The Regulation and Quality Improvement Authority

Inspection Report

02 - 31 March 2022

Belfast Health and Social Care Trust

Mental Health & Learning Disability Hospital
Muckamore Abbey Hospital
1 Abbey Road
Antrim
BT41 4SH
Tel no: 028 9446 3333

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

1.0 Service information

<table>
<tr>
<td>Organisation/Registered Provider:
Belfast Health and Social Care Trust (BHSCT)</td>
<td>Responsible Individual:
Dr. Cathy Jack
Chief Executive, BHSCT</td>
</tr>
<tr>
<td>Person in charge at the time of inspection:
Tracy Kennedy, Co-Director, LD Services</td>
<td>Number of registered places:

There are 5 wards operating within Muckamore Abbey Hospital

<table>
<tr><th>Name of ward:</th><th>No of patient's accommodated:</th></tr>
<tr><td>Cranfield 1</td><td>8</td></tr>
<tr><td>Cranfield 2</td><td>8</td></tr>
<tr><td>Six Mile</td><td>11</td></tr>
<tr><td>Killead</td><td>10</td></tr>
<tr><td>Donegore</td><td>5</td></tr>
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</tr>
<tr>
<td>Categories of care:
Acute Mental Health and Learning Disability</td>
<td>Number of beds occupied in the wards on the day of this inspection:
42</td>
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<tr>
<td colspan="2">Brief description of the accommodation/how the service operates:
Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability (MHLD) Hospital managed by the Belfast Health and Social Care Trust (the Trust). The hospital provides inpatient care to adult's aged18 years and over who have a learning disability and require assessment and treatment in an acute psychiatric care setting. MAH provides a service to people with a Learning Disability from the BHSCT, Northern Health and Social Care Trust (NHSCT), South Eastern Health and Social Care Trust (SEHSCT), Western Health and Social Care Trust (WHSCT) and Southern Health and Social Care Trust (SHSCT). Patients are admitted either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO). The Psychiatric Intensive Care Unit (PICU) has remained closed since 21 December 2018. Admission to any other ward within the hospital is significantly restricted, any decision to admit new patients is risk assessed on an individual patient basis and alternative options fully explored before an admission is facilitated.</td>
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2.0 Inspection summary

An unannounced inspection of MAH commenced on 02 March 2022 at 09:00 and concluded on 31 March 2022, with feedback to the Senior Management Team (SMT). All wards were inspected by a team comprised of four care inspectors with support from administration staff.

The inspection focused on five key themes: discharge and resettlement; patient's physical health care needs; staffing; incident management and safeguarding; and governance and leadership. The inspection also sought to assess progress with areas for improvement (AFI) identified during the previous inspection in July 2021.

The inspection identified good practice in relation to resettlement planning, with evidence of good Multi-Disciplinary Team (MDT) and family involvement. Progress has been made in relation to identifying suitable community placements to enable patients to leave hospital.

Significant progress has been achieved in the management of patient's physical health care, and health screening. A Trust employed General Practitioner (GP) is available on site four days per week.

MAH continues to experience a number of challenges to maintaining service delivery. The Public Inquiry into the historical abuse of patients in MAH commenced in October 2021, the impact of which is felt by patients, families and staff across the site. MAH continues to experience challenges with staff vacancies, a lack of skilled and experienced learning disability speciality staff, and the ongoing management of adult safeguarding incidents. Further information is detailed in the main body of this report.

During the course of our inspection we were informed of the Trust's decision to implement changes within the Senior Leadership Team at MAH. We determined that this change will support and enhance service delivery and continuity.

3.0 How we inspect

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

During the inspection we observed patient care and treatment, engaged with the MDT and Senior Management Team (SMT), and reviewed relevant patient and governance documentation. Experiences and views were gathered from staff, patients and their families.

Evidence was gathered to compliment the intelligence already gained through our contemporaneous scrutiny of all safeguarding notifications involving staff, which RQIA has undertaken since July 2019.

4.0 What people told us about the service

Posters and patient easy read leaflets were placed throughout wards inviting staff and patients to speak with inspectors and feedback on their views and experiences. We received six completed patient questionnaires during the inspection.

Feedback from patients about the staff and the care they received was for the most part positive.

Opportunities to speak with relatives during the course of the inspection were limited as a result of the Covid-19 visiting restrictions; consequently, we offered all families the opportunity to engage with us via a telephone call. Nineteen families availed of this opportunity. Some family members gave their permission to share their opinions with the SMT during the inspection.

Several staff interviews were conducted, including both Trust and agency staff, across the wards. Staff spoke openly about the concerns they had in relation to disparities between Trust and agency staff and the impact of the Public Inquiry. Despite this, staff remained committed to delivering safe and effective care.

5.0 The inspection

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

The last inspection to MAH, which was an MDT inspection, was undertaken on 28 July 2021 to 19 August 2021. Three areas for improvement were identified.

Areas for improvement from the last inspection to Muckamore Abbey Hospital 28 July to 19 August 2021.		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).		**Validation of compliance**
PHYSICAL HEALTH CARE		
Area for improvement 1 **Ref:** Standard: 8.1 Criteria: 8.3 **Stated:** First time **To be completed by:** 01 January 2022	The Belfast Health and Social Care Trust shall develop a robust system for sharing information between medical and nursing staff to ensure all relevant staff are kept informed and up to date in relation to patient's general/physical health screening.	**Met**
	Action taken as confirmed during the inspection: A robust system for sharing information between medical and nursing staff in relation to patient's general / physical health was in place. Patient	

	records reflected consideration and/or completion of physical health screening. All disciplines were recording in patient PARIS records.	
ADULT SAFEGUARDING		
Area for improvement 2 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 01 January 2022	The Belfast Health and Social Care Trust should ensure action is taken to improve the working relationship between the adult safeguarding teams and the ward staff with a particular focus on variation in practice and decision making in protection planning.	**Met**
	Action taken as confirmed during the inspection: There was evidence of a good working relationship between the adult safeguarding team and the ward staff. Staff at ward level followed the Adult Safeguarding (ASG) process and procedure with evidence of input and support from the adult safeguarding team. A review of the information confirmed that ward staff were making appropriate referrals to the ASG team.	
STAFF TRAINING (AGENCY STAFF)		
Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3.3 **Stated:** First time **To be completed by:** 01 January 2022	The Belfast Health and Social Care Trust should develop a specific training programme for agency staff that will develop knowledge and skills to support them to safely and effectively meet the specific needs of the patients within MAH. Ref 5.2.6	**Not Met**
	Action taken as confirmed during the inspection: Limited progress had been made in this area. There was no evidence of an agency specific training programme. There were no assurances that agency staff had the required level of knowledge or skill to safely and effectively meet patient needs. This area for improvement has not been met and will be stated for the second time.	

5.2 Inspection findings

5.2.1 Discharge/Resettlement Planning

The discharge planning processes for patients across all wards were reviewed. At the time of the inspection there were 42 patients on MAH site, 40 of whom were delayed in their discharge. A lack of suitable community placements and a lack of suitably skilled / experienced staff and environments were cited as contributing factors to some of the delays in progressing timely discharge.

MAH have a dedicated resettlement team to lead patient resettlement. Their role is to identify suitable community placements based on each individual patient's assessed needs. Five patients have been successfully resettled during 2021-2022, with resettlement advanced in the process for a further three patients. A number of the other patients, who are delayed in their discharge, have an identified community placement; however, the expected dates for discharges remain uncertain as they are reliant on construction of the facilities and the recruitment of appropriately qualified/skilled staff. It was positive to see evidence of staff employed by prospective care providers working on the hospital wards with patients (inreach) and also Trust employed staff supporting patients to transition to new accommodation (outreach) where appropriate. The resettlement team have good oversight of all patients and maintain a database to track the resettlement plans for individual patients. The resettlement team work collaboratively with the MDT, patients and families to identify placements. The resettlement team and the SMT have co-operated fully in the ongoing review of resettlement arrangements. The recommendations falling out of this review will further enhance the resettlement of patients from MAH.

Families spoke positively of their involvement in discharge planning, including decision making for placement, and for some, engagement with the prospective new service provider. Some families of patients who had not yet had a placement in the community identified remained positive that options were being explored, and understood that the complexity of their relative's needs may further delay identifying the most appropriate placement. We were assured that the resettlement team had oversight of all resettlement plans and were adopting a multi-disciplinary approach to discharge planning.

5.2.2 Physical Health Care

The physical healthcare provision for patients across all wards was reviewed. All patients had a robust health care pathway in place, and there was evidence that patients had routine blood tests and clinical observations completed, and also blood tests for specific reasons based on individual need. A full review of antipsychotic medicines was completed by the hospital psychiatrist in collaboration with the nursing staff twice yearly. There was evidence that these medicines were regularly reviewed during clinical ward rounds which has led to improved outcomes for patients regarding reduction in medication.

Patients have access to an onsite GP four days per week who co-ordinates physical health checks, medication and chronic disease monitoring; this includes six monthly electrocardiography (ECG) for patients who require antipsychotic medication monitoring (where patients had difficulty coping with an ECG, medical staff had explored other, more suitable options, with those patients). We found the GP provision to be a positive resource that met the needs of the patients.

Communication between medical and nursing staff in relation to physical health care had improved since the last inspection. All disciplines are now recording contemporaneously in patient electronic notes and there was evidence of physical health care discussed during MDT meetings twice weekly. There was clear evidence of the patients' journey in relation to physical healthcare needs.

5.2.3 Staffing

We reviewed the staffing arrangements at MAH through the analysis of staffing rotas, discussions with staff, and review of staffing model. The site is using the Telford model to determine staffing levels, which is a tool to assist staff in defining staffing levels based on patient acuity.

Staffing shortages remain a challenge; this is largely attributed to the regional shortage of registrants with Learning Disability specialism and the historical safeguarding investigation and subsequent Public Inquiry. These unprecedented issues are having an impact on the Trusts ability to secure and maintain adequate levels of substantive staffing. The site was operating at approximately 63% agency staffing, 29% substantive staffing and the remainder of the staff were working on a bank basis or additional hours. Less than 20% of agency staff registrants were Registered Nurse Learning Disability (RNLD); a Registered Learning Disability Nurse brings specialist knowledge and unique skills in relation to the management of complex and challenging behaviours. It was good to note that the majority of agency staff had committed to long term contracts which supported continuity of care for patients.

Processes and procedures were in place for escalation when staffing deficits were not met. The SMT work proactively to secure safe staffing levels across the site; a review of staffing rotas indicated the numbers of staff working on the majority of shifts was found to be above the expected level in relation to Telford. Staff skill mix was concerning as a limited number of staff were experienced in Learning Disability specialism and we were not assured that a number of these staff , namely those who were employed by an agency, were being utilised to their full potential to enable effective care delivery. An AFI has been identified.

There was a significant gap in senior nurse leadership roles across all of the wards. These leadership roles are critical in leading staff teams and overseeing care and treatment of patients. At the time of this inspection only one ward had a substantive Band 7 ward manager in post. The other four wards had a peripatetic manager or a Band 6 deputy manager acting up into the Band 7 ward manager role. The instability in the current Band 7 ward manager posts has led to disharmony amongst staff teams and a lack of collaborative working amongst the nursing staff.

We reviewed staff training records for Trust and agency staff. With respect to MAPA (Management of Actual or Potential Aggression) and Adult Safeguarding training; agency staff compliance was considerably higher than that for Trust staff. An AFI has been identified.

Three Nurse Development Leads (NDL) work in MAH. Their role is to improve patient care by facilitating, enabling and supporting the nursing workforce in the delivery of high quality, evidence based, person centred care. There was limited evidence of the impact the NDLs were having on the development and support for nursing staff. NDL were not ward based. Given the current gaps in leadership at Band 7 ward manager level across a number of wards we discussed the benefits of reviewing the NDL roles with a view to becoming more ward based to support the ward leadership and enhance nurse development. An AFI has been identified.

There were inconsistencies in management support provided to ward staff. Staff reported that they felt unsupported by management attributing to low morale. We discussed this with members of the Trust SMT during the inspection and were assured that actions had been taken, and further proposals were to be considered, to address the issues raised by staff. An AFI has been identified.

MDT input into the care and treatment of patients was reviewed. It was good to note that all wards had dedicated Positive Behavioural Support staff and access to two consultant psychiatrists. There is no dedicated Occupational Therapists or Social Workers, and limited input from Psychology professionals, which has potential to impact on and further delay the resettlement of patients. The Trust continues to proactively seek to recruit all grades and disciplines of staff with ongoing workforce plans in place.

5.2.4 Adult Safeguarding / Incident Management

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

Staff at ward level demonstrated a good understanding and knowledge of adult safeguarding processes, including the threshold for making a referral to the ASG team.

We reviewed the Trust incident process in line with ASG reporting procedures and we evidenced that Datix incident forms were in the main graded appropriately. A small number of incidents that may have constituted an ASG referral were identified. We sought assurances from the ASG team regarding these incidents and plans were in place to undertake a review of the incidents alongside the ASG referrals for quality assurance purposes.

The Regional ASG Policy was not fully adhered to in relation to protection planning. Delayed communication between the operational and ASG teams had resulted in delayed protection planning for a small number of patients. This was escalated to the SMT who gave assurances they had been aware of the same concerns and were taking the necessary steps to investigate same, the Trust have agreed to share the findings with RQIA. An AFI has been identified.

Team building sessions between the operational and ASG teams described as planned in the returned Quality Improvement Plan from the previous inspection had not progressed. It is recommended these be expedited with consideration to inclusion of senior Trust staff. The focus of these sessions should be patient safety and protection by all staff through the application of the Regional ASG Policy. An AFI has been identified.

Staff reported they found out they were on a protection plan from information contained in a folder available to all staff at ward level. This led us to determine that protection plans may not always have been implemented in a timely manner. We escalated our concerns around these folders to the SMT and they were removed from all wards during the course of the inspection.

5.2.5 Governance / Leadership

Governance arrangements were assessed through a range of meetings with the SMT and documentation relating to these meetings. It was positive to note the Trust had been aware of issues impacting leadership across the site and had taken measures to address these; including reconfiguration of senior staff to strengthen governance and leadership within MAH. It is acknowledged these changes need time to embed. The Trust has developed an action plan as a means of assurance regarding the necessary improvements required on the site and have agreed to share this with RQIA.

We reviewed a range of governance reports to include a weekly Hospital Safety Report, minutes of meetings and Live Governance report. We found the Hospital safety report to be a robust mechanism that captured a wide range of themes to include, resettlement, ASG, incident management, CCTV monitoring, staffing, restrictive practices and family engagement. Weekly incidents and the use of restrictive practices were detailed in this report. There was evidence of analysis of incidents with trends and themes identified to reduce reoccurrence.

Governance relating to ASG systems and processes was evident. The Divisional Lead for ASG had a clear programme of audit, gathered monthly per ward which provided the ASG team with assurances around the level of reporting.

There was evidence of appropriate sharing of information between the SMT, the Trust's Executive Management Team, the DoH and Trust Board.

Whilst we found the governance processes to be positive we could not evidence the impact of these at ward level; the lack of nursing leadership in all wards may have contributed to the information not being shared. Nursing and medical staff told us that the SMT did not have a visible presence on the wards; additionally we could not evidence a program of visits from ASM, or SMT or an outcome of any leadership walk rounds to improve culture and govern practice.

5.2.6 Patient Engagement

We met with five patients during the inspection; we also left questionnaires across all wards to allow patients the opportunity to engage with us. Feedback from patients in relation to their care and treatment and the staff delivering it, was for the most part, positive. Some patients took the opportunity to share individual issues they were experiencing, which, with their agreement, were passed onto ward staff for action.

5.2.7 Family Engagement

We sought contact with all families/carers of patients to establish their opinions about the care their relative received. Nineteen families/carers gave their opinions. Some families spoke highly of the care and treatment and praised staff; however, some families had a negative experience. One issue raised by a family member constituted an ASG referral which has since been made. A meeting was convened between RQIA and the SMT to discuss the opinions given during feedback, including the negative issues that had been raised. The SMT spoke directly with a number of families/carers that had raised concerns, with actions planned to address the issues.

5.2.8 Staff Engagement

We met with a number of staff, some of whom advised staff morale was low, citing disparities between substantive and agency staff as an area of concern. Both substantive and agency staff spoke openly about tensions amongst staff teams and the pressures they experienced while striving to deliver safe and effective care, namely the level of scrutiny they felt they were under and the negative media interest in the site. Despite this, staff remained committed to delivering safe and effective care.

6.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	N/A	6

The total number of areas for improvement includes one that has been stated for a second time and five which have been stated for the first time.

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

Quality Improvement Plan

Action required to ensure compliance with The Mental Health Order (Northern Ireland) 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

Area for improvement 1 **Ref:** Standard 5.1 Criteria: 5.3.3 **Stated**: Second time	The Belfast Health and Social Care Trust should develop a specific training programme for agency staff that will develop knowledge and skills to support them to safely and effectively meet the specific needs of the patients within MAH. Ref: 5.1
To be completed by: 30 June 2022	**Response by registered person detailing the actions taken:** The BHSCT Trust has developed a training plan for RMNs working on the hospital site as agency staff. This has been developed in partnership with the Trust's Clinical Educator from QUB. The Trust will use a practice development approach for implementation of the programme. They will work alongside staff at ward level, also with RMN staff currently working in the hospital and during the first month of employment with the new starts.
Area for improvement 2 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should ensure and support a collaborative approach to nursing care, and promote working well together. Agency staff should be embedded within the staff teams and their skills effectively utilised in the delivery of patient care. Ref: 5.2.3
	Response by registered person detailing the actions taken: The Belfast Trust held listening exercises for all staff working in MAH during April 2022. As an outcome the Trust plans to undertake values based team building, initially for senior leaders then followed by a roll out for all staff. Dates for these sessions are currently being confirmed. Two agency staff were promoted to Band 6 deputy managers in May 2022.
Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3.3 **Stated:** First time	The Belfast Health and Social Care Trust should develop an effective mechanism to monitor staff compliance with relevant training requirements and take the necessary actions to address any identified deficits. Ref: 5.2.3

To be completed by: 30 June 2022	**Response by registered person detailing the actions taken**: Training requirements are now recorded on the e-rostering system which is monitored by the ward manager's assistant. They alert the ward manager and staff member to any training that is about to expire. The roster will remain in alert status until training is updated as complete.
Area for improvement 4 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should review the role of the Nurse Development Leads and consider the utilisation of this resource to strengthen leadership and management at ward level and support the development of nursing staff within each ward. Ref: 5.2.3
	Response by registered person detailing the actions taken: The role of the Nurse Development Leads in the BHSCT is well established. The Nurse Development Leads in Learning Disability Services cover the MAH site, Iveagh and Community. There is currently one NLD employed within this role and an additional post is vacant. The NDLs will assist with leadership and development within the wards in MAH, alongside balancing other key aspects of their role.
Area for improvement 5 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust Senior Management Team for MAH should seek opportunities to engage with staff to determine how best to support them. Consideration should be given to: 1. A schedule of leadership walk rounds with a report to evaluate the outcome of the visit. 2. ASM & SMT having a visible presence across all wards to support staff and govern practice Ref: 5.2.3
	Response by registered person detailing the actions taken: The Belfast Trust held listening exercises for all staff working in MAH during April 2022. There are weekly reflective practice sessions in Donegore ward. There is an on-site counsellor with information sent to staff on self-care and signposting to services both internal and external to the Trust. There is a regular presence from ASMs and CLT on the wards. On MAH site from March 21 there were two safety quality visits from members of Executive Team, another is planned for 2/07/22. The CLT regularly communicate with staff- side representatives discussing staff views and experiences from working on site.

	The CLT have a template for recording leadership walk-arounds which will be introduced in July 22.
Area for improvement 6 **Ref:** Standard 5.1 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should ensure the Adult Safeguarding Regional Policy is adhered to by staff at all levels, including the SMT. Consideration should be given to: 1. A review of operational ASG processes and if required steps to address any identified gaps. 2. Prioritising team building sessions between operational and ASG team to promote a collective approach to patient safety and protection in line with the Adult Safeguarding Regional Policy. Ref: 5.2.4
	Response by registered person detailing the actions taken: In MAH an Adult Safeguarding audit is underway in relation to compliance with operational ASG processes. Upon completion all identified actions will be taken forward. A weekly operational Adult Safeguarding huddle is in place. The ASG and the Hospital Management Teams provide updates and share information in relation to ASG cases. A monthly ASG assurance group attended by ASG and Hospital SMT is in place to review and monitor ASG referrals, themes and trends. Current ASG data sets are under review. The CLT team has undertaken a shared learning event with ASG and Hospital management teams promoting more effective working. MAH specific Adult Safeguarding Training has been delivered in June 2022 to staff inclusive of ASG and Hospital leaders.The Trust plans to undertake values based team building work with all Leaders in Learning Disability, this will include Hospital and ASG staff. Dates for these sessions are currently being confirmed.

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The Regulation and Quality Improvement Authority

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