and staff engagement which was noted to be positive across all wards
- Collaborative working across all wards particularly during staffing deficits
- Effective medicines management

Staff feedback was positive with the majority of staff confirming that they enjoyed their role and the environment they worked in.

We were concerned that:

- A number of staff did not have the appropriate and necessary knowledge and understanding of adult safeguarding processes, including the recognition and management of safeguarding incidents; referral arrangements; and patient protection plans
- Staff recognition and management of adverse incidents and near misses was inconsistent. Incidents were graded incorrectly and there was no evidence that staff recognised the cumulative effect of repeated incidents
- The standard of record keeping across wards; disciplines; and systems was varied and included the use of multiple tools and IT systems. This made it difficult to follow a patient's journey
- Governance systems within Shannon Clinic were not robust and there was evidence of a disconnect between clinical leadership and management across the site.

4.1 Inspection outcome

Total number of areas for improvement	12

There are 12 areas for improvement (AFI's) arising from this inspection. These comprise of seven new AFI's, four AFI's stated for the third time and one AFI stated for the fourth time.

Details of the QIP were discussed with representatives of the SMT at an online feedback session on 22 December 2020. The timescales for implementation of these improvements commence from the date of this inspection. The findings of our inspection are outlined in the main body of the report.

This inspection did result in enforcement action.

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Enforcement notices for registered establishments and agencies are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

4.2 Enforcement action taken following this inspection

We provided feedback to members of SMT during a meeting on 22 December 2020 where we highlighted serious concerns in the following areas; adult safeguarding; incident management; and governance/clinical leadership.

We have taken into consideration the significant pressures the pandemic has placed on all our healthcare systems. When we identify serious concerns as a result of an inspection our normal processes would be to arrange a further meeting with the Trust to share our serious concerns and provide the Trust with an opportunity to assure us of their plans to address these concerns. In response to the pandemic, we have requested these assurances through the submission of a detailed action plan. We have since received a comprehensive and robust action plan from the Trust and await further updates to this as requested.

On 8 January 2021 we shared an Article 4 letter with the Chief Medical Officer, Department of Health, informing them of our serious concerns.

5.0 How we inspect

Prior to this inspection a range of information relevant to the service was reviewed, including the following records:

- Previous inspection reports;
- Serious Adverse Incident notifications;
- Information on Concerns;
- Information on Complaints; and
- Other relevant intelligence received by RQIA.

Each ward was assessed using an inspection framework. The methodology underpinning this inspection included discussion with patients; observation of practice; discussions with staff; and review of relevant documentation. Records examined during the inspection included: patients care and treatment records; ward operational records; training records; complaints and compliments; incident and accident and adult safeguarding records; medicine kardexes; Trust policies and procedures; senior management and governance reports; minutes of meetings; duty rotas; and environmental risk assessments.

Areas for improvement identified at the previous inspection were reviewed and an assessment of achievement was recorded as met, partially met or not met.

Questionnaires were provided to patients during the inspection. There were no returned completed patient questionnaires.

We invited staff to complete an electronic questionnaire during the inspection. No staff questionnaires were received by RQIA.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection from 8–10 January 2018

The previous inspection of Shannon Clinic was an unannounced inspection undertaken from 8-10 January 2018.

The completed QIP was returned by the Trust to RQIA and was subsequently approved by the inspector.

6.2 Review of areas for improvement from the previous inspection on 8–10 January 2018

Quality Improvement Plan		
Patient Promoting Quality Care (PQC) risk assessments/associated risk assessments		
Area for Improvement 1 **Stated: Second time** **Ref: Standard 5.3.1 (a)**	**Action taken as confirmed during the inspection:** Issues with respect to PQC risk assessments/associated risks assessments were identified during the previous inspections in 2016 and 2018 and areas for improvement were made. During this inspection we again identified challenges with inconsistency in recording and storage of PQC and associated risk assessments. This area for improvement has been assessed as not met and has been stated for the third time. Further detail is provided in section 6.3.1	**Not met**
Recording medical reviews		
Area for Improvement 2 **Stated: Second time** **Ref: Standard 5.3.1 (a)**	**Action taken as confirmed during the inspection:** Issues with respect to the recording of medical reviews were identified during the previous inspections in 2016 and 2018 and areas for improvement were made. During this inspection we again identified challenges with inconsistency in recording and storage of information with respect to medical reviews. This area for improvement has been assessed as not met and has been stated for the third time. Further detail is provided in section 6.3.2.	**Not met**

Clinical Leadership		
Area for Improvement 3 **Stated: Third time** **Ref: Standard 8.3**	**Action taken as confirmed during the inspection:** Issues with respect to clinical management were identified during the previous inspections in 2016 and 2018. During this inspection we again identified concerns with respect to the clinical management arrangements in Shannon Clinic. This area for improvement has been assessed as not met and has been stated for the fourth time. Further detail is provided in section 6.3.3.	**Not met**
Function of Shannon Clinic		
Area for Improvement 4 **Stated: Second time** **Ref: Standard 4.3**	**Action taken as confirmed during the inspection:** An area for improvement in relation to the Function of Shannon Clinic was originally stated in the QIP of the inspection from 30 August - 2 September 2016. During the subsequent inspection from 8 – 10 January 2018 the area for improvement was assessed as partially met. Two parts of the area for improvement which had not been met related to an overall analysis of the workforce and a review of staffing in Ward 3. They were subsequently stated for the second time. Issues with respect to staffing across Shannon Clinic were identified during this inspection and a new area for improvement in relation to staffing has been made. Further detail is provided in section 6.3.5 During this inspection issues were identified with respect to the mixed gender population on Ward 2. A specific area for improvement to undertake a review of the mixed gender population on Ward 2 has been made. Further detail is provided in section 6.3.4. This area for improvement has been assessed as met.	**Met**

Staffing		
Area for Improvement 5 **Stated: Second time** **Ref: Standard 4.3**	**Action taken as confirmed during the inspection:** An area for improvement in relation to staffing was originally stated in the QIP of the inspection from 30 August – 2 September 2016. During the subsequent inspection from 8–10 January 2018 the area for improvement was assessed as partially met. Two parts of the area for improvement which had not been met related to staffing in Ward 3 and the arrangements for managing patients leave. Issues with respect to staffing across Shannon Clinic were identified during this inspection and a new area for improvement in relation to staffing has been made which takes account of the two parts of the previous area for improvement which had not yet been met. Further detail is provided in section 6.3.5. This area for improvement has been assessed as met.	**Met**
Staffing		
Area for Improvement 6 **Stated: Second time** **Ref: Standard 4.3**	**Action taken as confirmed during the inspection:** An area for improvement in relation to mandatory training was originally stated in the QIP of the inspection from 30 August – 2 September 2016. During the subsequent inspection from 8 –10 January 2018 the area for improvement was assessed as not met. This area for improvement has been assessed as not met and has been stated for the third time. Further detail is provided in section 6.3.6.	**Not met**

Incidents and accidents		
Area for Improvement 7 **Stated: Second time** **Ref: Standard 5.3.2**	**Action taken as confirmed during the inspection:** An area for improvement in relation to incidents and accidents was originally stated in the QIP of the inspection from 30 August-2 September 2016. During the subsequent inspection from 8–10 January 2018 the area for improvement was assessed as not met. Significant issues with respect to the recognition and management of adverse incidents and near misses were identified during this inspection. This area for improvement has been assessed as not met and has been stated for the third time. Further detail is provided in section 6.3.7.	**Not met**
Pharmacy input		
Area for Improvement 8 **Stated: Second time** **Ref: Standard 5.3.1**	**Action taken as confirmed during the inspection:** This area for improvement has been assessed as met. Further detail is provided in section 6.3.8.	**Met**

6.3 Inspection findings

6.3.1 Promoting Quality Care (PQC) risk assessments/associated risk assessments.

Shannon Clinic is a regional service accommodating patients from each Trust. A forensic consultant psychiatrist from each of the five Trusts oversees the care and treatment of patients from their Trust area during their stay in Shannon Clinic. Shannon Clinic also has their own lead forensic consultant psychiatrist.

We reviewed a number of PQC and associated risk assessments, and discussed the management and oversight of PQC and associated risk assessments with ward staff and consultant psychiatrists. We identified a number of concerns.

Ward staff reported challenges in locating the PQC documents and risk assessments given the different consultant preferences for storing documentation across three systems; the T-Drive (the Trust's main electronic system), a separate patient electronic record system known as PARIS and on hardcopy.

One consultant informed us that their preference was to store risk assessments on the T-drive so they could share the document to their own Trust records as the PARIS system in the Trust is not linked to other Trust's PARIS systems.

Each consultant conducts and records PQC reviews differently in terms of the frequency of reviews and the level of detail contained within them. Some recording lacks detail in terms of assessing if the risk has increased or decreased or is unchanged, and there is no consistent recording of a chronology of incidents. Some consultants complete the management plan section in full while others do not, and despite this information being contained in the Comprehensive Risk Assessment (CRA) these are often located on a different system. Reports prepared for PQC reviews from other members of the Multi-Disciplinary Team (MDT) including the OT and social worker helped inform discussion and assess risk, but it was difficult to identify the patient's risks in one document. It was not clear how the information contained in PQC was being used to inform patient's care and treatment plans.

There was an inconsistent approach, across the consultant group, in their use of risk assessments and in addition a number of risk assessments were in use to measure the same or similar types of risk. These findings create a risk to patient safety in terms of nursing staff's ability to locate accurate up-to-date real time risks and management plans for patients. New members of staff would be unable to access this information in one place and would need to be familiar with the various consultants' recording preferences.

The HCR-20 Violence Risk Assessment Scheme is a 20-item violence risk assessment tool, intended to structure clinical decisions about the risk for violence posed by adult forensic psychiatric patients. The HoNOS (Health of the Nation Outcomes Scales) is a measure of the health and social functioning of people with severe mental illness which uses a 12 item scale to measure behaviour, impairment, symptoms and social functioning. Both of these tools were being used in Shannon Clinic to assess patients. Clinical and organisational leadership need to review the risk assessment tools available to determine which tool best supports decision making for patient risk. An area for improvement has been made.

6.3.2 Recording Medical Reviews

There are 18 ward round reviews taking place each week in Shannon Clinic for a patient population of 34. We reviewed the arrangements for conducting and recording these reviews and determined consultants and general practitioners (GP) are undertaking these reviews regularly and recording the outcomes.

Junior medical staff informed us that there are clear care and treatment plans which are updated weekly following the MDT reviews and they report that this is working well. However, there continues to be inconsistencies in the recording of information and both the PARIS and T-Drive systems are being used to store information. This can lead to difficulties in staff being able to follow the patient's most up to date care and treatment plan.

Issues with respect to the recording of medical reviews were identified during the previous inspections in 2016 and 2018 and areas for improvement were made. We determined that this area for improvement has not been met and has been stated for the third time.

6.3.3 Clinical Leadership

We reviewed the clinical leadership arrangements for Shannon Clinic. We spoke with a range of staff including clinical staff; nursing staff; and management at various levels and reviewed minutes of various meetings.

From the feedback we received we determined that supporting each of the 18 ward rounds is placing significant burden on a limited number of nursing staff and other multi-disciplinary team members as each ward round requires actions to be taken to progress care and treatment plans for the patients.

There were many different meetings taking place in Shannon Clinic each month. These include a monthly operational meeting; the security operations group; the monthly governance and patient safety meeting; the therapeutic co-ordination group; a weekly bed management group; and a recently established meeting of clinical staff only.

One of the first topics on the agenda for discussion at the recently established meeting of clinical staff was the outcome from a significant review of governance and leadership in another of the Trust's hospitals. As the outcomes from this review were not specific to clinical staff it should have been tabled for discussion at a full multi-disciplinary meeting where clear actions, timescales and action owners could be identified and agreed to embed learning, arising from the review, into Shannon Clinic. This would support improvement across the entire MDT team working in Shannon Clinic with a view to better outcomes for patient care and treatment.

Minutes of the various meetings evidenced a structure to the meetings with a set agenda to discuss mortality and morbidity review; safety graphs; local/ward incident themes; pharmacy issues; including medicine safety alerts and learning from serious adverse incident reports. There were limited data sets to adequately inform the meetings. The minutes lacked evidence of analysis of data, emergent themes or trends or performance against agreed key performance indicators. The data sets used to inform the directorate governance meeting are a combination of data sets from all acute inpatient wards making analysis of the data less effective. We were informed that work is underway to separate the data to more accurately reflect what is happening in forensic services and enable appropriate actions to be taken to address any identified risks in Shannon Clinic.

Our determination of all of the relevant meetings taking place was that of overlap in discussion, and that minutes do not accurately reflect the progress, decisions made, and action updates from one meeting to the next.

We met with a number of consultant staff. Shannon Clinic has a lead consultant and consultants with lead roles in both governance and quality improvement. We were pleased to note a focus on the areas of governance and quality improvement. However, there was a lack of connectivity between the various lead roles and their relevant work streams. The connectivity between clinical leadership and that of other management and governance arrangements was not clear and there was no evidence of prioritisation of the various strands of work.

Issues with respect to clinical leadership were identified during the previous inspections in 2016 and 2018. We determined that this area for improvement has not been met and has been stated for the fourth time.

6.3.4 Function of Shannon Clinic

Ward 2 is a mixed gender ward. Staff reported their concern about the gender mix in Ward 2 and stated that the female patients become frustrated as they see how male patient's progress through their journey via admission to the different wards but there is no similar pathway for female patients. Staff and the patient's advocate reported that this has an unsettling effect on female patients who feel they are not progressing in their recovery. This issue was previously identified by the SMT and some preliminary work had been undertaken to address the matter.

During the inspection of Shannon Clinic in January 2018 we were informed that a business case for the provision for a de-escalation suite and separate accommodation for female patients was sent to the Trust's SMT. We asked for a progress update during this inspection; staff were aware that at one stage this case been a priority one for the Trust however no-one understood the rationale for it to be downgraded to a priority three and no one was in a position to confirm what interim arrangements were considered. The outcome of the Trust's decision on the business case needs to be communicated to the SMT of Shannon Clinic, patients and relatives. An area for improvement has been made.

6.3.5 Staffing

We met with a range of staff across all wards to include, nursing; ancillary; medical; social work; and OT staff. We also met with nursing staff covering the night shift.

During our discussions with staff they raised concerns about the skill mix of staff and several staff stated more than one qualified staff nurse was needed on night duty in all wards. Some staff (both male and female) stated the gender mix of staff was not always suitable.

The current staffing for Ward 3 at night are two staff, comprising of a qualified nurse and a nursing assistant. There is an expectation that one of these staff members provides support to any one of the other two wards should an emergency alarm be activated, resulting in one staff member being left on their own in the ward. The off duty does not reflect the time staff spend off the ward supporting other wards, making auditing of this practice and implementing any necessary changes difficult. SMT should ensure staff movement between wards is recorded and audited in order to have oversight of any safety risks to patients and staff.

Staff informed us that agency staff are not used and that any staffing deficits are covered by substantive staff working additional bank shifts across the three wards. We were informed that some staff work excessive hours and many consecutive days/nights.

We noted good relationships between the nursing teams across all three wards to support each ward when short staffed.

Staff informed us there is an on call rota for escalating issues to senior management at evenings, weekends and bank holidays, however, they tend not to escalate staff shortages to the SMT as they are frequently able to obtain the cover required.

On review of staffing rotas we found evidence of an increase in staff numbers when a patient required a higher level of observation for a period of time. We found staffing levels on two of the three wards was appropriate to meet the patient's needs, including outings, court appearances and appointments. We determined that one ward did not have sufficient staff every time it was required to accommodate scheduled outings or appointments. We were informed by members of SMT that there had been a recent review of staffing levels using the Telford Model (the Telford Model is a tool that helps managers identify safe staffing levels across shifts). Staff at ward level were not aware of the Telford Model or how it is used to determine skill mix and staffing levels.

The current psychology compliment for Shannon Clinic and another two wards on Knockbracken site equates to 1.1 full time equivalents. This level of psychology service has remained the same for the past number of years. Given the number of consultants and their ward rounds the clinical psychologist cannot attend all MDT/case conference meetings. They reported a challenge in delivering psychology support as there are many patients who would benefit from more intensive input from trained clinical psychologists.

The occupational therapy (OT) compliment currently consists of two OT staff and one rotational OT. There remains a vacant OT position which has been advertised without success. Currently there is a high demand for OT input across the three wards. Staff from two wards indicated that OT and psychology input was not sufficient and that patients had a lengthy wait for these services.

An area for improvement has been made.

6.3.6 Mandatory training

During the previous inspection from 8-10 January 2018 records of mandatory training were not consistently monitored or recorded and assurances were not provided that staff had attended mandatory training.

During this inspection staff training records were available and upon review we noted good compliance with MAPA training.

Records reflected a significant number of staff had not completed fire safety training within the required time frame and there were no records to support annual practical fire safety training taking place. Ward staff and ward managers were unable to provide assurances that fire safety training and practical fire drills had been completed.

A number of staff had not received infection prevention control (IPC) training and records evidenced that IPC training was out of date for over one third of staff.

Adult and child safeguarding training had been completed by two thirds of staff. Despite this we found that the training had not been embedded in practice and we highlighted deficits in relation to staff knowledge of ASG processes.

Each ward's training matrix had a number of variances indicating ward managers were monitoring different training updates.

There was no central oversight and governance around staff mandatory training.

An area for improvement in relation to mandatory training was originally stated in the QIP of the inspection from 30 August–2 September 2016 and was stated a second time in the QIP of the inspection from 8-10 January 2018. We determined that this area for improvement has not been met and has been stated for the third time.

6.3.7 Incident management

We reviewed incidents reported on the Trust Datix system for all wards for the last three months and identified significant concerns about the recognition and management of adverse incidents and near misses.

We identified that not all incidents were recorded on PARIS and noted on some occasions incidents which had met the threshold for reporting under the Adult Safeguarding: Prevention and Protection in Partnership Policy (2015) and not been referred to the Trust's adult protection gateway team that investigates safeguarding concerns. The management of adult safeguarding concerns is discussed further in section 6.3.9.

We noted that the grading of incidents on the Trust Datix system was based on the outcome of the incident and not on the inherent risk, resulting in a significant number of incidents being graded as low risk. We were concerned that there was a risk of incidents being incorrectly categorised and therefore not appropriately escalated, for example, to a level requiring a Serious Adverse Incident (SAI) investigation.

Members of the SMT confirmed that incidents are only escalated to them when they are graded medium or high risk. Based on our findings only a minimal number of incidents reach the threshold for escalation to the SMT. In one ward, out of 150 incidents, only two were graded medium, all others were graded low despite the level of risk identified in the incidents. We identified a number of serious incidents that were graded low, including incidents where patients had attempted self-harm or required medical treatment at the accident and emergency department of an acute hospital. We also identified similar type incidents being graded at different levels dependent on the person completing the Datix entry. Numerous incidents involving the same patient were graded as low. There was no recognition of the cumulative effect of escalating behaviours or the cumulative impact of each incident on the patient. This was particularly evident in respect of patient on patient assaults. There was no evidence that staff re-evaluated these incidents to inform or update risk management plans.

We found evidence of smoking incidents being graded as low. We discussed this with ward managers and members of the SMT during feedback having recently identified risks associated with fire incidents which according to data held by RQIA are increasing across the region in acute mental health settings.

We found evidence that significant injury had been sustained in a small number of patients on patient assaults. The correct procedure for referring patients to the ASG team was not adhered to and the recording, grading and oversight of such incidents was lacking.

There was no evidence of Datix training, for staff. We could not see any prompts or Aide Memoires for staff to support them on completing and grading Datix incidents.

There are no safety briefs/huddles within Shannon Clinic, which would enable open discussion about the risk management of incidents. Incidents are reviewed each Monday morning at the bed management meeting; however they are reviewed as individual incidents and cumulative data which would identify increasing risk is not being considered. There is no formal recording of the outcomes from these discussions. We were informed of a recent quality improvement initiative to develop a hot–debrief following any untoward incidents with the implementation of a weekly reflective practice session. Members of the SMT confirmed that these sessions were poorly attended despite ward staff having protected time to attend. We were advised by ward staff that they had poor understanding of the benefit of the reflective practice sessions and as a result of work pressures were unable to set aside protective time to attend.

We identified a lack of governance and oversight of incident management across Shannon Clinic. Incident data is not being routinely monitored, audited and analysed by ward managers, SMT or the Trust's governance department and therefore opportunities to learn and improve are being missed.

We have determined that the system for identifying and managing adverse incidents and near misses was not sufficiently robust.

An area for improvement in relation to incident management was originally stated in the QIP of the inspection from 30 August-2 September 2016. During the subsequent inspection from 8–10 January 2018 the area for improvement was assessed as not met. We determined that this area for improvement has not been met and has been stated for the third time.

6.3.8 Pharmacy input and Medicines management

We reviewed a number of patient's medicine records and the pharmacy provision on site and we spoke to nursing and medical staff.

The Trust reviewed the pharmacy provision following the previous inspection of Shannon Clinic. We were informed that, since early 2020, there has been no commissioned pharmacy service at Shannon Clinic. Pharmacy support is now provided remotely from the Belfast City Hospital pharmacy and mainly consists of a dispensing and advisory service. The Trust have put in place robust protocols to manage the pharmacy needs of patients with a remote service. Both medical and nursing staff confirmed that this changed arrangement has not created any difficulties in the management of medicines.

We were assured by the systems in place to manage the patient's pharmacy needs and found no deficits in the monitoring, auditing or reviewing of medication.

In relation to patient's medicine records we identified good medicines management practices. We found that medical staff are managing frequent reviews of patient's medication, we found no issues regarding re-prescribing. There is good compliance with the policy for monitoring anti-psychotic medication.

The medical staff team has ongoing significant input into the regular review of patients' medicines.

A review of patient prescriptions and PRN medication is conducted at the weekly multi-disciplinary team conference, thus minimising the need for prescribing of PRN medication by Out of Hours Clinicians.

Currently there are no patients self-administering their medication; the majority of patients move to supported accommodation facilities upon discharge therefore education and assessment to self-administer medication for these patients is not required whilst they are in Shannon Clinic.

We noted that two wards did not have a list of critical medicines displayed and there were also inconsistent recordings of the fridge temperature in one ward. These issues were addressed with the nurse in charge of each ward at the time of the inspection.

It is good practice when there are two means of prescribing the same medication, such as oral and injectable, that medical staff make two separated entries on kardexes.

6.3.9 Adult Safeguarding

We reviewed the processes for the recognition and management of adult safeguarding (ASG) and identified a number of concerns in relation to adherence to regional guidance; Adult Safeguarding: Prevention and Protection in Partnership Policy (2015).

We met with staff, reviewed incidents on Datix and cross referenced incidents with referrals made to the adult safeguarding team. We found staff knowledge to be limited in relation to the adult safeguarding process.

We reviewed a number of safeguarding referrals known as ASP1 and determined that staff did not always make ASG referrals when one was required. We found the quality of referrals to be poor with significant gaps in recording, forms containing limited information, and some forms left blank in relation to immediate protection plans. Details of a referral were not always recorded on the patient's progress notes on PARIS and when discussed with staff they advised that they used their own knowledge of patients to safeguard them.

We found several incidents where ASP1 forms were completed by the nursing staff and referred to the ward manager for screening (in line with the policy). On two occasions the form had not been screened by the ward manager a number of months later. This was immediately escalated.

We identified two referrals where the ward sister had screened the ASP1 form and referred it onto the Designated Adult Protection Officer (DAPO). The PARIS record evidenced that the DAPO had not screened the form. The screening of forms is not timely and thus creates significant risks for patients.

There was limited evidence of any communication between the nursing staff and the DAPO in relation to protection plans.

We met with the acting lead social worker who is the only social worker covering Shannon Clinic and two other wards on the Knockbracken site. Temporary cover had been provided for two social workers for a period of time; however this is no longer available. The acting lead social worker was managing all safeguarding incidents alongside other social work roles and responsibilities. They advised us that they were fulfilling the role of investigating officer (IO) and DAPO and advised that it was impossible to fulfil all roles and expectations in relation to adult safeguarding. We are concerned that this situation creates a risk to patients and adherence to safeguarding procedures.

Where there was discussion at the MDT meeting, there was no record to evidence the MDT considered safeguarding protocols in relation to multiple referrals for the same patient. An example of this was where we identified that one patient had been a victim on multiple occasions. The incidents were reviewed at the MDT meeting and discussed in relation to a risk management plan, and level of risk, but not in consideration to the incidents meeting the threshold for onward referral to the adult safeguarding team. We are concerned that the MDT discussions are not led with a safeguarding focus and lack consideration to the patients as adults at risk of harm or in need of protection.

We could not evidence any auditing or analysis of safeguarding incidents and there was no oversight of data at ward or senior management level in relation to patterns or trends to identify learning and prevent reoccurrence.

There is no Adult Safeguarding Champion identified in Shannon Clinic.

Safeguarding has been a concern for RQIA across multiple areas in BHSCT. We wrote to the Trust on 21 October 2020 to raise concerns relating to adult safeguarding. We requested assurances on how the Trust intended to strengthen communication systems to enable effective sharing of safeguarding improvement work and assurance of robust safeguarding arrangements across all Trust services. On 19 November 2020 we received a response from the Chief Executive Officer (CEO) of the Trust assuring us that they were undertaking a review of adult safeguarding arrangements. It was anticipated that this review would be completed by end of February 2021. The findings of the review and the Trust's plans to improve the awareness and adherence to adult safeguarding procedures had not yet been implemented in Shannon Clinic.

We were not assured regarding the embedding of regional guidance into practice. We were concerned that the Trust does not have robust processes in place to embed safeguarding protocols within Shannon Clinic.

An area for improvement has been made.

6.3.10 Restrictive Practices

We reviewed the processes for the management of restrictive practices in Shannon Clinic.

We acknowledged that Shannon Clinic provides psychiatric treatment and rehabilitation for patients with a forensic history in a medium secure environment and that some patients had imposed restrictions as a result of their sentencing and offending behaviours.

We reviewed patients care plans and found that consideration had been given to patient's human rights; criminogenic needs; and legal implications based on patients offending behaviours. We reviewed PARIS notes that reflected detailed recording regarding restrictive practices.

We found that where patients required restrictive practices, this was risk assessed individually in relation to personal items, for example; access to razors, unsupervised ground leave and self-possession of items that may have the potential to cause harm.

We were assured that where there was an increase in risk, a review took place with the MDT and risk was assessed and individually managed. Although Shannon Clinic did not have an individual restrictive practice assessment tool to collate information on restrictive practices used, there was robust evidence of the type of restrictions used in individual's risk assessments.

We found staff had good awareness of restrictive practices and there was evidence of MDT oversight.

6.3.11 Environment

We reviewed the fire risk assessment completed for Shannon Clinic in 2019. We were later provided with an electronic copy of the fire risk assessment for 2020. In both assessments the fire risk was noted to be tolerable however we noted that items listed in the 2019 fire risk action plan remain on the 2020 fire risk action plan. We also found the issues listed for action were not signed off by ward managers or Trust senior management.

We were unable to evidence that every shift had two fire wardens on duty and we were not given assurances at ward level that practical fire drills were completed annually as per the Trust's policy.

The estates manager for the Knockbracken Site confirmed that the fire safety upgrades identified on the fire risk assessment were planned for commencement in January 2021. We requested a progress update be submitted to RQIA once the upgrades had been completed. .

An area for improvement has been made.

6.3.12 Records management

We reviewed the standard of record keeping and found that it varied across wards, disciplines and systems. The Trust use an electronic recording system, PARIS, for patient care records, however we noted there was a large volume of information stored on the T-drive and also in hardcopy. There are six consultant psychiatrists, each with a preferred system for recording. These variations cause difficulty for nursing staff in locating records; understanding management plans; and following the patient's journey. We noted very good levels of detail recorded in treatment and management plans however it was not clear which treatment and management plan was the current one. The use of multiple tools and IT systems for recording patient care and treatment makes it extremely difficult to triangulate information and to establish when risks are escalating.

Throughout the inspection staff experienced difficulties providing the information we requested. Information was recorded in a disjointed manner.

On review of one patient's management plan, we were unable to evidence updated risk assessments following incidents between them and another patient. These incidents had potential for physical violence, as documented on the patient's protection plan.

We evidenced staff encountering difficulty locating a speech and language therapist (SALT) assessment for a patient who had experienced a choking incident. We are not assured that staff were aware of the outcomes of the assessment and we have concerns that vital assessment information is not readily available to all staff.

We observed examples of care plans which were not signed by either nurse or patient.

There was no evidence of audits undertaken in respect of records management.

An area for improvement has been made.

6.3.13 Patient engagement

Throughout the inspection we observed staff and patient engagement. We noted staff demonstrated compassionate care and spoke to patients in a dignified respectful manner. This was observed in all wards.

There was evidence of various activities available to the patients and there were sufficient staff to accommodate activities in all but one of the wards where staff shortages impacted patient activity. As noted in section 6.3.5 we made an area for improvement in relation to staffing.

6.3.14 Complaints management

We reviewed how staff manage complaints. There were only four complaints on record from April 2020 to September 2020. During discussions with staff we learned that there are many issues raised by patients and relatives which are not recognised or recorded as complaints and handled accordingly.

There is no record if the complaint was resolved to the complainant's satisfaction or within the Trust's complaints policy timeframe or that complaints were used to drive improvements in service delivery or patient experience.

An area for improvement has been made.

6.3.15 Organisational and Clinical Governance

During our discussion with staff we were informed that Shannon Clinic had undergone a significant change in staff at ward and senior management level over the previous 18 months. Staff reported that while such change had a de-stabling impact on them at that time, there were newly appointed ward managers in place which helped staff feel more positive about stable leadership at ward level. Most of these staff advised the movement of ward managers (some had secured promotional positions elsewhere in the Trust) had impacted on team work and morale however they recognised this will improve over time as the new staff progress through their inductions.

All staff interviewed, expressed dissatisfaction in senior management presence on the wards. They acknowledged that the pandemic restrictions may have contributed to this however staff felt that senior Trust staff could be more visible on the wards.

Staff reported the changes in senior management positions across the clinic and staff acting into interim positions has had a negative impact on there being a sense of collective leadership.

There is uncertainty regarding the strategic direction and operational priorities for Shannon Clinic.

To understand the governance arrangements within Shannon Clinic we reviewed minutes of meetings, met with ward staff, divisional nurse leads, service leads, consultant psychiatrists, co-directors and directors and spoke with members of the governance department. We found a shortfall in governance systems.

A number of governance meetings that previously occurred within Shannon Clinic had been stepped-down as members of the SMT were re-deployed during the pandemic. This created a lack of certainty around who was overseeing governance arrangements and who was driving quality improvement initiatives. We reviewed minutes of meetings such as the forensic mental health and governance mortality review; and patient safety meetings and found the minutes lacked evidence of analysis of data; trends or performance outcomes against KPI's. An example of this was the lack of evidence of discussion of SAI/incidents at governance meetings to share learning and drive improvement within the unit.

A member of the SMT informed us that the only audits occurring were in relation to Infection Prevention Control (IPC) such as hand hygiene and use of Personal Protective Equipment (PPE). There were no audits in relation to record keeping, care or treatment plans, or PQC's. We met with the lead consultant who was recently assigned responsibility for governance oversight to understand how data from Shannon Clinic fed into the directorate and corporate governance forums. He advised that the directorate governance report contained data sets for all acute inpatient wards across the Trust and there was no separate data set to reflect what was happening in forensic services as a programme of care, or in Shannon Clinic.

The structure for clinical governance oversight needs reviewed with a shared understanding amongst staff of the key personnel with responsibility to monitor standards and drive improvements. This should also demonstrate how specific pieces of work are connected into Shannon Clinic's business objectives and used to inform the risk register.

An area for improvement has been made.

6.3.16. Management of illicit substances

A consultant psychiatrist informed us there was a patient who had become unwell and required treatment in an acute hospital for a number of days after consuming a number of tablets which were not prescribed to them. This had occurred some time ago. The consultant confirmed that the investigation into how the patient acquired the tablets did not provide any clear evidence of how the patient had obtained them. The consultant informed us that there had not been any prevalence of illicit drugs on the wards and confirmed that staff are aware of the need to check with patients who have been granted unescorted ground leave, upon their return, if they have brought any illicit substances back with them.

7.0 Patient and Staff Views

We met with 21randomly selected staff across all wards and shifts including night shift. Staff feedback was mostly positive with the majority of staff stating they enjoyed their role and the environment they worked in. The SMT had no input in the selection of staff we met with and none of them reported incidents of poor treatment, intimidation or bullying during the inspection.

Patients reported they viewed their care positively; they had good involvement in their care and treatment; and had opportunity to attend MDT meetings. Patients also stated they felt safe within their respective wards.

The patient and carer advocates reported that they believe patients are treated with respect and care is delivered in a compassionate, safe manner. They stated that the restrictions caused by the pandemic and the need to organise and plan visits in advance were sometimes difficult for patients and carers alike but that in general there was a good level of understanding. Neither advocate expressed concern about care delivery to patients.

No patients or staff submitted questionnaire responses.

8.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with representatives from the SMT including the Interim Director of Specialist Hospitals as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

The Trust should note that if the action outlined in the QIP is not taken to comply with the standards this may lead to further action. It is the responsibility of the Trust to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

8.1 Areas for improvement

Areas for improvement have been identified and action is required to ensure compliance with The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

8.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

The Trust must ensure the following findings are addressed:

Promoting Quality Care (PQC) risk assessments/ associated risk assessments

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 forms to be used
- 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 in Mental Health and Learning Disability Services

Ref: 6.3.1

Response by the Trust detailing the actions taken:
- A suite of risk assessments for each patient has been agreed. Each patient has a PQC and HCR20 in place as a minimum alongside a HoNOS assessment. Other specialist risk assessments will be completed dependent on patient risk.
- A working group has been set up to review documentation practices across teams. A scoping exercise has been completed and work plan is in place to address both standardisation of recording and storage of patient records.
- A record keeping audit is being led by the Assistant Service Manager in conjunction with corporate records. The subsequent action plan will be implemented. Regular record keeping audits have been included in the Unit's overall audit schedule.
- The Safety and Governance Lead for Forensic Services undertook an audit of risk assessments used within the unit in April 2021. The findings of this were that risk assessments were not easily located. The consultant group have agreed that risk assessments will be uploaded onto PARIS. This will be reaudited in June 2021.

Recording Medical Reviews	
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 **Ref: 6.3.2**
	Response by the Trust detailing the actions taken: - A workshop took place on 24/05/2021 to review the clinical model within Shannon Clinic and standardisation of clinical meetings. It was agreed that weekly case conferences are essential however the format of these will be changed to make them more efficient and patient centred. PiPA model (used in Acute Mental Health Inpatient Centre) was considered and is not suitable for use within Forensic Services. An audit of the weekly MDT meeting demonstrated that 20 minutes per patient is spent reviewing and updating care in a live forum. A review of the nursing summary is now being reviewed in line with PARIS as the current summary is outdated and time consuming for nurses. The 2 changes will be reviewed at the end of June 2021. - A working group has been convened to review documentation practices across teams. A scoping exercise has been completed and work plan is in place to address both standardisation and storage of documentation. - A record keeping audit is being led by the Assistant Service Manager in conjunction with corporate records. The action plan arising from this will be implemented. - Record keeping audits have been included in the Unit's overall audit schedule. - The Trust's PARIS Team are now included in the bi-monthly meeting "exploration of You in Mind" and the possibility of its integration onto PARIS.

Clinical Leadership	
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. **Ref: 6.3.3**
	Response by the Trust detailing the actions taken: - A workshop took place on 24/05/2021 to review the clinical model within Shannon Clinic and standardisation of clinical meetings. It was agreed that weekly cases conferences are essential however the format of these will be changed to make them more efficient and patient centred. PiPA model (used in Acute Mental Health Inpatient Centre) was considered and is not suitable for use within Forensic Services. - A Network Manager and Clinical Director for the regional Forensic Network have been appointed. A work plan is now in place. - A review of meetings taking place within Shannon Clinic has been undertaken. There are daily safety briefs for staff at ward level and weekly safety briefs to which a representative from each area attends. Each ward holds monthly staff meetings. The operational meeting and academic meeting are also held on a monthly basis. All of these feed into the service's monthly governance meeting whose terms of reference is in keeping with the regional mortality morbidity protocol. - There is a new management arrangement in place. Service Manager and Assistant Service Manager commenced post on 18 January 2021. Service and local management structure charts were created on 29/01/2021 and are available for all staff to refer to.

Function of Shannon Clinic	
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. **Ref: 6.3.4**
	Response by the Trust detailing the actions taken: The business case in relation to de-escalation suite is under review by the Service Manager to bring it up to date. The business case in relation to separate accommodation for female patients is the priority for the Regional Service.
Staffing	
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. **Ref: 6.3.5**
	Response by the Trust detailing the actions taken: - The Delivering Safe Staffing documentation has been completed and is available with a staged implementation plan. The plan will be implemented once funding has been released. A social media based recruitment plan commenced in February 2021. 11 Staff Nurse posts and 6 X Band 6 nurses have been offered as a result. - Staffing levels are reviewed on a daily basis at the Ward Manager Safety Huddle. The Service has also been able to use regular bank and agency staff where required to manage services safely.

	- Ward Managers, the Assistant Service Manager and Service Manager all have access to e-rostering system to ensure managerial oversight of working hours. - Social Work and Allied Health Professionals within Shannon Clinic report to the Assistant Service Manager. Monthly meetings with each are held.
Mandatory Training	
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. **Ref:6.3.6**
	Response by the Trust detailing the actions taken: A review of staff training matrixes for all disciplines within Shannon Clinic has taken place to ascertain both compliance with training and supervision. The Trust mandatory training matrix is held centrally and is up to date. Staff have been allocated time to achieve the required mandatory training. The Assistant Service Manager has responsibility for the overview of the training of all professions within Shannon Clinic. Nurse training is also held by managers at ward level. 1:1 supervision sessions are provided in line with professional standards. Nursing staff are on target to achieve mandatory supervision compliance by the end of the financial year. However an escalation process is in place where there are any concerns in relation to training for nursing staff.

Incident management	
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. **Ref: 6.3.7**
	Response by the Trust detailing the actions taken: - A weekly safety huddle has been introduced for the multidisciplinary team. This covers incidents, accidents, complaints and safeguarding with documented actions and learning. This is supported by a monthly governance meeting which is chaired by the Safety and Governance Lead for Forensic Services. Consideration is given to escalating any incident to a Serious Adverse Incident where it meets guidance. - The Collective Leadership Team also review any incidents of moderate and above severity/consequence on a weekly basis at their huddle. - Incident approvers are grading the severity of incidents on the outcome of the incident as per Trust policy. An audit of incidents following RQIA's inspection in December 2020 showed 98 % compliance in the grading of severity of incidents Approvers also

	showed 95 % compliance with the grading of the consequence (potential outcome) of the incident. An action plan was developed following completion of the thematic review. The report and resulting action plan is currently with the Divisional Collective Leadership Team for sign off and will be presented to staff. The audit will be repeated on a quarterly basis by governance team in conjunction with a representative from the service group. - Guidance has been provided to staff both on the completion of incident forms and the grading of incidents. The regional risk matrix is on display in each ward for approvers to refer to. - There are plans in place to facilitate refresher training for all staff in relation to the reporting of incidents and bespoke training for incident approvers. - The Trust is currently recruiting a patient data officer for Forensic Services who will assist in the formation of data/reports and analysis of information. This post was passed through scrutiny committee in February 2021 and is currently with BSO for advertisement.

Adult Safeguarding	
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 **Ref: 6.3.9**
	Response by the Trust detailing the actions taken: - The Trust's Adult Safeguarding Policy has been circulated to all staff within Shannon Clinic and approximately 60 % of staff have been trained on adult safeguarding to-date. - The Senior Social Worker in Shannon Clinic is the DAPO for Shannon Clinic and a number of staff throughout the unit have been trained as IOs. - All staff within Shannon Clinic were asked to complete a questionnaire in relation to adult safeguarding on 29/01/2021. An action plan will be developed and implemented once results have been reviewed and analysed. - There are dedicated notice board spaces in place in relation to learning from the Muckamore Abbey Hospital review and these are updated on a monthly basis. - Advice session was provided to ward managers by the Senior Social Worker on 14/01/2021 in relation to the completion of ASP1 forms and recording of interim protection plans. - An aide memoire is in place to assist staff in the completion of ASP1s - Weekly meetings between the Senior Social Worker and Assistant Service Manager commenced at the start of February 2021 to discuss safeguarding incidents/incident reports.

	- Adult safeguarding is discussed at daily safety briefs, weekly safety briefs and the monthly governance meeting for Forensic Services. Current ASG referrals are screened by ward managers within 3 days and reviewed by the DAPO. - Adult safeguarding referrals are also discussed at patient weekly case conferences. - Any learning arising from adult safeguarding investigations is discussed at both the weekly safety huddle and monthly governance meeting. - Safeguarding leads for Shannon Clinic have been identified and are currently undertaking training to enable them to fulfil the needs of the roles.
Environment	
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. **Ref: 6.3.11**
	Response by the Trust detailing the actions taken: - All ward staff within Shannon Clinic will be trained as fire wardens. It is envisaged that this training will be completed by September 2021 - A fire drill and evacuation took place 27/05/2021. The Service Manager will ensure that these are scheduled on an annual basis. - The Assistant Service Manager will have responsibility for the oversight of fire risk assessments and will monitor the progress on completion of any identified actions. - Estates Services have completed the fire safety upgrade on Ward 2. It is envisaged that upgrades for Wards 1 and 3 will be completed by the end of July 2021.

Records Management	
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. **Ref: 6.3.12**
	Response by the Trust detailing the actions taken: - A working group has been set up to review documentation practices across the unit. A scoping exercise has been completed and work plan is in place to address both standardisation and storage of documentation. - A record keeping audit is being led by the Assistant Service Manager in conjunction with corporate records. An action plan will arise from this piece of work and implemented. - Regular record keeping audits have been included in the unit's overall audit scheduled. - Training is being facilitated for staff in July 2021.
Complaints Management	
Area for Improvement 11 **Ref**: Standard 8.1 Criteria 8.3 (k) Stan **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. **Ref: 6.3.14**

	Response by the Trust detailing the actions taken: - A review of the current complaints process/mechanisms in place within Shannon Clinic has taken place using safety briefs and monthly governance meetings. - Complaints are discussed at weekly safety briefs which are recorded. Any learning outcomes will form part of this record. All local resolutions are also held by Corporate Complaints. - A complaints flowchart was shared with all staff on 20/01/2021. - A tiger page tutorial on complaints management was circulated to all staff on 20/01/2021. - A "You Said/We Did" board will be introduced following the introduction of patient experience surveys. A request has been submitted for these to commence by the Divisional Nurse via Central Nursing. Audits commenced on 19/03/2021. - The Unit's Patient Advocate facilitates a monthly patient community group during which complaints can be raised/discussed. - Complaints leaflets are available on each ward. - Carers feedback was provided by the Quality Network during their last peer review in October 2020. A meeting took place on 20/04/2021 regarding a formal carer feedback mechanism. The carer advocate attends the operational management meeting. She is developing a carer toolkit and focus groups will be held once restrictions allow.
Organisational and Clinical Governance	
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 and involved of 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 **Ref: 6.3.15**
	Response by the Trust detailing the actions taken: - Governance arrangements within Shannon Clinic have been reviewed and an action plan developed which is reviewed at the monthly local governance meeting. A number of meetings take place within Shannon Clinic including daily and weekly safety briefs, operation meetings, academic meetings and governance meetings.

	These all feed into the Divisional and overall Trust organisational and clinical governance structure. - There is a new management arrangement in place. Service Manager and Assistant Service Manager commenced post on 18 January 2021. Service and local management structure charts were created on 29/01/2021 and are available for all staff to refer to. - Collective Leadership Team visits have been scheduled for the remainder of 2021. - An organisational structure has been completed for the overall Division including Shannon Clinic. This has been shared with all staff. - Roles and responsibilities for quality improvement in Forensic Services have been reviewed. Job plans have been re-circulated to relevant staff. - Quality 2020 on-line training was circulated to all staff in February 2021. Quality improvement training was facilitated for all staff (Band 6 or above) and medical staff on 16/04/2021. - An event on the development of a quality improvement culture within Forensic Services has been arranged for 27/05/2021. - A calendar of audit for Forensic Services has been put in place. - Data sets for Shannon Clinic have now been separated to that of acute mental health inpatient facilities. A data officer is currently being appointed to assist with development of further reports and trends analysis.

Please ensure this document is completed in full and returned via web portal

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews