The Regulation and Quality Improvement Authority

Inspection Report

19 July 2023 – 30 May 2024

Muckamore Abbey Hospital

Type of service: HSC Hospital
Address: 1 Abbey Road
Antrim
BT41 4SH
Telephone number: 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

Organisation/Registered Provider: Belfast Health and Social Care Trust (BHSCT)	**Responsible Individual:** Dr Cathy Jack (Chief Executive)
Person in charge at the time of inspection: Billie Hughes, Co-Director Intellectual Disability Services, Muckamore Abbey Hospital	**Number of registered places:** Cranfield Ward – nine Six Mile Assessment Ward – four Six Mile Treatment Ward – six Killead Ward – four Donegore – four
Categories of care: Acute Mental Health and Learning Disability (MHLD)	**Number of patients accommodated in the hospital on the day of the onsite inspection:** 25 Two patients were out of hospital as part of their resettlement journey.
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 a regional, acute psychiatric inpatient service to adults from across Northern Ireland, aged 18 years and over who have a learning disability. A small number of patients, admitted in accordance with the Mental Health (Northern Ireland) Order 1986, are detained at MAH for assessment or treatment. MAH also provides care and support to patients who require resettlement, some of whom have been resident at the hospital for an extended period of time and no longer meet the criteria for hospital care and treatment. A number of patients who have been assessed as ready for discharge, are delayed in their discharge. Following a public consultation on 24 October 2022 regarding the future of MAH, the Department of Health (DoH) announced the planned closure of the hospital by June 2024. On 5 June 2024 the DoH announced an extension to the closure date. The DoH acknowledges much work has been done in sourcing suitable community placements for patients. However, a number patients remain in Muckamore.	

*Source: Procedure-for-the-reporting-and-follow-up-of-SAIs-2016 - DOH/HSCNI Strategic Planning and Performance Group (SPPG)

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The extension is to allow the continuation of the phase process in place to ensure the successful resettlement of patients into community settings. The DoH stated "planning will continue at pace in relation to establishing resettlement timelines for the remaining patients, and the work being progressed by the Belfast Trust to close the hospital will continue. However, setting a further target date at this point for the hospital's closure is not helpful to patients or families. Nonetheless, the direction of travel remains closure and this will happen when all those at Muckamore have been resettled". Admission to all wards within the hospital is significantly restricted. Alternative options are explored in full before patients who are in need of an inpatient bed are accepted for admission.

2.0 Inspection background and summary

The Strategic Planning and Performance Group (SPPG) requested that RQIA undertake a retrospective review of previous adverse incidents at MAH, to establish if appropriate thresholds for reporting were being adhered to in line with the reporting criteria (HSCB Procedure for the Reporting & Follow up of Serious Adverse Incidents (SAIs) (2016)) * (The Regional Procedure) and the HSC Early Alert System Circular (2020) **. This request was made following concerns identified with the BHSCT's management of adverse incidents.

The Regional Procedure includes the definition for an adverse incident, as: "**any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation** arising during the course of the business of a HSC organisation / Special Agency or commissioned service".

The Regional Procedures also includes the following criteria that determines whether or not an adverse incident constitutes a SAI.

4.2 SAI criteria

4.2.1 serious injury to, or the unexpected/unexplained death of:

- a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)

- a staff member in the course of their work

- a member of the public whilst visiting a HSC facility;

4.2.2 unexpected serious risk to a service user and/or staff member and/or a member of the public;

4.2.3 unexpected or significant threat to provide service and/or maintain business continuity;

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4.2.4 serious self-harm or serious assault (including attempted suicide, homicide and sexual assaults) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

4.2.5 serious self-harm or serious assault (including homicide and sexual assaults)

- on other service users,
- on staff or
- on members of the public

by a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident;

4.2.6 suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident;

4.2.7 serious incidents of public interest or concern relating to:

- any criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner.

The Regional Procedure states that any adverse incident which meets one or more of the above criteria should be reported as a SAI.

The procedure also recommends The HSC Regional Risk Matrix (Appendix 16) may assist organisations in determining the level of "seriousness".

The purpose of reporting and following up of SAIs, as explained within The Regional Procedure, provides a mechanism to effectively share learning in a meaningful way, with a focus on safety and quality, which ultimately leads to service improvement for service users and their families. All SAIs involving persons known to mental health and / or learning disability services are reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.

The HSC Early Alert System Circular (2020) provides guidance for the procedure to be followed when the reporting of an Early Alert is indicated. The purpose of Early Alert system is to ensure that the Department of Health is notified in a timely fashion of significant events which may require the immediate attention of the Minister, Chief Professional Officers or policy leads and /or require urgent regional action by the DoH.

RQIA agreed to undertake a robust assessment under the Provisions of Article 86 (2) of the Mental Health (NI) Order 1986, to establish whether incidents that occurred within MAH were

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being reported in line with the definition and reporting criteria outlined within The Regional Procedure and the Early Alert System Circular (2020).

This inspection sought to determine the effectiveness of the incident management processes within MAH, to identify any requirement for improvement, any requirement for further regulatory response and to establish any regional learning.

The following Terms of Reference were determined and agreed internally by RQIA to assess the effectiveness of the Trust's oversight and assurance arrangements as they relate to incident management within MAH:

1. To assess the effectiveness of local incident management processes within MAH, including the views and experiences of staff.
2. To seek the views and experiences of patients and relatives in relation to patient/family involvement in procedures for incident reporting and investigation within MAH.
3. To conduct an audit of incidents reported between 1 August 2022 and 31 July 2023, taking into consideration the definition and criteria set out within regional guidance for SAI and Early Alert reporting.
4. To identify learning and make recommendation/s for improvement.
5. To provide a report of our findings to the Trust, the DOH, the SPPG and to the public, including any recommendation/s for further assurance work or remedial action.

These objectives have been achieved through two threads of assurance: an audit and analysis of incidents that occurred between 1 August 2022 and 31 July 2023 and an onsite inspection. The findings from the audit and the onsite inspection are detailed throughout the report. Five Areas for Improvement (AFI) have been identified as a result of this inspection and are detailed in the Quality Improvement Plan (QIP) in Section 7.0.

During this inspection two of the five AFIs made following the last inspection of MAH on 5 March 2023 in relation to patients living environments, were assessed as met. Three AFIs have been carried forward and are included within the QIP. See Section 5.1 for details.

3.0 How we inspect

RQIA utilised its authority under the Mental Health (Northern Ireland) Order 1986 and The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland Order) 2003 to conduct this inspection. 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 to damage or 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 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

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ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

The inspection commenced on the 19 July 2023 with an audit and analysis of the incident data. The onsite element of the inspection took place on the 10 and 11 January 2024, between 9am and 5pm.

The following RQIA staff were involved in the inspection; Director of Mental Health Learning Disability (MHLD), Assistant Director for Governance; Assistant Director MHLD; Senior Inspector (MHLD); three care inspectors; Data Analyst; and the Clinical Lead and Sessional Consultant Psychiatrist.

Experiences and views were gathered from patients and relatives; ward staff; ward managers; Assistant Service Managers; Governance Lead; Co-Directors.

The results and outcome of the inspection were shared with the Trust's Senior Management Team (SMT) on 29 March 2024. The inspection concluded with a summary of the findings shared with the SPPG on 30 May 2024.

4.0 What people told us about the service

Posters were placed throughout the wards to ensure staff, patients and relatives were aware of the inspection, should they wish to speak with inspectors or feedback any views or experiences.

We spoke to a number of families to gather their views on how incidents are managed to determine if good family engagement was in place.

The feedback we received from families varied. Some expressed satisfaction with the Trust's management of incidents and with the level of communication shared. Others reported dissatisfaction with how incidents are managed at the hospital and the level of information shared. Some family members felt there wasn't enough engagement from the Trust. Patient and family views are detailed further in section 5.2.4.

Staff interviews were conducted with a range of substantive and agency staff working across all wards. Operational staff working at ward level demonstrated good knowledge of incident management, they were aware of the recording, reporting and escalation processes for incidents. Staff spoke assuredly about completing incident reports on the Trust's incident reporting system (Datix).

There was some understanding by operational staff that further investigations took place at a senior management/governance level, however, knowledge in relation to the Regional Serious Adverse Incident recording and reporting procedure, Early Alert system and/or the Trust's internal investigation procedures was limited. This is detailed further in section 5.2.3.

*Source: Procedure-for-the-reporting-and-follow-up-of-SAIs-2016 - DOH/HSCNI Strategic Planning and Performance Group (SPPG)

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5.0 The Inspection

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

The most recent inspection, undertaken on 5 March 2023, identified five areas for improvement (AFIs).

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 5 March 2023</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><td rowspan="2">Area for improvement 1

Ref: Standard 4.1 Criteria: 4.3

Stated: First time</td><td>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.</td><td rowspan="2">Carried forward to the next inspection</td></tr>
<tr><td>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.</td></tr>
</table>

*Source: Procedure-for-the-reporting-and-follow-up-of-SAIs-2016 - DOH/HSCNI Strategic Planning and Performance Group (SPPG)

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Area for improvement 2 **Ref:** Standard 5.3 Criteria: 5.3.1 **Stated:** First time	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. **Action taken as confirmed during the inspection**: Patient living areas presented as therapeutic and were reflective of individual patient's assessed needs. An appropriate recording tool captured actions required and taken to improve the patient environment. This provides assurance that when necessary, remedial works are identified and actioned.	**Met**
Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3 **Stated:** First time	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. **Action taken as confirmed during the inspection**: Patient living spaces visited were of an acceptable standard. The completion of estates works was evident and managers within the hospital were monitoring progress of remaining works.	**Met**
Area for improvement 4 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time	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. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward to the next inspection**

*Source: Procedure-for-the-reporting-and-follow-up-of-SAIs-2016 - DOH/HSCNI Strategic Planning and Performance Group (SPPG)

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Area for improvement 5 **Ref:** Standard 4.1, Criteria: 4.3 **Stated:** First time	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.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.	

5.2 Inspection Findings

5.2.1 Audit of incidents

RQIA requested the Trust submit the details of incidents that had occurred in Muckamore Abbey Hospital between 1 August 2022 and 31 July 2023. A total of 2,765 incident reports were received from the Trust's electronic incident recording system; Datix.

In order to identify a representative sample size to review, RQIA's information analytical team applied sampling methodology for analysis of the data (source - How to Determine Sample Size in Research | Qualtrics).[1] This methodology determined that a sample size of 337 would deliver a confidence level of 95% and a margin of error of 5%, which was deemed acceptable and representative of the population data.

An additional 61 incidents were selected to include 16 incidents categorised as either major or moderate risk incidents, and 45 incidents that the Trust reported they had reviewed using Serious Event Audit (SEA) methodology.

A rigor of moderation was applied. Inspectors, a senior inspector and an assistant director were involved in the audit.

The Trust define SEA methodology as ***"a local, internal review using the Serious Event Analysis method to establish poor practice, good practice, an action plan for prevention of re-occurrence and to share learning across the service if applicable."***

This sample selection was representative of incidents that the Trust had graded as low, moderate or major risk and included incidents that resulted in the Trust investigating using SEA methodology. A total of **398** incidents were audited and analysed by members of the RQIA Mental Health and Learning Disability Team (MHLD) team.

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[1] - How to Determine Sample Size in Research | Qualtrics).
*Source: Procedure-for-the-reporting-and-follow-up-of-SAIs-2016 - DOH/HSCNI Strategic Planning and Performance Group (SPPG)

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The audit involved reviewing each of the 398 incidents, and using the definition and criteria as set out within The Regional Procedure and the HSC Early Alert System Circular (2020), we determined if each incident met the reporting criteria for Early Alert and / or a Serious Adverse Incident (SAI).

The findings from the audit suggest that 85% of incidents had been reported on Datix and managed appropriately by the Trust.

The audit determined that 34 incidents had not been reported and managed in accordance with regional procedures (This number is inclusive of an incident retrospectively reported as a SAI and an EA). Some of these incidents had been investigated by the Trust using SEA methodology.

All incidents had been reported through the Trust's Datix incident management system. However, the audit undertaken by RQIA found the Trust had failed to adhere to regional reporting mechanisms on 34 occasions between 1 August 2022 and 31 July 2023.

10 of the 34 incidents also had potential to be reported as an Early Alert (this number is inclusive of the incident retrospectively reported as an EA).

23 incidents did not have enough information recorded to determine if the incident met the criteria for regional reporting.

The Trust completed a SEA on 45 occasions. RQIA determined that 28 of the 45 incidents would have met the definition and criteria for regional reporting.

This interchangeable language was found to cause confusion among Trust staff. The Trust's Senior Management Team (SMT) confirmed that the use of the term 'SEA methodology;' referring to 'local, internal investigations' has ceased since this inspection.

The detail recorded in some incidents either did not provide enough information; or included information that made it difficult to establish what both the incident was and the presenting risk. There was also an inconsistent approach to recording the information on the Datix system.

The outcome of this audit demonstrates that further training is required to promote consistency in recording, analysis and reporting of SAIs/EAs; enabling the Trust to adhere to the statutory reporting mechanisms in place for HSC organisations in the future. This is discussed further in Section 5.2.3.

5.2.2 Policies and Procedures

The Trust's Adverse Incident Reporting and Management Policy references a suite of related procedures relevant to the grading of incidents, reporting, investigating and learning.

The Trust's procedure for grading an incident offered guidance to staff to determine the severity and subsequent grading of an incident including explanation how to use the HSC Regional Risk Matrix.

*Source: Procedure-for-the-reporting-and-follow-up-of-SAIs-2016 - DOH/HSCNI Strategic Planning and Performance Group (SPPG)

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However, staff did not always grade incidents correctly. RQIA found evidence where grading was at times changed by senior managers, and operational staff did not understand the reason why. This indicates an inconsistent approach to the reporting and management of incidents.

We found incidents were graded based on the immediate outcome following an incident. RQIA determined this was due to how the HSC Risk Matrix was being utilised. There was limited consideration given to the risk likelihood scoring table when determining the consequence. From the review of incidents and engagement with staff it was evident to RQIA that some incidents of a similar nature were occurring frequently, as defined in the time framed description of frequency. This should have been considered when determining the likelihood score. There was also limited consideration given to the psychological / emotional impact of the incident on the patient and staff.

Greater management oversight and testing of all staff knowledge in relation to incident recording and grading is recommended.

The Trust's Procedure for Serious Adverse Incidents aligns to The Regional Procedure reporting criteria for a SAI. However, an alternative approach to investigation using a localised internal review (SEA), which identifies and disseminates learning within the hospital was adopted by the Trust in respect to a number of incidents that have occurred in MAH.

This alternative approach to investigation under local procedures is a concern as it both deviates from the Trust's own policy and from The Regional Procedure. As a consequence, incidents that meet the definition and criteria for reporting in line with The Regional Procedures are not reported as such and are at risk of being reviewed using a less rigorous investigation approach. There is a risk that learning which may improve outcomes for patients across the region, is not shared.

In addition, the opportunity for additional scrutiny for serious incidents is lost. This has the potential to impact on the Trust's standards in relation to clear, open and transparent communication and engagement.

An AFI has been identified in respect to Policy and Procedures.

5.2.3 Training and skill development

Inspectors spoke with a range of both substantive and agency staff including, deputy ward managers and ward managers. The inspection team also spoke with Assistant Service Managers (ASM's), the Senior Management Team (SMT), Co-Directors (clinical and operational) and with the Trust's Governance team.

Operational staff had good knowledge on how to report and manage incidents at ward level. Staff effectively explained how to manage an incident in real time, utilising de-escalation techniques. Skills used to reassure patients were described alongside the benefits of using hot debriefs immediately following an incident and cold debriefs at a later date. Staff described when to complete an incident report on Datix and how to escalate using the appropriate line management channels.

*Source: Procedure-for-the-reporting-and-follow-up-of-SAIs-2016 - DOH/HSCNI Strategic Planning and Performance Group (SPPG)

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Operational staff had good knowledge on how to manage an incident in real time, however, a significant piece of developmental work is required to ensure staff are supported to improve their understanding, skill and competence in relation to the recording, reporting, grading and escalation of incidents. This correlates with the findings of the audit of incidents.

Staff training records reflected 79% of substantive staff had received adverse incident report training, however, the criteria for reporting incidents in line with The Regional Procedure was not well understood. The terms ‘SAI’ and ‘SEA’ were familiar to staff, however, there was lack of clarity and therefore limited awareness in relation to what the terms mean regarding the level of investigation. It was accepted by the Trust’s SMT that there remains work to be done to improve staff knowledge and understanding.

Learning identified from incidents investigated under SEA methodology had been delivered to MAH staff through training. RQIA identified some of this learning was lost and would have benefited the region due these not being reported in line with The Regional Procedure.

Interpretation and application of the HSC Risk Matrix varied. Some staff were rigid in their application which can impact professional judgement and decision making, and some staff did not fully consider the ‘Likelihood’ scoring descriptors when similar incidents were occurring on a frequent basis.

An AFI has been identified in relation to upskilling staff on incident management.

*Source: Procedure-for-the-reporting-and-follow-up-of-SAIs-2016 - DOH/HSCNI Strategic Planning and Performance Group (SPPG)

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5.2.4 Patient and family Feedback

Inspectors spoke with the family representatives following confirmation of patient consent. Feedback from patient relatives was varied; some families expressed satisfaction with how incidents are managed and the level of information shared following an incident involving their relative. Other families described feeling detached from any investigation process or outcomes following investigations.

During the onsite inspection, inspectors reviewed incident investigation documentation. Inconsistencies in relation to family involvement were noted, with limited recording of decision making in relation to sharing of information with families during or following the completion of the investigation.

The views of families were shared with members of the Trust's SMT during the inspection. It was accepted that on all occasions it may not always be appropriate to fully involve families within incident investigation processes. However, there is a need to have some level of engagement with families to provide assurance and maintain an open, honest and trusting relationship. The Trust accepted that work to re-establish rapport with families is paramount to ensure good engagement during and at the close of the investigation.

Information received by relatives also indicates that they were not always involved in incidents that resulted in regional reporting. Clear guidance is available for health and social care staff on engagement/communication with patients and their families following a Serious Adverse Incident. This guidance is included within The Regional Procedure (Addendum 1). Using an alternative approach to investigate incidents, that meet the definition and criteria for regional reporting has the potential to exclude families in the process.

An area for improvement has been identified in relation to patient and family engagement.

5.2.5 Assurance and Oversight

Daily safety brief meetings were in place across all wards. Daily safety huddles, attended by members of the SMT, were taking place during weekdays each morning to discuss and escalate incidents over the previous 24-hour period. Senior management cover arrangements were on a rota basis for evenings and weekends providing ward staff opportunity to avail of guidance and an avenue for escalation as needed.

Datix incident reports were automatically transferred to a designated approver's dashboard within the Trust's Datix system. Designated approvers for incident management were required to complete Datix approver training. Senior staff nurses, ward managers and assistant service managers hold this responsibility.

Incidents were reviewed and screened by ASMs who determined if any further discussion with the governance lead was required.

*Source: Procedure-for-the-reporting-and-follow-up-of-SAIs-2016 - DOH/HSCNI Strategic Planning and Performance Group (SPPG)

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Contact with the governance lead provides opportunity to consider appropriate action and to discuss rationale for investigating particular incidents as part of a local or regional review process.

Acknowledging the Trust's Governance lead for Intellectual Disability (ID) services holds Trust wide management responsibility for a high volume of complex incidents, it was encouraging to note the level of support dedicated to MAH.

The audit completed prior to the onsite inspection identified inconsistencies within the records held on the Trust's Datix system. Several incidents detailed a significant amount of narrative which leads to confusion while others lacked sufficient detail relevant to the incident. Some incidents had no recorded lessons learned. Other incident recordings reflected the same text, often copied and pasted from earlier incidents of a similar nature. Whilst some incident records were identified through the Trust's own governance processes as inadequate, others had not. There was recognition from governance staff that relevant staff require training.

RQIA determined that these inconsistencies in recording may result in the wrong escalation pathways being triggered, potentially resulting in learning missed or not shared widely enough to prevent re-occurrence in another facility in the region.

The inconsistency and inappropriate grading of incidents was discussed with members of the Trust's SMT and Governance team during the inspection. The SMT and Governance team acknowledged there is work to be done to support staff to record incident information to an acceptable standard.

Governance mechanisms have been put in place by the Trust to ensure that each incident including those graded as 'low/green' are discussed weekly as part of a 'Live Governance Meeting' attended by Senior Nurse Managers, the Collective Leadership Team (CLT) and the Governance Lead.

When three or more incidents, similar in nature are identified, the cumulative impact is considered, the grading is escalated to moderate/amber and the incident is reviewed in more detail with the Governance team as part of the weekly Live Governance meeting for all Intellectual Disability (ID) Services within the Trust.

While governance meetings and oversight mechanisms were in place within MAH, RQIA identified through the finding of the audit, these mechanisms were not always effectively identifying incidents that required escalation, whether through increasing the incident grading or regional reporting.

During the inspection The Trust initiated a revised review process, called a Rapid Appraisal of Care. This rapid review incurs a 72-hour period for the review to take place; the expectation is that any immediate learning will be identified and where the criteria for an EA or a SAI is met, the incident will be escalated to the SPPG in line with The Regional Procedure and /or the HSC Early Alert (EA) System Circular (2020). Operational staff did not reference the rapid review process during any staff interviews.

*Source: Procedure-for-the-reporting-and-follow-up-of-SAIs-2016 - DOH/HSCNI Strategic Planning and Performance Group (SPPG)

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RQIA recommend that the Trust ensure that the policy and procedures in relation to incident management provides clear criteria to guide staff on the use of the Rapid Appraisal of Care approach to investigate incidents and includes the escalation process.

An area for Improvement has been identified in relation to Governance and Assurance.

6.0 Conclusion

RQIA agreed to undertake a retrospective review of previous adverse incidents at Muckamore Abbey Hospital (MAH), to establish whether the regional definition and criteria for reporting incidents was being adhered to.

RQIA found evidence where SEA methodology was used, learning had been identified and was shared and implemented at ward level.

However, this alternative approach to investigation has the potential to result in missed opportunities for regional learning.

The Trust must invest time to train and upskill staff to record and report appropriately; to strengthen processes in relation to decision making, ensuring that if appropriate, the opportunity for external scrutiny, and regional learning is not lost.

The Trust must ensure it meets the Quality Standards for HSC (2006) in relation to clear communication principles which include open and honest engagement with patients, their families and other key stakeholders.

The incidents that met the definition and criteria for regional reporting were highlighted to the Trust's SMT. Incidents that were not reported require to be reviewed by the Trust and appropriate action taken.

RQIA shared the outcome from this inspection with the SPPG on 7 June 2024.

RQIA recommends the learning from the outcomes of this inspection are shared with all relevant stakeholders across all directorates in the Trust, so appropriate actions can be taken.

*Source: Procedure-for-the-reporting-and-follow-up-of-SAIs-2016 - DOH/HSCNI Strategic Planning and Performance Group (SPPG)

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7.0 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).

	Regulations	Standards
Total number of Areas for Improvement	0	8

There are eight areas for improvement, five have been stated for the first time and three have been carried forward from the Inspection completed 5 March 2023.

Areas for Improvement (AFI's) and details of the Quality Improvement Plan were discussed with the Trust's Senior Management Team (SMT) and the Strategic Planning & Performance Group (SPPG), 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 5.1, 7.1 Criteria: 5.3.2, 7.3 **Stated:** First time **To be completed by:** 1 September 2024	The BHSCT should ensure that incident reviews are conducted in a way that captures learning from all incidents, with the aim of avoiding similar incidents occurring again. All incident reviews should be approached with the aim to improve outcomes for patients and their relatives and promote patient safety, dignity and Human Rights. Patient capacity should always be assessed and documented. Information sharing with patients and relatives should be in keeping with Department of Health Share Guidelines 2024. Staff should formally document their decision making on patient and family involvement. Ref: 5.2.2 and 5.2.4
	Response by registered person detailing the actions taken: Service continue the Governance audit to complete the following schedule:

*Source: Procedure-for-the-reporting-and-follow-up-of-SAIs-2016 - DOH/HSCNI Strategic Planning and Performance Group (SPPG)

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	Auditing of incident review and associated learning dissemination process continues, and is mapped against improved outcomes for patients. Auditing of evidence of documentation of capacity assessment continues as part of a six week schedule. Information sharing with patients and relatives will be in keeping with Department of Health Share Guidelines 2024, there is continuing review and monitoring of staff and family engagement documentation underway.
Area for improvement 2 **Ref:** Standard 5.1 Criteria: 5.3.2 **Stated:** First time **To be completed by:** 1 September 2024	The BHSCT must review the current operational policy and procedures for incident management. This review must ensure: • there are clear procedures to guide staff on action to be taken across a broad spectrum of incidents and near misses. • there is a consistent approach to grading that is based on inherent risk. • escalation is clearly defined and in keeping with regional policy. • identification of local and potential regional learning and the mechanism for sharing learning. The review must also include a quality assurance mechanism to evidence the policy has been fully and robustly implemented and embedded. Ref: 5.2.2 & 5.2.4
	Response by registered person detailing the actions taken: As the BHSCT policy is trust wide and under Regional review a Standard Operating Procedure (SOP) is currently being authored with an aim to incorporate specific guidance for staff and their associated roles and responsibilities. This will focus on consistent guidance on grading, review and escalation processes specifically for Muckamore Abbey Hospital. This will also include an audit review 6 monthly cycle to ensure consistency.

*Source: [Procedure-for-the-reporting-and-follow-up-of-SAIs-2016 - DOH/HSCNI Strategic Planning and Performance Group (SPPG)]

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	Advice, guidance and support in relation to the dissemination of learning internally and externally will be included within the SOP.

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Area for improvement 3 **Ref:** Standard 7.1 Criteria 7.3 **Stated:** First time **To be completed by:** 1 August 2024	The BHSCT must retrospectively report the incidents, assessed as meeting the criteria for reporting as a Serious Adverse Incident, in accordance with the regional procedures. The BHSCT must consider the issue of an Early Alert for those incidents, assessed as meeting the criteria, which have not previously been reported as such. The BHSCT must liaise with colleagues in the Strategic Planning and Performance Group to determine the way forward with respect to the incidents not included in the RQIA sample and give consideration to the necessary actions, in accordance with regional procedures. The BHSCT should ensure that all staff involved in incident management have a clear understanding of the definition and criteria for reporting an Adverse Incident in accordance with the regional procedures. This recommendation also applies to the reporting of incidents in accordance with the criteria as set out in the Regional Early Alert (EA) System Circular (2020). Ref: 5.2.2
	Response by registered person detailing the actions taken: BHSCT have notified all 34 incidents identified by RQIA as meeting the threshold for SAI. These have been notified to SPPG in line with Regional procedures. BHSCT will meet with DOH colleagues regarding the appropriate submissions of Early alerts. The BHSCT have already met with SPPG for an initial discussion on how to approach the incident not included in the RQIA sample. Agreement will be reached on necessary actions. All appropriate staff have been provided with, and reminded of, their responsibilities to escalate under Early Alert and SAI criteria.

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Area for improvement 4 **Ref:** Standard 5.1 Criteria: 5.3.1, 5.3.3 **Stated:** First time **To be completed by:** 11 January 2024	The BHSCT must ensure all staff involved in incident management have received competency based training appropriate to their role and responsibility. Training and development should include any upskilling associated with the implementation of Encompass, engagement with Trust's own incident management teams and the redesign of Regional SAI procedures. Staff training should incorporate the changes made to the Trust's operational policy; and the outcomes from this inspection. Ref: 5.2.2
	All staff have been fully trained in Encompass appropriate to their roles and responsibilities. The service continues to engage with Corporate Governance Team weekly, and attends SAI redesign Consultation meetings. High level updates are provided to all Governance Managers within BHSCT at the Monthly Governance Forum by Trust Risk and Governance Leads. This information is shared directly with CLT and Service Managers for dissemination within teams.

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Area for improvement 5 **Ref:** Standard 5.1 Criteria: 5.3.2 **Stated:** First time **To be completed by:** 7 October 2024	The BHSCT must strengthen the current governance system in place to prevent, identify, assess and manage all incidents. The system must take account of the processes in place for reporting, collating, analysing and learning from all incidents and should include oversight of decision making with regards to escalating and regional reporting. Communication arrangements should be strengthened to ensure information and learning is shared and assurances are in place which evidence that learning has been implemented and monitored. The governance system must be outcomes focused and drive improvement in the quality, safety and experience of patients using the service. Ref: 5.2.5
	Response by registered person detailing the actions taken: Service currently reports and discusses adverse incidents at ward level daily safety briefs. Incidents of concern are escalated to the daily service manager safety huddle, which informs the Charles Vincent Daily Report. There is currently a weekly live governance and end of week review of flagged incidents requiring action. The Governance Manager reports all incidents for all services at a weekly CLT meeting, providing graphical trends and analysis. Service are currently are raising the profile of the local shared learning template, and Governance Manager attends Shared Learning Review group where learning letters from SAI are authored and presented for discussion and approval. These are then presented for final approval at Serious Adverse Incident Group. When approved Governance Manager disseminates all SAI shared learning letters to CLT and Services. All notable adverse incidents, EA and SAI from the previous week are reported on and discussed at the weekly Medical Director Governance Teleconference for sense checking.

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	All services present a report at the ID monthly Divisional Governance meeting, where incidents of all grades are discussed, themed and analysed for trends. BHSCT ID Division has commissioned an independent review of the Governance arrangements within Inpatient LD services. This includes the prevention, identification, assessment and management of all adverse incidents with an aim to strengthen our current structures and provide Level 3 assurance. BHSCT also intend to raise the profile, via information sessions, of shared learning processes.

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Area for improvement 6 **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. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward**
Area for improvement 7 **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. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward**
Area for improvement 8 **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. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward**

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The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

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

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