The Regulation and Quality Improvement Authority

Inspection Report

28 July 2021-19 August 2021

Belfast Health and Social Care Trust

Mental Health and Learning Disability Hospital
Muckamore Abbey Hospital
1 Abbey Road,
Antrim,
BT41 2RJ
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 Person:
Dr. Cathy Jack
Chief Executive, BHSCT</td></tr>
<tr><td>Person in charge at the time of inspection:
Ms.Tracy Kennedy, Co-Director, Learning Disability</td><td>Number of beds:
There are 6 wards operating within MAH:

<table><tr><td>Name of ward:</td><td>No of patient's accommodated:</td></tr><tr><td>Cranfield 1</td><td>9</td></tr><tr><td>Cranfield 2</td><td>7</td></tr><tr><td>Sixmile</td><td>10</td></tr><tr><td>Killead</td><td>9</td></tr><tr><td>Donegore</td><td>6</td></tr><tr><td>Erne</td><td>Since closed</td></tr></table></td></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:
41</td></tr>
<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) and South Eastern Health and Social Care Trust (SEHSCT). Patients were 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. Admissions 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></tr>
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2.0 Inspection summary

An unannounced inspection of MAH commenced on 28 July 2021 at 09:00 and concluded on 19 August 2021 with feedback to the Senior Management Team (SMT).

All wards were inspected by a team comprised of care inspectors (nurses and social workers) and administration staff, supported remotely by pharmacists, a medical practitioner and a finance inspector.

This inspection focused on eight key themes: staffing; patient's physical health care needs; discharge and resettlement; environment; restrictive practices; incident management and safeguarding; patient's finances; and governance and leadership. The inspection also sought to assess progress with issues raised during the previous inspections of MAH in October 2020 and Erne Ward in January 2021.

The inspection identified good practice in relation to resettlement planning, with evidence of good Multi-Disciplinary Team (MDT) and family involvement. 'In reach' staff visit the patients, to become familiar with their needs and begin to develop a relationship with them prior to transitioning to the community.

The Trust have employed a General Practitioner (GP) service to ensure the physical health care needs of patients can be managed in a timely manner, and to ensure patients have access to the appropriate general population screening programmes.

It was noted that the use of restrictive practices were proportionate to the assessed risks and reviewed regularly by the MDT.

MAH continues to experience a number of challenges to maintaining service delivery. These relate to staff shortages, 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.

Staff morale was low in some areas. Staff indicated that this was due to the impact experienced from the historical adult safeguarding concerns and the imminent Public Inquiry.

At the time of our inspection an Adult Safeguarding File Review was in progress. The review had been commissioned by the Department of Health in response to concerns about the numbers of Early Alerts implicating staff in alleged abuse of patients. Findings from the review have been shared and discussed with RQIA and the Trust. RQIA will ensure that the findings of this review are considered in future inspections of MAH.

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 and reviewed patient care and treatment, engaged with the MDT and senior management team 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.

Opportunities to speak with relatives during the course of the inspection were limited as a result of the Covid-19 visiting restrictions; consequently, questionnaires were sent to each family/carer to establish their opinions of the care and treatment provided to their relative.

4.0 What people told us about the service

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

Several staff interviews with nurses and nursing assistants were conducted. These included Trust and Agency staff across all of the wards. Staff spoke openly about the intensity of the scrutiny that they felt and commented that this contributes to low morale amongst all staff. Despite this, staff remained committed to delivering safe, effective and therapeutic care and treatment.

The feedback from patients indicated that they were satisfied with their care and treatment. Patients told us they 'liked their bedrooms and the nurses and doctors looked after them well.' Other patients described how they enjoyed going to the Cosy Corner Café situated on the hospital grounds and going on outings to Antrim Town.

RQIA are aware of a number of families who continue to raise important concerns about their loved ones care. For some families, the historical safeguarding concerns and pending Public Inquiry continue to impact on their confidence in the service provided within MAH. However, several relatives reported a good experience and high degree of confidence in the professionals providing that care. The care observed during the inspection was compassionate and responsive to meeting patient's needs.

Family feedback highlighted that Covid-19 has proved challenging, as the Government restrictions have resulted in families no longer attending meetings on site. It was noted that the Trust have devised a communication strategy to ensure effective sharing of information with families, with several families commenting that they found this helpful.

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 was undertaken on 27-28 October 2020 and Erne Ward was inspected on 21 January 2021. The tables below outline the Area's for Improvement (AFI) that were identified during these respective inspections and evidences our assessment of work the Trust has completed to meet the AFIs.

Areas for improvement from the last inspection to Muckamore Abbey Hospital on 27-28 October 2020		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)		**Validation of compliance**
Communication with Next of Kin		
Area for Improvement 1 **Ref:** Standard 5.1 Criteria 5.3.2 (d) **Stated:** First Time	The Belfast Health and Social Care Trust shall ensure that a communication plan is developed which provides clarity to all staff about the information provided to the next of kin (NOK) following an incident, the date and by whom the information was provided, the NOK's response to the information, and the follow up arrangements planned. This information should be recorded in a standardised manner across the hospital site.	**Met**
	Action taken as confirmed during the inspection: A communication plan was in place for each patient's NOK that provides clarity to all staff regarding the information which should be provided to the NOK following an incident. The communication plan provided information on what level of detail the family would like, who the family would like to receive the information from and how, for example, by phone or email.	
Engagement with relatives/carers		
Area for Improvement 2 **Ref**: Standard 6.1 Criteria 6.3.2 (a) (b) **Stated:** First time	The Belfast Health and Social Care Trust shall develop and implement a communication strategy that will ensure that relatives/carers receive their requested level of communication about their relative's care and treatment in Muckamore Abbey Hospital. The agreed communication strategy should be documented and accessible to relevant staff.	**Met**
	Action taken as confirmed during the inspection: A communication strategy has been developed that ensures relatives/carers receive the requested levels of communication about their relatives care and treatment. These communication plans were available and up to date at the time of inspection.	

Escalation procedure for temperature variances in medicine refrigerators		
Area for Improvement 3 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First time	The Belfast Health and Social Care Trust shall ensure that an escalation procedure for temperature variances in medicine refrigerators is developed to guide staff in Muckamore Abbey Hospital to take the appropriate actions if medicine refrigerators fall outside the permitted temperature range.	**Met**
	Action taken as confirmed during the inspection: An escalation procedure for temperature variances in the medication refrigerators has been developed and shared with each ward for displaying on the refrigerator.	
Monthly audit of patients' monies and valuables		
Area for Improvement 4 **Ref**: Standard 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1) **Stated:** First time	The Belfast Health and Social Care Trust shall ensure that all patients in Muckamore Abbey Hospital are subject to a monthly financial audit of monies and valuables by the Assistant Service Manager (ASM).	**Met**
	Action taken as confirmed during the inspection: There was evidence of audits being completed each month by the ASM.	

<table>
<tr><th colspan="3">Areas for improvement from the last inspection to Erne Ward
on 21 January 2021</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)</th><th>Validation of compliance</th></tr>
<tr><th colspan="3">Support of patients who present with behaviours that challenge</th></tr>
<tr><td rowspan="2">Area for Improvement 1

Ref: Standard 5.1
Criteria 5.3 (5.3.1) (a)
(5.3.3) (d)

Stated: First Time</td><td>The Belfast Health and Social Care Trust shall ensure all patients on Erne Ward have appropriate and timely access to the positive behaviour support service.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

Erne Ward has a Behaviour Specialist Practitioner and a Behaviour Assistant assigned to the ward. They attend Purposeful Inpatient Admission (PIpA) meetings, support with resettlement and complete Positive Behaviour Support Plans for all patients assessed as requiring input.</td></tr>
<tr><td rowspan="2">Area for Improvement 2

Ref: Standard 5.1
Criteria 5.3 (5.3.1) (a)
(5.3.3) (d)

Stated: First Time</td><td>The Belfast Health and Social Care Trust shall ensure that all staff working on the ward have the skills and knowledge to effectively support patients who present with behaviours that challenge, including implementation of each patient’s positive behaviour support plans.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

Staff, including agency were knowledgeable about all patient’s behaviours and appeared confident in de-escalation techniques.

Behavioural Support Plans were available for patients. These were person centred and completed in accordance with evidenced based practice.</td></tr>
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<tr><th colspan="3">Infection Prevention Control (IPC)</th></tr>
<tr><td rowspan="2">Area for Improvement 3

Ref: Standard 5.1
Criteria 5.3.1 (f)

Stated: First Time</td><td>The Belfast Health and Social Care Trust shall ensure that records of the Trust IPC team visits to wards in MAH contain evidence of escalation by IPC nurse to the ward manager/nurse in charge following any IPC visit and the actions taken to address issues identified.

This may include detail of collaborative work with the Trust’s Estates Department and The Patient Client Support Services (PCSS) team for MAH.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

The recently appointed deputy ward manager was unable to recall or provide a record of the most recent Infection Prevention Control visit to Erne Ward; however, there was evidence that the Nurse Development Lead (NDL) had undertaken an environmental walk around. From this there was evidence of escalation and work having commenced to address the environmental/IPC concerns.

There was evidence of collaborative working with the Trust’s Estates Department and PCSS.</td></tr>
<tr><th colspan="3">Covid-19 Track and Trace</th></tr>
<tr><td rowspan="2">Area for Improvement 4

Ref: Standard 5.1
Criteria 5.3.1 (f)

Stated: First time</td><td>The Belfast Health and Social Care Trust shall ensure a robust track and trace system is in place in Erne Ward which takes account of its multiple entrances and exits.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
There was good signage relating to safety precautions around Covid-19 and recommendations of safe practices were displayed in the foyer and around the ward.

There is a ‘signing in’ book in the foyer and all staff/visitors are required to have temperature checks, sign in and provide contact details.</td></tr>
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<tr><th colspan="3">Environmental Issues</th></tr>
<tr><td rowspan="2">Area for Improvement 5

Ref: Standard 5.1
Criteria 5.3.1 (f)

Stated: First time</td><td>The Belfast Health and Social Care Trust shall ensure that all patients in Erne Ward have access to a comfortable, clean, and warm, living area. This should include robust audits of the ward environment and timely repair of broken items by the Trust’s estates department.</td><td rowspan="2">Not Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

The inspection team continued to identify significant environmental issues within Erne Ward.

We raised our concerns with the SMT who informed us that they were in the process of transitioning the remaining patients from Erne Ward to other wards across the hospital site. Following the successful transition Erne Ward would be closed.

We received confirmation from the Trust that Erne Ward closed on 26 August 2021.

This area for improvement had not been met, but will not be carried forward as Erne Ward is no longer operational.</td></tr>
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<table>
<tr><th colspan="3">Staffing Levels</th></tr>
<tr><td rowspan="2">Area for Improvement 6

Ref: Standards 4.1
Criteria 4.3 (l)

Stated: First time</td><td>The Belfast Health and Social Care Trust shall ensure that staffing levels allow for staff clinical supervision sessions, staff appraisals and the facilitation of regular ward/staff meetings.</td><td rowspan="2">Not Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

The ward manager responsible for providing supervision, appraisals and coordinating staff meetings has been off on extended leave.

The Trust were in the process of seeking to fill this position on a temporary basis. The deputy ward manager has not been in a position to complete these managerial tasks as a result of staffing pressures across the site.

This area for improvement had not been met, but will not be carried forward as Erne Ward is no longer operational.</td></tr>
<tr><th colspan="3">Incident Management</th></tr>
<tr><td rowspan="2">Area for Improvement 7

Ref: Standard 5.1
Criteria 5.3 (5.3.2) (a)(c)

Stated: First Time</td><td>The Belfast Health and Social Care Trust shall ensure that a robust system is in place to ensure that all incidents are graded appropriately to reflect the inherent risk rather than the outcome. The system should include audits of incidents and implementation of learning arising from the audits.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

We reviewed the arrangements for the management of incidents and determined that incidents were being well managed in line with the Trusts policies and procedures.

Further detail in relation to incident management can be found in the incident section of the report.</td></tr>
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<tr><th colspan="3">Debriefing System</th></tr>
<tr><td rowspan="2">Area for Improvement 8

Ref: Standard 5.1
Criteria 5.3 (5.3.2)(a)(b)(c)

Stated: First Time</td><td>The Belfast Health and Social Care Trust shall ensure that a local incident debrief policy and procedure is implemented so that:

• Learning arising from incidents is shared across MDT’s and across the MAH site in a timely manner;
• Trends are identified;
• Records are maintained for all incident debrief sessions details the actions required and the persons responsible for ensuring the action is completed.</td><td rowspan="2">Partially Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

In Erne Ward learning from incidents was shared appropriately and trends identified, however, post incident debriefs were not happening in Erne Ward. This matter was discussed with members of the SMT for action at the time of inspection.

Learning from incidents, including post incident debriefs were in place across the other hospital wards.

As outlined previously we received confirmation from the Trust that Erne Ward closed on 26 August 2021.

This area for improvement had been partially met, but will not be carried forward as Erne Ward is no longer operational.</td></tr>
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5.2.1 Staffing

Staff shortages remain a challenge within MAH. At present 73% of registered nurses and 35% of health care assistants are provided by nursing agencies. In addition, the majority of registered nursing staff are Registered Mental Health Nurses as opposed to Registered Learning Disability Nurses. Registered Learning Disability Nurses bring specialist knowledge and unique skills in relation to the management of complex and challenging behaviours. In seeking to manage the impact of the staffing shortages in Registered Learning Disability Nurses the Trust has increased their behavioural support team resource.

It was established that staffing shortages present challenges for staff at all levels within the hospital. Staff told us that staffing shortages negatively impacts on their role as the majority of their time is spent on 'task orientated' duties. This limits the scope for innovation and the ability to deliver on quality improvement initiatives.

Ward managers were visibly present on the wards, interacting with patients and supporting staff with various clinical and non-clinical tasks.

RQIA welcomes the closing of Erne Ward, and anticipate that having patients accommodated in the "core" hospital will help somewhat in managing staffing deficits. The process of moving patients to more appropriate wards such as Cranfield wards, Killead and Donegore in accordance to their assessed needs had commenced prior to the inspection.

Covid-19 has added pressures to an already exhausted workforce, due to staff contracting the virus and requiring sick leave, close contact isolation and shielding. Throughout all of these challenges all grades of staff and disciplines have continued to navigate their way through the pandemic while supporting patients who present with complex needs and some who have significant challenging behaviours.

There were notable staff shortages amongst all disciplines. The SMT informed us that recruitment has been particularly difficult and cited both the historical and current adult safeguarding concerns and the pending Public Inquiry as having an impact. Despite this it was observed that staff are committed to providing safe and effective care and treatment.

The Trust are supporting several healthcare assistants to complete their Learning Disability Nursing via the Open University. This will bring specialist skills and knowledge to MAH and improve practice.

5.2.2 Physical Health Care

Physical health care needs were comprehensively assessed by the MDT, with individualised, up to date care plans in place that met the needs of each patient. It was encouraging to see evidence of specific care pathways for patient's prescribed Clozapine therapy and for those who had contracted Covid-19.

Nursing staff demonstrated a good understanding of patient's physical healthcare needs, identifying signs, symptoms and changes in behaviours that may indicate when a patient's physical health is deteriorating. There was evidence of patient's attending Emergency Departments for review and treatment as necessary.

Patients have access to an onsite GP who co-ordinates physical health checks, medication and chronic disease monitoring; this includes yearly Electrocardiogram (ECG) testing and six monthly ECG's for patients who require antipsychotic medication monitoring.

Some patients did not have an up to date ECG because they had difficulty coping with this examination, however, medical staff endeavour to explore other, more suitable options, with these patients.

During the December 2019 assurance was provided that all patients had access to a GP service to ensure they had appropriate routine general population screening. On reviewing the evidence, patients did have access to general population screening; however, this information was not easily accessible. An AFI has been identified recommending that the Trust 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 patients physical health screening.

5.2.3 Discharge/Resettlement Planning

Since the last inspection a number of patients have been discharged or resettled into the community successfully.

At the time of the inspection 39 of the 42 patients in the hospital where delayed in their discharge. There was evidence of ongoing resettlement planning work through the MDT and good communication with placement providers and patient's families. A lack of available placements within the community to accommodate the assessed needs of the patients is creating delays in successful discharges/resettlements.

Community placements have been identified for some patients; however, the expected date of discharge is sometime in 2022/2023, as these placements are under construction and staff need to be recruited and trained.

Covid-19 has had an impact on the resettlement of patients from MAH, patients were unable to visit their identified placements prior to transition and staff from the identified placements were unable to provide in-reach. Since the restrictions have eased, in-reach has recommenced.

Some patients confirmed they did not wish for the MDT to actively seek a resettlement placement, as their preference is to remain in MAH. A working group has been established to look at how the wishes of this small group of patients can be met.

RQIA would advise that all Trusts and the Health and Social Care Board (HSCB) urgently expedite efforts to support the resettlement of patients. This process should identify clear options that provide better alternatives for the large majority of patients, and fully consider the needs of individuals.

5.2.4 Environment

The wards within the hospital are spacious, bright, clean and clutter free. Patients had their own bedroom and ensuite. Patients had access to 'quiet rooms' away from the main communal areas.

Most of the wards had 'pod' areas for patients who have been assessed as requiring this type of environment. Staff are always present in the patient's pod area and the need for the patients to be cared for in these environments is clearly documented in the patient's risk assessments and care plans and reviewed regularly by the MDT. The pods usually consisted of four rooms, a bedroom, bathroom, quiet living area and a dining area.

At the time of the inspection Erne Ward remained operational. Erne Ward is an old ward and the environment was not conducive in meeting the therapeutic needs of patients, due to the layout and the internal fabric of the building. Despite the challenges provided by the ward environment, it was evident that ward staff were doing the best they could to promote therapeutic intervention, patient engagement and maintain patient and staff safety. RQIA were informed by the SMT that the planned closure of Erne Ward has been expedited to the end of August 2021. Following our inspection we were informed that Erne Ward closed on 26 August 2021 and all patients have been relocated to the most suitable wards to meet their assessed needs.

Ligature Risk Assessments, Fire Risk Assessments, Mattress Audits and Environmental Cleanliness Audits were reviewed. There was evidence of good compliance levels and any issues identified were raised with the ward managers on the day of inspection for escalation and action.

5.2.5: Restrictive Practices

The main restrictive practices in use across the hospital were: a locked environment; patients detained under the Mental Health (NI) Order 1986; the use of enhanced observations; the use of physical intervention; money/high valuable items locked securely; the use of self-seclusion and restrictions on certain items.

Restrictive practices were managed in line with the Trust Policy. Staff knowledge was good and restrictive practices were proportionate, used as a last resort, carefully reviewed by the MDT and reduced or discontinued when necessary.

There was good up to date record keeping in relation to restrictive practices and evidence of good MDT decision making.

5.2.6: Incident Management & Adult Safeguarding

There was a good level of detail in the incident reports examined and incidents were appropriately graded, in accordance with the Trust's policies and procedures.

There was a high level of reporting evident; with action plans created for every incident which are reflected in patient's care plans. It was evident that similar types of incidents were recurring as a result of the unpredictability of the environment and complexities of the patients.

It was encouraging that Serious Event Audits (SEA's) were being completed for recurring incidents and it is hoped that learning from these SEA's will be implemented in an attempt to not only reduce the likelihood of incidents recurring but also reduce the overall number of incidents.

There was evidence of post incident debriefs for staff working within the core hospital. A post incident debrief is a supportive mechanism for staff to encourage reflection on what worked well and what could be managed differently in the future.
There were variations in how post incident debriefs were conducted, low level incidents usually taking the form of informal conversations, with higher level incidents resulting in formal debriefs with minutes recorded.

On reviewing a number of incidents in relation to self-injurious behaviours, on some occasions the first line of management recorded was the administration of PRN (as and when required) medication. Acknowledging that the MDT had a sound knowledge of the patients and their needs, this may have been the most appropriate response to these significant behaviours.

There were some areas of good practice in relation to Adult Safeguarding (ASG). Inspectors found the system in place afforded good protection. Staff had a good knowledge of the referral process and there was evidence of interim protection plans and good recording of MDT discussions and decision making.

Staff highlighted significant challenges as a consequence of continued scrutiny and reported hyper-vigilance in respect of safeguarding referrals. Staff highlighted a disharmony between the safeguarding team and ward staff in relation to appreciating the value of each other's roles. An AFI has been identified, recommending that the Trust take action to improve the working relationships between the adult safeguarding team and ward staff with a particular focus on variation in practice and decision making in protection planning.

Outside of periodic inspection, inspectors review all incidents involving staff which has led to a safeguarding referral being made to the ASG team. Review of a number of these safeguarding incidents, particularly, those involving agency staff, has identified a gap in the skills and experience of agency staff in relation to the management of patient's needs. An AFI has been identified, recommending that the Trust develop a specific training programme for agency staff that will develop knowledge and skills to support staff to safely and effectively meet the needs of the patients within MAH.

The safeguarding team, including Designated Adult Protection Officers (DAPO's), was under resourced and this was having an impact on the timeliness of communication between ASG teams and ward staff. Plans were underway to increase the resource available in the ASG team.

RQIA recognise that there is a growing number of staff on protection plans which, from an operational perspective, is challenging. The recent protection plans are reviewed regularly by the ASM and the DAPO on site and protection plans relating to Historical CCTV investigations are reviewed 3 weekly at the Muckamore Abbey Hospital Operational Group meeting.

5.2.7 Finance

The finances within the hospital were well managed. Ward staff were adhering to the Trust's policy with nursing staff and managers completing relevant checks and audits. Transactions were managed appropriately with patients confirming that they could access their money when they required it. Staff had a good knowledge and understanding of the financial processes in place.

The ASM completed financial audits of patient's monies and high value items on each ward on a monthly basis. Following review of completed audits there were some minor discrepancies relating to the recording of high value items, this was raised with the SMT during the inspection and actioned accordingly.

5.2.8 Governance & Leadership

Good governance systems were in place to monitor safety on the site which included daily safety briefs, weekly live risk and governance meetings, clinical improvement meetings and ward managers meetings. There was evidence of appropriate sharing of information between the SMT, the Trust's Executive Management Team, the DoH and Trust Board.

The availability and experience of ward managers across the site was impacting on the consistency and quality of leadership. RQIA highlighted this with SMT and were assured that the Trust were providing support to newly appointed ward managers.

There is a Governance Lead appointed within MAH who alongside Senior Trust staff collated data and themes which are shared with ward managers. This informs wards of their performance and improvements, enhancing a collective ownership of the Trust's goals.

Each ward has an assigned ASM in place. At the time of the inspection there was a reduction in the availability of the ASMs which was having an impact on the ability to provide timely support to staff and maintain governance oversight in some areas such as auditing.

In February 2021 The Muckamore Abbey Carers Questionnaire was devised by the Trust and disseminated to families/carers of those who reside in MAH. A total of 48 Questionnaires were sent with a total of 19 families availing of the opportunity to respond. Following review of the responses two thirds of families were satisfied with several aspects of the service, with one third of carers feeling dissatisfied. The majority of carers found staff approachable, respectful and valued carers' input. There was a less positive response when it came to staff responding quickly and proactively to concerns.

Some carers suggested that improvement was required in respect of the support provided to them. Some described that carers' needs had not been reviewed and that they did not have sufficient information about supports available to them. Some carers suggested that work should be undertaken with carers to ensure they are aware of the supports available, including the access to the advocate, and that they receive regular/annual reminders of this resource. A further suggestion was that the service should work with carers to develop and build trust and confidence. The SMT are currently developing an action plan to implement the recommendations emerging from these findings.

6.0 Conclusion

Since the previous two inspections there was evidence of numerous improvements having been made across the site. However, it remains the case that there continues to be a shortage of staff on all levels within MAH, especially staff trained in a Learning Disability speciality; it is welcomed that the Trust are supporting several health care assistants to undertake their Learning Disability Nurse training.

It was evident that the staff continued to endure a challenging working environment due to the impact of the historical safeguarding concerns and the pending Public Inquiry. Despite this, staff remained committed to their patients and keen to deliver high quality services to patients and restore public confidence in the hospital.

RQIA remained concerned about the future sustainability of the site in view of the high dependency upon agency staff. The working experience of staff had deteriorated from previous inspections and there are a growing number of protection plans. In view of this RQIA remain concerned about the pace of progress of resettlement.

RQIA would like to take this opportunity to thank the hospital staff, patients and families for taking time to engage with the inspection team, enabling us to complete this inspection which aims to support improvement for patients and develop a more supportive working culture for staff.

Three areas for improvement have been made in relation to physical health care and adult safeguarding. Details can be found in the Quality Improvement Plan (QIP).

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with: **The Mental Health (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	3

There are a total of three AFIs set out in the Quality Improvement Plan (QIP) relating to physical health care and adult safeguarding.

The AFI's and details of the QIP 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 (Northern Ireland) 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

Area for improvement 1 **Ref:** Standard: 8.1 Criteria: 8.3 **Stated:** First time **To be completed by:** 01 January 2022	The BHSCT 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. Ref 5.2.2
	Response by registered person detailing the actions taken: The BHSCT have developed 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. A small project team consisting of the onsite GP, a Ward Manager and an Assistant Service Manager has been established. The working group has developed the agreed system and are now working to implement the changes across the hospital site.
Area for improvement 2 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 01 January 2022	The BHSCT 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. Ref 5.2.6
	Response by registered person detailing the actions taken: BHSCT will ensure that 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. This work will be commissioned by the Interim Director with a focus on joint review of existing policies, procedures and flowcharts to ensure teams are working to agreed processes and policies. Facilitated team building sessions will be arranged to allow the two teams to spend time together discussing the challenges each face and how they can work as team to ensure patient safety and best practice. Due to vacant posts within the Adult Safeguarding team which are currently progressing through the recruitment process and the upcoming Christmas holidays, this work will commence in 2022.

Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3.3 **Stated:** First time **To be completed by:** 01 January 2022	The BHSCT 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
	Response by registered person detailing the actions taken: BHSCT has commenced the development of a specific training programme for agency staff that will develop knowledge and skills to support them safely and effectively meet the specific needs of the patients within MAH. This training programme will be delivered to existing agency staff and any new agency staff commencing employment within the hospital. This work will be led by the Nurse Development Lead (NDL) supported by the Service Manager and Divisional Nurse.

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

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