The Regulation and Quality Improvement Authority

Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland

Overview Report

February 2013

informing and improving health and social care
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The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews are designed to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health Social Services and Public Safety and are available on the RQIA website at www.rqia.org.uk.

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Executive Summary

The Regulation and Quality Improvement Authority (RQIA) believes the right to be protected from abuse or harm is a fundamental principle underpinning the safeguarding of children and vulnerable adults. Individuals who are vulnerable because they lack capacity rely on others to keep them safe from abuse or potentially abusive situations. Those who abuse that trust are liable to prosecution under the criminal law.

RQIA is one of four organisations which collaborate to ensure that alleged and suspected cases of abuse of vulnerable adults are fully investigated and that measures are in place to offer appropriate protection. RQIA also works closely with other agencies to ensure appropriate measures are in place to protect children from abuse.

In April 2011 the Department for Health, Social Services and Public Safety (DHSSPS) commissioned RQIA to carry out a review of the effectiveness of safeguarding arrangements within mental health and learning disability (MHLD) hospitals across the five health and social care (HSC) trusts in Northern Ireland.

RQIA's Mental Health and Learning Disability Team incorporated the theme of safeguarding into a planned programme of inspections for 2011-2012. This report summarises the findings from 33 inspections carried out between December 2011 and July 2012. It contains 26 recommendations to ensure the continued safeguarding and protection of children and vulnerable adults.

Inspectors found that all trusts had policies and procedures in place to keep people safe from the risk of harm and abuse. Trusts had established safeguarding partnerships to promote the awareness of safeguarding. Much effort has been made to ensure staff were appropriately trained.

Responsibility for safeguarding adults was vested in the Northern Ireland Adult Safeguarding Partnership (NIASP). At the time of the review, the Regional Child Protection Committee (RCPC) had responsibility for safeguarding and promoting the welfare of children. The new independent Safeguarding Board for Northern Ireland (SBNI) has now been established to include the duties of the former RCPC. These arrangements had not been fully reflected within the trust's safeguarding policies and procedures. Further work is required to ensure this occurs in a timely way.

Although there was evidence that safeguarding was being promoted, a common theme across all trusts was that there were instances where procedures were not always being appropriately and consistently applied.

To ensure that patients' rights are fully protected, there are areas that require improvement by trusts. These include: variation in thresholds for referring safeguarding concerns; the inappropriate use of restraint by untrained staff; and the lack of application of the correct procedures to protect patients' money and possessions.

Trusts need to continue their efforts to ensure staff are made aware of the indicators of abuse, and monitor closely the evidence of the effectiveness of the implementation of safeguarding policies, procedures and practices.

Inspectors noted the efforts made by all trusts to increase advocacy services for patients, but this was variable in some places. Discrepancies were noted in record keeping and many records were not appropriately signed. Assessments were not always updated and the types of interventions made were not appropriately recorded.

Recommendations for improvement are made within this report. These have been raised with the DHSSPS, HSC Board and with the trusts, through the inspection process.

In order that children and vulnerable adults are protected and kept safe from harm, the focus on safeguarding needs to continue to be a priority for all HSC organisations.

The findings of all adult mental health and learning disability inspections are reported on the RQIA website. The MHLD team also continues to follow up progress in respect of the implementation of the recommendations contained in the individual inspection reports.

Section 1 – Introduction

1.1 Context for the Review

In April 2011 DHSSPS commissioned RQIA to carry out a review of safeguarding in mental health and learning disability hospitals. The purpose of the review was to consider and report on the effectiveness of the safeguarding arrangements in place within the MHLD hospitals across the five HSC trusts in Northern Ireland.

This review focused primarily on the arrangements in place to prevent abuse and assist staff to protect patients and themselves. The inspectors also examined a number of aspects of patient care and the findings are detailed in the individual inspection reports.

Safeguarding is a generic term which is used to describe the multidisciplinary measures put in place to minimise and manage risks to children and vulnerable adults. The safeguarding of children and vulnerable adults is a shared responsibility. Safeguarding arrangements require to be effective across a number of dimensions including awareness, prevention, identification and response.

To further develop the existing standards and guidance for safeguarding children and vulnerable adults, in 2009, DHSSPS introduced the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults.

For the purpose of this report, the term safeguarding refers to the HSC organisations' responsibilities to protect people whose circumstances make them particularly vulnerable to abuse. For adults, the definition of vulnerability is defined as:

> "a person aged 18 years or over who is, or may be, in need of community care services, or is resident in a continuing care facility by reason of mental or other disability, age or illness or who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation."[1]

It is accepted that a person's need to be safe from harm is determined, not only by their individual circumstances, but also by the care setting they are in. Abuse may be committed as the result of negligence, ignorance or deliberate intent and targeting of vulnerable people, either in a single act or on a continuing basis.

At the time of the review, the definitions of abuse for both children and vulnerable adults were determined from available guidance. For adults, the

[1] Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance. (September 2006)

Safeguarding Vulnerable Adults Guidance (September 2006) defined abuse as:

> "The physical, psychological, emotional, financial or sexual maltreatment, or neglect of a vulnerable adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is an expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependant, whether they be formal or informal carers, staff or family members or others. It can also occur outside such a relationship."[2]

For children, Co-operating to Safeguard Children (DHSSPS, 2003) document defined abuse as:

> "Child abuse occurs when a child is neglected, harmed or not provided with proper care. Children may be abused in many settings, in a family, in an institutional or community setting, by those known to them, or more rarely, by a stranger. There are different types of abuse and a child may suffer more than one of them."[3]

For the purposes of the inspections, forms of abuse were categorised as:

- physical abuse (including inappropriate restraint or use of medication)
- emotional abuse
- sexual abuse
- psychological abuse
- financial or material abuse
- neglect and acts of omission
- institutional abuse
- discriminatory abuse

In meeting the objectives of the term of reference, the review focused on:

- policies and procedures associated with safeguarding
- management, supervision and training of staff
- arrangements for the recruitment of staff
- awareness and response to safeguarding concerns
- identification and prevention of abuse
- concerns and complaints from patients and relatives
- records management arrangements

[2] Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance. (September 2006)
[3] Co-operating to Safeguard Children (DHSSPS, 2003)

Inspectors examined the safeguarding arrangements in place across the MHLD hospital wards in all five HSC trusts, including:

- children's learning disability wards
- children's and adolescent mental health wards
- acute learning disability wards
- acute mental health wards
- brain injuries units
- continuing care learning disability wards
- continuing care and rehabilitation units
- dementia wards and
- psychiatric intensive care units

Relevant legislation, policies, procedures, guidance and best practice documents were considered by the inspectors in their assessment of the effectiveness of each trusts' safeguarding arrangements.

Services or facilities excluded from this review included: those attended by children and vulnerable adults that are not either mental health or learning disability facilities; any MHLD services provided by private, independent and voluntary agencies; and the agencies and establishments (see Appendix 1) currently regulated by RQIA.

This report summarises the findings from these inspections and makes the recommendations necessary to ensure the continued safeguarding and protection of vulnerable adults and children.

1.2 Review Methodology

Seventy-two MHLD wards fell within the scope of this review. It was necessary to adopt a suitable methodology that would maximise the ability to validate the quality of safeguarding arrangements across the trusts. The review team agreed that validation of the safeguarding arrangements would be undertaken through a programme of announced inspections, carried out by RQIA's MHLD team. The rationale for this approach was to maximise the number of facilities inspected and make best use of the time available for discussions with management, staff and patients.

The Review Process:

1. Prior to the inspections 113 patient experience interviews were undertaken by RQIA from July to September 2011. Patients' views were used to inform the assessment of the effectiveness of the safeguarding arrangements in place.

2. Prior to inspection each ward completed a self-assessment questionnaire, detailing its safeguarding arrangements. Each HSC trust was also asked to complete a questionnaire regarding its corporate responsibility in all areas of safeguarding.

3. In view of the timescale for reporting, it was not possible to inspect all 72 MHLD wards. A proportionate risk-based approach was adopted to determine the wards to be inspected. Wards considered to have a higher risk rating, based on certain criteria, were selected over those wards that had a lower risk rating. RQIA's MHLD team analysed the available information on each ward and used the following risk based criteria to select the wards to be inspected:

   - intelligence and recommendations made from previous inspections
   - information gathered from patient experience reviews
   - information received from complaints and serious adverse incidents
   - the analysis of self-assessment questionnaires returned by the trusts
   - type of ward or service provided

   From this analysis, 33 wards (four children's and 29 adult wards) were rated as high priority and selected for inclusion in the inspection programme (see Appendix 2). RQIA agreed with DHSSPS that this sample would provide an overview of the quality of safeguarding and safety arrangements across the five trust areas. While every effort was made to select wards in each trust based on the type of care provided, on occasion the need to inspect wards identified with a higher risk rating took precedence.

4. Each inspection examined aspects of safeguarding arrangements. Evidence to support the findings was drawn from:

    - meetings held with patients, staff and other professionals
    - an examination of patient case files, complaints and serious adverse incidents
    - an analysis of the findings from recent RQIA inspections and reviews.

5. In line with the methodology, two stages of reporting of the findings were agreed:

    - individual inspection reports would be produced for each ward and presented to the trusts in line with the normal inspection process.
    - a single overview report containing a summary of the regional findings would be produced for the DHSSPS.

Section 2 – Findings from the Review

2.1 Background to the Findings

The findings of this review are presented under the following themes:

- governance arrangements both in the trust and in specific hospital wards
- the level of awareness of safeguarding arrangements and issues
- the ability of trust staff to recognise signs of abuse
- the mechanisms in place to prevent people experiencing abuse in the first place
- the procedures in place for staff to act appropriately if made aware of allegations or cases of abuse

In measuring effectiveness, it was important to recognise the broader context of practice and the internal and external challenges that impact on performance. It was not appropriate to judge safeguarding arrangements using a single effectiveness measure, as there are many components that need to be considered. Rather, different evidence was used to inform the development of indicators that could be used to assess the effectiveness of safeguarding arrangements.

Inspectors considered these would offer an appropriate basis for determining whether the safeguarding arrangements were sufficient to enable staff to effectively promote the welfare of children and vulnerable adults.

During the course of the inspections of the wards, issues were identified such as: a lack of consultation regarding human rights; environmental issues; and other areas not directly associated with safeguarding. Any issues identified during the inspection were brought to the immediate attention of relevant trust personnel for action, or raised under RQIA's escalation policy and procedure. The required action was detailed in the relevant quality improvement plan, for response by the trust.

The only provision for dedicated MHLD children's wards were in the Belfast Health and Social Care Trust (Belfast Trust) and the Western Health and Social Care Trust (Western Trust). The policy within the Western Trust was to minimise the admission of young people under 18 and to strive for a hospital at home model[4]. Although there were no children admitted to Crannog ward (Western Trust) at the time of the inspection, the ward still fell within the scope of the review and was inspected.

Although there were four dedicated MHLD children's wards, inspectors identified the continued admission of young people under 18 to adult wards in all trusts.

[4] This enables specialist supports to be provided in the community as an alternative to hospital admission.

2.2 Governance Arrangements in Respect of Safeguarding

A successful safeguarding agenda requires the support of a wide network of agencies, organisations and communities of interest from across the statutory, voluntary, community, private and faith sectors.

Unlike child protection, prior to 2010 the coordination of arrangements for the safeguarding of vulnerable adults was limited. However, the recent work undertaken by DHSSPS and the Department of Justice (DoJ), formerly the Northern Ireland Office, led to the establishment of safeguarding partnerships and to the development of working groups to standardise regional policies and procedures.

Adult Safeguarding Partnerships

While HSC organisations were able to clearly demonstrate their structures, governance and working arrangements, inspectors considered that safeguarding arrangements were in the early stages of development, as many policies and procedures were not updated. At the time of the review, the adult safeguarding partnerships had been in place for approximately 18 months. Inspectors considered that the publication of new regional adult safeguarding policy and procedures, completion of further safeguarding training for all staff, and the compilation of information on safeguarding are key factors requiring progression, to bring these partnerships to a more established stage of development.

Overall regional responsibility for adult safeguarding rests with the Northern Ireland Adult Safeguarding Partnership (NIASP), chaired by the HSC Board. The NIASP includes representatives from the statutory, voluntary, community and faith sectors. It has responsibility for the strategic direction and development of adult safeguarding throughout health and social care.

Within each trust area, a Local Adult Safeguarding Partnership (LASP) has been established, with responsibility for implementing the NIASP's guidance and operational policies and procedures at local level. Each LASP is chaired by an assistant director from the trust and includes representation from the trust and statutory, voluntary, community and faith sectors. The chairs of the LASPs are integral members of the NIASP, which provides direct links for communication and reporting between the partnership groups.

Inspectors considered there is an effective infrastructure in each trust to support the operation of partnership groups. This includes sub-groups of NIASP, which lead in the areas of: policies and procedures; performance management and information; training; and communication and service user experience. During the review, some representatives of the partnerships suggested that the effectiveness of the sub-groups could be further improved by restructuring into trust led sub-groups, with a regional focus to improve practice.

Communication and reporting arrangements between the LASPs and NIASP were considered to be effective. LASPs regularly report on standards and outcomes such as training, trends, serious incidents related to adult safeguarding and vulnerable adult reviews. This information is used in the compilation of NIASP progress reports and a delegated statutory functions report is delivered annually by each trust to the HSC Board.

The only vacancy reported in the LASP, was one position within the Northern Health and Social Care Trust's (Northern Trust). This was in the process of being filled and was not adversely impacting on the activities of the group. Good attendance at NIASP and LASP meetings was reported, but attendance had fallen in both, particularly at the sub-group level.

Child Safeguarding Partnerships

Well established child protection arrangements have been in place in HSC organisations for many years, in response to the events surrounding child abuse and historical child abuse inquiries. These focused more on child protection, than on wider aspects of safeguarding. However, this focus will change with the introduction of new child safeguarding legislation by DHSSPS and the establishment of new safeguarding structures. These new structures include a regional independent Safeguarding Board for Northern Ireland (SBNI) and five safeguarding panels located within each trust geographical area. These will mirror existing child protection arrangements, but with increased independence and direct accountability to the Minister for Health, Social Services and Public Safety.

As child protection partnerships have been in place for many years, HSC organisations were able to demonstrate evidence of appropriate structures, governance and joint working arrangements. At the time of the review, the Regional Child Protection Committee (RCPC) held overall responsibility for child safeguarding partnerships, which was chaired by the HSC Board. The RCPC is made up of representatives from the statutory, voluntary and community sectors and has responsibility for the strategic direction and development of child protection throughout Northern Ireland.

Considerable progress has been made in establishing new child safeguarding arrangements. During the transition period, the chair of the SBNI sat on the RCPC partnership, and the RCPC continued responsibility for child protection on an interim basis. During the review, it was established that the delay in transition of responsibility was impacting on the development of some aspects of child safeguarding arrangement, in particular, the development of up-to-date policies and procedures.

Within each trust area, a child protection panel (CPP) was established, with responsibility for implementing RCPC guidance and operational policies and procedures at local level. Each CPP was chaired by a trust assistant director and included representatives from the trust and the statutory, voluntary and community sectors. The chairs of the CPPs are also integral members of the

RCPC, which provides direct links for communication and reporting between the partnership groups.

Inspectors considered that there was an effective infrastructure to support the operation of the partnership groups. Established RCPC sub-groups had taken a lead in the areas of: policies and procedures; case management reviews; education, training and audit; and communication and media management.

Communication and reporting arrangements between the CPPs and the RCPC are considered to be effective as there is a set of requirements for regular reporting and direct links for communication. CPPs regularly reported on standards and outcomes, which included statistical reporting, training, serious incidents related to child safeguarding and case management reviews. This information is used to compile RCPC quarterly reports and each trust's delegated statutory functions report to the HSC Board.

No vacancies were reported on the RCPC or CPPs, and attendance at their meetings was generally good. Inspectors noted that the position of the designated paediatrician for child protection within the HSC Board was vacant; however, another paediatrician was currently fulfilling the responsibilities of the post.

Policies, Procedures and Protocols

While partnership groups were able to demonstrate a strategic plan for adult safeguarding, inspectors were concerned about the lack of an up-to-date regional policy and procedures for safeguarding vulnerable adults. Some trusts had developed their own policy and procedures in accordance with the DHSSPS regional guidance - Safeguarding Vulnerable Adults - Regional Adult Protection Policy and Procedural Guidance (2006) and the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009). Others had embraced the best practice elements from Safeguarding Vulnerable Adults - A Shared Responsibility: Standards and Guidance for Good Practice in Safeguarding Vulnerable Adults (Volunteer Now, 2010). However, the most used guidance by most MHLD hospital settings was the 2006 document Safeguarding Vulnerable Adults - Regional Adult Protection Policy and Procedural Guidance[5]. Inspectors considered the 2006 document to be out-dated as it does not reflect current best practice for safeguarding vulnerable adults.

A NIASP sub-group has developed new draft operational policy and procedures for regional adoption, which are currently under review. However, given the direct relationship between these procedures and the development of an Adult Safeguarding Policy Framework being undertaken between DHSSPS and DoJ, the policy and procedures will not be released in advance of the Adult Safeguarding Policy Framework being published. Inspectors considered that until this is published, NIASP will be unable to fully deliver an

[5] Safeguarding Vulnerable Adults - Regional Adult Protection Policy and Procedural Guidance (2006)

effective safeguarding plan in the absence of up-to-date policies and procedures.

While children's partnership groups were able to demonstrate a strategic plan for child protection based on regional policy and procedures, few trusts had taken steps to further develop trust specific child safeguarding policy and procedures. With the transfer of responsibility to SBNI, both the regional policy and procedures and trust specific child safeguarding policies and procedures will need to be updated accordingly.

Patient Experiences

An area that was not fully evident in the reporting process was that of the lack of reporting of adult patient experience. The inspectors considered that work on patient experience with adults, undertaken within the trusts, should be reported on and the information used to inform the commissioning of services by the HSC Board. NIASP has already been tasked with establishing arrangements for user engagement.

While work on patient experience of children has been initiated, it was not evident in the reporting process. The RCPC had already identified this gap and was planning to incorporate this in its work in the period before transfer to the SBNI. The communication between the SBNI and children and young people had already been established as a key priority of the new SBNI.

Inspectors considered that the newly established partnerships within children and vulnerable adult services provide effective arrangements in terms of leadership, governance, infrastructure, communication and reporting. This constitutes a sound foundation for safeguarding in Northern Ireland. The findings from inspections also indicated a number of on-going challenges, including the need for more direct patient experience and feedback; the release of revised regional policy and procedures; and the further development of the new safeguarding structures.

Recommendations

1. The DHSSPS should prioritise the publication of the Adult Safeguarding Policy Framework to facilitate the release of the new Adult Safeguarding Policy and Procedures.

2. Trusts should ensure that work capturing patient experience is included in their quarterly and annual reports to the HSC Board.

2.3 Awareness of Safeguarding Practice

The abuse of children or vulnerable adults can occur when a person is neglected, harmed or not provided with proper care. Raising awareness of abuse is one of the building blocks of effective safeguarding and not only enables staff within services to recognise and prevent it, but assists those at risk to recognise it and to seek help in protecting themselves.

For systems to be fully effective, all safeguarding arrangements must be promoted and not limited to the awareness of abuse. Staff must be familiar with the safeguarding structures within their organisation; understand their role and the roles of others; be aware of the policies and procedures; and know what action to take in relation to safeguarding issues. Similarly, patients and relatives should be made aware of the procedures and support arrangements associated with safeguarding.

Responsibility for safeguarding children and vulnerable adults is not specific to MHLD staff and applies equally across all services provided by the trusts. Information obtained during this review and also from the previous RQIA review of the Joint Protocol[6], demonstrated that trusts had clear lines of management accountability and corporate responsibility in relation to safeguarding children and vulnerable adults.

Whilst structures associated with the safeguarding of children and vulnerable adults are in place, they differ from trust to trust. Each trust has representation at board and director level; designated officers[7] and investigating officers[8] for vulnerable adults; and designated paediatricians and named nurses for child protection. The effectiveness of the structures was confirmed by evidence of clear channels of accountability and communication. All trusts were able to demonstrate how they reported information from service level to trust board, and externally to the HSC Board. This included general information, performance returns, case management, risk management, governance oversight arrangements and information on the discharge of statutory functions.

On adult wards, inspectors considered that staff awareness of the designated officer role was not fully understood. However, in speaking with staff during inspections it was clear to inspectors that awareness of the role still not fully developed, as a limited number of staff were unsure of, or unable to identify the designated officer. Of the staff who replied to the questionnaires, approximately 15% claimed to be unable to identify their designated officer. A

[6] RQIA Review of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults

[7] Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance, defines the Designated Officer as: The person within the Trust deemed to be responsible for the decision to proceed under the Adult Protection Procedures and for coordinating any subsequent investigation which takes place.

[8] Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance, defines the Investigating Officer as: The experienced and suitably qualified professional appointed by the Designated Officer to carry out an investigation of the alleged abuse as agreed at the Strategy Discussion.

similar view was expressed by visiting professionals, such as consultant psychiatrists, social workers and therapists. Staff perceptions of their roles in relation to safeguarding vulnerable adults varied and was clearly linked to awareness and understanding received through training. Staff who had received training considered that it was mostly effective in terms of raising awareness of their roles in safeguarding vulnerable adults.

Each trust was developing the role of the designated officer and also the role of the investigating officer within MHLD services, either in individual wards or in covering a hospital site. Inspectors considered this development to be beneficial in terms of improved communication, reporting and providing advice on adult safeguarding issues. The Northern Trust had the lowest number of designated officers, compared to other trusts. Its approach is to establish the number of designated officers proportionate to the level of safeguarding activity. The trust confirmed that the number of designated officers would increase if the level of safeguarding activity increased.

In relation to child safeguarding, the roles of designated paediatricians and named nurses were clear in all trusts and staff awareness was also very good.

All wards were noted to be proactive in promoting the awareness of child and adult safeguarding and had information regarding safeguarding displayed appropriately on notice boards. Posters and information leaflets were displayed at the entrance to wards to alert relatives and visitors. Policy and procedures and other information was available for staff in ward offices.

Training in Safeguarding Children and Vulnerable Adults

Awareness of adult safeguarding and knowing what to do in a safeguarding situation can be improved through experience. If staff are to be equipped to deal effectively with an adult safeguarding situation, they must be appropriately trained. Approximately 66% of staff across the trusts were trained in safeguarding vulnerable adults. At the time of the review, only 16 wards were found to have had all staff trained in safeguarding vulnerable adults, although training schedules were noted to be in place for those who had not been trained.

On children's wards, child protection training was considered to be an integral element in maintaining appropriate child safeguarding arrangements. However, inspectors identified 16 staff working on the wards that had not received child protection training or training in Understanding the Needs of Children in Northern Ireland (UNOCINI)[9]. Inspectors expressed concern about this and recommended that all staff working on children's wards are appropriately trained in child protection

[9] UNOCINI Guidance - Understanding the Needs of Children in Northern Ireland (Revised 2011)

Knowledge and Awareness of Policy and Procedures

Effective adult safeguarding is unsustainable without appropriate guidance or policy and procedures. Arrangements for ward staff to access adult safeguarding guidance, policy and procedures were in place, with information being maintained and accessible either in hard copy or electronically via the trust's intranet. Inspectors identified that supporting procedures, such as the joint protocols[10] for investigations for both children and vulnerable adults and procedures for reporting and responding to allegations made against staff were absent from 15 wards across the Belfast (six wards), Western (five wards) and South Eastern Health and Social Care Trusts (South Eastern Trust) (four wards).

Staff awareness of each trust's policy and procedures for safeguarding vulnerable adults is an indicator of how alert an organisation is to the possibility of abuse occurring. During inspections, inspectors encountered a small number of staff in a few wards who claimed not to be aware of these policies and procedures. Even though it had been previously identified that not all staff across the trusts had completed safeguarding vulnerable adults training, inspectors considered that this was unlikely to be the primary contributing factor for the lack of awareness.

While trusts are taking positive steps in this area, inspectors considered that current regional guidance for adult safeguarding is not fully effective. Inspectors considered that the guidance was not up-to-date and did not reflect current best practice for safeguarding vulnerable adults. NIASP is in the process of developing a new operational policy and procedure. However, the delay in release of the revised guidance is having an impact on the ability of trusts to fully progress the adult safeguarding agenda at a local and regional level.

Guidance, policy and procedures for safeguarding children, the ACPC Regional Policy and Procedures (2005), were well established within all trusts and staff within children's wards were aware of them. Inspectors also observed appropriate policies and procedures specific to looked after children on the children's wards. The arrangements for staff on children's wards to access each trust's guidance, policy and procedures were considered to be effective, with information both available and accessible either in hard copy or electronically via trusts' intranets.

It was identified that supporting documentation on three of the four children's wards was outdated. Although these wards were aware of this, it was highlighted they had refrained from instigating any changes to documentation until the completion of the transfer of responsibilities and updated regional policies and procedures were available.

[10] The Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults and the Protocol for Joint Investigation by Social Workers and Police Officers, of Alleged and Suspected Cases of Child Abuse.

Policies and procedures to support adult safeguarding and child protection, such as policies for management of violence and aggression, restrictive practices and the use of restraint and physical interventions were in place across all trusts. The majority of staff across all trusts demonstrated an awareness of the supporting policies and procedures and how and where to access them, if required. However, on a small number of wards some of these policies were not up-to-date.

Effective awareness of safeguarding should not be limited to trust staff, but should include both patients and relatives. While wards were actively promoting safeguarding and raising the awareness through posters and information leaflets, many patients and relatives had little understanding or awareness of their respective trusts' safeguarding arrangements. On average, 42% of patients and 43% of relatives who responded during the review, claimed to be unaware that the ward had a safeguarding vulnerable adults policy. Inspectors considered patients and relatives should have been made aware of trust procedures in order to be able to reflect any safeguarding concerns.

Recommendations

3. Trusts should ensure that all staff working within mental health and learning disability wards are appropriately trained in safeguarding vulnerable adults.

4. Trusts should ensure that all staff working on children's wards within mental health and learning disability services are appropriately trained in child protection and Understanding the Needs of Children in Northern Ireland (UNOCINI).

5. Trusts should ensure that the awareness of their safeguarding structures and roles is fully promoted in all wards and ensure that this information is readily accessible to staff, patients, relatives and visitors.

2.4 Identification of Safeguarding Concerns

Determining whether abuse has occurred or not, can be a difficult task. To help to ensure effective safeguarding arrangements are in place, staff must be suitably skilled and competent in identifying signs of abuse and managing potential risks to vulnerable adults or children.

At the time of the review, inspectors were advised that about one third of staff had not received updated training in safeguarding vulnerable adults. While almost all staff were able to demonstrate good working knowledge and understanding of adult safeguarding and the types of abuse, a small number of staff were less able to demonstrate the same levels of knowledge or understanding. This was evidenced across all trusts during the inspection of wards.

The lack of ability to identify safeguarding issues was an area of particular concern to inspectors. Inspectors identified that on ten of the wards inspected, instances where safeguarding cases were not being classified by staff as a safeguarding concern. This meant that appropriate follow up and prevention mechanisms were not initiated. Such cases included patient on patient assaults or unexplained bruising. Lack of consideration of these incidents as possible abuse, was associated with what staff determined to be the threshold at which an incident should be designated as a safeguarding issue. In cases where a staff member is faced with doubt about a threshold decision, the appropriate course of action should be a referral to the designated officer for advice, but on occasions this did not occur. Nine wards received a recommendation in relation to the identification of threshold levels.

A lack of training was cited by some to be a contributing factor, however, not the only factor. Inspectors also found that a limited number of staff were unable to provide assurances that they fully understood safeguarding procedures and requirements, while others stated they did not feel confident in dealing with safeguarding issues, even after receiving training.

In light of this, inspectors considered that some aspects of safeguarding vulnerable adults training were not effective in providing staff with the understanding and confidence necessary to discharge their roles. A similar view was shared by a ward manager in one trust, who stated that clarification on the content of adult safeguarding training was required. Inspectors considered that the understanding of staff of the threshold level for reporting issues requires to be reviewed by NIASP.

Risk Assessment and Management

Identifying potential risks and putting measures in place to deal with them are crucial in the prevention of abuse. All trusts have systems in place to identify and manage risks to patients, which included the use of the DHSSPS 2010 guidance on Promoting Quality Care (PQC).

Patient files were reviewed in all trusts and it was noted that risk assessments and care plans were completed for all patients. There was also clear evidence of these documents being reviewed and discussed at multidisciplinary team meetings, with many instances of the patients being involved. Information provided by relatives indicated that some considered they were not being informed or kept up-to-date with what was happening on the ward. Although this was not the case in all wards, many relatives expressed dissatisfaction with the feedback they had received from staff.

While patients in all trusts had received a risk assessment following admission to the ward, inspectors identified that the comprehensiveness of the documentation varied considerably between trusts. Concerns included:

- risks had been identified and recorded, but sometimes subsequent management plans had not been recorded in the notes, or notes were not correctly updated
- records were not updated to reflect patients' changing circumstances
- occurrences of risks that were considered to be serious had not been reviewed in detail
- some risks were not being recorded within the risk assessment
- patient assaults on staff were not reported as a risk

Staff indicated that assaults from patients formed part of the job; however, inspectors considered this may also be an indicator of potential risk to others and should be reported. A strategy should also be put in place to review, manage and minimise the risk.

Although each trust was able to demonstrate they had risk management systems in place, inspectors considered that staff on at least eight wards were not adhering or fully using the policy and procedures. A risk management plan is considered to be a live document and should be regularly updated to reflect any changes in patients' assessed needs and risks. Inspectors concluded that while the initial stages of the risk management process were being adhered to in all trusts, follow-up actions to update these documents were not always occurring. In the absence of updated and accurate patient documentation, arrangements to safeguard patients could be compromised.

All staff reported being aware of the risk assessment procedure. However, of the 345 staff across all trusts who replied to the questionnaires, approximately 61% advised of receiving training in how to carry out a patient risk assessment. While it is possible that not all staff would be required to carry out a patient risk assessment, inspectors considered this training would enhance their skills in the identification of risks.

Key indicators used in identifying child or adult safeguarding issues include accidents, incidents and near misses, where recurrences can highlight potential risks. It is important therefore, that trusts have in place procedures for reporting and recording accidents, incidents and near misses. Lessons can be learned from the analysis of these events which should be

disseminated to staff and used to inform changes in practice, policy and procedures.

Serious Adverse Incidents and Complaints

All trusts had policies and procedures in place for recording and reporting accidents and incidents, supported by accident and incident log books on the wards. Staff demonstrated high levels of awareness of the accident and incident reporting process.

Each trust had its own individual reporting process and demonstrated how accidents and incidents were regularly reported and discussed at respective governance meetings. Mechanisms to bring risks and concerns to the attention of the trust board/ senior management were also in place. Evidence of the analysis and learning being fed back to the wards was presented, and staff also confirmed that learning was discussed at staff meetings.

Inspectors identified effective accident and incident reporting processes in place across all trusts to complement their safeguarding arrangements. However, the effectiveness of these processes was, on occasions, comprised by the lack of application of the procedures by some staff on at least seven wards. In particular, the previously identified problem associated with the threshold level for reporting an incident of abuse resulted in cases not being entered into the safeguarding process. These cases were not being investigated and learning from them could not be identified and shared appropriately with staff.

Other indicators applied to the identification of safeguarding issues include the concerns and complaints received from patients, relatives and staff. Information of this nature can highlight issues or cases of abuse never previously identified or reported. When patients, relatives or staff have a concern or complaint they should have access to the organisation's complaints procedure.

The arrangements for complaints were well established in all trusts, with policy and procedures in place in all wards, supported by robust recording and reporting mechanisms. All staff demonstrated a high awareness of the complaints procedures. However, just under 50% of staff who responded to the questionnaire indicated that they had received complaints training. The high levels of awareness in this area were attributed to staff experience of managing complaints over the years.

Inspectors considered that effective arrangements were in place for the handling of complaints in order to provide patients, relatives or staff the opportunity to have their issues addressed. However, awareness and access to the process needs to be addressed. It was identified on the majority of wards visited, that information regarding the complaints policy was displayed and was available either on a poster, in leaflets or both. Information regarding complaints was also included in the information packs provided for patients and relatives on admission. Even though this information was readily

available, patients and relatives still reported having low awareness. Of the wards inspected, 17 received a recommendation in relation to promoting the complaints procedure with patients and relatives. Of the remaining 16 wards, only a small number demonstrated evidence of being proactive in the promotion of the complaints procedure. Inspectors were unable to determine a reason for low levels of awareness of the complaints procedure among patients and relatives and considered this as an area the trusts should investigate further.

The awareness of whistleblowing and cases arising from it are becoming more prevalent and offers a further opportunity for the identification of safeguarding issues. All trusts have a whistleblowing policy which was observed on all wards visited and all staff indicated a high awareness of the policy. While inspectors considered that effective arrangements are in place in relation to whistleblowing, they considered that trusts needed to update their whistleblowing policies to indicate that RQIA is a designated body under the provision of the Public Disclosure (Northern Ireland) Order[11] which staff can contact if they are concerned about abuse.

Recommendations

6. Trusts should develop in consultation with ward managers a mechanism to review the effectiveness of safeguarding vulnerable adults training.

7. Trusts should undertake an audit of practice to determine if all staff are robustly adhering to safeguarding policies and procedures.

8. Trusts should ensure that comprehensive investigations and risk assessments are carried out as required by relevant staff.

9. Trusts should ensure that risk assessment training is provided for all staff.

10. Trusts should ensure that all staff receive training in relation to the complaints policy and procedure.

11. Trusts should ensure that the complaints policy and procedures are clearly communicated and promoted to patients and relatives in a user-friendly format.

[11] The Public Interest Disclosure (Northern Ireland) Order 1998

2.5 Safeguarding Practice in Preventing Abuse

It is often difficult to prove that an abusive event has occurred and equally difficult to demonstrate that an abusive event has been prevented. Identifying what constitutes a successful preventative intervention is difficult to determine. It is for this reason that appropriate safeguarding prevention arrangements need to be in place. The prevention of abuse is preferable to supporting children or vulnerable adults after an abusive event has taken place.

Prevention is most likely to be effective where proper arrangements are in place such as: legislation and regulation; policies and procedures; training; awareness raising; information, advice and advocacy; interagency collaboration; and promoting the involvement of patients and relatives. However, the success of these arrangements will be determined by how well staff operate and adhere to them.

Appropriate recruitment and selection procedures are required to minimise the opportunity for unsuitable people to work with children or vulnerable adults. All trusts confirmed they had arrangements in place for vetting applicants, including carrying out pre-employment checks, requesting evidence of qualifications and registration with professional bodies, the provision of written references, and Access NI checks. Inspectors found these arrangements to be evident as protective measures in preventing unsuitable applicants from being employed by the trusts.

Good organisational practice requires a thorough induction process. In all trusts, new staff were required to undertake both a corporate induction and a local ward induction. Three trusts advised that the induction process included information on the trust's safeguarding arrangements. However, in the South Eastern and the Northern Trusts inspectors noted that safeguarding was not included in the corporate induction process. Inspectors considered this should be addressed, and safeguarding included as an integral part of all trusts' induction programmes.

Ward inductions tended to include reference to safeguarding arrangements. Evidence of the use of an induction checklist was observed on the wards. The only notable exception was in one ward in each of the Belfast and Western Trusts, where adult safeguarding was not observed to be part of the induction process. From observation of induction processes on other wards, inspectors considered the arrangements to be effective, as they provided an appropriate introduction to safeguarding for all new staff.

Good management of staff will ensure that everyone on the wards is clear about their roles and responsibilities in relation to safeguarding. Alongside the daily management responsibilities, supervision and appraisal should be available to assure the trusts that staff are carrying out their work to the required standard. Supervision is also essential to ensure that staff feel supported.

All trusts were noted to have policies and procedures in place for supervision and appraisal, although it was only in approximately half of wards visited that both processes occurred on a regular basis in line with the trusts' policies and procedures. Feedback from staff in these wards confirmed that regular supervision is offered and staff stated they felt supported by the ward manager. However, in 17 wards it was observed that no regular supervision was offered, or no supervision was taking place.

Appraisals had taken place in the majority of wards, with the exception of five wards in the Western Trust, where the absence of appraisals had been confirmed by staff. The Western Trust advised that in one instance this was due to no permanent ward manager being in place.

Inspectors considered there were effective arrangements in place to facilitate appropriate supervision and appraisal; however, these were not being applied consistently in 17 of the wards inspected. Inspectors also considered that by not adhering to supervision and appraisal procedures there is a risk that safeguarding arrangements may be compromised by the failure to identify potential safeguarding issues and staff training needs.

For those staff receiving supervision and appraisal, the tools used to identify training needs included personal development plans and the Knowledge and Skills Framework. While most staff members were satisfied that their training needs were being met, there were a couple of instances where staff indicated this was not the case, with a few staff stating they had found it difficult to access appropriate training or be released to attend training.

Safeguarding practices were assessed in several areas on the wards to determine what arrangements were in place and whether staff were adhering to best practice guidance, policies and procedures. The areas covered included aspects of care considered under the following headings:

- the practice of seclusion and restraint
- protecting patients' money and possessions
- visitation of children to the wards
- admission of young people under 18 years of age to adult wards
- management of records and record keeping

These areas must be properly managed and controlled to prevent potential abuse occurring.

The Practice of Seclusion and Restraint

Inspectors examined the circumstances in which patients may be subject of seclusion and/or restraint, and the practice of close observation of both adult and children on wards. All trusts had policies and procedures for the management of interventions. Nine wards received a recommendation in relation to updating their policy on restraint, while on one ward within the South Eastern Trust, no policy on restraint was available.

Staff demonstrated good awareness of the need for documentation associated with close observation and restraint. Staff on two wards seemed less aware of the need to monitor seclusion and a recommendation was stated. The Southern and Northern Trusts advised of using seclusion as an intervention on a limited number of wards. Of the staff who responded in the questionnaire, approximately 49% advised of being trained in seclusion; however, this may be a consequence of seclusion no longer being practiced within three of the five trusts.

The numbers of staff trained in close observation and restraint was high, but not all staff had completed this training. Of the staff who responded, approximately 67% advised of being trained in close observation and 85% advised of being trained in restraint. To prevent unintentional abuse to patients, and to ensure staff are protected from inadvertently causing harm to a patient, inspectors considered that further training in this area is required.

The appropriate management of challenging behaviour could reduce the need for further interventions and limit the number of potential safeguarding cases. In the Western Trust it was noted that the use of de-escalation techniques had resulted in a reduction in the number of incidents of physical aggression. From the information provided by the five trusts, not all staff were trained in this area. The majority of staff were trained in de-escalation techniques and the management of challenging behaviour, the exception being the South Eastern Trust which reported having less than 50% of staff trained.

Throughout the trusts, it was observed that the application of policies and procedures for seclusion, restraint and close observation varied between wards. It was noted that the use of such interventions was only employed after discussion and agreement during multidisciplinary team meetings or after a risk assessment had been completed. A review of a number of patient records confirmed this to be the case and inspectors noted that staff were following the recommendations contained within patients' care plans. While there were areas of good practice, there were cases where the interventions had not been recorded or updated in patients' notes in eight wards and recommendations was stated. A concern was raised on five wards in relation to a small number of staff who were not adequately trained in applying behaviour intervention techniques on patients and a recommendation was stated. Since not all staff were fully adhering to the procedures and others were not fully trained, inspectors considered the arrangements for managing interventions could not be deemed to be fully effective.

Protection of Patients' Money and Property

While children and vulnerable adults are in hospital, protection arrangements should be in place to safeguard their property and possessions. It was recognised that this was a difficult area to administer and manage, a view reiterated by staff across all trusts.

Where children and vulnerable adults are incapable of managing their affairs, suitable arrangements must be in place to protect them from financial abuse.

Each trust has arrangements in place which govern the management of patients' money, which include policies and procedures and mechanisms for receipt and storage of patients' property, including personal finance. The majority of staff in all trusts were familiar with the arrangements for handling patients' money. Staff expressed concern that the processes were applied on a trust wide basis and were not specific to MHLD wards, and suggested that further clarification was necessary.

Each trust had its own policy and procedure to govern patients' property. Patients were actively discouraged from bringing valuable items onto the wards. This was considered a sensible approach; safeguarding patients' property effectively requires trusts to redirect staff resources away from patient care.

When patients deposit money, it is recorded in an inventory book and deposited in the ward safe, a locked cabinet or lodged in the trust's cash office. Each ward had arrangements to allow patients access to their money. Even though patients and relatives did not raise concerns about the arrangements in relation to patients' money, inspectors identified issues in relation to how patients' money was managed. Records of expenditure were not always maintained. In particular, inspectors identified that on some wards, patient finances were used to purchase furnishings for the ward, such as curtains and bed linen. Trusts advised that such items could not be given to the patients upon discharge. This matter was raised with the trusts following the inspections.

In the management of patients' property, wards provided guidance and information to patients and relatives upon admission, used an inventory book to record patients' property brought onto the ward and provided patients with locked storage facilities. Relatives were also requested to label patient's property and clothing. Even with these arrangements in place, staff found this a difficult area to manage and patients regularly advised of items going missing. A contributing factor to this issue was that clothing and personal possessions were brought to and from the wards by relatives, which were not recorded in the inventory books. In these circumstances, staff had no way of maintaining an accurate inventory of patients' possessions. Inspectors considered that trusts had put basic arrangements in place to safeguard patients' property but considered that unless patients and relatives fully adhered to the arrangements, it was difficult to see how the wards could be expected to achieve effective oversight of this area.

Although there were policies and procedures in place, as well as mechanisms to record the receipt of patients' money, inspectors considered the current arrangements were not sufficiently robust to provide effective safeguarding of patients finances. This matter is being closely monitored by RQIA. Inspectors also considered that guidelines on the use of patients' money needs to be further developed and communicated to all relevant staff.

Visits of Children to the Wards

Children visiting parents and relatives is central to maintaining normal family relationships. However, the best interests of the child must be paramount and taken into account when considering a visit. All trusts have incorporated this into their safeguarding prevention arrangements and it has been outlined in policies and procedures for children visiting MHLD wards. This was not fully reflected in the practice observed on some wards.

While many staff on adult wards demonstrated awareness of the procedures associated with child protection, there were instances where the procedures were not available on the ward and staff did not know what the arrangements were. There was a perception from some staff that they did not require extensive knowledge of child protection, as they worked in predominantly adult services. Inspectors considered that these staff had failed to understand the importance of child protection issues of children visiting adult wards.

The number of staff on adult wards trained in child protection varied considerably across trusts, with an overall average of only 50% recorded as having received child protection training.

Information provided in relation to children visiting adult wards included posters, leaflets and a patient information booklet. This information was only observed on some wards throughout the trusts. In the Southern Trust it was observed that risk assessments were carried out prior to the child visiting, to allow for suitable monitoring arrangements to be put in place. In the Northern Trust, there was a protocol that stipulated that all child visits were to be pre-arranged with the ward manager. However, staff advised that this was difficult to manage as relatives did not adhere to this protocol and often arrived at the ward unannounced.

The physical arrangements in place on the wards to facilitate a child visiting varied considerably. While many wards had separate rooms to accommodate such a visit, many had no visiting area and some visits took place in the manager's office or the patient's bedroom.

Inspectors considered that the arrangements for children visiting adult wards are only partially effective, due to the lack child protection training, staff understanding of the procedures and the lack of suitable visiting arrangements on the wards.

Admission of Young People Under 18 to Adult Wards

In accordance with best practice, all children and adolescents should be accommodated within age appropriate services, rather than admitted onto adult wards. During the period from November 2010 to November 2011, a total of 71 admissions of young people under 18 to adult wards were reported by the five trusts.

All trusts had policies and procedures in place for the admission of young people under 18 to adult wards and staff demonstrated high levels of awareness in relation to this. Evidence was observed of wards adhering to the relevant guidance from DHSSPS and of the arrangements put in place by the trusts for such occurrences. These included: one-to-one nursing care; admission to single bedded rooms; and close observation. Admission of young people under 18 to adult wards is categorised as a serious adverse incident and requires notification to external organisations. Evidence of notification of these incidents to RQIA was presented to inspectors.

Inspectors were concerned about the level of adequate child protection training in respect of arrangements for the admission of young people under 18 to adult wards. Of the wards which admitted young people under 18, only one ward in the Western Trust was recorded as having all staff trained in child protection. The lack of staff with appropriate child protection training in the other wards was considered a potential risk to the safeguarding of children admitted to these wards. Inspectors recommended that immediate action is required in relation to child protection training.

Management of Records and Record Keeping

As well as a requirement to implement best practice, the mechanisms that support robust safeguarding prevention arrangements, such as good records management, contribute in their own right to better safeguarding arrangements. Accurate recording of clinical outcomes, interventions, training and supervision help to ensure appropriate information is available for the purposes of patient care and also assists managers to identify gaps in staff capability that might impact on patient care.

Records management policies and procedures have been established in all trusts and schedules for auditing of records were identified by each trust. Staff demonstrated a high awareness of the procedures. However, information provided by staff indicated that on average, only 41% of staff had received records management training. In the majority of patient records reviewed, the notes reflected good record keeping, but there were some instances where information had not been recorded in line with trust procedures or best practice. In particular, discrepancies included: notes that had not been signed; risk assessments not being updated or completed; and interventions not having been recorded.

Records management procedures were also applicable to recording information about training, supervision and appraisal. Recording in this area was generally acceptable, with up-to-date information being maintained about staff training and the dates for supervision and appraisal. However, the review of records highlighted some gaps in mandatory training, out-of-date training and also that supervision and appraisal were not taking place. With such information readily available, the inspectors raised concerns in respect of the lack of application of training, supervision and appraisal.

While inspectors determined there were effective arrangements in place to facilitate best practice in records management, this area was only considered to be partially effective as there were too many instances where the procedures were not being followed.

Recommendations

12. Trusts should ensure that appropriate safeguarding awareness should be included in staff induction training.

13. Trusts should ensure that all staff receive regular supervision and appraisal.

14. Trusts should ensure that all policies and procedures associated with safeguarding are kept up-to-date and made available to all staff on the wards.

15. Trusts should ensure that staff are appropriately trained in the area of management of challenging behaviour.

16. Trusts should ensure that staff are appropriately trained in the areas of seclusion, restraint and close observation.

17. Trusts should ensure that only staff who are appropriately trained should employ restrictive intervention techniques.

18. Trusts should ensure that policies and procedures that govern patients' money and property should be reviewed and updated.

19. Trusts should ensure that all staff have received the appropriate level of training in child protection.

20. Trusts should ensure that all arrangements in place for children visiting or those admitted to adult wards should comply with child protection requirements.

21. Trusts should ensure that all staff receive training in records management.

22. Trusts should ensure that all staff adhere to the records management policy and procedures.

2.6 Response to Safeguarding Concerns

Even when organisations have arrangements in place to safeguard people from abuse, there can still be instances where abuse occurs. In such cases, it is the safeguarding response employed by the organisation that will determine whether appropriate action and support has been provided to individuals who may have been abused.

The response arrangements do not operate in isolation, or only when abuse occurs. These are intertwined throughout the policies, procedures and training, which are the mechanisms that enable staff to know how to respond following an incident of alleged abuse. The effectiveness of many aspects in these areas have been discussed throughout the report.

This section focuses on the arrangements for communication and the involvement of and support available for patients.

For people who experience abuse, the need to involve and work with other organisations is key in protecting them from further abuse. Promoting the welfare of patients is a joint responsibility that should be shared by a range of organisations. Engagement with other organisations was observed to be working well in all trusts. In particular, representatives from external organisations were represented on the RCPC, CPPs, NIASP and LASPs and were involved in serious case reviews. This was similar to the findings obtained during RQIA's Review of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (February 2012). Inspectors considered that the arrangements in place for liaison with other organisations were effective due to the multiagency approach, established lines of communication and regular meetings.

Each ward advised of promoting and communicating an ethos of inclusion and transparency to patients and relatives. While the majority of wards displayed a philosophy or mission statement either on the ward or in their information booklets, there were still a small number of wards where such information was not evident. It is therefore important to communicate a commitment to the principles of openness and transparency to patients, relatives, advocates and staff. Of the 33 wards inspected, 26 received a recommendation in relation to information provided to patients and relatives.

Although there was good communication throughout each trust, and externally to other organisations, inspectors identified that communication with patients and relatives was not always of an appropriate standard. Communication and involvement were also areas highlighted by both patients and relatives. While many felt they had received adequate communication, others were concerned about the lack of information regarding their relative’s care and about incidents that happened on the ward. Across all trusts, patients' notes identified that many relatives were being informed about incidents, but other patients' notes and reports from relatives identified this practice was not happening routinely on all wards.

The inclusion of patients and relatives was often referenced in patients' notes; however, there were cases in each trust where they were not represented during discussions about care practices. Recommendations for involving patients and relatives were applied to 15 wards. The instances of weekly meetings with patients and relatives were limited to a few wards in each trust.

In terms of openness and transparency, a concern raised by many relatives was their access to the wards to see where their relatives were staying. All visits were facilitated in side rooms or outside the ward, with the exception of only a limited number of wards, where relatives were permitted access to the ward. While this practice was to facilitate ward routine and reduce disruption, relatives viewed it as a lack of transparency. In some cases the ward manager facilitated relatives access to the ward, but this was limited. RQIA believes that an appropriate balance needs to be struck between assuring relatives of the comfort of the ward, including sleeping arrangements, without comprising the privacy and dignity of the patients.

Patients' access to information held about them was considered an area that was not well promoted in most trusts and was further reflected in the comments from patients and relatives. While the trusts advised of having policies and procedures in place, it was determined these were simply freedom of information procedures. The South Eastern Trust had additional information about accessing personal information made available to patients on the wards. Inspectors considered the current arrangements were only fulfilling the minimum requirements in respect of access to information and considered that trusts should be more proactive in informing patients of their rights.

Where patients, relatives or their advocates have concerns or complaints about any aspect of treatment or care, they should have access to the trust's complaints procedure. Although there was evidence of relatives being encouraged to make a complaint in some patients' records, patients and relatives claimed not to be aware of the complaints procedures. From the patients and relatives who replied during the review, approximately 53% advised of being aware of their respective trusts' complaints policy. In 15 wards throughout the trusts, there was no evidence of informing or promoting the procedures to patients or relatives.

While the trusts strived to have a culture of openness and transparency in safeguarding practice, this was not evident on all wards. Inspectors considered the arrangements to promote inclusion were not sufficiently effective, as 15 wards received a recommendation in relation to involving patients and relatives. Although many mechanisms were in place to facilitate best practice, they were not being fully applied.

Advocacy services can make a significant contribution to the prevention of abuse, by enabling patients to become more aware of their rights and facilitating them to express their concerns. The availability of advocacy services varied considerably across trusts and between wards. Most wards

were promoting advocacy services to patients and relatives, through leaflets and posters. In a few wards, where advocacy services were available, the ward was not seen to be promoting this service to patients or relatives. To improve the advocacy arrangements for patients, 16 wards received a recommendation in this area.

Advocates spoken to during the review confirmed the benefits of promoting the services and reported an increase in the number of consultations. While many patients had access to advocacy services there were still a number of patients who were unable to avail of this service. The most proactive wards had patient advocates attending on a regular basis.

Inspectors considered the trusts were making good progress in providing advocacy services, but this should be available to patients in all wards.

Recommendations

23. Trusts should ensure that a culture of inclusion of patients and relatives and transparency in communication across all wards.

24. Trusts should ensure that patients and relatives are, where possible, fully included in discussions about their care.

25. Trusts should ensure that patients and relatives are fully communicated with in relation to their care, and about incidents and accidents on the wards.

26. Trusts should ensure that patients and relatives on all wards have access to advocacy services.

Section 3 - Conclusion and Recommendations

3.1 Conclusion

This report presents an overview of the safeguarding arrangements in place to protect children and vulnerable adults in mental health and learning disability hospitals across Northern Ireland. The recommendations apply to all trusts even though some may already be compliant. All five trusts have made good progress in establishing effective safeguarding arrangements for both children and vulnerable adults, although inspectors found that the levels of progress varied both across trusts and between wards.

Wards, where a designated officer or safeguarding lead was based or spent a considerable amount of time, demonstrated higher levels of safeguarding awareness, more up-to-date training, and the application of policies and procedures was more evident. The role of the designated officer is invaluable in establishing and delivering more effective safeguarding arrangements. Local and regional groups were established to facilitate multiagency working and clear communication protocols were in place for staff to report any concerns about the safeguarding of vulnerable people. Through these groups, trusts are able to share information, and to work on regional initiatives to drive further improvements in safeguarding practice.

The overall governance arrangements in place to support effective safeguarding were considered to be robust, with clear management and accountability structures evident in both children and adult wards.

Generally, the trusts have successfully determined the main priorities for safeguarding and maintained a focus on meeting these. However, the areas requiring progression were the development of the new adult safeguarding policy framework and the transfer of responsibilities for children to the new SBNI. Once in place a clearer focus can be brought to further improvements in safeguarding practices.

Most staff were able to demonstrate a basic awareness of safeguarding issues, of policies and procedures and of the required reporting arrangements. Improvement is required to ensure that all staff are trained appropriately in vulnerable adults and child protection procedures; that all relevant policies and procedures are updated and implemented; and that staff are proactive in the promotion of safeguarding processes to patients and relatives.

Inspectors found that different thresholds and mechanisms are being employed by trusts to identify potential safeguarding issues, such as patient risk assessments, reporting accidents and incidents and in the promotion of training in the complaints procedures. Although procedures are in place to support best practice, their effectiveness is being hindered by the lack of implementation by some staff. Although complaints policies and procedures are in place, 53% patients and relatives indicated through the questionnaires

that they were not familiar with or aware of them. The complaints process needs to be promoted further with patients and relatives.

The reporting and analysis of accidents and incidents is being carried out, but inspectors noted that many incidents had not been considered as a safeguarding concern and subsequently were not appropriately reported. There was evidence of risk management of patients and of risks being discussed at multidisciplinary meetings; however, there were instances where further follow-up was required. Further training is required to drive improvement in this area.

All trusts had effective arrangements in place to prevent unsuitable people working with children or vulnerable adults. Policies and procedures for supervision and appraisal were noted to be in place in all trusts. Many staff reported they were supported by management, but there were still cases where both regular supervision and appraisal were only being carried out in half of the wards visited.

All trusts had policies and procedures in place to prevent abuse. In some instances trusts' arrangements for managing patients' money and property were not wholly effective in providing adequate protection of patient money and belongings.

Although there was evidence of policy and procedures in relation to deprivation of liberty, a number of concerns were evident. Inspectors found that physical restraint was being applied by a small number of staff who were not appropriately trained. Nine wards received recommendations on updating their policy on the use of restraint.

Procedures were in place for children to visit adult wards. However, inspectors considered that the current arrangements on each ward should be reviewed to ensure that child protection procedures are being consistently followed. Further staff training in child protection in both staff in adult and children's wards is required, and this was recognised by the trusts.

The arrangements for responding to safeguarding issues varied across trusts. While arrangements for working with other organisations were in place, the internal arrangements and communication with relatives requires improvement in relation to the types and levels of information provided to them. Both patients and relatives should be consulted and involved more in decisions about safeguarding and patient care.

Advocacy services were available to most patients and relatives; however, inspectors noted many wards did not actively promote the services to patients or relatives. 16 wards required recommendations in this regard.

RQIA wishes to thank the management and staff from the Health and Social Care Board, the health and social care trusts, and all the patients and relatives who agreed to be interviewed for their cooperation and contribution to this review.

3.2 Summary of Recommendations

1. The DHSSPS should prioritise the publication of the Adult Safeguarding Policy Framework to facilitate the release of the new Adult Safeguarding Policy and Procedures.

2. Trusts should ensure that work capturing patient experience is included in their quarterly and annual reports.

3. Trusts should ensure that all staff working within mental health and learning disability wards are appropriately trained in safeguarding vulnerable adults.

4. Trusts should ensure that all staff working on children's wards within mental health and learning disability services are appropriately trained in child protection and Understanding the Needs of Children in Northern Ireland (UNOCINI).

5. Trusts should ensure that the awareness of their safeguarding structures and roles is fully promoted in all wards and ensure that this information is readily accessible to staff, patients, relatives and visitors.

6. Trusts should develop in consultation with ward managers a mechanism to review the effectiveness of safeguarding vulnerable adults training.

7. Trusts should undertake a review to determine if all staff robustly adhere to safeguarding policies and procedures.

8. Trusts should ensure that comprehensive investigations and risk assessments are carried out when required by relevant staff.

9. Trusts should ensure that risk assessment training is provided for all staff.

10. Trusts should ensure that all staff receive training in relation to the complaints policy and procedure.

11. Trusts should ensure that the complaints policy and procedures are clearly communicated and promoted to patients and relatives in a user-friendly format.

12. Trusts should ensure that appropriate safeguarding awareness should be included in staff induction training.

13. Trusts should ensure that all staff receive regular supervision and appraisal.

14. Trusts should ensure that all policies and procedures associated with safeguarding are kept up-to-date and made available to all staff on the wards.

15. Trusts should ensure that staff are appropriately trained in the area of management of challenging behaviour.

16. Trusts should ensure that staff are appropriately trained in the areas of seclusion, restraint and close observation.

17. Trusts should ensure that only staff who are appropriately trained should employ intervention techniques.

18. Trusts should ensure that policies and procedures that govern patients' money and property should be reviewed and updated.

19. Trusts should ensure that all staff have received the appropriate level of training in child protection.

20. Trusts should ensure that all arrangements in place for children visiting or those admitted to adult wards should comply with child protection requirements.

21. Trusts should ensure that all staff receive training in records management.

22. Trusts should ensure that all staff adhere to the records management policy and procedures.

23. Trusts should ensure that a culture of inclusion of patients and relatives and transparency in communication across all wards.

24. Trusts should ensure that patients and relatives are, where possible, fully included in discussions about their care.

25. Trusts should ensure that patients and relatives are fully communicated with, in relation to their care and incidents and accidents on the wards.

26. Trusts should ensure that patients and relatives on all wards have access to advocacy services.

Glossary of Terms

Belfast Health and Social Care Trust (Belfast Trust)

Child Protection Panel (CPP)

Department of Health, Social Services and Public Safety (DHSSPS)

Department of Justice (DoJ),

Health and Social Care (HSC)

Local Adult Safeguarding Partnership (LASP)

Mental Health and Learning Disability (MHLD)

Northern Ireland Adult Safeguarding Partnership (NIASP)

Northern Health and Social Care Trust's (Northern Trust)

Promoting Quality Care (PQC)

Regional Child Protection Committee (RCPC)

Regulation and Quality Improvement Authority (RQIA)

Safeguarding Board for Northern Ireland (SBNI)

South Eastern Health and Social Care Trust (South Eastern Trust)

Southern Health and Social Care Trust (Southern Trust)

Understanding the Needs of Children in Northern Ireland (UNOCINI)

Western Health and Social Care Trust (Western Trust)

APPENDIX 1 - Types of Agencies and Establishments Regulated by RQIA

- Adult Placement Agencies
- Children's Homes
- Day Care Settings
- Domiciliary Care Agencies
- Nursing Homes
- Residential Care Homes
- Residential Family Centres

APPENDIX 2 - List of Wards Inspected

Trust	Hospital	Ward
Belfast Trust	Mater Hospital	Ward L
	Foster Green Hospital	Beechcroft Adolescent Unit
	Foster Green Hospital	Beechcroft Children's Unit
	Muckamore Abbey Hospital	Iveagh Centre
	Muckamore Abbey Hospital	Greenan
	Muckamore Abbey Hospital	Cranfield ICU
	Muckamore Abbey Hospital	Moylena
	Muckamore Abbey Hospital	Finglass
	Knockbracken Healthcare Park	Avoca
	Knockbracken Healthcare Park	Valencia
Northern Trust	Causeway Hospital	Ross Thompson Unit
	Holywell Hospital	Inver 3
	Holywell Hospital	Carrick 4
	Holywell Hospital	Tardree 1
	Holywell Hospital	Inver 4
	Holywell Hospital	Lissan 1
South Eastern Trust	Lagan Valley Hospital	Ward 12
	Downe Hospital	Downe Acute
	Downshire Hospital	Ward 28
	Downshire Hospital	Ward 29
	Downe Hospital	Downe Dementia Ward
	Lagan Valley Hospital	Ward 11
Southern Trust	Longstone Hospital	Sperrin
	Longstone Hospital	Donard
	Longstone Hospital	Cherry Villa
	Longstone Hospital	Mourne
	St. Lukes Hospital	Gillis Memory Centre
Western Trust	Lakeview Hospital	Brooke Lodge
	Lakeview Hospital	Crannog
	Tyrone and Fermanagh Hospital	Ash
	Lakeview Hospital	Strule
	Waterside Hospital	Wards 1 and 3

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