The Regulation and Quality Improvement Authority

Inspection Report

5 March – 6 April 2023

Muckamore Hospital

Type of service: HSC Hospital
Address: 1 Abbey Road
Antrim
BT41 2SH
Telephone number: 028 9024 0503

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</td></tr>
<tr><td>Person in charge at the time of inspection:
Billie Hughes, Co-Director, Muckamore Hospital</td><td>Number of registered places:
There are five wards operating within Muckamore Abbey Hospital

<table><tr><td>Name of ward:</td><td>No of patient's accommodated:</td></tr><tr><td>Cranfield 1</td><td>Four</td></tr><tr><td>Cranfield 2</td><td>Six</td></tr><tr><td>Six Mile</td><td>Ten</td></tr><tr><td>Killead</td><td>Five</td></tr><tr><td>Donegore</td><td>Four</td></tr></table></td></tr>
<tr><td>Categories of care:
Acute Mental Health and Learning Disability</td><td>Number of patients accommodated in the wards on the day of this inspection:
29</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 adults aged 18 years and over who have a learning disability and require assessment and treatment in an acute psychiatric care setting.

MAH provides a regional service to people with a learning disability from across Northern Ireland. 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 ward within the hospital is significantly restricted, any decision to admit new patients is risk assessed on an individual patient basis and all alternative options are explored in full before an admission is facilitated.</td></tr>
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2.0 Inspection summary

During the last inspection of MAH in July 2022, RQIA identified serious concerns relating to deficiencies in care and treatment and as a result of those findings intended to issue two Improvement Notices to the Trust. Following this inspection, we held an intention to serve Improvement Notices meeting with the Trust. At this meeting the Trust provided assurances of the actions that they had taken/planned to take to address the deficiencies in care and treatment and following the meeting the Trust shared a written action plan with RQIA that further detailed the actions taken/planned to take to address the concerns identified. Regular updates were submitted to RQIA via live action plans at agreed intervals. RQIA accepted the assurances provided and made a determination not to serve Improvement Notices at this time.

RQIA monitored the Trust's progress by reviewing the live action plans submitted in September and October 2022, and January 2023. The Trust's action plan reflected the improvements required, which were included in the Quality Improvement Plan from the inspection in July.

The Trust have remained under serious concerns processes since July 2022.

The decision to undertake this inspection was based on information detailed in action plan updates and notifications (Early Alerts) received by RQIA in February 2023. Additional intelligence was also received which raised concerns about care delivery to patients in MAH. RQIA determined to bring the scheduled date for the unannounced inspection forward.

The focus of the inspection was to observe daily life for patients and establish what had changed for them since the previous inspection. We assessed progress made against submitted action plans, and compliance with the Quality Improvement Plan (QIP). The overall aim of the inspection was to assess the quality and safety of care delivered to patients, whilst awaiting discharge and resettlement.

An unannounced inspection of MAH commenced on 5 March 2023 at 10:00am and concluded on 6 April 2023 with feedback to the Trust's Senior Leadership Team (SLT). All wards were inspected at least once during this period. The inspection team comprised of care inspectors, a senior inspector, and an assistant director.

Care observed throughout the inspection was found to be safe, compassionate, and delivered to a good standard. Staff knew the patients and were responsive to their individual needs. An upskilling training programme for staff had commenced and there was evidence that Positive Behaviour Support (PBS) was implemented in the delivery of patient care. Staffing levels were good, with approx. 85 - 90% of the staffing compliment blocked booked through agencies.

A patient resettlement programme had commenced. The pace was slow due to a number of factors, some of which are beyond the Trust's control, such as, securing suitable accommodation in the community to meet individual patient needs, and the recruitment of suitably skilled staff by independent providers.

MAH continues to experience a number of challenges maintaining service delivery. The hospital remains under scrutiny due to the ongoing Public Inquiry into the historical abuse of patients. The recruitment and retention of permanent staff also remains challenging.

Good progress has been made towards meeting the nine areas for improvement (AFI) identified during the inspection in July 2022. Seven AFIs were met, and two were partially met.

3.0 How we inspect

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

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect performance at the time of our inspection, highlighting both good practice and any areas for improvement (AFI). 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.

This inspection was undertaken by making unannounced visits at different times of day and night to ensure patient care was observed on every ward across the full 24hour period.

The inspection team directly observed patient experiences; staff engagement with patients; how patients spent their day; the reaction to and management of incidents; staffing levels; senior leadership oversight; and ward environments. The inspection team also reviewed patient care records; patient resettlement progress; and governance documentation.

Experiences and views were gathered from staff, patients, and their families.

4.0 What people told us about the service

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

We spoke with a number of patients across the wards, all of whom reflected positively on the care they received. Patients who did not have the ability to verbally express their opinions were observed receiving compassionate care from staff. These patients appeared comfortable in the presence of staff and were observed to engage well with staff they were familiar with.

Eleven relatives spoke to us about their experiences of their loved one's care. Some relatives expressed satisfaction with the standard of care provided, whilst others expressed concerns about patient environments, resettlement progress, patient food at ward level, patient finances, and communication with hospital management.

5.0 The inspection

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

Areas for improvement from the last inspection on 1 July 2022		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 5.1 Criteria: 5.3.3 **Stated**: Third time	The Belfast Health and Social Care Trust must urgently undertake a review of the induction, training and ongoing development needs of all staff supplied to work in MAH, including those who are supplied at short notice. A training and development plan must be implemented that sets out the range of mandatory and other relevant training to be undertaken by staff. Training plans must be specific and records maintained of when training was provided, by whom and the date of any update or refresher.	**Met**
	Action taken as confirmed during the inspection: The Trust completed an urgent review of induction, training and ongoing development needs of all staff supplied to work in MAH. An induction programme was available for new staff and had been completed within expected time frames. Plans detailing staff training and ongoing developmental needs were in place, and up to date with good oversight by the Nurse Manager. A mechanism was in place to assure the Trust that staff supplied by agencies had received the required mandatory training to work in the hospital. Staff demonstrated improved skills, knowledge and understanding of patients with a learning disability. They had improved understanding and knowledge of the PBS model which enabled them to better support	

	patients with distressing/challenging behaviours. A review of staff development needs was completed and there was evidence of oversight of staff training. This area for improvement has been met.	
Area for improvement 2 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time	The Belfast Health and Social Care Trust must urgently review the staffing arrangements to ensure there are at all times sufficient numbers of adequately skilled and experienced staff available to meet the needs of patients. The Trust must implement a staffing model to determine staffing levels which must be consistent with the changing needs of patients and the challenges associated with the use of agency staff.	**Met**
	Action taken as confirmed during the inspection: Staffing levels are reviewed on a daily basis. There were sufficient numbers of adequately skilled and trained staff across the site and we were assured that this met the needs of patients. This area for improvement has been met.	
Area for improvement 3 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time	The Belfast Health and Social Care Trust must put in place arrangements for the effective oversight of staff supply and deployment across the site. This will include the establishment and implementation of robust protocols relating to the supply of agency and new staff, their fitness and suitability to practice, and the management and oversight of records relating to staff supplied.	**Partially met**
	Action taken as confirmed during the inspection: There were robust processes in place for the supply of agency and new staff, to assure of their fitness and suitability to practice, and the management and oversight of records relating to them.	

	Staffing levels were not always deployed to where they were most needed. Whilst overall staffing numbers always met safe staffing levels, the oversight of the deployment of staff across the site was not always effective. There was a lack of effective planning in advance of shifts to ensure that adequate staff were deployed to each ward. The Trust should review the effectiveness of the mechanism in place to monitor staffing levels across the site. This area for improvement has been partially met and will be revised.	
Area for improvement 4 **Ref:** Standard 5.3 Criteria: 5.3.1 **Stated:** First time	The Belfast Health and Social Care Trust must urgently review the care and treatment plans of all patients to ensure that their assessed needs are adequately outlined and that a plan is in place to meet their needs. The Trust must ensure that appropriately skilled staff have oversight of each patient's plan, that the patient and their relatives are involved in its development, and that there are arrangements in place for plans to be reviewed regularly by the multi-disciplinary team.	**Met**
	Action taken as confirmed during the inspection: A review of all patients care and treatment had been undertaken by the MDT. Patients had personalised care plans and PBS plans, that detailed their individual needs. Each patient had a named nurse identified. This nurse was responsible for the oversight, delivery and review of patient care plans. There was evidence of relative and patient involvement in care plans. Patients care was discussed and reviewed weekly at MDT meetings. This area for improvement has been met.	

Area for improvement 5 **Ref:** Standard 5.3 Criteria: 5.3.1 **Stated:** First time	With the current focus on resettlement of patients from MAH resulting in a reduction in numbers of patients across each of the five wards, the Belfast Health and Social Care Trust must keep under review each patient's living areas to ensure that patients are receiving care and treatment in the most therapeutic environment. The review should take account of matters relating to excessive noise, restrictions in freedom of movement, or incompatibility with other patients and should be developed with the patient and where appropriate, their relatives.	**Partially met**
	Action taken as confirmed during the inspection: Environments were being kept under review. We found a small number of individual patient living spaces were not therapeutic. Some patient areas required immediate attention due to cleanliness, mal odour, and décor. Throughout the inspection there were a number of occasions when excessive noise levels were noted, staff were observed to respond appropriately to manage noise levels for the comfort of all patients. It is acknowledged that there is potential for patient incompatibility which can fluctuate and the staff were observed during the inspection to manage this effectively. This area for improvement has been partially met and will be revised to include additional findings.	

Area for improvement 6 **Ref:** Standard 7.1 Criteria: 7.3 **Stated:** First time	The Belfast Health and Social Care Trust must put in place arrangements to promote the wellbeing of all staff. A staff wellbeing plan must be developed which sets out the Trust's arrangements for staff to access and receive support and guidance.	**Met**
	Action taken as confirmed during the inspection: The Trust has put in place mechanisms to promote staff wellbeing and ensure staff can access support and guidance as required. These included listening sessions with members of senior management and a going home checklist, which encourages staff to reflect on their shift, prior to leaving site. This area for improvement has been met.	
Area for improvement 7 **Ref:** Standard 5.3 Criteria: 5.3.1 **Stated:** Second time	The Belfast Health and Social Care Trust must urgently undertake a review of the Adult Safeguarding Operational Procedures in Muckamore Abbey Hospital in line with Regional Policy. An action plan must be developed to address the deficits in the implementation of the regional Policy, the measures to be taken to address these, and the timescales for completion.	**Met**
	Action taken as confirmed during the inspection: Significant progress has been made in relation to ASG. Considerable resources have been secured to ensure adequate and timely responses can be made to all ASG incidents. A review of ASG Operational Procedures in MAH was undertaken in line with Regional Policy. An action plan was developed which addressed the deficits in the implementation of regional policy and the measures required to address these. This area for improvement has been met.	

Area for improvement 8 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time	The Belfast Health and Social Care Trust must put in place suitable arrangements for the effective delivery and oversight of adult safeguarding policy and procedures. These arrangements should include an ongoing evaluation of the effectiveness of the safeguarding arrangements on MAH site and the impact the adult safeguarding process has on patients, relatives and staff.	**Met**
	Action taken as confirmed during the inspection: Significant progress has been made in relation to ASG. Considerable resources have been secured to ensure the effective delivery and oversight of adult safeguarding policy and procedures. Robust systems, including ASG trackers, have been developed and implemented to improve the safeguarding processes, including timescales. This has impacted positively for patients, relatives and staff. This area for improvement has been met.	
Area for improvement 9 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time	The Belfast Health and Social Care Trust must urgently take steps to strengthen the leadership and governance arrangements in MAH taking account of the clinical leadership and middle management structures. The outcome of this process must be shared with RQIA and must set out clearly any revisions to the management structure, roles and responsibilities and accountability arrangements.	**Met**
	Action taken as confirmed during the inspection: Revisions to the management structure have been implemented and shared with RQIA. Within this structure there are clear roles, responsibilities, and accountability arrangements. Clinical leadership has been reconfigured with a new Clinical Director appointed.	

	Consideration has been given to middle-management structures with a number of additional resources secured at this level. Lack of ward managers has been reviewed and experienced senior managers have been allocated to assist Band 6 staff to lead and manage wards. This includes the management of staff to ensure safe and effective care is delivered to patients. This area for improvement has been met.	

5.2 Inspection findings

5.2.1 Environment

There are five wards in operation across the MAH site. Six Mile ward has two separate units; Six Mile assessment unit, and Six Mile treatment unit.

The state of repair of the wards varied, as did the individual living arrangements for some patients. Main ward areas would benefit from some repairs and fresh paint. Outside patient areas also require attention. One ward in particular, requires assessment for essential refurbishment and redecoration as a matter of priority. The flooring in one en-suite bathroom required immediate attention due to discolouration and lifting. This matter was raised with senior management during inspection feedback and assurances were given this issue would be addressed in a timely manner. Some of these issues were cited on an estates programme of works, however had not been actioned.

A number of patients reside in individual areas known as “pods”. The decision making around patients residing in pods is based upon safety and risk and is a multidisciplinary team decision. Through engagement with family and our observation, it was concerning to note one pod area was not of an acceptable standard and urgent action was required. The Trust met with family representatives (during the course of the inspection) to discuss and address these issues. The Trust took action to address these concerns and an alternative environment was agreed for the patient.

Senior staff advised they regularly visited the wards, which we observed to be the case throughout the duration of the inspection. However, this was not reflected in what staff told us. Evidence of recording of ward visits by senior staff was limited. The Trust should consider the implementation of a recording tool, used in other areas of the Trust, to capture actions from environmental walk arounds.

Two areas for improvement have been made to reflect the environmental improvements required.

5.2.2 Adult Safeguarding

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 is likely to occur without intervention).

Adult safeguarding incidents and concerns are identified and managed through various measures across the site, including, the review of CCTV footage. This is completed both contemporaneously and post incident. The viewing of CCTV is carried out by a range of staff such as SLT, ASG personnel, and MDT representatives, all of whom have advanced training in Safety Interventions (Safety Intervention training incorporates trauma informed, and person centred approaches, to prevent and/or intervene in crisis situations).

Significant improvement has been achieved in ASG processes since the last inspection. A review of ASG practices indicated that prompt action is taken following ASG incidents. Staffing resources within the ASG team have been increased and robust systems, including ASG trackers, have been implemented to improve the safeguarding processes and the timescales involved.

Evidence of appropriate ASG arrangements were in place with protection plans for individual patients, where required. Staff at ward level had good knowledge of what constituted an ASG incident and there was information pertaining to ASG and related policies available throughout the wards.

Staff involved in ASG investigations were subject to additional training and had additional supervision arrangements in place. RQIA were assured that protective arrangements were in place to protect patients. Some issues were identified in relation to the management of staff supervision plan records. These issues were brought to the attention of senior management. An AFI has been identified in relation to this.

There has been improved adherence to regional ASG policy since the last inspection. Appropriate use of adult safeguarding strategy meetings, with proactive engagement of relatives has resulted in identification of trends and themes. This was not the case previously. It is positive to note the active engagement of relatives at the majority of these meetings.

A review of DATIX, which is the Trust electronic recording system for incidents, was completed. Recurring incidents involving more than one patient, had not been considered collectively and were viewed in isolation. It is recommended that the Trust applies a collective approach as used in ASG strategy meetings when reviewing recurring incidents, to ensure early identification of themes and trends.

An area for improvement has been made regarding the management of recording, storage and effective oversight of staff supervision plan records.

5.2.3 Staffing

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

Acknowledging the current challenges in recruiting Learning Disability (LD) nurses it was positive to note that the Trust had secured a small number of newly qualified LD nurses since the previous inspection.

Approximately 85% - 90% of the staffing compliment was provided by agency staff. A high ratio of agency staff can present a challenge when managing safe staffing levels, and deployment of staff across a site. These challenges can impact upon consistency of care for patients due to the frequent change of staff. The Trust have several mitigating mechanisms in place to manage and reduce this risk.

The majority of the agency staff were block booked, some of which have worked at MAH for a number of years and were able to speak in detail about the patients they were caring for. Block booking agency staff provides benefits such as consistency in care and team integration. A small number of long-term Trust staff remain in employment at MAH.

The majority of shifts were noted to have well above the required safe staffing levels on duty, compared to the minimum safe staffing level required. Issues were identified with the deployment of staff across the site. Improved deployment of staff would better support planning for patients' activities and structuring of patients' days. It was positive to note that staffing levels across the site allowed for the quick deployment of staff to areas that were short staffed.

We observed good staff engagement with patients, which was a marked improvement since the last inspection. Staff demonstrated improved skills, knowledge, and understanding of each patient's needs, including the support patients required to manage distressing behaviours.

Staff Training

Following the last inspection in July 2022, the Trust submitted an action plan, and progress updates, by way of providing assurances of actions taken to address concerns identified. One such required assurance was in relation to the upskilling of staff who did not have a Learning Disability qualification.

Information received advised that only a small number of staff had completed an upskilling training programme; however, observation of staff reflected a workforce, with improved skills, delivering care to patients with Learning Disabilities. This is positive progression which is partly attributed to the increased use of PBS staff, influencing and educating ward staff in best practice of care delivery for patients with complex needs.

Mandatory training was reviewed, with nine training topics selected; Adult Safeguarding, Infection Prevention Control, Fire safety, Dysphagia, Basic Life Support, Moving and Handling, Mental Capacity Act, Safety Intervention, and Positive Behaviour Support.

85 – 90 % of the staffing compliment is agency staff, whose mandatory training was good. Training compliance for the remaining small number of substantive staff was poor. The Trust must address this deficit, and implement a mechanism to assure themselves that substantive staff have completed up to date mandatory training.

An area for improvement has been made in relation to substantive staff mandatory training.

5.2.4 Patient Care

Assessment and treatment for patients was assessed through the observation of patient care, discussions with patients, their relatives, and with ward staff, and from the review of patients' care documentation.

All patients had personalised care plans in place, however, some care plans were out of date and required review.

Positive Behaviour Support (PBS) is an evidenced-based, person centred approach that aims to better understand and address the underlying causes of behaviours that challenge and cause distress. Working with the individual and those who know them best improves understanding of why the individual has become distressed, the impact their environment has on them and the best ways to help them feel safe and free from stress. Effective use of the PBS model could contribute to an overall reduction in incidents of challenging behaviours as patients are engaged in meaningful therapeutic activities.

There was an increased presence of PBS staff who were working collaboratively with ward staff to deliver care aligned with patient's individual needs. The majority of patients had PBS plans in place and it was evident that PBS impacted positively for patients and was effective in the reduction of incidents, and improved care and communication with patients.

Patient records reflected good input from multidisciplinary agencies involved in patient care, e.g. Occupational Therapists, Physiotherapists, Social Workers and Speech and Language Therapists. Patients have access to an on-site General Practitioner (GP) and can be referred to a range of services within other hospitals and community settings.

A number of patients were prescribed enhanced observations by the medical team. These were proportionate to the risk and were reviewed as appropriate. Staff were familiar with each patient's observation requirements, however there were inconsistencies in the recording of these. On one occasion prescribed observations were not adhered to which resulted in an incident. The Trust took action to address this incident through ASG processes, learning was identified, shared, and action was taken. A new system for contemporaneous recording of staff engagement with patients who are prescribed observations has been developed and implemented.

Medicines Management

The use of pro re nata (PRN) medication, which is medication that is prescribed on an as and when necessary basis, was reviewed.

Feedback from relatives reflected some concerns in relation to the over use of PRN medication.

Patients records indicated PRN medication was used in accordance with the Doctor's prescription. Records reflected first line PRN medication was always used before second line PRN medication was considered or administered as per patients care and/or PBS plan. The administration of PRN medication was recorded correctly and additional supporting documentation was also completed.

Patient progress notes correlated with each patient's PRN administrations and provided information and a rationale on what led to the use of PRN medication. Patients were monitored for the effectiveness of PRN medication and care records were updated accordingly. There was no recorded evidence that indicated PRN medication was being administered unnecessarily or more frequently than it was prescribed.

Some patients had opportunity to request PRN medication in an effort to self-regulate their behaviours before they escalated. Self-requested doses of PRN were given as prescribed, within permitted parameters, and in line with patient's care plans.

Finances

Patients finances are either managed by their relative or the Trust who acts as the patient's Corporate Appointee. Feedback from a small number of relatives reflected some concerns in relation to the Trust's management of their family member's finances at ward level. We reviewed this during the inspection and found an inconsistent approach to the management of patients finances across the site. All issues found in relation to patients finances were reported to senior management.

It was positive to see a financial audit, by Trust auditors, taking place across the site whilst the inspection was underway and it is recommended all wards are subject to this level of scrutiny. Patients finances will be reviewed during the next inspection.

Meal Time Experience

Patient's dining experiences were individualised and were adapted to the patients' needs where required. Patients were observed to eat at a time of their choosing and the majority were accompanied by staff whilst they ate. It was positive to see staff accommodating patient's dietary needs and requests regardless of time of day.

The meal time experience is an integral part of a patients PBS plan and should be considered when engaging patients during the dining experience. We observed some staff not considering all aspects of patients PBS plans during mealtimes. This issue was raised with senior management who gave assurances that action would be taken to address the issue.

Patients requiring food and fluid modification had been assessed by a Speech and Language Therapist (SALT). The outcome of these assessments was available to all relevant staff, including staff involved in catering and meal serving.

Concerns were raised by relatives about the quality of food available at ward level and that patients were buying meals at the on-site café because when they did not always like the food available on the ward. A review of food and catering arrangements evidenced good patient choice from a menu that was observed as appetising and appropriate. Patients, could also choose to avail of and purchase food and snacks at an on-site café. This was in keeping with the patient's care/PBS plan.

Relatives concerns were raised with the Trust and assurances given that these would be addressed. The Trust should ensure that patients and relatives have an opportunity to give their views on all aspects of patient care, including the standard and availability of food.

Patient Activities

The majority of patients had an individualised activity planner, these were not all up to date. However, this did not impact on the delivery and support to patients to engage in various activities throughout their day. Patients spent a significant amount of time each day occupied in a good range of activities, which were in keeping with their PBS plans.

5.2.5 Patient Resettlement

There were 29 patients in MAH, a small number of whom are receiving active care and treatment. This is a reduction from 37 since July 2022. The pace of the resettlement programme has been slow, as a result of multiple factors such as, securing suitable accommodation in the community to meet individual patient needs, and the recruitment of suitably skilled staff by independent providers. RQIA are aware of the plans for resettlement and receive regular updates from the Learning Disability Resettlement Board (Strategic Planning and Performance Group) on progress toward the discharge / resettling of patients to the community.

There are plans in place to resettle all patients in MAH, however not every patient has an identified placement that will meet their particular support needs. A dedicated resettlement team is managing all patient resettlement and the obstacles encountered within.

It was positive to note that in-reach staff (these are staff supplied by independent providers from alternative accommodation that has been identified for a patient) were working collaboratively with hospital staff to assist with some patient transitions to the community. Staff from MAH were also going out to identified accommodation with patients to assist them to become familiar with their new surroundings and their new staff teams.

Relatives we spoke to were involved and proactively engaged in their family member's resettlement plans. On the whole relatives were content with the plans in place; however, noted that the overall pace of resettlement was slow.

5.2.6 Patient / Staff / Family Engagement

Patient Engagement

We spoke with a number of patients during the inspection. Patients, who were able to give their opinion on their care, spoke positively about the staff and the care they received. A small number of patients took the opportunity to inform us they would like to remain in hospital rather than moving out into the community.

The Trust supports patient and carer advocacy, and should encourage patient and relative feedback through the available forums. There is a strong advocacy input in MAH for both patients and their relatives.

Relative Engagement

We spoke to eleven relatives about the care their family member received. Some relatives spoke positively about the care delivered whilst others shared some negative experiences. Positive views shared related to staffing levels, increased patients' activities and outings, and timely response to ASG incidents.

Concerns raised by relatives related to the environment, the pace of resettlement, the quality of food and catering arrangements, communication, and the management of their family member's finances. These concerns were raised directly with members of senior management during inspection feedback and assurances were given that these concerns would be addressed.

Staff Engagement

We spoke to a number of staff, substantive and agency, across all wards. Staff expressed a range of views about working in MAH and some relayed concerns about the future for patients and the plans for the hospital.

Some staff thought transitioning to the community was the best option for the majority of patients, whilst others shared their views that some patients, who had been in MAH for many years, and see the hospital as their home, should remain there.

We were informed by Trust SLT that they had received information through whistleblowing policy, about tensions amongst groups of agency staff. Assurances were given that measures were being put in in place to address this issue and this was not impacting patient care.

6.0 Quality Improvement Plan/Areas for Improvement

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

	Standards
Total number of Areas for Improvement	5

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

Quality Improvement Plan

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

Area for improvement 1 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 31 July 2023	The Belfast Health and Social Care Trust must put in place arrangements for the effective oversight of the deployment of staff across the site. This should include planning and managing staff allocations and deployment in advance of shifts. Ref: 5.2.3
	Response by registered person detailing the actions taken: Effective from the 26th April 2023, a new site safety brief was created and diseminated amongst all staff and site coordinators. This provides clear oversight and rationale for staff being deployed. Focus is on staffing throughout the day, all allocations are managed in advance of shifts being worked. Site safety brief is checked against the fully approved rosters and in each area the names and skill mix of staff available is recorded. Deployment of staff across the site is now contingency managed allowing for last minute notification in unavailbility e.g. sickness absence, bereavement.
Area for improvement 2 **Ref:** Standard 5.3 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 31 July 2023	The Belfast Health and Social Care Trust must keep under review each patient's living areas to ensure that patients are receiving care and treatment in the most therapeutic environment. The Trust should consider the implementation of a recording tool, used in other areas of the Trust, to capture actions from environmental walk arounds. Ref: 5.2.1
	Response by registered person detailing the actions taken: The Trust has an enviromental assurance walkaround recording proforma. Senior managers complete this monthly providing actionable records and assurance. In collaboration, Patient Client Support Services complete monthly environmental audits which are available for monitoring and review.

Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3 **Stated:** First time **To be completed by:** 31 August 2023	The Belfast Health and Social Care Trust must ensure all patient living spaces are inspected and maintained to an acceptable standard. The estate works required must be completed within agreed time frames. Outstanding estates work must be expedited and progress recorded. Ref: 5.2.1
	Response by registered person detailing the actions taken: Effective from 26th April 2023 the new site safety brief includes all environmental and estate issues requiring attention, ensuring each patient's living area is in good repair. Divisional Nurse and PCSS monthly environmental walkarounds identifies areas for improvement and decluttering of the non-patient storage areas. Enviromental and cleanliness audits are conducted monthly and shared widely across the site and with senior managers, clear timelines of completion and progress monitoring is available. Any estates work required is raised immediately a concern is noted or identied. Expected timeframes provided by the estates department are tracked and monitored to completion.

Area for improvement 4 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 30 June 2023	The Belfast Health and Social Care Trust must put in place arrangements for the management of recording, storage and effective oversight of supervision plan records. Ref: 5.2.2
	Response by registered person detailing the actions taken: A central private microsoft teams channel is in use displaying a tracker citing any staff on a supervision plan. Each case has a named supervisor with review meetings conducted on a quarterly basis with the Divisional Nurse. Individualised portfolios and action plan evidence are detailed against any areas of concern. Site safety brief includes a section for staff on supervision plans and the stipulations around possible patients they may be advised not to work with directly. Information visibility assists in the appropriate incident deployment of staff responders across site.
Area for improvement 5 **Ref:** Standard 4.1, Criteria: 4.3 **Stated:** First time **To be completed by:** 30 July 2023	The Belfast Health and Social Care Trust must review substantive staff mandatory training compliance and put in place a mechanism for the oversight of this. Ref: 5.2.3
	Response by registered person detailing the actions taken: Monthly assurance meetings are in place to report and record mandatory training compliance. A recent appointment of a Nurse Development Lead occurred following interviews on 20th June 2023. Post roles and responsibilities includes monitoring and support - ensuring all staff meet the mandatory training requirements. Monthly monitoring is in place, all staff are afforded study time now staffing capacity is built into the workforce, ensuring training deficits remain low.

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

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