3.001

Belfast Health and Social Care Trust

Ennis Report

Investigation into alleged incidents reported on 8th November 2012 In relation to [redacted] H197

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1. INTRODUCTION

In July 2013 Esther Rafferty, Service Manager, Learning Disability commissioned Rhonda Scott, Senior Nurse Manager, Learning Disability Manager and Geraldine Hamilton, Service Improvement Manager, Mental Health and Learning Disability to undertake an investigation into incidents alleged to have taken place within Ennis Ward involving Belfast Trust employees. These allegations were reported to RQIA on 8th November 2012 by a care assistant from the Priory Group, Bohill Care Home who had been working on the ward as part of the resettlement programme for patients who were moving to the Bohill.

A joint Adult Safeguarding Investigation started immediately between the PSNI and the Belfast Health and Social Care Trust. This report details an internal investigation which followed the Adult Safeguarding Investigation and draws on information from the subsequent report which was completed in October 2013.

2. TERMS OF REFERENCE

1. To investigate allegations of abuse of vulnerable adults reported as safeguarding concerns raised in relation to H197 Band 5 Staff Nurse Bank whilst working in Ennis ward in October and November 2012

In addition the investigation team must:

2. Consider any other issues of concern relevant to the investigation.
3. Report any other matter which may undermine the investigation or any issues of concern not relevant to the terms of reference to the appropriate senior manager for action.
4. To make recommendations including referral for disciplinary action.

To support the investigation process the investigators were provided with:

- Witness statements
- Adverse Incident/ Accident Reports
- Minutes of Ward Meetings and Resettlement Meetings
- Adult Safeguarding Report with related interviews and minutes of meetings
- Briefing Reports post allegations by Moira Mannion, Co-Director, Education & Learning
- Duty Rotas (including rosters for Bohill Staff (Appendix 21)who worked on Ennis Ward)
- Shift Planner
- Daily Ward Reports
- Vulnerable Adult Referrals

- Patients notes/ Care Plans
- Medical Files
- Day Care Attendances
- Access to interview Ennis staff and Bohill staff who were still available

NB: B2 (Bohill) not available during entirety of investigation and declined to be interviewed when contacted via PSNI on 1st August 2014
B3 (Bohill) not available during entirety of investigation
B8 (Bohill) unable to contact
B9 Bohill) unable to contact
B10 (Bohill) unable to contact
B1 Bohill) did not attend for interview in spite of pro-active attempts to accommodate
H198 (Ennis) no longer a Trust employee, declined to be interviewed but provided written statement (Appendix 2)
H870 (staff on relief to Ennis on the 7th November 2012) no longer a Trust employee, declined to be interviewed but provided written statement (Appendix 3)

The following Bohill staff also worked on Ennis during this period. These staff made no allegations or raised any concerns during their time on Ennis but have since left the service and no contact details were available:

B11
B12
B13
B14

- Access to interview Ward Manager (Appendix 4) on Ennis during this period and Senior Nurse Manager responsible for Ennis Ward, Muckamore Abbey Hospital (Appendix 5)
- Access to interview Bohill staff, B4 (Appendix 6), B7 (Appendix 7), B5 B5 Appendix 8) and B6 (Appendix 9) who worked in Ennis at the time of the allegations.
- Access to interview H197 (Appendix 10), Bank Nurse and H159 (Appendix 11) Health Care Support Worker who were named in the allegations.
- Access to interview H205 (Appendix 12), H869 (Appendix 13), H203 (Appendix 14) and H206 (Appendix 15) Health Care Support Workers who worked in Ennis at the time of the allegations
- Access to interview H196 (Appendix 16) Student Nurse on placement in Ennis at the time of the allegations.
- Access to interview Moira Mannion, Co-Director, Education & Learning

- Access to interview Aine Morrison, Senior Officer, Adult Safeguarding Investigation Team and lead author of Adult Safeguarding Report

SCOPE OF INTERVIEWS

The interviews covered the themes below – with specific adaptation for those involved in the allegations:

- Induction processes
- Training
- Staffing (numbers, attitudes, team working, morale)
- Supervision
- The Environment (Physical and General Atmosphere)
- Resources
- Summary of allegations from Adult Safeguarding Investigation (Appendix 1)
- Reporting processes

3. ADDITIONAL EVIDENCES

- Duty Rota – confirmed all involved in investigation worked in Ennis (allegations as per Adult Safeguarding Report state the alleged incidences occurred between **9th October and 7th November 2012** – same information elicited and confirmed from interview with [redacted] (Bohill) 19th May 2014.

- Allocation Book – Inadequate skill mix on ward at time of allegations. Skill mix 60% unregistered: 40% registered staff; this was further reduced by registered nurse sick leave. No clear allocation of duties – this was corroborated in subsequent staff interviews. Clear evidence in Duty Allocation Book that the responsibility for the patients at the lower end of Ennis (where incidents were alleged to have taken place) was mostly with unregistered staff.

- Adverse Incidents/ Accident Reports – no evidence of under reporting; all correlated with entries documented in patient notes, daily ward reports and care plans. An increase in incidents was also noted from November 2012 until February 2013 – this correlates with a monitoring rota which was implemented post allegations (Appendix 17). Staff noted in interviews that the monitoring in itself was disruptive to the patients and this may have had a bearing on these statistics.

- Day Care Attendances from Ennis (Appendix 18). This information highlighted a significant number of cancelled Day Care places during the period the alleged incidents took place. These cancellations added additional pressure to a ward that was already short staffed. The attached attendance report also highlights staff shortages in Day Care Services around this time

- Minutes of Resettlement Meetings (Appendix 19)

FINDINGS

This was a complex and lengthy investigation. The Terms of Reference as noted above required the investigating team to look at the whole system i.e. the context of Ennis Ward within the wider Muckamore Abbey Hospital site, the managerial processes on the ward, staffing, practices and individual patient needs. All interviews are attached and conclusions/ findings are summarised under each term of reference as follows:

1. **To investigate allegations of abuse of vulnerable adults reported as safeguarding concerns raised in relation to H197 Band 5 Staff Nurse Bank whilst working in Ennis ward in October and November 2012**

The allegations listed below are from the Adult Safeguarding Report. For ease and consistency of reference the allegation numbers correspond to their chronological order in the Adult Safeguarding Report.

5. H197 MAH Staff, pushed P41 (patient) so hard into her chair that she hit her head off the back of the chair (Source: B2 Bohill Staff)

H197 interviewed re allegation. Question 15, Response: *"She P41 has involuntary constant jerking and hits her head off the chair frequently. She becomes agitated at times and this is an indication that she needs an enema. She has Bi-Polar Affective Disorder with associated mood fluctuation and self-injurious behaviours."*

H197 was asked how these behaviours managed at ward level. Response: *"We used the same chair for P41 and administered an enema once a week as was prescribed."* Question 16, Response: P41 *has a very unsteady gait and walks on her tip toes, when outside she would use a wheelchair. She positions herself into her chair but her upper and lower body movements would have caused her head to hit the back of the chair."*

H159 interviewed re allegation. Question 15, Response: *"Constant jerking movements and throws her head back when agitated. Has a problem with bowel movements which can cause agitation and needs enema to manage this. She can be aggressive can kick out and hit."*

H159 was asked how these behaviours were managed at ward level? Response: *"She loves music. You always worked to the side of her and she needs constant supervision."* Question 16, Response: *"In a wheelchair at times when off the ward. On ward when walking if needed used an elbow block and guided her with your hand on her back. She always settled herself into her chair."*

The following is an abstract taken from the 2nd Briefing Paper prepared by M Mannion 9th January 2013 (Appendix 22)

"Ergonomics trainer advised that staff need to position themselves in such a manner to reduce potential harm to themselves and patients, therefore patients with presenting jerk like behaviours will require a firm and appropriate paced manoeuvre personal to the individual patient. Also it was noted with patients who are potentially unsteady in gait and are perceived or known to be somewhat over weight this must also affect a change of manoeuvres, further acknowledgement of furniture which is set lowly (as it is in Ennis) although comfortable is also a feature of staff when required to assist and support movement of patients."

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) and H870 (Staff on relief to Ennis) however, H870 declared in her statement that she had not seen anything untoward during her time in Ennis.

In relation to the allegation made by B2 that H197 MAH Staff, pushed P41 (patient) so hard into her chair that she hit her head off the back of the chair the investigating team concluded that the allegation could not be substantiated

6. H197 MAH staff, said to P22 (patient) when P41 (patient) had attacked her "not to be a big softie and hit her back," (Source B2 B2 Bohill staff)

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) and H870 (Staff on relief to Ennis).

H197 s statement from interview re: this allegation as follows: *"On the day of this allegation P P41 went over to P22 who was lying on the couch P41 jumped up and down on P22 I went over and took P41 by her arm and elbow. P41 put her legs down on the ground and I walked her to another chair. B2 was at the window in the day room and her view of this was restricted as I was between her and P41 I put P41 into her chair and she settled herself as described earlier."*

H870 declined to attend for interview however provided a written statement on the 22nd February 2015 (Appendix 3) stating that she was allocated to the back dayroom alongside Ennis staff on the day in question. She worked on the ward from 9am to 12md. H870 stated that she worked alongside a community staff member during this period (Bohill).

In relation to the allegation made by B2 that H197 MAH Staff, said to P22 when P41 had attached her not to be a big softie and hit her back the investigating team concluded that the allegation could not be substantiated

7. H197 MAH Staff, pulled P41 (patient) into a standing position and shoved, nudged and pushed P41 towards her chair. (Source: B2 B2 Bohill Staff)

Refer to allegation 5

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) and H870 (Staff on relief to Ennis) however, Mrs H870 declared in her statement that she had not seen anything untoward during her time in Ennis.

The investigating team concluded that the allegation could not be substantiated

8. H197 MAH staff, was being rough with P39 (patient); grabbing the band of her trousers, turning her and pushing her away, pulling her back by the band of her trousers on a few occasions when P39 stumbled. (Source: B2 B2 Bohill Staff)

H197 interviewed re allegation. Question 12, Response: *"No. You would have turned P39 away by placing your hands on her shoulders and moving her that way. You would have moved her to de-escalate her behaviours."*

H159 interviewed re allegation. Question 12, Response: No never

B7 B5 B4 and B6 (Bohill) all interviewed re: this and no issues/ concerns raised by any of these staff.

The following staff; H196, H206, H205, H203 and H869 from Ennis were asked:

Did you witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing? Response from all staff was No

Investigating team unable to interview B2 (Bohill) B1 (Bohill Manager) and H870 (Staff on relief to Ennis) however H870 declared in her statement that she had not seen anything untoward during her time in Ennis.

The investigating team concluded that the allegation made by B2 could not be substantiated.

9. H197 MAH staff, told P39 (patient) that if she did not stop stripping, she would not be allowed any lunch.

Source: B2 Bohill staff.

The investigation team were unable to interview B2 or B1 (Bohill Manager)

B7 B5, B4 and B6 (Bohill) all interviewed re: this and no issues/ concerns raised by any of these staff.

In relation to the allegation made by B2 above, the investigation team were unable to substantiate the allegation.

10. H197, MAH staff told B2 Bohill Staff that if she continued trying to put P39 s (patient) clothes back on, she would do it all day and advised B2 not to be face on to P39 and to turn her away by the band of her trousers. (Source: B2 Bohill Staff)

Refer to allegation 8

The investigating team concluded that the allegation made by B2 could not be substantiated

12. H197 and H196 MAH Staff, ignored B2 s requests for help with P40 (patient). H196 did then respond. (source: B2 B2 Bohill Staff)

H197 interviewed re: allegation. Question 9, Response: *"I cannot remember I was administering an enema to* P41

H159 interviewed re: allegation, Question 9, Response: "*No"*

H196 interviewed. Question 5, Response: *"Can remember the staff from the Bohill but cannot recall her name. Conversation was that it was B2 s first day. B2 had stated that she had applied for nursing but did not get in. Cannot remember B2 asking for assistance. "*

H197 and H159 gave the investigation team a thorough account of their activities the evening this was alleged to have taken place. If B2 requested staff's assistance H197 and H159 it appears that they did not intentionally ignore this request. H197 cannot remember if she was asked but has stated that she was not in a position to leave the patient she was working with and H159 has stated that she did not hear this request. H196 stated she does not remember if B2 asked for assistance and cannot give any further information regarding this.

Investigating team unable to interview B2 (Bohill), B1 Bohill Manager) and H870 (Staff on relief to Ennis) however Mrs H870 declared in her statement that she had not seen anything untoward during her time in Ennis.

In relation to the allegation made by B2 above, the investigation team were unable to substantiate the allegation.

13. H197 MAH Staff – told B2 Bohill Staff who had just arrived on ward for the first time that she was going to the toilet and would be back soon. B2 left with patient for approximately 20 minutes, patients became agitated. B2 was assaulted and had no means of obtaining assistance. P39 (patient) had got faeces on her hand and B2 had no means of cleaning this or gaining access to the bathroom and had to sit holding P39 's wrist to prevent her from putting her hand near her mouth. When H197 returned, B2 asked if she could change P39 . She was given a key. She asked where the pads were kept and was informed they were in a cupboard. P39 's clothes had also got soiled. B2 did not know where P39 's bedroom was and stood at the door of the bathroom shouting for assistance before help arrived. (Source: B2 Bohill Staff)

H197 interviewed re allegation. Question 9, Response: *"I did not leave B2 for 20 minutes in the day room alone, H870 , relief staff, was in the day room with B2 when I left. When I returned P39 has faeces on her hand B2 took P39 to the toilet and H870 got P39 a change of clothes."*

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) and H870 (Staff on relief to Ennis).

H870 declined to attend for interview however provided a written statement on the 22nd February 2015 stating that she was allocated to the back dayroom alongside Ennis staff on the day in question. She worked on the ward from 9am to 12md. H870 stated that she worked alongside a community staff member during this period (Bohill).

In relation to the allegation made by B2 the investigating team have a statement from H870 to substantiate H197 s account.

16. H197 MAH Staff, grabbed P39 (patient), threw her on sofa and told her to get out of my f*ing face' (Source: B3 or B4 Bohill Staff)**

Refer to allegations 49 & 52.

Interview with B4 Question 7, Response: "*I seen two staff pull a patient up from the floor tighten her belt she was wearing, one nurse held her and said to her to 'get the fuck out of my face' and heavily pushed her onto the sofa. One of these staff was called* H159 *and* Description of H159 *the other staff was blond and called* H197 *who was banking that day.*"

If yes how were these issues addressed? Response: "*No did not raise these issues with Ennis staff*"

If not why not? Response: "*I did not know these people I was in a new environment. I reported these to my manager* B1 *at the Bohill the next day; this was then reported to* B1 B15 *The next thing the CID came to the Bohill to interview me.*"

When questioned B4 confirmed that she has attended Vulnerable Adults training prior to working in Muckamore and that this was around the second week in September 2012.

H197 interviewed and denied the allegation.

H159 interviewed re: allegation, Question 18, Response: *"Definitely not. May have changed my tone depending on the behaviours of the patients but never yelled or squealed at the patients."*

B7, B5, B4 and B6 (Bohill) interviewed and no issues/concerns raised d by any of these staff.

H206, H205, H203 and H869 from Ennis were asked:

Have you ever heard staff shout at P39 with a raised voice? Response from all staff was No.

Investigating team unable to interview B3 (Bohill) or B1 (Bohill Manager).

In relation to the allegation above, made by B3 or B4 the investigating team concluded that during interview B4 re-stated that this incident had occurred. The investigation team contacted Bohill on the 20th February 2015 @ 4pm to speak to B4 to seek her cooperation to proceed with this allegation. B7 informed the investigation team that B4 had a "*panic attack*" when informed that they wished to speak to her. B7 spoke to B4 and she reported on B4's behalf that B4 B4 would not take part in any further discussion in relation to the allegations. She refused to speak to the investigation team herself.

The investigation noted that B4 and B3 worked in Ennis during the 7th 8th and 9th October 2012. B4 stated during interview that she had reported this to her manager B1 the following day. The allegations were reported to the hospital on the 8th November 2012. The investigation team contacted the manager of the Bohill, B15; she has confirmed via e mail that these allegations were reported on the 8th November 2012 (Appendix 20)

49. 9th October 2012 (B3, Bohill Staff also there) H197 MAH Staff (a Bank nurse) and H159, MAH Staff (care assistant). P39 taking her clothes off – H197 got up and grabbed P39, who was wearing a hoodie, at the chest area, said 'get the f* out of my face', and pulled P39 over to the sofa and pushes her onto it. P39 got up again and tried taking her clothes off. She lay on the floor and**

took her trousers down past her hips. H159 and H197 got out of their chairs and lifted her up, pulled her trousers up, pulled her belt quite forcefully and pulled the belt tightly. H159 and H197 took an arm each and pulled other out of the living room. They walked her to the fire doors, opened them, put P39 outside where it was raining and closed the door (no handle on outside). Then they walked away. (source: B4, Bohill Staff)

B4 (Bohill) interviewed. Question 7, Response: "No I seen two staff pull a patient up from the floor tighten her belt she was wearing, one nurse held her and said to her to get the fuck out of my face and heavily pushed her onto the sofa. One of these staff was called H159 and Description of H159 the other staff was blond and called H197 who was banking that day."

When asked how she addressed what she witnessed she said that she did not raise this with any staff in Ennis. When questioned why she didn't speak to other staff in Ennis about this incident she responded: "I did not know these people I was in a new environment. I reported these to my manager B1 at the Bohill the next day, this was then reported to B15 The next thing the CID came to the Bohill to interview me."

When asked she confirmed that she had attended Vulnerable Adults training prior to working in Muckamore and that this was around the second week in September.

She was asked to confirm when she raised this as a concern and how it was addressed Question 8 and she responded: "I reported this the next day to my manager B1 this was then reported to B15 The next thing the CID came to the Bohill to interview me."

B4 (Bohill) Question 9, Response; "Yes on one occasion I seen staff pull P39 by her hoodie and place her outside in the garden." If so who was this staff member, Response; "Cannot be 100% sure may have been H159 This was the same day I seen staff pull P39 up from the floor."

Both H159 (Ennis) and H197 (Ennis) denied this allegation.

Anomalies identified by Investigating Team in relation to the above allegation as follows:

1. Timeline discrepancy to be accounted for as this allegation is similar to allegation 52 dated the 9th October 2012; however issues/concerns were not reported until the 8th November 2012. The investigation team have checked duty rotas and it was on the 9th October that B4 and B3 worked in Ennis, both of these staff were not on the duty rota for the 7th November 2012. B15, Bohill Manager has clearly stated that she was made aware of concerns/issues on the 8th November 2012 and in resettlement minutes dated 21st October 2012 it states clearly that B1 (Bohill Manager) was in attendance and highlighted no concerns.

2. Weather report checked with the Met Office for the 8th and 9th October 2012. Records show that it did not rain on these two days and the moisture content was low.

3. B4 during interview with the internal investigation team stated that she thought it was H159 who had pulled P39 by the clothing and placed her outside however in the allegations reported in the Adult Safeguarding it states that B4 had identified H197 and H159 as the staff members who allegedly did this.

4. Meeting 9th October 2012 in Erne with Community Integration Officer, ward sister of Erne ward sister Ennis Care Manager and Dr H19 no issues/concerns raised.

25/10/12 B1 expressed no concerns at meeting with H491

The Investigating team unable to interview B3 or B1 (Bohill Manager).

The investigating team were unable to substantiate this allegation and found some evidence to undermine its validity.

50. 9th October 2012 – P43 (patient) sitting outside on the grass and was soaking. B4 (Bohill Staff) asked H197 (MAH Staff) and H159 (MAH Staff) would she bring her in. H197 said she was alright where she was and that she had a wet suit if it got any heavier. (source B4, Bohill Staff)

Refer to Allegation 49

Anomalies identified by Investigating Team in relation to the above allegation as follows:

1. Timeline discrepancy to be accounted for as this allegation is similar to allegation 45 dated the 9th October 2012; however issues/concerns were not reported until the 8th November 2012. The investigation team have checked duty rotas and it was on the 9th October that B4 and B3 worked in Ennis, both of these staff were not on the duty rota for the 7th November 2012. B15 Bohill Manager has clearly stated that she was made aware of concerns/issues on the 8th November 2012 (Appendix 20) and in resettlement minutes dated 21st October 2012 it states clearly that B1 (Bohill Manager) was in attendance and highlighted no concerns.

2. Weather report checked with the Met Office for the 8th and 9th October 2012. Records show that it did not rain on these two days and the moisture content was low.

3. B4 during interview identified one member of staff, H159, placing P39 outside in the rain and in the allegation it states that B4 identified two staff doing this, H159 and H197

4. Different patient identified during interview

Investigating team unable to interview B3 (Bohill) or B1 (Bohill Manager).

The investigating team were unable to substantiate this allegation and found some evidence to undermine its validity.

52. 9th October 2012 8am -8pm. P39 was removing her clothing frequently and needing dressed. A bank nurse got up from her chair and said either "this is doing my head in "or "she is ****ing doing my head in". She grabbed P39 by the clothing at the chest and forcibly pulled her over to a sofa where she pushed her into the sofa. Later on P39 couldn't get her top off so she lay on the floor and was trying to get her trousers off. She had got them down a bit when the bank nurse and a care assistant got up and went over to her. They tied her belt very tightly and lifted her up and marched her to the back door beside the living room, opened it, pushed her out and locked it, leaving her outside by herself. The care assistant described as being in her 50s, really thin. The two staff left and went into the dining room. B3 let P39 back in. Bank nurse described as heavy set, brown or dirty blonde hair styled in a bob, wore glasses, said she was retired and was banking, would say she was in her 60s. (source B3 Bohill staff, worked 8am-8pm on 8/10/12)

Refer to allegation 49.

B4 (Bohill) interviewed. Question 10, Response: Yes I heard a staff say to a patient get the f*** out of my face. This occurred around lunchtime or the afternoon. This was the only time I heard abusive language.

B4 was asked If so who was this staff member. Response; H197 the Bank Nurse I had been talking to these staff so I knew their names. Stated she was in her 60's and her husband had passed away."

B4 during interviewed stated to the investigation team that she was not happy that B3 had taken off to Australia and that she was left to deal with all of this. She stated that she did not want to be involved and that she had been to her doctor as this was affecting her mental health. B4 stated that she would not be attending the pending court case if she got support from her GP. The investigation team are confident that if allegations involving B4 proceed to disciplinary hearing that she will not attend.

Meeting 9th October 2012 in Erne with Community Integration Officer, ward sister of Erne ward sister Ennis Care Manager and Dr H19 no issues/concerns raised.

25/10/12 B1 expressed no concerns at meeting with H491

B4 stated in interview that H197 said get the f*** out of my face. B3 as per allegations from Safeguarding Report stated this is doing my head in "or "she is ****ing doing my head in.

The investigation team found the anomaly relating to the time of the alleged incident and the confirmed reporting of the incident 4 weeks later to be of significance and passed this information to the PSNI.

The Investigating team unable to interview B3 or B1 (Bohill Manager).

In relation to the allegation made by B3 the investigating team concluded that the allegation could not be substantiated and as per allegation 49 there is some evidence to discredit it.

1. Limitations of Investigation Process

The investigation team would acknowledge that this investigation has had its limitations. The allegations were reported on the 8th November 2012 and immediately following this there was an Adult Safeguarding Investigation in joint protocol with the PSNI investigation. The Internal Investigation Team used the Adult Safeguarding Report as a frame of reference and with the exception of the recommendations to discipline 2 named staff, the general outcomes, conclusions and recommendations where similar. The Internal Investigation Team met with the Senior Officer leading the Adult Safeguarding Investigation in June 2015 to discuss these differing conclusions and acknowledged that some evidence given to the Adult Safeguarding Team from Bohill staff in December 2012 differed from evidence given to the Internal Investigation Team when they were re-interviewed in June 2014. The Adult Safeguarding Team also had access to interview 2 key witnesses one of whom declined to be interviewed by the Internal Investigation Team and the other was not contactable. The Internal Investigation Team also was able to interview staff directly involved in the allegations that weren't accessible to the Adult Safeguarding Team. The Senior Officer acknowledged this but re-stated that the recommendations to discipline 2 named staff remain valid.

This internal investigation commenced in September 2013 and was concluded in February 2015. The duration of the internal investigation was delayed due to a number of factors:

Reviewing patients notes, staff duties, accident and incident forms

Gaining access to the allegations

Gaining access to all parties' statements - the investigation team were unable to view the statements taken by the PSNI from Ennis and Bohill staff

Engaging staff in the investigation process

Some relevant staff who worked in Ennis in November 2012 have since left the service and the investigation team had to make proactive attempts to engage them in interviews

Interviews being cancelled and rescheduled at short notice

Staff who worked in the Bohill in November 2012 having left the service and the investigation team making proactive attempts to engage them in interviews – the Team Leader B1 cancelling appointment for interview on day they were scheduled to take place on three occasions.

To consider any other issues of concern relevant to the investigation .Report any other matter which may undermine the investigation or any issues of concern not relevant to the terms of reference to the appropriate senior manager for action.

1. **Induction**

The ward staff on Ennis all gave good accounts of what their expectations were of the Bohill staff and this had been communicated to them, however, Sr H491 had instructed the staff in Ennis to induct Bohill staff using the Hospital Induction book which requires to be completed over a period of 5 days. This proved difficult for staff to complete as Bohill staff only worked 3 days maximum and were not always there as per rota i.e. different staff names/sickness/changed.

The ward communication book was used to communicate induction requirements to staff and staff were familiar with this process, this was then recorded using the ward diary for each day of induction. Pen pictures and care plans were shared with the Bohill staff. Ennis staff had visited Bohill and the Bohill Team Leader, B1 attended resettlement meetings and was given information about the individual patients.

Band 8A staff report that they were in contact with the Bohill Team Leader over this period and the feedback was very positive, no issues/concerns were raised or identified. Ennis staff reported that some Bohill staff were not working with the patients transitioning choosing to spend time with other patients.

On examining staff records it is clearly recorded that staff on Ennis have received an Induction when they commenced work on the ward using the hospital induction booklet. The information elicited during interview highlighted that the quality of the induction received by Bohill staff was dependent on the member of registered staff completing this.

2. **Training**

The investigation team reviewed staff training records within Ennis. H197 had completed her mandatory training to include Management of Actual or Potential Aggression however she had not attended Adult Safeguarding training as was the same for other staff

on Ennis ward. There is evidence of continuing development and training for registered staff to provide a skilled and highly motivated workforce, the ward sister highlighted that additional training had been sought for registered staff on care planning.

H197 had no formal training outside of her nurse training on how to support people with behaviours that challenge and little or no other training outside of the required Trust Mandatory Training. The ward sister had completed the Trust Leadership programme which addresses the needs of good clinical and managerial leadership.

All staff on Ennis interviewed had a good understanding of their personal accountability. The Health Care Support Workers had limited understanding of the legislation as most viewed the use of the belt on one patient as not being a restrictive practice.

The investigation team noted that prior to the allegation Ennis was a nursing practice placement for student nurses. No students have raised any concerns within this placement and the ward is audited at regular intervals by Queens University as a suitable learning environment; last audit was in September 2012.

3. Staffing (numbers, attitudes, team working, morale)

It is evident from this investigation that there were significant staffing deficits on Ennis ward prior to the allegations. Sr H491 had reported her concerns about staffing to Senior Nurse Manager H377 and H77 and had completed incident forms on the 18/9/12 and 23/10/12 regarding staffing deficits on the ward.

Bohill staff have reported a perception of lack of staffing and Ennis staff also reported that this was a concern in the period before the allegations were made. The incident reports correlate with this.

The Senior Nurse Manager with responsibility for Ennis, Mr H377 was interviewed by the investigation team. During interview Mr H377 stated he was responsible for Erne, Ennis, Moylena, Iveagh and Night Staff plus he had input to Forrest Lodge during this period. He works eighteen and half hours per week. There were widespread shortages within the whole hospital site at this time and this was a regular agenda on the Senior Nurse Manager Meetings and Senior Managers meetings involving the Service Manager for the hospital. He reported to the investigation team that Iveagh at this time was his main concern and priority as it also had staffing shortages and given the location of this service, i.e. being geographically isolated from the main MAH site, it was difficult to staff as resources within the hospital were already stretched and staff did not want to travel to Belfast to work. At this time staffing was addressed on a day to day basis as no wards were in a position to release staff to work in other areas.

A meeting was held at the Millennium Centre on the 24.9.12 with Mr Veitch, Dr H50 Dr O'Kane, Mrs Rafferty and Mrs McLarnon to address the shortfall of staff within the site. It was agreed that Finglass would close sooner than anticipated to help address the staff shortage within the hospital. A meeting with Sr H491, Mrs McLarnon and Mr H377 was held the week prior to the allegations to address the shortfall of staff within Ennis. It was agreed that staff from Greenan ward would be released to work in Ennis to help alleviate the staff shortages within this ward.

Banking within the ward was carried out mainly by internal experienced staff or staff who had worked with this group of patients for a number of years. The majority of bank shifts used to cover the shortfalls within Ennis were booked directly by staff within Ennis and this resulted in staff time being taken up to cover these shifts.

Ward reports prior to the allegations were fairly static. When unfamiliar staff came onto the ward to work towards resettlement of patients, it was highlighted to Mr H377 by the ward sister that this had an unsettling effect on the patients. The resettlement process increased the workload within the ward in that additional assessments needed to be completed for the care manager, resettlement meetings etc.

Telford Assessment for staffing levels was completed for the ward. The 1st level of enhanced observations was included in the staffing ratio. Ennis had two enhanced level of observations so staffing should have been 6. Telford was reassessed post allegations and there were no big changes to staffing ratios. The Telford Assessments were completed by the Service Manager Ward Sister and Mr H377

Staff from Ennis who were interviewed stated that the staff team worked short staffed but they all worked together to help each other. Some staff stated that there they were stressed due to the shortage of staff. No staff raised any concerns or issues regarding attitudes, or morale, all staff stated they worked as a team.

Staff from the Bohill who were interviewed clearly stated the ward was shorted staff. Some said the staff were friendly and made them fell welcome; one said there was a clique on the ward and one said she was not made feel welcome, however, later in interview at a different question said staff spoke away and got on well together. One said staff in Ennis were 'lovely'. She stated the following in interview: "*The staff in Ennis worked really well together they kept the ward going. They knew what they were doing I could not praise the staff enough for the work they do. I was shocked when I heard the allegations about Ennis. They are excellent staff.*" Another staff said 1st day was good we were observing the staff on that day. Staff Nurse with long blonde hair just qualified gave us a very good induction Second day there was different staff on duty and the atmosphere was flat.

The investigation team concluded that the staffing levels impacted on the ward regarding the safety and quality of the care to the patients. The investigation team did not feel that there was a culture of poor attitude within the ward environment, however, the reduced staffing levels, challenging behaviours described and restricted ward environment would most probably have impacted on morale without the staff within the team realising this.

4. **Supervision**

Staff within Ennis all stated they had their Personal Contribution Plan and Appraisal completed. They all stated that they had no concerns/issues on the ward and the investigation team felt confident that the staff felt safe and comfortable to raise anything they thought was wrong. While some staff in Ennis had not completed their Safeguarding training staff were clear in their roles and responsibilities as they stated they reported behaviours etc. to the nurse in charge.

Sr H491 stated during interview that when Fairview staff came to the ward in 2010 KSF supervision was a new process for them and attempting to implement this within a busy, short-staffed ward was difficult.

Mr H377 Senior Nurse Manager, stated during interview that copies of team meetings were forwarded to him on a two to three monthly basis and that he was satisfied that Supervision and Appraisal processes were in place and occurred on a regular basis.

Families and other visitors were allowed access to the ward or individual patients' bedrooms. This meant there was opportunity for outsiders to observe daily living in the ward and limited the opportunity for a closed culture to develop on the ward, the ward was open and transparent.

The investigation team concluded from the evidence provided that staff had supervision and annual appraisals completed.

5. The Environment (Physical and General Atmosphere)

The ward as described by all staff interviewed was divided into two parts; the upper end of the ward where the patients who were more independent lived and the lower end of the ward were the patients (11) who were more dependant lived; these patients were mainly patients from Fairview and were transferred to Ennis when Fairview closed (2010). These patients' behaviours were challenging in that they stripped, pushed/shoved etc. It was in the lower end of the ward where all the incidents were alleged to have taken place.

The upper end of the ward was described by all staff as brighter with lighter paint work. It had artwork and the windows were draped. Each patient had their own individual personal items on display. One patient had a double room that had been converted into her own personal space with a settee and TV and this patient refers to this as her apartment. The lower end of the ward was darker in paint work, had no personal items on display, windows are not draped and many of the patients are in one room.

Physical changes had been made to the ward over the previous few years by Sr H491 these included:

Feb 09 – activity room created for beauty activity

Aug 09 – storage for kitchen. Re-decoration and 3 new shower rooms. Bathroom on ward was changed to create staff toilet and locker room

Aug 09 – New blinds

Jan 10 – Additional medication cupboard put up

Jan 10 – Snozelum Room created and swing

Oct 10 – highlighted that ward was small – reported challenging behaviours and requested fence which took a full year to get

Jan 11 - New flooring replaced

June 11 – re-painting of ward

June 11 – activity room turned into a second office, this was good for observation – other office doubled up as a visitors' room and office.

Staff on Ennis who were interviewed stated that they were informed of the changes but were not consulted. The investigation team were informed by all staff interviewed that the activity room being converted into an office had impact as it was missed by the patients and staff who previously could utilise this room to separate patients and do activities that helped to manage behaviours e.g. hair, nails etc.

A Bathroom was converted to a staff toilet and locker room and this also had an effect on the patients as they only had one bathroom left to use. When patient P198 became challenging this caused delays as the bathroom became blocked and other patients were unable to have their hygiene completed which caused them and staff additional distress.

The investigation team concluded that the wards physical environment did not meet the needs of the patients; the lower end of the ward was over-crowded; there was limited room

available for the patients and the behaviours they displayed. The conversion of the activity room resulted in patients being confined to one room in the lower end of the ward further impacting on behaviours.

The investigation team note that the ward was due to close in 2012 with the resettlement agenda therefore no major work was being commissioned for this ward.

6. Resources

The investigation team noted from interview with H377 that the resettlement wards, Ennis being one of them, do not have the same service delivered by Patient and Client Support Services (PCSS) as wards within the CORE Hospital do. Nursing staff on the resettlement wards still maintain the responsibility of bed making and laundry whereas in the CORE wards this is completed by PCSS staff. There were also limited resources from psychology Adult Behaviour Services (ABS) as these services were concentrated on the Core Hospital.

The investigation team spoke to ABS and their manager Mr H77 they stated that all referrals are forward to Mr H77 and that these are allocated to a member of the Behaviour Team, each behaviour nurse will then prioritise each case. In most case prioritising is based on the intensity of the behaviour presented i.e. high level of restrictive practice used i.e. Seclusion, Physical intervention and PRN medication. ABS confirmed that they had not received any referrals for P39 P40 or P43 pre the allegations.

Sr H491 stated during interview that patients from the Core Hospital who came to Ennis had Support Plans but that the other patients on Ennis did not have these and that they wouldn't be requested unless there was a significant change in a patient's behaviour. She stated that LD nurses are trained in behaviour and how to manage this and that generally challenging behaviours are managed by activities, however, she acknowledged that scope for activity was reduced due to low staffing levels.

The investigation team concluded that referrals for the behaviours described by the staff in Ennis should have been referred to Adult Behaviour Services.

7. Reporting processes

P39, P43, P40 and P41's care plans were reviewed; Roper, Logan and Tierney was the model used. The named nurse and associate nurse were identified and evidence of person-centred care including personal care needs, protection plans recorded, body charts completed, daily entries by registered nurses, multidisciplinary meetings/Community Integration meetings and entries in relation to accident and incident forms, Adult Safeguarding and Physical Intervention. There was evidence of multidisciplinary team working. The investigation team found that there was a description of the types of behaviour that patients displayed recorded in the care plans there was little detail in strategies for staff to manage or de-escalate these behaviours.

A record of physical interventions employed within the ward was reviewed, September 2012, October 2012 and November 2012, however, none of these was with any of the patients identified in the allegations.

The number of safeguarding incidents was reviewed by the investigation team from April 2012 to March 2013. It was noted that in November 2012 there was a dramatic increase in the number of referrals from an average of 3.57 for the period April 2012 to October 2012 to

an average of 22.4 for November 2012 to March 2013 (Appendix 23). This would be in keeping with reports from Ennis staff that the challenging behaviour of the patients increased with strange people coming onto the ward. The November 2012 data correlates with the monitoring commencing on the ward and new staff starting to work in Ennis. It is also possible that this increase post allegations represents previous under reporting. The investigation can only present these variables but are unable to identify a specific cause.

Review of Incidents/Accidents in Ennis was reviewed from April 2012 to March 2013. It was noted that in November 2012 there was a dramatic increase in the number of incidents from an average of 7.57 for the period April 2012 to October 2012 to an average of 30.6 for November 2012 to March 2013 (Appendix 17). This would be in keeping with reports from Ennis staff that the challenging behaviour of the patients increased with strange people coming onto the ward. The November 2012 data correlates with the monitoring commencing on the ward and new staff starting to work in Ennis. It is also possible that this increase post allegations represents previous under reporting. The investigation can only present these variables but are unable to identify a specific cause.

There was evidence on the ward of information sharing via the ward communication book and care plans in relation to visitors/carers/advocates, patient's requests and staffing levels.

Monitoring of the ward took place post the allegations; this was over a 24 hour period. This allowed for observation of staff interacting with the patients and practices on the ward. This supportive process gave a clear picture of what was happening on the ward and formed part of the reporting of risk management up through its governance. The investigation team noted on reviewing these monitoring forms that supervision and observations for patients were maintained. An area highlighted for concern was the ward environment i.e. overcrowding, décor.

Prior to the allegations there was an incident reported in May 2012 when a day-care staff reported a Band 2 bank nursing assistant who was working on Ennis Ward as handling a patient roughly and threatening them. This incident was investigated by the police who did not take any further action. Senior management undertook a full investigation and concluded that there was a case to answer, recommendations were sent to Human Resources but the member of staff left the employment of the Trust before disciplinary action took place. The matter was referred to ISA. This demonstrates that Ennis had accountability and governance in place.

In summary the investigation team noted a number of themes that, not individually, but collectively created a situation on Ennis Ward that created vulnerability for both the patients and the staff:

1. Reduced staffing levels across the entire service
2. Ennis' status as a Resettlement Ward – reduced support from PCSS as opposed to the wards in the CORE Hospital.
3. A cramped and dark environment in the lower end of the ward
4. Environmental changes being agreed that had a negative effect on patients and the staff managing the patients
5. Poor skill mix on the ward – i.e. staff working in the lower end of the ward were mostly unregistered staff
6. Poorly documented evidence based practice for managing/ de-escalating identified challenging behaviours

7. Lack of communication to and training of unregistered staff in understanding and being able to articulate the strategies that they were using to manage challenging behaviours

8. Lack of knowledge generally within the ward staff re: legislation around restrictive practices and their implications

The allegations as noted in this report were thoroughly investigated but in the majority of cases the investigating team were unable to substantiate these. During this internal investigation however, a number of statements given by Bohill staff and interpreted as 'incidences' were subsequently refuted by the staff. One allegation was re-iterated by B B4 (Bohill) during interview however, during interview B4 informed the investigation team that she was not happy that B3 had *"taken off to Australia"* and that she was *"left to deal with all of this."* She stated that she did not want to be involved in this case and that she had been to her GP as this was affecting her mental health. B4 B4 stated that she had hoped to be exempt from attending the pending court case with support from her GP but she was informed that this was not permissible and could result in legal action being taken against her. The investigation team do not anticipate the attendance or co-operation of B4 if the allegation she has made were to proceed to disciplinary hearing as she has refused to engage with the investigation team since her interview with them and has refused to take phone calls from the investigation team. Of note, the investigation team found evidence to discredit other allegations made by B4. The Senior Officer who led the Adult Safeguarding Report states that the recommendations made by the PSNI to proceed with a court hearing both H197 and H159 remain valid.

8. Recommendations

In view of the findings elicited through this process the investigation team recommend the following:

- An overview of this Report should be shared with all the staff involved. During interviews staff reported that they found the process of investigation immediately post allegations to be covert and unsupportive and for some this has had a lasting and negative impact.
- Immediate training for all staff on the legislation and use of restrictive practice
- Refresher training for all staff on manual handling techniques
- All care plans to be updated to include strategies for managing behaviours
- Mechanisms within the ward to be introduced to ensure all staff – registered and unregistered - understand and can articulate practices/ techniques employed to respond to patients needs e.g. MAPA, Manual Handling techniques, restrictive practices, diversionary techniques, de-escalating techniques
- A review of how future allegations are handled by mapping and reflecting on the process from 8th November 2012 to present
- Increased supervision for H491 and support re: roistering to ensure good skill mix and support for all staff

- Future stringent review and justification of any environmental changes on wards
- All staff to be made aware of Here4U and Staffcare services available to them for extra emotional support if needed.
- Adult Safeguarding Team to consider NMC referral for B1 Manager of Bohill at time of allegations to investigate non-reporting of incidents alleged to have taken place on Ennis on 9th October 2012.
- The internal investigation team are unable to support the recommendation to progress to formal disciplinary action in relation to the allegations made re: H197 due to the following:

  1. The internal investigation were unable to substantiate the allegations based on the available evidence
  2. Three witnesses from the Bohill were unavailable for interview (B1 , B2 and B3 .

9. Signatures

Signed_____

Rhonda Scott,

Senior Nurse Manager,

Learning Disability Manager

Date_____

Signed_____

Geraldine Hamilton

Service Improvement Manager

Mental Health and Learning Disability

Date_____

3.004d1

Appendix 1

REXEL Ref. 75650

REXEL ACCO

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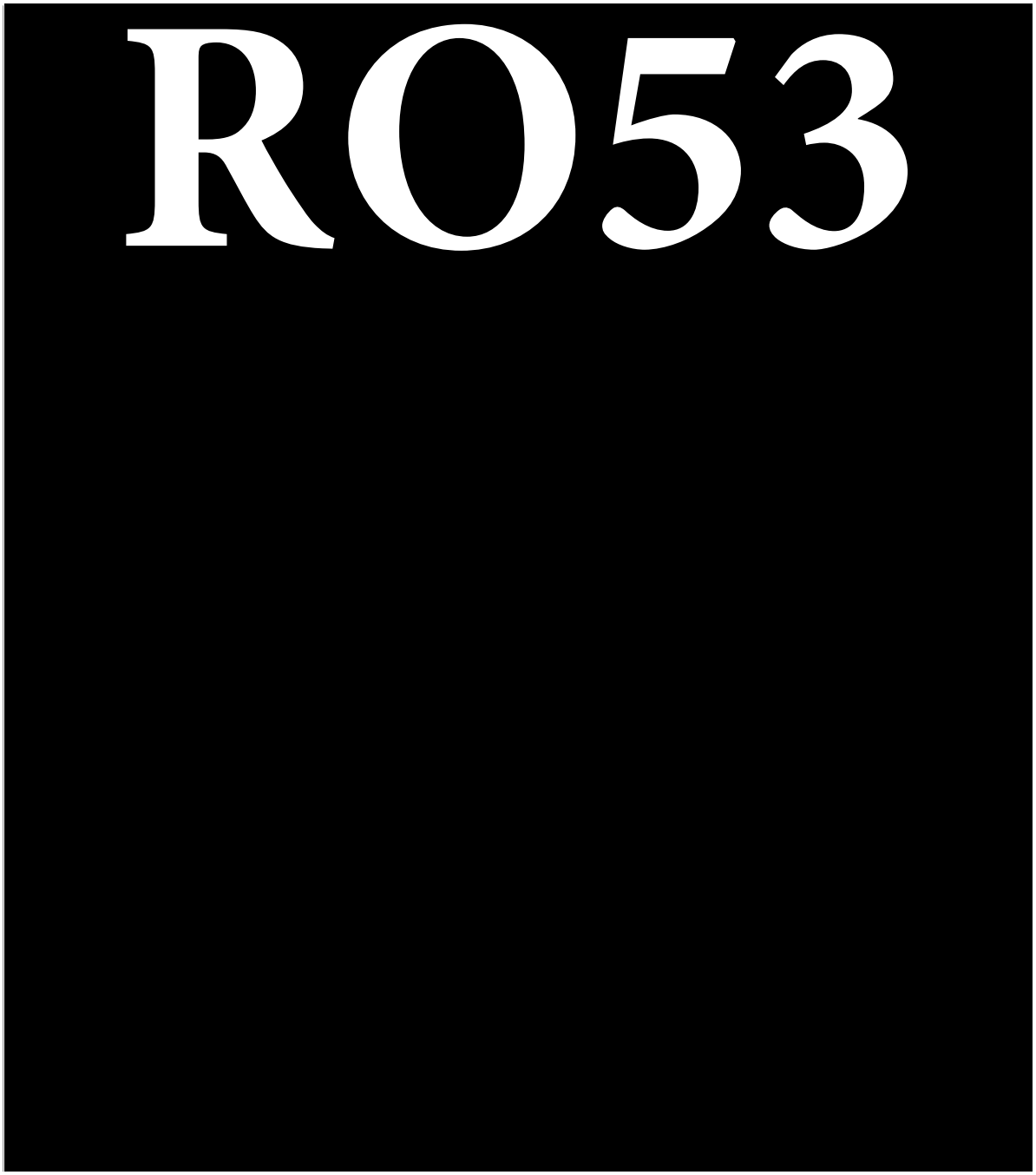
3.0057

Summary of Allegations under Investigation for [redacted] RO53
Taken from Adult Safeguarding Report

[redacted]

RO53


RO53

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Appendix 2

3.006

H198's address
[redacted]

Rhonda,

I will not be attending the disciplinary meeting on 16/4/14 as I no longer work for the Belfast trust on Muchamore Abbey Hospital.
My nursing Career was terminated on the gounds of my failing Ill Health which was exacerbated by events over the last 16 mths.

I am forwarding to yourself a Statement of events for 7/11/12.

Kinds Regards.

H198
[redacted]

(1) 8/4/14.

I have been nursing in Muckamore Abbey Hosp Since 80's and I have always maintained my professionalism throughout my career.

On the morning of the 7th Nov '12 I Commenced working E/H at 7.25am in Ennis to learn I had only one permanent ward staff one Barber and a relief staff from Erne. Altogether 4 staff when in fact I should have had 7 staff. There was then another relief staff from Oldstone at 9.30a

The student and the Priory Nurse Commenced duty @ approx 10am. The Priory nurse was in to shadow some of our ladies who were part of the resettlement process to the Priory in Coleraine.

The Student Commenced her own studies working in the front office. I introduced the Priory nurse to the staff down at the back end of the ward and asked them to keep the Priory nurse informed on what to do as I was extremely busy. I didnt get time to give her an introduction as I was dealing with many ward issues on that particular morning. i.e. Incident of Aggression, Family coming on ward to take their sister to an APP in A.A.H. and dealing with a Patients relative Per Phone. Altogether I had an extremely busy Stressfull morning. I Continued to carry out the remaind of my office duties for the morning.

Staffing levels dropped back down to 4 over lunchtime when the 2 relief staff left at 12.mid.

We Commenced giving out lunch and doing medicatio Another Inc occoured over lunch time which was dealt with by myself. The Ward was very noisy at this Period in time as workmen were in all morning Carrying out repair works to many of the doors.

The afternoon was much quitar. I worked on Some

Peices for the resettlement programme, The Privvy nurse took the opportunity to go through some care plans in the afternoon.

I again was busy after tea time typing up my report for the nursing office, Completing Progress and evolution sheets, Checking Patients money drawers and entering Bank slips on the Computer.

The staff were busy Putting away laundry and getting Patients ready for bed and giving out Suppers. The student and Privvy staff were Supernumery but did help after tea time at my request.

Another one occoured @ 8.pm which I dealt with accordingly and to the best of my ability.

Altogether I feel the day was stressfull but I had an excellent Ward team on duty who kept along with myself the Ward running Smoothly and so therefore I had no Concerns and was happy and Content all was well Considering the staffing levels were low.

our staffing levels were $\frac{4}{17}$ 7.30 - 9.30 $\frac{5}{17}$ to 12 and $\frac{4}{17}$ over lunch time and $\frac{5}{17}$ remainder of Pm. our staffing levels should have been 7 - 6 - 7.

There was also daycare Consultations morn & afternoon and as a result the ward was unsettled at different intervals.

I handed over to the night staff with no worries, reports, or Concerns from any member of staff on duty that day. I went off duty at 8.30Pm.

H198

3006d3

Appendix 3

REXEL Ref. 75650

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H870'S address
[redacted]

Dear Rhonda Scott,

From what I can recall on the day of question I was working in Ennis ward, on relief from ddstone I think the hours I spent in Ennis wae 9am - 12pm.

During the hours I spent in Ennis Ward I seen nothing untoward or unproffessional during that time. For the 3 hours I was in Ennis I was allocated to supervise the backdayroom alongside Ennis staff and then for a short while alongside a community staff member who was working with particular patients.

As I am no longer an emptyee of muckamore Abbey I would prefer to have no more contact regarding this issue. The information I have given is true to my knowledge and what I recall.

Yours Sincerely H870 [redacted]

3.007d4

Appendix 4

Notes of Interview with

H491

29th April 2014

Question 1

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you as the ward manager ensure the following;

Patient Safety

Highlighted staffing via e mails to line manager from May 2012 ie about incidences, safety, danger and the changing needs of the patients from 2008 to present.

Poor staffing Staff banking on top of their contracted hours in substantive post.

Could not do activities these are very important to decrease incidences. Used experienced staff to engage patients in activities to reduce incidences

Incidences increased when Bohill staff came to ward. Communicated with Duty Nurse Manager re staff shortages, Duty Nurse Managers changing every day which made this difficult

Wards working on safety levels. Telford was completed but this incorrect - Ennis worked below safety numbers. Highlighted this on the 12.10.12 to H77 via email as own Line Manager on leave

Current levels insufficient to run resettlement programme on ward

Incidences increased once monitoring commenced

Issues highlighted at resettlement meetings

2010 patients from Fairview moved over

7-8 referrals made to Behaviour Support Services

Changes in behaviours of patients highlighted in Care Plans

Patient P43 was allocated additional space on ward

We believed Ennis was closing Dec 2012 but still had a Bar B Que and Picnic in the summer of 2012

Staff Safety

Supervision was completed as and when it could be given – I try to be as approachable as possible to staff

In 2010 when Fairview closed the two staff teams amalgamated in Ennis which was difficult

Locked doors on ward – and patient P43 had extra area

Snozelum room

Meetings held on ward to bring team together every 2-3 months – topic covered were; waste, KSF, supervision, restrictive practices

Routines were reviewed constantly to look at safety, staff practices, allocation, standards, activities, policies, staff development – e.g.number of patients in dining room

ABS had no remit on Ennis but referrals were made re: P39 & P44?

Staff team were not used to working with behaviours

There was difficulty with staff sickness on ward

Specific management of patients was discussed one patient at a time and how to manage the behaviours

Staff handovers

The Resource Nurse was used to improve Care Plans from 2010 to 2011

Patients from Core Hospital caused anxiety amongst staff (P201 & P198

Safety alarms were installed

Security on ward re-looked at as ward not for challenging behaviours

Telford assessment completed – this resulted in working one staff down due to level of observations on the ward – worked on 7 staff pre- the Telford assessment but 6 was deemed safe. Telford showed 6 in the morning and 5 in the afternoon staffing levels. This was not completed by me but by H377 and Esther

There were no hotel services on Ennis which had significant impact

Skill mix allocation

Talked to Line Manager in Supervision regularly – I felt skill mix on ward was inadequate e.g. in August 2012 the only full time band 5 was on capability. There was always 2 qualified staff on duty then the rest were nursing assistants

It was agreed that night duty was to be covered in the first instance -the communication book was used for daily communication

Gave all band 5s turns at taking on new roles and responsibilities

There was a lot of staff sickness on ward this was highlighted in supervision and informal discussion

Duties were allocated by ward allocation sheet of which several versions had been tried

The rota was heavily subsidised by banking staff but they were predominantly ward staff which lead to tiredness and sickness

There was more enrolled nurses in Ennis than in any other ward and therefore there were learning issues such computers

Staff Rotation

Band 5 turn taking – i.e. band 5s all got opportunity to be nurse in charge

Staff rotated between front and back of ward

Duty rota shortages were covered by ward staff

One staff was re-allocated to anther ward as she got promotion

Ward Manager felt she was doing a Band 5 role

Small senior staff team taught other staff on ward

Patient engagement in activities

Activities ongoing on ward – gardening and cookery

Valentine's Day – Build a Bear

Easter Hunt every year

December 12 Ennis was to close and in Summer 2012 there was a Summer Fair on the Ward

Patients re: allegations lived in a more protective environment

Ward environment was not being maintained as ward was due to close however new floors were laid

Visits to Ramada Hotel

Visits to Nail Bars

The workload of staff in resettlement wards .i.e laundry, bed making

Engagement was ongoing but reduced due to staffing levels

There was an activity rota on the ward but not in individual care plans

There was a record on the ward of patient activities that H491 monitored

The ward vehicle was removed

Question 2

Was staff's annual appraisal, supervision and team meetings all carried out consistently within Ennis.

As much as possible I was not supernumerary

New to KSF supervision - Fairview ward came in 2010 – this was a new process for staff which they had to learn, this was hard to meet due to staffing levels

Question 3

Have any staff raised any issues with yourself regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that they were not comfortable with pre the allegations.

One staff raised her voice and this was reported by a Band 3 to me. I witnessed this and spoke to the staff member – this was documented and monitored

Band 5 nurse – this was addressed

If yes how did you address these issues

Re: Band 5 - Spoke to staff, recorded and documented, monitored the behaviour and no further issues appeared

Question 4

Please tell us how you monitored staff's practices, attitudes and professional conduct.

That is my role

I monitor everything – my job is a problem solver. I monitor everything from patient happiness, safety, families and staff interaction

I identify problems and act upon these

Induction of staff, induction booklets

Clear expectations from Ward Manager outlined at meetings to all staff and followed up with email e.g. April 2011

Regular meetings

Monitored and addressed issues with staff such as motivation

Supervision – identified issues staff would have and talked about how to change things

Question 5

Can you explain the Induction that was in place for the Bohill staff and how this was disseminated to your staff team?

Staff knew through the communication book that they needed induction

Communication book relayed to staff that they had to go through the Hospital Induction Booklet with Bohill staff – Nurse in Charge or the 'back-up' nurse had responsibility to make sure this was allocated and done. This was not identified on an allocation sheet as staff knew to do this

B1 (Bohill Manager) attended resettlement meetings on ward pre the Bohill staff coming to work on Ennis – it was expected that she would give her staff information on working on Ennis and the patients they would be working with

When Bohill staff arrived on ward I got the impression that these staff were not experienced and that these patients needed a high level of trained staff and the Bohill staff were not trained and had limited experience

Bohill staff asked could they work with patients not identified for their service

Patients' behaviour changed when new faces arrived on ward

Question 6

Was there restrictive practice employed in Ennis

Yes – 2 doors locked most times – dining room and door near office were locked

At times the door at the back of the ward was locked to allow for personal hygiene

All in one suits were not allowed to be used on the ward – P39 wore a swimsuit – this was not deemed to be restrictive as it was not always worn and was used to maintain her dignity

A belt was used to hold up another patient's trousers but was not used to stop her stripping

If Yes how were these monitored and audited

Documented in Careplan re locked doors

Were these written in the patients care plans

Yes documented in care plans – not sure if P39's swimsuit was in care plan

Question 7

How were Behavioural Support Plans developed and how often where they reviewed?

Patients from Core Hospital who came to Ennis had Support Plans – other patients on Ennis did not have these

There was 4 handovers a day on the ward

Support Plans were not required until the patients' behaviour changed. LD nurses are trained in behaviour and how to manage this. Behaviours are managed by activities but these reduced due to staffing levels.

Question 8

Was there any CRA's completed for the patients in Ennis

No – except for the patients from the core Hospital- the CRAs came with them

The Consultant would not sign the CRAs as he felt they were for Forensic patients only – Ward Manager had brought 16 completed CRAs to be signed – these were not signed and he refused to look at them. Discussed this with Senior Management and Resource Nurse

I was unaware if CRAs were kept updated and reviewed by the Consultant

No MDT Meeting and Social Worker withdrawn in 2008 however we could call on them if required

When resettlement commenced in May 2012 annual reviews were discontinued – there was a high level of work with resettlement i.e. All About Me

Question 9

Was there any Risk Screening Tools completed for the patients in Ennis

They were competed for all patients but not agreed by an MDT as there was none and the Consultant refused to sign

Question 10

Did patients have it identified in there care plans their behaviours such as stripping, allegations

P197 and P40 – making allegations should be in their care plan

Stripping should be in their Care plans

If yes was it documented how staff where to manage these behaviours.

Yes it was expected to be

Ward Manager monitored care plans

If new behaviours occurred I would check Care plan to see if this was documented – if this was not documented I would either add this myself or leave message for Named Nurse to do this

Evaluation sheets read every day

Care plans audited by EQC

Resource Nurse offered additional training and support for Care plans

Question 11

Did Support Workers have access to the care plans and how often did they read them

They were encouraged to read them and to write in them. The nurse in Charge would be the one responsible to review this. Mostly NAs would not write in the care plans – it was generally left to trained staff

Question 12

There were environmental changes to the ward. Can you please tell us how you consulted with staff on these changes and what were the outcome of these changes for patients and staff?

Feb 09 – created activity room for beauty activity

Aug 09 – requested storage for kitchen – did not do this initially but then did. Requested re-decoration and 3 new shower rooms. Bathroom on ward was changed to create staff toilet and locker room

Aug 09 – ordered new blinds

Jan 10 – there was an extra medication cupboard put up

Jan 10 – Snozelum Room created and swing

Oct 10 – highlighted that ward was small – reported challenging behaviours and requested fence which took a full year to get

Jan 11 - New flooring requested – same replaced

June 11 – re-painting of ward

June 11 – activity room turned into a second office – this was good for observation – other office doubled up as a visitors' room and office – staff did not like this but I felt this was improvement for patients and staff

Ward was over-crowded

Is there anything that you would like to tell us that you feel would be helpful to the investigation

The 11/10/12 highlighted at resettlement meeting that patients' behaviour had deteriorated – Bohill staff arrived in 3s and 4s and did not adhere to rota issued to them re: their shifts. Also swapped shifts amongst themselves. If on sick leave they would report sick to the ward but not to Bohill. Male staff came onto ward who should have been in Erne

12/10/12 email to P77 re: staffing levels on ward saying resettlement could not conitune due to staffing levels

25/10/12 B1 expressed no concerns at meeting with H491

2/11/12 identified unsafe staffing levels to H377 Staffing was poor. Highlighted risks re: own health and well-being and how situation unmanageable – H491 on leave following this

ADDITIONAL NOTES

Interview with WD/SR H491

29th April 2014

Patient Safety

- Incident forms were completed with reference to 5 separate days reporting issues of patient and staff safety caused by staffing shortage. These were completed during my own time.
- Telford. Actual form devised Duty Nurse Office had incorrect information, no plus on ennis form indicating that no extra staff were to be provided for levels of supervision led to confusion amongst duty nurse managers
- SNM H77 informed Service Manager Mrs Rafferty of this who asked SNM H377 to discuss this with me following his leave
- Outside Garden party was attended by almost all patient's families and ex patients with community staff and other patients. SNM x 2 attended. Monies were provided by the trust for the hire of a marquee as this was also a Closing Party.

Staff Safety

Patient P43 had extra garden area fenced off, also built due to fact P39 and P30 would leave ward on occasion

Staff team were not used to working with SEVERLY CHALLENGING behaviours

Staff Sickness was discussed with SNM. Noticable rise from Oct 11 and explained that this was when patients from Core Hospital were transferred to Ennis

Specific Management of patients was discussed at ward meetings and opportunity given at daily handovers

Daily handovers – 3 minimum per day and introduced another for 6/11 worker when they came on duty.

Behaviour of patient P201 deteriorated only when Monitoring began. Patient begun to block doorways, removed her clothing and agitated others causing major disturbance to running of the ward re routines and reactions of peers. Ward staff and visiting could not walk through the ward feely, patients were more disturnbed. Staff were dealing with this whilst being monitored. What was being witnessed was not usual behaviour of patients in Ennis and there was less staff to who knew patients to deal with this.

Hotel Services in Ennis was minimal since core hospital opened. No improvement despite requests for extra staff. No bedmaking, assistance with breaks/suppers, laundry and putting away of linen. Required significant time. Service manager secured extra time for putting away of linen during this time.

Skill Mix Allocation

Sickness was not casual and was noted to have risen when patients came from Core Hospital

Ward Allocation – changed as patient need changed therefore a number of templates were tried

Enrolled Nurses – Had not been Named Nurses before, this required considerable and consistent direction from small senior team

Staff Rotation

One staff re-allocated was loss of senior staff who was one of two full time staff and was not replaced

No band 6 on ward

Patient Engagement in Activities

Had explained there was a Full Rota from Morning until nightime for all patients displayed which was followed.

Protective Enviroment provided at one end of the ward was described and photos evidenced provided of soft furnishings and high back chairs

Question 5

Staff were instructed to induct staff using the Hospital Induction book. A request was made in the ward Communication book. Staff were familiar with this process using the ward diary for each day of induction. As this induction is completed over a period of 5 days it became difficult for staff to complete as community staff only worked an of 3 days maximum and were not always there as per rota ie diff staff names/sickness/changed shifts.

Review meeting held, I explained the volatile nature of some of the patients in Ennis to B1 giving examples also requested that she would ask her staff to come to myself or other nic.

Visiting Community Staff read care-plans almost all day everyday, was told they declined to do activities with patients on occasions

Question 6

Explained that patients came to Ennis wearing all in one vests/suits and that It required significant work to change staff attitudes/behaviour and to encourage patients into other clothing. Also that there was significant amount of shopping for clothing/shoes and perfume in an effort to improve standards.

Re wearing of a swimsuit P39 – explained this was being discussed fully through MDT with B1 B1 present, the reason for this was explained to B1 current MDT considered this was necessary on occasions to maintain P39 dignity.

Question 7

Behavioural Support plans explanation was given that P42 P45 had one, P46 and P44 n process of.

Was explained that prior to investigation/presence of monitoring the behaviours of patients in ennis were not thought to have been severe.

By giving examples explained how the behaviours of the patients changed dramatically when monitoring begun explained clearly this was an artificial situation both what staff were trying to manage and what others may have perceived.

Also that ABS did not have a remit to work in Resettlement wards but we could make a referral if we deemed it necessary

Question 8

Risk Screening tools had been completed for all. CRA's for 7/8

Consultant declined to sign explaining he felt they were for forensic patients

Question 10

Phrase removing of clothes was used as opposed to stripping (staff had been asked to use this terminology also)

When reviewing incident forms I would then add newly denoted behaviours to cplan or leave message for staff to do this

Question 11

Nurse in charge responsible to ensure entries in care plans by nurse assistants were appropriate and to guide staff

Question 12

States staff did not like this - I had explained that I learned that one particular staff member did not like the change of office but she had not come to discuss this with myself at any point

Helpful to investigation

12/10/12 As before explained that SNM H77 shared my concerns with Service Manager who requested that SNM H377 would discuss them with me on return from his leave. Explained that this was done just before I went on leave and that some action was agreed at this point.

25/10/12 B1 expressed that she had no concerns at a Resettlement meeting with full MDT. I explained there are minutes available which evidence this. Also that this meeting was weeks after a date reported in local paper as to when alleged assaults had taken place.

I explained following no response from anyone regarding Incident forms I had submitted of a serious nature I had lost faith in the Incident Reporting System within the trust. I gave examples of how the system in the hospital prior to this flagged up issues immediately and action was taken as a result.

I explained on three occasions that I felt I was not being given enough time to answer the questions I was being asked in full.

RCN Michael McQuillan was present during this interview.

H491

August 2014

3.008d5

Appendix 5

3.009

Notes of Interview with H377

16th April 2014

Administration Building

Muckamore Abbey Hospital

Question 1

It is acknowledged that the ward worked with limited resources. How did you address the staff shortages?

I was responsible for Erne Ennis Moylena Iveagh and Night Staff plus I had input to Forrest Lodge during this period. There were widespread shortages within the whole hospital site at this time and this was a regular agenda on our Senior Nurse Manager Meetings and Senior Managers meetings involving the Service Manager for the hospital. Iveagh at this time was a main concern as it also had staffing shortages and given the location of this service it was difficult to staff as resources within the hospital was already stretched and staff did not want to travel to Belfast to work. At this time staffing was addressed on a day to day basis as no wards were in a position to release staff to work in other areas.

A meeting was held at the Millennium Centre on the 24.9.12 with Mr Veitch Dr H50 Dr O'Kane Mrs Rafferty and Mrs McLarnon to address the shortfall of staff within the site. It was agreed that Finglass would close sooner than anticipated to help address the staff shortage within the hospital.

A meeting with Sr H491 Mrs McLarnon and myself was held I believe the week prior to the allegations to address the shortfall of staff within Ennis. It was agreed that staff from Greenan ward would be released to work in Ennis to help alleviate the staff shortages within this ward.

The staff shortages was continually raised at meetings with Senior Managers. The staff shortages within the hospital was placed on the Risk Registar.

Question 2

As the Senior Nurse Manager was there annual appraisal, supervision and team meetings all carried out consistently with Ennis staff and did you get copies of team meetings.

Yes copies of team meetings were forwarded to me on a two to three monthly basis. I am satisfied that the above processes, Supervision and Appraisal were in place and occurred on a regular basis.

Question 3

Did the Ward Sister keep you fully appraised of patient activities, nursing staff levels and was there any risks highlighted to you.

Ward Sister kept me fully appraised of staffing levels within the ward on a regular basis. No risks were raised with me. There were a few issues with a few of the patients such as P198 and her epilepsy and Restrictive Practices these should be well documented within her care plan. Issues re patient P201 and her behaviours were raised by the ward sister. Prior to her moving to Ennis I did voice my objection to her suitability for the ward at our Senior Nurse Mangers meeting as this was a resettlement ward and P201 was a Delayed Discharge patient however regardless of this the patient did move to Ennis.

Banking within the ward was carried out mainly by internal experienced staff or staff who had worked with this group of patients for a number of years. Ward reports prior to the allegations was fairly static. When unfamiliar staff came onto the ward to work for the resettlement it was highlighted to me by the ward sister that this had an unsettling effect on the patients. The resettlement process increased the workload within the ward in that additional assessments needed to be completed for the care manager, resettlement meetings.

Telford Assessment for staffing levels was completed for the ward. The 1st level of enhanced obs was included in the staffing ratio. Ennis had two enhanced level of obs so staffing should have been 6. Telford was reassessed post allegations and there were no big changes to staffing ratios. The Telford Assessments were completed by the Service Manager Ward Sister and me.

Question 4

Within Ennis there was a proportion of shifts that was covered with banking did you monitor this and was any issues raised by the ward sister regarding this

Ward Sister raised issues re the banking within the ward on a regular basis and unfamiliar staff. A large % of the deficits were covered by experience staff who worked in Ennis, internal staff within the hospital or staff who had retired from the hospital and banked. Ennis was short staffed as was all wards within the hospital at that time. The majority of bank shifts used to cover the shortfalls within Ennis was booked directly by staff within Ennis this resulted in staff's time being taken up to cover these shifts.

The resettlement wards within the hospital do not have the same support as the Core Hospital wards i.e. PCSS Services put away laundry, bed making again staff time in Ennis was spent on these chores instead of with the patients. There were also limited resources from psychology ABS as these services were concentrated on the Core Hospital.

Question 5

Did you raise the shortage of resources with your line manager

On a regular basis. There were widespread shortages within the whole hospital site at this time and this was a regular agenda on our Senior Nurse Manager Meetings and Senior Managers meetings involving the Service Manager for the hospital.

Staffing shortages within the hospital was requested to be placed on the Risk Register.

Question 6

Have you ever had any issues raised with you regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices pre the allegations in Ennis.

There was one incident of an allegation from a patient about a staff member regarding the patient's cup. The patient later withdrew this allegation.

RQIA reports on Ennis were positive and Ennis was expressed as an area of good practice at Moylena's inspection feedback one year prior to the allegations.

The resettlement wards are environmentally not up to 21st Century standards.

No issues have been raised re staff attitudes, treatment of patients etc in Ennis.

If yes how were these issues addressed

The process regarding allegations was followed

Question 7

Will you explain the patient group that was in Ennis at the time of the allegation and any difficulties that this posed to the staff team?

The ward at the time of the allegations accommodated 17 patients. Patients P198 and P201 were two Delayed Discharge patients that moved from the Core Hospital into Ennis a resettlement ward; this changed the dynamics of the ward due to the challenging behaviour of these two patients.

The ward was divided into two; the more independent patients (approx 6) were accommodated at the front/upper end of the ward. These patients' behaviours would have been more physically aggressive. These patients would have had a better environment in that they had more individual rooms. The patients who were more dependant (11 patients) were accommodated at the back/lower end of the ward; these patients were mainly patients from Fairview and were transferred to Ennis when Fairview closed. These patients' behaviours were challenging in that they stripped, pushed/shoved etc. Patient P201 was accommodated in the back/lower end of the ward and some of her behaviours included stripping and blocking doors with her body. This patient's presence on the ward made a big change to the ward dynamics and may have impacted on the behaviours of the other patients in this area. P201 was a large lady and intimidating person. She would have stood at the door blocking entry and exit to the area particularly at meal times when there was additional traffic in the area. When the door was opened she would pushed through as she was very focused on food and the kitchen. Staff would have to use persuasion techniques to move her or navigated her to move.

Environmentally the ward was not good.

Is there anything that you would like to tell us that you feel would be helpful to the investigation

H377 demonstrated how to move a patient blocking a doorway by placing two hands on each shoulder and using a push/pull technique to move a patient left or right. This is a technique taught in MAPA on how to move patients. Staff in Ennis would have been trained in this technique when attending MAPA training. All staff would be up to date with MAPA training.

Any previous issues/concerns of this nature would have been addressed within the hospital in line with procedures.

3009d6

Appendix 6

3.0D

Notes of Interview with B4

19th May 2014

Priory Coleraine

Question 1

Can you please tell us what time and shifts you worked on Ennis Ward?

I worked from 8am to 6pm on Ennis ward I was only there for a short space of time I think I worked on the ward on the 6th to the 8th ?November cannot remember exactly the dates.

Question 2

Can you please tell us the Induction you had to Ennis Ward?

I was given limited information from Bohill management on the ladies in Ennis prior to going there. Given limited information on patient P39 and the wee lady who like to carry the cigarette paper. We were told we were going to observe staff managing the patients and to ask questions and then after a few days we were to work with the patients.

On the ward the Ward Sister spoke to me and B3 re the patients and introduced us to the patients and staff. We were given a set of keys for the ward. We shadowed staff who were working with the patients. We were given a good Induction and made feel welcome.

Question 3

Did you feel supported while working on the ward and did you get support from your line manager?

I thought that the staff was very good they gave us information on the patients. Staff took me with them when working with the patients; the staff knew the patients very well and gave me good information about them, it was amazing what they were able to tell me about the patients.

I felt supported by my line manager and was looking forward to going to work in Muckamore.

Question 4

What was your understanding of the communication that was given to yourself re coming to work in Ennis and how was this information disseminated to you?

B1 the manager, at one meeting, informed us that the patient's from Ennis Muckamore Abbey Hospital was to come to the Bohill. We were going to Muckamore to work with these patients and staff. Pen pictures of the patients were given to us. Initially we were informed that we were to shadow the staff at Muckamore.

Question 5

Did you read the identified patients care plans?

No. Did read care plans in Erne but not in Ennis I did not think I asked to read the care plans in Ennis did not think about this.

Question 6

Did you ask staff on Ennis for information pertaining to these patients and if so how useful did you find this?

Yes I asked about the likes and dislikes of the patients. Asked about had they ever tried P39 without the use of the swimsuit. Staff was very knowledgeable about the patients and gave me good information on them. I asked about other patients on the ward as well.

Question 7

Have you ever raised any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with?

No I seen two staff pull a patient up from the floor tighten her belt she was wearing, one nurse held her and said to her to get the fuck out of my face and heavily pushed her onto the sofa. One of these staff was called H159 and Description of H159 the other staff was blond and called H197 who was banking that day.

If yes how were these issues addressed

No did not raise these issues with Ennis staff

If no why not

I did not know these people I was in a new environment. I reported these to my manager B1 at the Bohill the next day, this was then reported to B15 The next thing the CID came to the Bohill to interview me. I have attended my Vulnerable Adults training prior to working in Muckamore this was around the second week in September.

Question 8

Did you raise any concerns with your line manager at the Bohill?

I reported these to my manager B1 at the Bohill

If yes when you did raise these concerns and how were they addressed?

I reported this the next day to my manager B1 this was then reported to B15 The next thing the CID came to the Bohill to interview me.

Question 9

Did you witness staff push and/or pull P39 items of clothing? If yes please describe what you witnessed.

Yes on one occasion I seen staff pull P39 by her hoodie and place her outside in the garden

If so who was this staff member

Cannot be 100% sure may have been H159 This was the same day I seen staff pull P39 up from the floor.

B3 went over and opened the door and let P39 back in.

This was reported to B1 my manger at the Bohill the day I reported the other incident Both of these happened on the one day.

Question 10

Did you witness staff use abusive language to patients on Ennis. If yes please tell us the words you heard.

Yes I heard a staff say to a patient "get the fuck out of my face". This occurred around lunchtime or the afternoon This was the only time I heard abusive language.

If so who was this staff member

H197 the Bank Nurse I had been talking to these staff so I knew their names. Stated she was in her 60's and her husband had passed away.

Question 11

Did you witness staff put a patient outside in the rain.

Yes

If so who was this member of staff

H159 I think was her name

If yes who was the patient

P39

If yes please describe the clothing the patients had on

P39 was wearing a hoodie and Jeans

If yes did you make any attempt to bring the patient back in

No B3 brough her back in immediately I did not say anything

Question 12

Did you hear staff say to patients what you were doing on the ward and if so what was said?

H491 Ward Sister) introduced me the first day Explained I was there to see the patients.

Question 13

How did you observe staff to transfer patients from one area to another?

Staff would have taken P39 s hand to move her other patients walked on their own Staff did not have to help them.

Question 14

How did staff on Ennis interact with the patients?

Staff spoke to the patients there was not a lot of interaction as the staff were very busy on the ward.

Question 15

What activities were the patients on Ennis engaged in and did you participate in these activities

Staff on the ward were busy I did not witness any ward activities. I mainly shadowed staff working with P39 She was hard to work with re her stripping, grabbing and attention seeking behaviours.

Asked what was the routine like at Meal Times

The patients were taken in small groups three I think at a time this was organised. P39 P39 was to go in for her meals as she would have over loaded her mouth and it took longer than the others to feed her as she needed help with feeding and drinking.

Question 16

Please describe how you found the atmosphere on the ward

The ward was very busy. Atmosphere was quite dull the ward décor was outdated with not much colour.

Atmosphere between staff was quite they got on with their work. The ward staff were stretched, staff were busy and the patients had many needs which was tough on the staff.

1st day was good we were observing the staff on that day. Staff Nurse with long blonde hair just qualified gave us a very good induction Second day there was different staff on duty and the atmosphere was flat.

Question 17

Have you attended any training in Physical Restraint such as MAPA?

Not MAPA prior to working in Ennis but did attend some form of PI training prior to working in Ennis cannot remember the name of it.

If yes please tell us when and what training.

Attended MAPA training a few weeks ago

Is there anything that you would like to tell us that you feel would be helpful to the investigation

No

3010d7

Appendix 7

3 011

Notes of Interview with B7

19th May 2014

Priory Coleraine

Question 1

Can you please tell us what time and shifts you worked on Ennis Ward

I was only there for a day and a half this was only if someone had to go to Ennis and did not want to be there on their own, I was there to work with the boys in Erne. I worked with B8 I think, on Saturday 6th in Ennis and I think the 1st

Question 2

Can you please tell us the Induction you had to Ennis Ward

We were to work with the patients prior to them coming to the Bohill to find out their daily routine, personal care, care plans etc to add to our own care planning. The first week was information gathering and for the patients to get used to us and us to them, this was to happen over several weeks.

There was not much of an Induction we arrived about 7.30am on the Saturday and staff were having a cup of tea in the dining room. We sat at one table and the Ennis staff sat at another table. We were told they were not expecting us until 8am. Me B8 and B10 were in Ennis that day. The Nurse in Charge was a big lady I cannot remember her name. We were not given any keys, there was not much chat with the staff and we did not feel very welcome. Erne was a different ward very welcoming

Question 3

Did you feel supported while working on the ward and did you get support from your line manager

I didn't feel supported on Ennis ward I felt a bit abandoned. We took a lady to the shower room she had on two pads from the night duty. We were shown were the pads etc were dept. There was not much information given to what was happening, staff what they were doing and went about this.

B1 line manager called at the ward to see how we were doing I reported to her that everything was fine.

Question 4

What was your understanding of the communication that was given to yourself re coming to work in Ennis and how was this information disseminated to you.

Our manager informed us that the patients were coming to the Bohill we were to go to Muckamnore to get to know the ladies, get the ladies familiar with us, read their care plans, learn how to work with them and commence our own care plans for the ladies.

Question 5

Did you read the identified patients care plans

Yes I did read the care plans the medical files were better but I was looking specifically at physical health.

Question 6

Did you ask staff on Ennis was for information pertaining to these patients and if so how useful did you find this

We would have asked the staff in Ennis about the ladies and they gave us advise. Regarding the other patients on the ward there was no explanation given to us on these patients on how to manage the behaviours and reasons for staff practices.

Question 7

Have you ever raised any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with.

I didn't have concerns when I was there the only thing was the pads which was more of a query than a concern.

If yes how were these issues addressed

If no why not

Question 8

Did you raise any concerns with your line manager at the Bohill

No I didn't raise anything I had no concerns. I was approached by line manager afterwards post the allegations. I was interviewed regarding the VA process I did not see any abusive practices.

If yes when you did raise these concerns

Question 9

Did you witness staff push and/or pull P39 items of clothing? If yes please describe what you witnessed.

No

If so who was this staff member

Question 10

Did you witness staff put a belt around P39

Cannot remember

If yes, can you explain how and why this was done?

Question 11

Did you witness staff throwing P39 's shoes away to occupy her or were you informed that staff did this?

No

Question 12

Did you witness staff use abusive language to patients on Ennis. If yes please tell us the words you heard.

No

If so who was this staff member

Question 13

Did you hear staff say to patients what you were doing on the ward and if so what was said

We did not really get introduced staff in Ennis showed us their rooms and we introduced ourselves

Question 14

How did you observe staff to transfer patients from one area to another?

Patients moved themselves

Question 15

You have stated that you were informed if you offer the patients too much attention they will want it all the time. Can you please tell us who said this when it was said and under what context it was said?

This was pertaining to one patient who was not moving to the Bohill. She was singing in the day room one staff said do not give too much attention to this. This was not a concern.

Question 16

You have stated that staff was putting on 2 pads at a time on a patient. When you queried this staff said to you patients were wetting too much. Can you please tell us

Who said this to you

This was not said by a member of staff in Ennis it was said by a member of staff Erne I believe when I was talking about it in this ward.

What context was this said in

It was said in the context that when a patient was incontinent they passed a large volume of urine. They was no concerns re this.

Question 17

How did staff on Ennis interact with the patients?

Ennis staff spoke to each other there was not much interaction between patients and staff. The music channel was on the staff were busy there was a lot going on there were patterns of routine there may have been more time in the afternoon for staff to interact with patients.

Question 18

What activities were the patients on Ennis engaged in and did you participate in these activities

None it was very un-stimulating

Question 19

Please describe how you found the atmosphere on the ward

The ward was segregated the dining room was the focus of the ward. There was two sides to Ennis the doors between each side was locked. The lower end of the ward was quite dark but this was the design of the building and the décor was very plain it was an institutional building. The staff spoke away and got on well together.

Question 20

Have you attended any training in Physical Restraint such as MAPA?

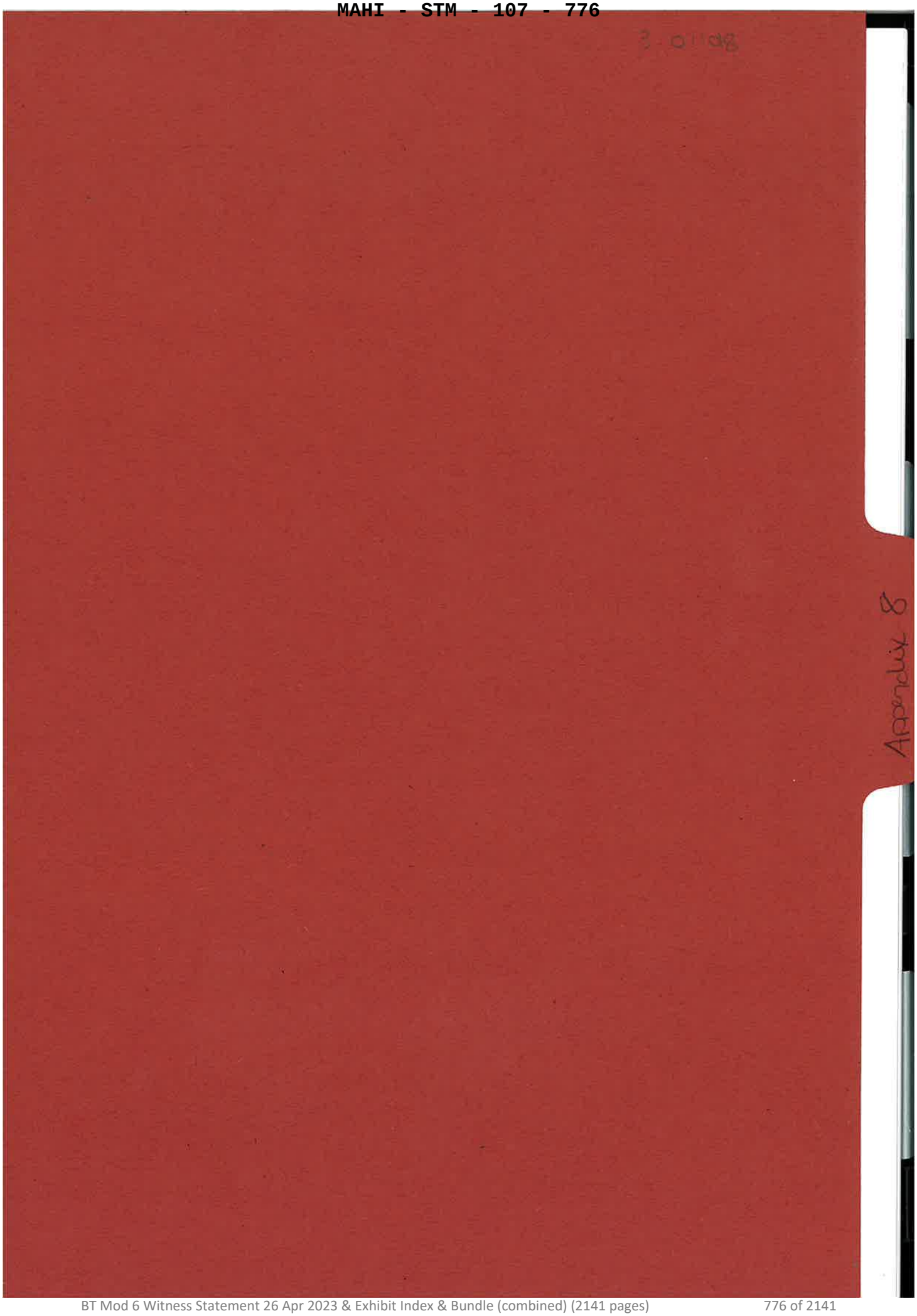
Yes

If yes please tell us when and what training.

Prior to working in the Priory worked in Muckamore and did my MAPA training there

Is there anything that you would like to tell us that you feel would be helpful to the investigation

I never seen abuse I think the building contributed to the allegations. Staff would have done what was right for the patients but may not have explained this to the staff from the Bohill. What the others witnessed sounds more like older practices. Our staff had little experience of Learning Disability especially Challenging Behaviour. They probably did not know what to expect and this may have been a shock to them.


Appendix 8

3.012

Notes of Interview with B5

19th May 2014

Priory Coleraine

Question 1

Can you please tell us what time and shifts you worked on Ennis Ward?

I worked a lot of shifts at Muckamore. Not sure of the dates I worked but will have them in my old diary. It was agreed that these would be e-mailed to R Scott.

Question 2

Can you please tell us the Induction you had to Ennis Ward?

We were going to Muckamore to shadow the staff working with the patients and we were supernumery. We were to get involved with the patients care when we felt confident to work with them.

I got a very good induction by Mary she was great.

Question 3

Did you feel supported while working on the ward and did you get support from your line manager?

Yes got good support from Ennis staff and my line manager at the Bohill Staff in Ennis were lovely

Question 4

What was your understanding of the communication that was given to yourself re coming to work in Ennis and how was this information disseminated to you?

We were going to Muckamore to shadow the staff working with the patients and we were supernumery. We were to get involved with the patients care when we felt confident to work with them.

Question 5

Did you read the identified patients care plans?

Yes I was on night duty one night and read the care plans They gave good detail and insight into the patients.

Question 6

Did you ask staff on Ennis for information pertaining to these patients and if so how useful did you find this?

Staff were really informative Staff kept me updated as we went along and worked with the patients.

Question 7

Have you ever raised any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with?

No

If yes how were these issues addressed?

If no why not?

No issues

Question 8

Did you raise any concerns with your line manager at the Bohill?

On one occasion there was rough handling of P39 I was commencing night duty and P39 was taken to a chair and a belt was put on quite tightly. I did not say anything as I was not sure if two staff were needed this was the only occasion.

If yes when you did raise these concerns?

How were they addressed?

Question 9

Did you witness staff push and/or pull P39 items of clothing? If yes please describe what you witnessed?

No

If so who was this staff member?

Question 10

Did you witness staff put a belt around P39 ?

I was commencing night duty and P39 was taken to a chair and a belt was put on quite tightly. One staff was 22 to 23 years of age with different hair colours the other one was older probably in her 40's.

If yes, can you explain how and why this was done?

I did not say anything as I was not sure if two staff were needed this was the only occasion.

Question 11

Did you witness staff throwing P39 s shoes away to occupy her or were you informed that staff did this?

I saw this twice in one day by the same staff member. P39 was on the floor and was stripping her clothes off. The staff member removed her shoes and set them to the side to divert P39 from stripping. This was acceptable for the staff to do this as it was used as a diversion for P39 to stop her stripping.

Question 12

Did you witness staff use abusive language to patients on Ennis. If yes please tell us the words you heard?

Not to patients sometimes amongst staff

If so who was this staff member?

Question 13

Did you hear staff say to patients what you were doing on the ward and if so what was said?

Nothing bad was said regarding this. I felt part of the Ennis team Staff were friendly and helpful I would apply for a job at Muckamore

Question 14

How did you observe staff to transfer patients from one area to another?

Staff would have held patients hands to transfer them.

Question 15

How did staff on Ennis interact with the patients?

Staff were good Patients were not left sitting staff interacted with them Staff were very calm and made an effort

Question 16

What activities were the patients on Ennis engaged in and did you participate in these activities?

None that I saw

Question 17

Please describe how you found the atmosphere on the ward?

The staff in Ennis worked really well together they kept the ward going. They knew what they were doing I could not praise the staff enough for the work they do. I was shocked when I heard the allegations about Ennis. They are excellent staff

Question 18

Have you attended any training in Physical Restraint such as MAPA?

Not sure will check diary

If yes please tell us when and what training?

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

No

3.012d9

Appendix 9

3.013

Interview Questions B6

19th May 2014

Priory Coleraine

Question 1

Can you please tell us what time and shifts you worked on Ennis Ward?

I worked in Erne for ½ a day I worked in Ennis 2 to 3 days as far as I can remember but I am not sure what month this was. I drove in one day with B7 and worked with her and one day with B13 and one day on my own.

Question 2

Can you please tell us the Induction you had to Ennis Ward?

A young nurse with long blonde hair did my induction. She was very nice and friendly. She showed me around the ward, informed of ward routines, informed me I was there to observe initially, introduced me to the staff and patients and answered any questions I had, She made me feel welcome.

Question 3

Did you feel supported while working on the ward and did you get support from your line manager?

We were told that we were going to Muckamore and that was it. There was limited communication given to us. Line manager was not really involved and I did not feel supported.

Question 4

What was your understanding of the communication that was given to yourself re coming to work in Ennis and how was this information disseminated to you?

We were told just to go up to get to know the routines, read the care plans and get to know as much as possible about the patients. Not really discussed with line manager, this was discussed among staff, it was identified on the duty sheet who was to go and that was it.

Question 5

Did you read the identified patients care plans?

Yes they contained good information and were useful. Care plans were given to us by staff in Ennis.

Question 6

Did you ask staff on Ennis for information pertaining to these patients and if so how useful did you find this?

Yes I asked questions staff were very helpful they seemed to know the patients well this was very helpful.

Question 7

Have you ever raised any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with?

No

If yes how were these issues addressed?

If no why not?

Staff pushed patients away from dining room door. Not sure that this was right or wrong.

Question 8

Did you raise any concerns with your line manager at the Bohill?

Yes re patients at window of dining room door how they were moved and them staring into the dining room. Did not think it was abusive how staff worked with the patients. Staff did not give an explanation on what they were doing when working with the patients.

If yes when you did raise these concerns?

I reported these the next time I seen my line manager but at his stage issues of concerns had already been raised about Ennis.

Would you have reported this if concerns had not already been raised?

No did not think it was abusive practices.

How were they addressed?

I was told not to worry about it, other things had come to light about Ennis and that this was being taken further.

Question 9

Did you witness staff push and/or pull P39 **items of clothing? If yes please describe what you witnessed?**

No.

If so who was this staff member?

Question 10

Did you witness staff put a belt around P39 ?

No

If yes, can you explain how and why this was done?

Question 11

Did you witness staff throwing P39 s shoes away to occupy her or were you informed that staff did this?

No

Question 12

You have stated that staff in Ennis would push P39 away when she came up and held your hand. Can you please tell us:

What exactly did staff say?

Staff said if you take her hand P39 will pull you around all the time. Staff knew the patients.

How did they remove P39 s hand from yours?

This did not happen No one took P39 hand away I allowed her to hold my hand.

Was there any reason given to you by staff on why they did this?

As stated above

Did you ask staff in Ennis why they did this?

Question 13

Did you witness staff use abusive language to patients on Ennis. If yes please tell us the words you heard?

No

If so who was this staff member?

Question 14

You have stated that when 2 patients emptied out all the laundry bags staff came in and shouted aggressively "who did this"? Can you please tell us:

Where you were at this time, what were you doing and where was the staff?

I was coming out of the office walking towards the bottom of the ward. I was not in the room I did not see the patient I only heard

Who were the two patients?

Do not know

Who were the members of staff?

Do not know did not see

What did the staff in Ennis do when a staff member made the assumption that a patient had done this?

Was walking towards bottom of ward when I heard this I could not see.

What did you do when staff allegedly shouted aggressively?

Walked on past

Who did you report this to at the time?

No

Question 15

Did you hear staff say to patients what you were doing on the ward and if so what was said?

Staff told me about the patients but I was not introduced to them I did this myself

Question 16

How did you observe staff to transfer patients from one area to another?

No did not see this

Question 17

How did staff on Ennis interact with the patients?

Staff were a bit abrupt but not all of them. Got the impression that they did not have much time for them. Staff on this day may have been having a bad day. Lunch time was stressful for staff on this day patients meals appeared rushed.

Question 18

What activities were the patients on Ennis engaged in and did you participate in these activities?

I helped with feeding patients, changing patients. I got a couple of patients changed and helped staff out when I could. The ward was busy.

Question 19

Please describe how you found the atmosphere on the ward?

Décor and age of the place did not help and it was not homely. Staff did not speak to each other very much Seemed to be a click of staff on the ward Did not feel that I could join them at breaks etc or join in on the conversations. Felt staff were a bit stressed out for no reason. This was on both my shifts.

Question 20

Have you attended any training in Physical Restraint such as MAPA?

Not while employed at the Bohill Have not done any training whilst at the Bohill

If yes please tell us when and what training?

Did this training while completing my degree training as nurse

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

No

If yes can you please give a description of the MAPA techniques employed?

Covering a patient's elbow or putting your hands on a patients shoulder to redirect them or turn them away. This was used with patients T McGrath and L McMullen.

Question 24

How would you describe the atmosphere on the ward within the staff team during this time?

The ward was very busy but we all worked well as a team and helped each other out, you looked out for each other. There was stress on the ward especially in the mornings as the workload was greater at this time and there was staff shortages.

Question 25

Is there anything that you would like to tell us that you feel would be helpful to the investigation

The ward was very short staffed. Nothing untoward happened on the ward. The staff from the Bohill did not want these three patients said there was other patients on the ward that they could take that had not been identified.

When H McFaul and I went out for a smoke she did not raise any concerns with me she talked to me about hair, nails etc.

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Appendix 10

3 014

Notes of Interview H197

12.5.14

Question 1

As a Bank Nurse in Ennis did you feel supported while working on the ward?

All the time

What supports were available to you?

The ward sister was a good support had previously worked with her in 2010. All the staff on the ward were a great bunch.

Question 2

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you ensure the following?

Patient Safety

Your duty of care was to the patients. You had to work faster made sure you prioritised your care of patients. One staff that morning was on a relief staff from another ward this was a good help her name was H870 and she came from Oldstone. Group one patients were left in bed to allow the other patients to get their personal hygiene attended to. Then I and the relief staff worked together. Staff was usually taken from Ennis to go on relief to Greenan or one of the Core Wards.

Staff Safety

There were two patients on the ward who required level 3 observations. I usually worked on groups 2, 3 or 4 all these patients had challenging behaviour. We had to contain the patients by locking doors so that we could supervise them and observe them. I have nursed for 42 years and knew these patients. I never felt unsafe on the ward. The ward manager had risen issues regarding staffing on the ward and she was aware of the locked doors as this was at her direction. A lot of the trained staff time was wasted looking for additional staff to come into the ward to work to cover the shortfalls of staff. The nurse in charge would have prioritised the workload of staff to meet the staffing levels.

Was there Staff Rotation within the ward?

Yes there was staff rotation this helped staff to know all the patients; I worked in all areas of the ward although staff who knew the patients generally worked with these patients. The behaviours of the patients increased when there were strange people on the ward.

Was there clear allocation of duties for each shift?

There was not clear allocation of duties on the 7.11.12 due to limited staff on the ward. There was only three staff on the day of the allegation, one staff to each area. I had changed duty to accommodate the staff shortages. Two staff was required for group 2, 3 and 4. Group 1 can dress themselves and need help with personal hygiene. At the start of each shift you were given a hand over. The nurse in charge on the day of the allegation did the breakfasts that morning she was on her own until 10am.

Was there scope for patient engagement in activities apart from day care?

The patients on the ward have severe Learning Disability and have Challenging Behaviour. Few of the patients would engage in activities, one patient was blind. P39 P39 threw items out the window, P201 stripped of her clothes lay on the floor and defecated, other patients had ADSD. There was no time to engage patients in activities as there were staff shortages. Group 2 patients had their own TV, music colouring in books, spools etc. One patient in the bottom areas had PICA. Main role was to supervise the patients and maintain their safety due to staffing levels. Ward did have a bus but could not be used due to staffing levels.

Question 3

As a Bank Nurse did you have annual appraisal, supervision and team meetings all carried out consistently with Ennis.

Did b=not attend meetings minutes of these were available. I attended all my in service training. I have no PCP or supervision in any ward.

Question 4

Have you ever raised any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with pre the allegations.

There was never anything to report. Is a good ward to work in and staff are good.

If yes how were these issues addressed

Question 5

Can you explain the Induction that was in place for the Bohill staff and how this was disseminated to you?

Bohill staff said they were there to familiarise themselves and to observe the patients. Nurses on the ward said they were to work with the patients. Nurse in charge said they were there to work with the patients. Bohill staff did not start until 8am at the earliest, I did not work with a lot of staff from the Bohill if they were asked they helped some of them were more helpful than others. I was informed of what Bohill staff were on duty that day by the nurse in charge. The staff from the Bohill arrived and came into the ward and sat down they had the opportunity to read care plans. The nurse in charge was doing the medication round which took two hours when they arrived so an Induction was not done then but this was done later in the shift I think. The strange people on the ward were unsettling for the patients.

Question 6

Can you please describe the behaviours that would be exhibited by patient P40 P40 ?

P40 displayed different behaviours from day to day and from hour to hour. She liked to interact with staff and referred to me as Nurse H197 Was very vocal, striped clothing at will and would say get me my buttons; I want chocolate I want lemonade, loved sweets and chocolate. She moved furniture around with her shoulder on the floor. When having a bowel motion sat on toilet and screamed. Was very vocal especially during hygiene and would shout leave me alone. She would also laugh a lot.

How were these behaviours managed at ward level?

She was nursed in group 2 with two other patients; she got on well with P44 and P199. She was in day room with group 3 and4.

Question 7

Have you ever heard P40 allege that a member of staff or patient had hit her?

Quite a few times this was one of her behaviours. Would have said this and laughed. Sometimes no one was in the area. Was vocal during hygiene shouting leave me alone or would have squealed.

If yes how was this addressed?

You would have said no one was there or you would have diverted her attention.

Question 8

Can you please explain what you recall the evening that it was alleged that a staff member assaulted patient P40?

P40 was in the day room. I apparently cleaned her mouth I cannot remember this I and the student nurse H196 were administering an enema the student nurse went to get pyjamas for the patient. The only patient I changed that night was P41 after her enema I was supervising the day room. I cannot recall P40 P40 saying a staff had hit her if so I would not have paid much attention to this as this was normal behaviour for P40 she alleges these things all the time.

Question 9

Did you hear B2 (Bohill Staff) request help to settle P40 on this evening (7.11.12) and if so how did you respond?

I cannot remember as I was so involved with L McMullan. If I had been called I would not have been in a position to help as I could not leave L McMullan.

Question 10

Can you please describe the behaviours that would be exhibited by patient P39

P39 is hard work as she had very challenging behaviours. Openly masturbates in public, wilful incontinence to command attention, smearing faeces over people or the ward or will attempt to eat this, striping clothing, pulling her hair out. She is very destructive on the ward will throw clothing out the window, steal food, stuff her mouth with food, regurgitate food and then eat same is obsessed with food, throw items out the window such as clothes and shoes.

How were these behaviours managed at ward level?

She was nursed in the bottom day room so she could be observed. Staff had to maintain her dignity so was continually redressed. Would walk along the ward corridor. Parts of her day she could display no challenging behaviours, Bohill staff where informed that she demanded attention and not to let her stand in front of you as she would nip you. Staff kept boundaries with the patients to manage their behaviours. They prevented her from striping by distracting her. All new and strange staff were informed of her behaviours.

Question 11

Did you or did you ever witness staff throwing P39 s shoes away to occupy her?

No staff ever did this. P39 would have removed her own socks and shoes and would throw them away this was one of her behaviours.

Question 12

Did you or did you ever witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

No, staff would have turned P39 away by the shoulders to de-escalate her behaviours.

Question 13

Have you or have you ever heard staff shout at P39 with a raised voice?

No not shouting. If she was about to hit another patient staff would have used a firmer tone to stop her, she responded to this.

Question 14

Were patients P39 and P43 ever placed outside in the garden areas?

P43 oved out in the garden. All the patients liked this area and used it in the summer.

P39 was never outside unless staff was with her. The door was always open. If there was no staff outside patients would have come inside, only out there when staff was out there. There are tables and a swing out there.

Question 15

Can you please describe the behaviours that would be exhibited by patient P41 P41

Some days there are no issues/concerns with P41 she likes music and would sit and listen to this in her chair would sit with her legs underneath her. Have involuntary movements so jerks all the time due to this would hit her head of her chair frequently. Would become agitated at times and this may indicate that an enema is required as she suffers from constipation. She has Bi-polar so moods can fluctuate can display self-injurious behaviour.

How were these behaviours managed at ward level?

P41 loves music so this was used to settle her. She likes to sit in the same chair and staff would sit her in this. Enema's when required were administer this is usually mid-week to alleviate constipation.

Question 16

Can you describe how P41 is assisted to mobilise?

P41 has a very unsteady gait; she walks on her tip toes. When out of the ward uses a wheelchair. When walking with P41 you would take her arm to guide her where you wanted to go. When you put her in her chair you placed her arms on the arms of the chair, P41 then put her legs below her when sitting and moved in the chair to position herself. She has upper and lower body involuntary movements and her head would have hit off the back of the chair due to this.

Question 17

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

No

Question 18

Have you ever raised your voice or used foul language to any patient or staff

No

Question 19

Was there restrictive practice employed in Ennis?

Not at all. Environment was restrictive. The space was small for the type of patients in the area. Doors were locked for patient's safety and to prevent accidents. Some patients have distasteful habits and this was to prevent this. Belt was used but this was not used as a restrictive practice it was used to hold up the patients trousers to maintain her dignity.

Were these written in the patients care plans?

Do not know. The nurse in charge was aware of all of these.

Question 20

Was there Behavioural Support Plans in place for the patients in Ennis?

Do not know, not aware of this.

If yes how was this information disseminated to you

Question 21

Did patients have it identified and noted in their care plans their behaviours such as stripping, making allegations etc.?

Yes

If yes was it documented how staff where to manage these behaviours?

Risk assessment was completed for P40 re making allegations.

Question 22

Have you attended your MAPA training and updates?

Yes

Question 23

Did you employ MAPA techniques within Ennis Ward?

Yes. P39 we would place our hands on her two shoulders and turn her around, this was used when we wanted to redirect her and would have been employed daily this was also used with P41.

P41 on the day of the allegation went over to P22 who was lying on the couch P41 jumped up and down on P22 I went over and took P41 P41 by her arm and elbow. P41 put her legs down on the ground and I walked her to another chair. B2 was at the window in the day room and her view of this was restricted as I was between her and P41. I put P41 into her chair and she settled herself as described earlier.

If yes can you please give a description of the MAPA techniques employed?

P39 we would place our hands on her two shoulders and turn her around, this was used when we wanted to redirect her and would have been employed daily this was also used with P41

Question 24

How would you describe the atmosphere on the ward within the staff team during this time?

The ward was good to work in. The staff all worked as part of a team and were helpful to each other. There was no stress on the ward; all staff helped each other to address the staff shortages on the ward. Everyone helped each other. The patients were in a small area and they all had Challenging Behaviour.

Question 25

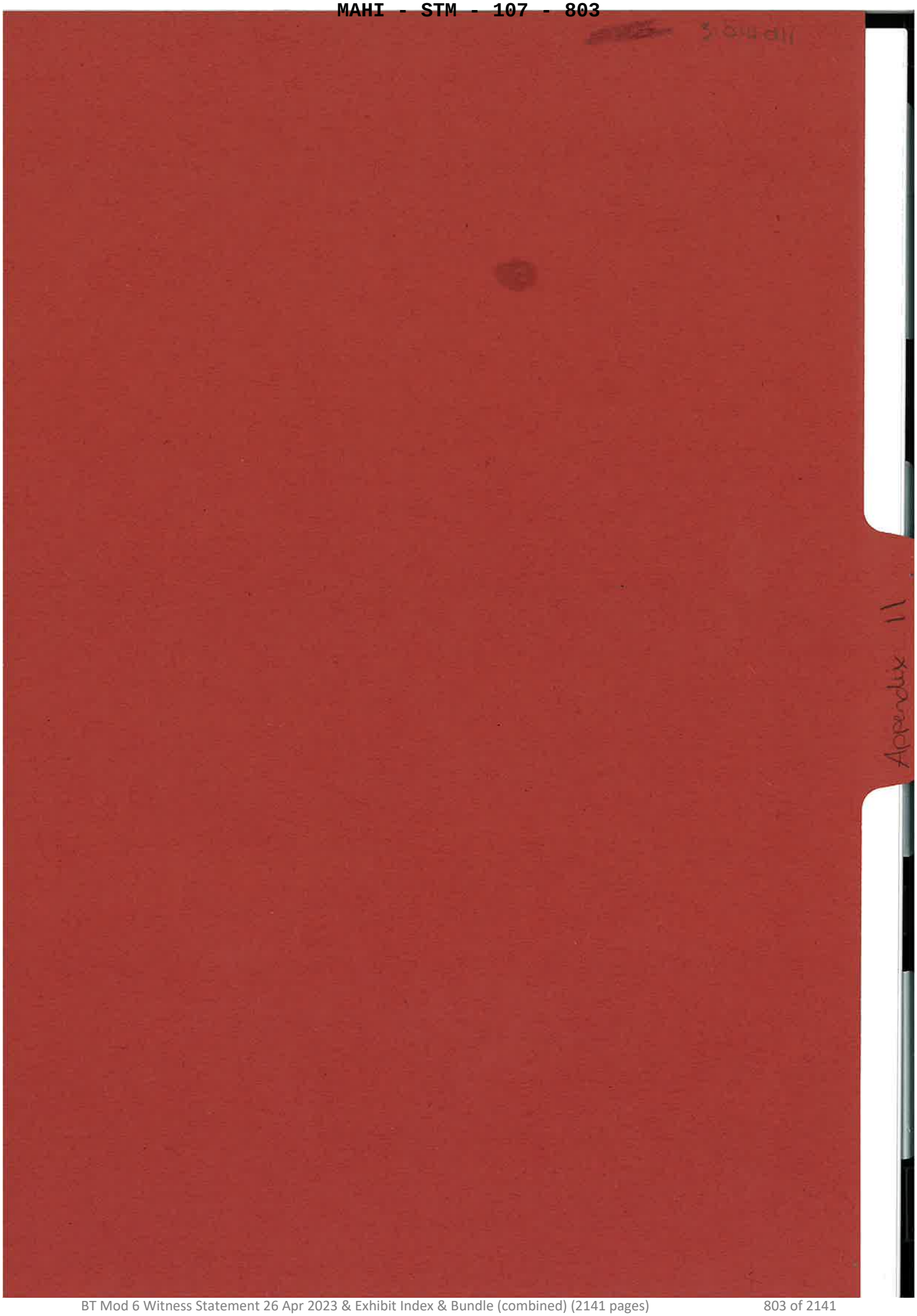
Is there anything that you would like to tell us that you feel would be helpful to the investigation

Some of the staff from the Bohill did not want to be there. B2 told me that she had been told horrendous stories about Ennis. The Bohill staff were watching and looking at the staff in Ennis they did not want to be there. The patient's behaviour deteriorated when the Bohill staff were there as they were strange to the patients. Bohill staff had made comments about Ennis said it was a horrible place.

The environment on the ward was too small for the number of patients and their challenging behaviours. Day care was cancelled regularly for the patients in Ennis as the day care staff were used to cover the shortfalls of staff on the wards within Muckamore Abbey Hospital.

I did not leave B2 for 20 minutes in the day room alone as she stated. I did go to the toilet but H870 was in the day room with B2 When I returned to the day room P39 had faeces on her hands B2 had no keys for the ward; she had taken P39 to the toilet. H870 went down to the toilet to assist B2 B2 and she was the staff who got P39 her change of clothes' I thought I had heard someone shout but I am not sure.

I left B2 with 2 patients while I gave out the lunches to the other patients; I gave B2 a full explanation the reason for this. I then brough B2 into the dining room and asked her to give P39 her lunch; I gave B2 a full explanation of P39 s behaviours during mealtime and explained how to feed her.


Appendix 11

3.015

Interview Questions **H159**

12.5.14

Question 1

As a Support Worker in Ennis did you feel supported while working on the ward.

Yes

What supports were available to you?

Staff were great The ward sister was approachable There was a good staff team in Ennis and we all worked and got on well together

Question 2

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you ensure the following;

Patient Safety

On occasions had to lock a door to keep patients safe and in one area for supervision and observations this was at the direction of the nurse in charge. Staff assisted each other and the work was prioritised to keep self and patients safe.

Staff Safety

There was usually a second staff present, staff had alarms. Felt safe on ward as we knew the patients really well and their behaviours.

Was there Staff Rotation within the ward

Generally worked on the same group usually at the bottom of the ward were the patients had challenging behaviour. It was better as this allowed the patients to get used to the staff and the staff to know the behaviours of the patients. Patients at the

top end of the ward had Challenging behaviour as well but these were not as challenging and they knew the staff that worked with them. Strange staff on the ward could escalate these behaviours.

Was there clear allocation of duties for each shift?

The nurse in charge gave the handover this was three times a day and was always completed regardless of staffing levels. There were allocation sheets on ward for staff, communication book and the ward diary. Changes were discussed with staff.

Was there scope for patient engagement in activities apart from daycare

Not really. Doors were open for the patients to go outside weather permitting. The Snoozelem Room off the dayroom was well used. Walks etc were not possible due to staffing levels on the ward. Music was on for the patients. Daycare would have been the main activity for the patients.

Question 3

As a Support Worker did you have annual appraisal and team meetings all carried out consistently with Ennis.

I had my KSF and PCP completed annually I did not have supervision like the trained staff. Team meetings were held monthly approx. I attended these and there were helpful. There was also the ward handovers.

Question 4

Have you ever raised any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with pre the allegations.

No never. The ward had a lot of students families members of the MDT on ward nothing was ever reported. Patient care was a priority to the staff. I was never asked to do anything I did not feel comfortable with.

If yes how were these issues address

Question 5

What was your understanding of the communication that was given to yourself re the Bohill staff coming to work in Ennis and how was this information disseminated to you.

They were coming to Ennis to familiarise themselves, get to know and work with the 3 patients who were to resettle to the Bohill. They were to ask staff in Ennis questions about these three patients. We knew when staff were coming and at what time. The staff did not come onto the ward until after all the patients were up washed and away to daycare, some staff from the Bohill would have followed them to daycare when they arrived. Some staff from the Bohill stayed on the ward and sat around in the day room. [redacted] spent three and half hours in the office reading care plans on the 7.11.12. Bohill said that the ward was not what they had expected though it may have been more like a nursing home said it was dismal, thought they were coming to the ward to paint patients nails etc. The staff from the Bohill was made to feel welcome by the staff in Ennis.

Question 6

Can you please describe the behaviours that would be exhibited by patient [redacted]

She had an unsteady gait walked with her chin in her chest. Would squeal and yell say I hate you I don't like you epically at toileting times or she won't give me that. Accused peers and staff of hitting her and hating her. Also striped of her clothing, pulled trousers down did not wear pyjamas. Liked to play with tops or buttons and would crawl about the floor moving furniture to retrieve her tops. Did not like strangers on the ward none of the patients did. Was known for bleeding gums and generally had bad breath. I had a good rapport with her.

How were these behaviours managed at ward level?

Was nursed in the middle day room of the ward on occasions would have come into the lower of the day rooms. Was settled when she had a top or button to play with, this made her content.

Question 7

Have you ever heard P40 allege that a member of staff or patient had hit her?

Oh yes frequently

If yes how was this addressed?

You would have cajoled P40 distracted her of offered her a drink and biscuit. Never made an allegation against me until the 7th November when later on I was informed of this.

Question 8

Can you please explain of what you recall the evening that it was alleged that a staff member assaulted patient P40

I was there on my own H196 came down to help about ten minutes later as we were short staffed. I decided that I would start the self-care after tea, I cannot remember the order I carried this out on the patients. I did not change P40 that evening. She was in the toilet and I was in the bathroom. I could hear P40 squealing and yelling as she was on the toilet having a bowel motion, she more than likely had taken her clothes off as that is what she normally does but I do not know as I did not see her; I heard her but did not see her.

Between 6.15 and 6.30pm I was changing the girls and bringing them to the day room. I finished this about 7pm locked the bathroom door and began to help with the suppers for the patients. I was in the day room for about ten minutes when P43 was very badly soiled and I took her to the bathroom to change her. H196 brought P40 to the bathroom to change her she was naked. B2 came down to bathroom to help when I was changing P43 she stood and watched me but did not help. I asked B2 to get fresh pyjamas for her which she did and then went back to the day room. I did not do P40 's oral hygiene that evening nor did I see any blood. No staff was made aware of anything P40 had said that night that I am aware of. P40 immediately stripped going to bed each night and again first thing in the morning when she went into the bathroom.

Question 9

Did you hear B2 (Bohill Staff) request help to settle P40 on this evening (7.11.12) and if so how did you respond?

No

Question 10

Can you please describe the behaviours that would be exhibited by patient P39?

P39 can display very challenging behaviours. She is obsessed with food, stripes off her clothing, masturbates, will PR herself and smear faeces or attempt to eat this and can be wilfully incontinent throughout the day. These behaviours increase when there are strangers in the ward. She would throw things out the window such as her clothes and toys and pull down curtains. P39 knew that she had to have her clothes on at meal times so would attempt to dress herself if she had striped at these times.

How were these behaviours managed at ward level?

Staff tried to amuse P39 with soft balls, toys that sang or played music, this help her to behave. Staff constantly redressed her. P39 's behaviours usually got worse between lunch and tea time. New or strange staff were informed not to let P39 grab your hand as she would nip you or pull you around you had to set boundaries with P39

P39 wore a crop top or swimsuit to prevent her putting her hands down her trousers to prevent her masturbating in the day room. She also wore high waist trousers with a belt to maintain her dignity.

Question 11

Did you or did you ever witness staff throwing P39 's shoes away to occupy her?

No P39 threw her shoes away in the day room or put them out the window. She did not like new shoes.

Question 12

Did you or did you ever witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

No never

Question 13

Have you or have you ever heard staff shout at P39 with a raised voice?

The day room is very noisy there is eleven patients with Challenging Behaviour Staff would have been more assertive to be heard and changed tone when Challenging Behaviour was evident. Staff did not shout.

Question 14

Were patients P39 and P43 ever placed outside in the garden areas?

No P43 likes to be on her own and loves the garden she sits in the same area all the time. P43 was able to get back into the ward by the door but generally staff had to go and get her to bring her back in. P43 would have become agitated or self-injurious if she wanted out to the garden. P43 was only out in the garden if the weather permitted this and was observed by staff.

P39 did not go out unless staff were with her she was never put out.

Question 15

Can you please describe the behaviours that would be exhibited by patient P41 P41 ?

P41 constantly has jerking movements, throws her head back this usually gets worse when she becomes agitated or annoyed. Has problems with her bowels and needs an enema to manage this, when she becomes agitated this is usually a sign that she is constipated. P41 could be aggressive in that she could kick out or hit. She also had pre menstruation pain. She could have thrown cutlery/crockery across the room.

How were these behaviours managed at ward level?

You always stayed to the side when walking or working with her due to her jerking movements P41 loved music. Needed supervised at all times. I had a very good way with P41 on occasions you had to wait until her agitation decreased to work with her. When she was constipated she had an enema.

Question 16

Can you describe how P41 is assisted to mobilise?

At times needed her wheelchair such as when she was outside the ward would have walked her to the bus for day care. You always placed her away from other patients to prevent them getting injured. P41 jerked while sitting. You walked to the side of P41 and if you needed would have placed you hand on her elbow to prevent her jerking her elbow into and to protect you. Staff also placed their hand on her back to guide her in the right direction. When she sat in a chair she always jerked and moved around to get comfortable.

Question 17

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

Never

Question 18

Have you ever raised your voice or used foul language to any patient or staff

Definitely not. May have changed my tone depending on the behaviours of the patients but never yelled or squealed at the patients.

Question 19

Was there restrictive practice employed in Ennis?

No restrictive practices. When questioned further stated the doors would have been locked into middle day rooms. Doors in the bottom area of the ward locked for the patient's safety. Swim suit was not used as a restrictive practice as the patient could remove this it was for her dignity and for the environment for the other patients.

Were these written in the patients care plans?

I would have thought so but I did not read these everyday as I would not have had time to do this. Read care plans when patients first come to the ward.

Question 20

Was there Behavioural Support Plans in place for the patients in Ennis?

Not with the patients at the bottom of the ward.

If yes how was this information disseminated to you?

Question 21

Did patients have it identified and noted in their care plans their behaviours such as stripping, making allegations etc.?

Not sure. Nursing staff that came from the ward that the patients had come from worked with us on the floor and informed us on how to work with these patients.

If yes was it documented how staff where to manage these behaviours?

Staff from the other ward worked with you on the floor and told you how to work with the patients.

Question 22

Have you attended your MAPA training and updates?

Yes

Question 23

Did you employ MAPA techniques within Ennis Ward?

Yes.

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Appendix 12

3.016

Notes of Interview with H205

29th April 2014

Administration Building

Muckamore Abbey Hospital

Question 1

As a Support Worker in Ennis did you feel supported while working on the ward?

Yes I was supported by own staff on the ward. We all mucked in as we were under stress due to staff shortages but we managed. I got support directly by my Ward Manager H491 The workload on the ward was adjusted to meet the staffing levels we prioritised our work.

Question 2

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you ensure the following?

Patient Safety

This was our main priority and I always ensured this. I always made sure someone was with them or within eyesight and not away doing other things. We prioritised our work.

Staff Safety

We completed our main duties things that needed to be done. We helped each other out and looked out for each other.

Was there Staff Rotation within the ward?

Most of the time you stayed with the same group the patients were dependant on staff who knew them well, You generally worked on the group you were key worker for. I mainly worked on Group 4 the girls at the front of the ward and I worked well with patient P198

Was there clear allocation of duties for each shift?

There was an allocation sheet on the ward showing who was to work were this was adjusted when there was staff shortages. The allocation sheet identified what groups you were working with and who was doing the escorts.

Was there scope for patient engagement in activities apart from day-care?

The ward car would have been used even just to take the girls out for a drive. The activity room was used for beauty treatments. There was DVD's Games Cold Cookery in the evenings and the garden was used depending on the weather.

Question 3

Did you as a Support Worker have an annual appraisal and attend regular team meetings within Ennis?

I think I may have had my KSF completed once. There was ward meeting regularly and if you did not attend you received minutes of the meeting.

Question 4

Have you or any staff raised any issues regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that caused concern pre the allegations.

Never had to

If yes how were these issues addressed

Question 5

Have you ever heard P40 allege that a member of staff or patient had hit her?

Yes but about patients only not staff. Heard her say patient P43 had hit her but this patient was not in the area at the time she was in the garden area. Patient P40 was coming from the bathroom on that occasion. P40 would have alleged this a lot.

If yes how was this addressed?

Asked patient were she had been hit and I identified that the patient was not on the ward at the time.

Question 6

Have you ever heard staff shout at P39 with a raised voice?

Not in a raised voice but in a firm voice when P39 was displaying her behaviours. This was not in an angry way.

Question 7

Did you witness staff throwing P39 s shoes away to occupy her?

No P39 would take her shoes off herself and bring them to you this was her way of gaining attention. If the shoes were off P39 would bring them to staff to put them on. If she had new shoes she frequently took them off and threw them away until she got used to them.

Question 8

Did you witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

No never

Question 9

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

Never

Question 10

Did you ever assist staff to put a belt around P39 ?

No staff did not need assistance to put the belt on P39 she always let you put the belt on her. P39 liked her belt and if she did not have one on she would take staff to her room to get one for her. P39 s weight fluctuated so the belt was needed to keep her trousers up, she felt secure with the belt on.

If yes, can you explain how and why this was done?

Question 11

Can you explain the Induction that was in place for the Bohill staff and how this was disseminated to you?

When they came onto the ward they were introduced to the staff they were to shadow the staff who worked with the patients identified for the Bohill, these were the only patients they were to shadow us for. Many times they did not work with the identified patients and would be with other patients eg P202 The manager of the Bohill arrived on the ward to talk to the staff and they were outside with patient P202 P202 the three of them stayed outside during this time. I worked quite a bit with the Bohill staff and never seen them work with patient P199 who was identified to go there.

The Bohill staff did not arrive on the ward until late morning we would have put back the personal hygiene on the patients going to the Bohill for as long as we could to allow them to work with them but generally the patients would have been at daycare by the time they arrived. The Bohill staff would then have went to daycare to see the patients there. I cannot remember the Bohill staff being there in the evenings I recall that they usually left about 5.30pm or before this.

Question 12

Was there restrictive practice employed in Ennis?

No

Were these written in the patients care plans?

Question 13

Was there Behavioural Support Plans in place for the patients in Ennis?

No We worked with the patients and their behaviours by trying different things to see what worked and what did not and knowing our patients. This was communicated within the staff team at handovers and through each other.

If yes how was this information disseminated to you?

Question 14

Did patients have it identified and noted in their care plans their behaviours such as stripping, making allegations etc.?

Yes I think it was as we reported these behaviours to the trained staff.

If yes was it documented how staff where to manage these behaviours?

I am not sure We would have looked at any new patients care plan but we did not have time to read the care plans on a daily basis Infomration regarding patients was communicated between staff.

Question 15

Have you attended your MAPA training and updates?

Yes

Question 16

Did you employ MAPA techniques within Ennis Ward?

Yes

If yes can you please give a description of the MAPA techniques employed?

Level 1 and 2 holds were used with the patients at the front of the ward. I think it may have been used on patient P30 for Self Injurious behaviour but this would have been a level 1 hold to prevent her injuring herself as she was banging her head.

Patient P39 would have stood at the door of dining room There was no reason to move P39 from the this door as she would move herself when asked by staff to do so.

Question 17

How would you describe the atmosphere on the ward within the staff team during this time?

Stressful due to staffing levels and the additional work with the Bohill staff. This put pressure on staff as the patients behaviours increased as they were not familiar with these staff. Some of the Bohill staff appeared very inexperienced. The staff team in Ennis all worked together.

Question 18

There was environmental changes to the ward Can you please tell us how you were consulted on these changes and what was the outcome of these changes for patients and staff.

We were informed of the changes but were not consulted. The bathroom on the front corridor was changed to make this a staff cloakroom. This had an effect on the patients as they only had one bathroom left to use. When patient P198 became challenging this caused delays as the bathroom became blocked and other patients were unable to have their hygiene completed which caused them distress.

The activity room was converted to an office. This was used for patients activities pre this such as beauty, spas and cold cookery this only left the big dayroom for this. This impacted on the patients if one patient was watching the TV and another activity was taking place in this room which could cause challenging behaviour.

Snoozlen room was of no benefit as all the patients could open the door if someone was using it.

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

We were under pressure and stress due to staffing levels on the ward and we did the best we could. Our main priority was the care of the patients.

3016d13

Appendix 13

3.017

Notes of Interview with H869

16th May 2014

Administration Building

Muckamore Abbey Hospital

Question 1

As a Support Worker in Ennis did you feel supported while working on the ward?

Yes I enjoy my work in Muckamore Abbey Hospital the only thing was the staff shortages. My colleagues and the nurses in charge gave me support. Everyone helped each other out we got on well as a team and you only had to ask for help if you needed it.

Ward Sister had e-mailed Senior Nurse Manger regarding the staff shortages on the ward. Staff on the ward did cope with the staff shortages.

Question 2

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you ensure the following?

Patient Safety

We had a level 3 observation in the lower end of the ward her staff was always with her. There were 2 groups in the lower end of the ward on occasions one staff had to do the two groups.

Staff's knowledge and experience of the patients helped to keep them safe. P39 P39 loved to walk and I would have taken her with me when doing laundry etc.

Staff Safety

Staff had a good knowledge of the girls and because I knew the girls I felt safe. The area was never left without staff supervision if I had to leave the area I would have asked the Nurse in Charge to come to the area to let me leave. I would never had left the area and left one member of staff on their own.

Was there Staff Rotation within the ward?

There was rotation but I was generally down the lower end of the ward. I was allocated to these girls as I was their associate nurse. I preferred to work in this area of the ward as I knew these girls, I loved working with these girls and being down the back.

Was there clear allocation of duties for each shift?

Yes there was a communication book allocation sheet on the ward. I knew what I had to do. Allocation sheet identified groups. Escorts and laundry etc was work that everyone knew had to be completed

Was there scope for patient engagement in activities apart from day-care?

There was the Snoozlem Room, music was always on as the girls liked this, TV which was generally the music channel. The garden area was used which summer seats and swings, one patient in particular had liked outside. Foot spa's was carried out in the dayroom in the afternoons and evenings.

Question 3

Did you as a Support Worker have an annual appraisal and attend regular team meetings within Ennis?

Yes I had my KSF/PCP completed 2 to 3 times in Ennis.

Team Meetings I did not get to a lot of them as I do voluntary work. I cannot remember how often they occurred but I did get minutes of these meetings. These meetings contained information on resettlement, use of ward vehicle updates on patients and any items staff raised.

Question 4

Have you or any staff raised any issues regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that caused concern pre the allegations.

No. When the patients moved from Fairview to Ennis it was a smaller ward but the patients adapted well to this environment change. The two staff teams when combined as one worked well together and gelled.

If yes how were these issues addressed?

Question 5

Have you ever heard P40 allege that a member of staff or patient had hit her?

No never

If yes how was this addressed?

Question 6

Have you ever heard staff shout at P39 with a raised voice?

I have never heard staff shout or use aggressive language. Staff would have lifted their voices because of the noise levels within that area. Patients P202, P43 and P41 could be very vocal and it could be hard to be heard.

Question 7

Did you witness staff throwing P39 's shoes away to occupy her?

No P39 iked her shoes, she could take these off. She would have thrown her won clothing and shoes out the window on occasions.

Question 8

Did you witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

No. P39 wore a belt to help keep her trousers up as she wore incontinence products which resulted in her hips being wider than her waist. Her trousers were usually too big for her on the waist as a result of this so a belt was used to keep her trousers up. On occasions she wore tracksuit bottoms so she did not need a belt.

Question 9

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

No some of the patients wore vests with poppers at the bottom.

Question 10

Can you explain the Induction that was in place for the Bohill staff and how this was disseminated to you?

The Bohill staff were there to get to know the patients. I saw some of the Bohill staff getting their Induction by the nurse in charge. They were shown around the ward, introduced to staff and patients and it appeared to be well done. A few of the Bohill staff worked with me I would have given them information on the patients. Sometimes it was hard to get them to concentrate on the patients going to the Bohill as P202 would have taken up some of their attention. Some of the staff were young and had said they had not worked in an environment like Ennis before.

I worked a 1230 to 2300 on the 7.11.12. I worked in the lower end of the ward until 1800 that day and the remainder of my shift I worked with the girls at the upper end of the ward I think I may have been carry out P198 s level 3 observations.

Question 11

Was there restrictive practice employed in Ennis?

Bottom half of ward was locked. Garden area was secure/enclosed. Kitchen was locked. Level 3 observations.

Patient P43 would have drop attacks and would these usually were in the mornings. On occasions she would return to ward from day care in her wheelchair staff would have kept her in her wheelchair with the strap on to prevent injury to herself as she would have been drowsy and unsteady on her feet. Once she was fully recovered staff would take her from the wheelchair.

Patient P39 wore a swimsuit and or a vest.

Were these written in the patients care plans?

Yes P22 evel of observations.

Not sure about the others

Question 12

Was there Behavioural Support Plans in place for the patients in Ennis?

Would have completed sheets on patients behaviours in the lower end of the ward this would then have went to ABS not sure if this was pre or post the allegations.

If yes how was this information disseminated to you?

Asked to complete these sheets

Question 13

Did patients have it identified and noted in their care plans their behaviours such as stripping, making allegations etc.?

Yes

If yes was it documented how staff where to manage these behaviours?

Yes

Question 14

Have you attended your MAPA training and updates?

Yes

Question 15

Did you employ MAPA techniques within Ennis Ward?

Yes blocking to prevent patients being self-injurious

If yes can you please give a description of the MAPA techniques employed?

Hand over their hand to prevent patient nipping themselves

To move patients would have put hand on their elbow and the other hand on their waist.

Question 16

How would you describe the atmosphere on the ward within the staff team during this time?

I always found it a good team we were short staffed but we got on with our work. I was not stressed re this.

Question 18

There was environmental changes to the ward Can you please tell us how you were consulted on these changes and what was the outcome of these changes for patients and staff.

I was not consulted I am not sure about other staff being consulted. I probably would have kept the activity room if I had been asked

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

I have worked with these girls (patients) so long and I am really attached to them that if I though anyone hurt them I would speak up immediately I would not hide anything. (H822 is very passionate about these patients it is clearly evident)

3.017d14

Appendix 14

3 018

Notes of Interview [redacted]

12TH May 2014

Administration Building

Muckamore Abbey Hospital

Question 1

As a Support Worker in Ennis did you feel supported while working on the ward?

Response

Not all of the time we were short staffed. There was a lot of bus outings still going on but it was always the girls/patients at the top end of the ward who went out on these. This left us with all the other girls/patients down at the bottom end of the ward, one of which was on level 3 observations, the girls from the bottom end of the ward all had challenging behaviours such as stripping. Sometimes staff from the upper ward would give the staff help in the lower end of the ward if they were not out on the bus. Support dependant on what staff were on duty.

There was a click on the ward and these staff usually worked with the patients at the upper end of the ward. When they were finished they would be in the office.

There was support from the staff who worked in the bottom end of the ward they helped each other out.

Question 2

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you ensure the following?

Patient Safety

We did our best most of the time we were running around like headless chickens. We tried our best to supervise the patients at all times. In the good weather we opened the doors to allow patients outside, P43 and P202 liked outside. The middle dayroom was utilised. The AM shifts were easier to manage as a lot of the patients were out at day care. The majority of the work such as laundry was done in the mornings to allow staff to supervise the patients in the afternoon as not as many patients were at day care then. The staff team worked together.

Staff Safety

Staff were hit or slapped by patients. There was only enough seating in the dayroom for the patients, staff had to sit on the arms of chairs this was when we got hit or slapped. I have had a jumper ripped off and items threw at me, I never really felt safe. I tried to know my patients and the triggers for their behaviours.

When patients from the upper end of the ward became challenging they were placed in the lower end of the ward. This was as the top end of the ward had ornaments etc sitting about and this was to prevent them getting broke. When the patients came down to the lower end of the ward due to challenging behaviour they would have broken items in that end of the ward. This resulted in the lower end of the ward being baron and dismal.

Was there Staff Rotation within the ward?

Some people worked in the same groups I would have liked a change as the lower end was constant. The staff in the lower end of the ward always did the laundry for the whole ward as staff from the upper end of the ward was working with patients.

Was there clear allocation of duties for each shift?

Not really only groups, activities and outings were allocated. Laundry escorts etc were not allocated.

Was there scope for patient engagement in activities apart from day care?

No the activity room had been turned into an office. There was not a lot of activity for the patients in the lower end of the ward. Jigsaws etc well not well maintained with pieces missing. The upper end of the ward had more activities such as bingo for the patients. The Snoozelem room at the bottom end of the ward was taken over by patient P202 Music was always on at the lower end of the ward as patient P41 liked music.

The activity room had been used for the patients in the lower end of the ward to do hairdressing, make-up painting, games etc this was a great wee room for these patients.

Question 3

Did you as a Support Worker have an annual appraisal and attend regular team meetings within Ennis?

KSF/PCP completed once by the Ward Sister a couple of years ago.

There were team meetings one or two a year for all staff; minutes were available for these meetings. There were more frequent meetings for trained staff; I was not given minutes of these meetings.

Meetings contained the Ward Sisters agenda. Any issues brough up by staff was given lip service such as staffing levels on ward.

Ward Sister delegated al lot of tasks to staff, I was asked on occasions to phone staff to see if they would work to cover shortfalls. The Ward Sister never came to the lower end of the ward except to get the drug trolley. She did not know the patients and would not have understood how hard it was.

Question 4

Have you or any staff raised any issues regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that caused concern pre the allegations.

No never

If yes how were these issues addressed?

Question 5

Have you ever heard P40 allege that a member of staff or patient had hit her?

Frequently alleged that other patients had hit her eg P44 or P43 If she said that P43 had hit her then this would be true. Does not think that she has said that staff have hit her.

If yes how was this addressed?

P40 would be comforted by staff a bit like when you sooth a toddler. We would have reported this to the NIC or another trained staff member that day.

Question 6

Have you ever heard staff shout at P39 with a raised voice?

Not shouting at her staff may have used a firmer tone if P39 was displaying Challenging Behaviour.

Question 7

Did you witness staff throwing P39 s shoes away to occupy her?

No

Question 8

Did you witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

No

Question 9

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

No

Question 10

Did you ever assist staff to put a belt around P39

No you did not need assistance to put a belt on P39 as she liked a belt. The belt was never on too tight so that she could not remove her clothing or that it would leave marks on her.

If yes, can you explain how and why this was done?

She liked a belt

Question 11

Can you explain the Induction that was in place for the Bohill staff and how this was disseminated to you?

I was informed that the Bohill staff were coming to see certain patients. I was told they could come with us to learn for the first few days and then the Bohill staff were to work with the patients directly.

It was felt by the staff in Ennis that the Bohill staff did not want to be there and they did not want the patients that had been identified to go to the Bohill when they seen their behaviours especially P39 They spend most of their time with patient P202 P202 in the garden area. Some of the Bohill staff came in and sat most of the shift in the day room and did not interact with the patients. Some of the staff from the Bohill did interact with patients and staff.

Question 12

Was there restrictive practice employed in Ennis?

Patients in the lower end of the ward were moved from the dayroom when a patient from the upper end of the ward was there due to aggression.

There were locked doors on the ward at the lower end of the ward

Were these written in the patients care plans?

I don't think so I am not sure

Question 13

Was there Behavioural Support Plans in place for the patients in Ennis?

Some of the patients from the upper end of the ward had Incentive Plans the patients in the lower end of the ward did not

If yes how was this information disseminated to you?

This is written up in their Incentive Plan which is kept in the office and that can be easily read by staff. Patients were able to inform you of their Incentive Plans.

Question 14

Did patients have it identified and noted in their care plans their behaviours such as stripping, making allegations etc.?

I do not know as I never got the chance to read the care plans as I was never in the office. Due to my shift pattern I was always covering ward duties during handovers and did not get a handover when I came on duty. Other staff kept me up to date on what was happening within the ward.

If yes was it documented how staff where to manage these behaviours?

Question 15

Have you attended your MAPA training and updates?

Yes

Question 16

Did you employ MAPA techniques within Ennis Ward?

Yes

If yes can you please give a description of the MAPA techniques employed?

P198 full PI

P46 full PI

Both of the above either sitting or standing

Question 17

How would you describe the atmosphere on the ward within the staff team during this time?

The atmosphere on the ward was awful due to staff shortages; ward was always working short staffed, staff were stressed due to this. In the lower end of the ward it was the same routine day after day.

The atmosphere between staff was good we worked really well together and everyone got on with the work. Staff helped each other out and pulled together as a team.

Question 18

There was environmental changes to the ward Can you please tell us how you were consulted on these changes and what was the outcome of these changes for patients and staff.

Activity room was made into an office we were not consulted on this it was just done. The patients enjoyed the activity room it was an area to allow the patients in the lower day room to be spaced out and separated.

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

No

Since the allegations there was a new Ward Sister on the ward which made a big difference she was;

- Approachable
- She knew the patients, had a relationship with the patients and they all liked her
- She help out on the ward and was hands on
- She was a breath of fresh air
- She made a big difference

3.018d15

Appendix 15

Notes of Interview with H206

29th April 2014

Administration Building

Muckamore Abbey Hospital

Question 1

As a Support Worker in Ennis did you feel supported while working on the ward?

Yes felt supported by the staff team. Staff shortages were a big issue but we got used to this and adopted to it. Trained staff would be allocated to work on groups, usually they were allocated to work on the group they were named nurses for, in the morning and evenings and would then be in the office. The trained staff came to help/assist when asked but we mainly worked with Support Workers without direct supervision of trained staff. The Nurse in Charge would do the tablets and office work.

Question 2

It is acknowledged that prior to the allegations the ward worked with limited resources. How did you ensure the following?

Patient Safety

Patients were supervised by staff. Observations of patients and patients on Constant Supervision was completed.

Staff Safety

The staff in Ennis worked as a team helping each other out.

Was there Staff Rotation within the ward?

No generally you worked on the group you were Key Worker for. I was on night duty so would have floated between groups but mainly worked with the patients at the back of the ward. Only change was if you were on a Level 3 Observation.

Was there clear allocation of duties for each shift?

You looked to see what group you were on there was no allocation of other duties. Staff worked a team to complete other duties.

Was there scope for patient engagement in activities apart from daycare?

We used the car pre the allegations this was taken away just after the allegations. There was an activity room on the ward but this was turned into an office, not sure when this occurred. The patients from the top end of the ward went to the cinema every Sunday. All the patients went on holidays in small groups about two years ago there has been no holidays since this.

Question 3

Did you as a Support Worker have an annual appraisal and attend regular team meetings within Ennis?

I had my appraisal completed annually by H325 on the ward. Staff meetings were once every six months I attended these on a couple of occasions those I did not attend I got minutes of the meeting.

Question 4

Have you or any staff raised any issues regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that caused concern pre the allegations.

No Nobody ever raised any issues with me

If yes how were these issues addressed?

Question 5

Have you ever heard P40 allege that a member of staff or patient had hit her?

Yes P40 would say this about other patients never heard her say this about a member of staff.

If yes how was this addressed?

If we had not witnessed anything we would have reported this to the Nurse in Charge.

Question 6

Have you ever heard staff shout at P39 with a raised voice?

No

Question 7

Did you witness staff throwing P39 's shoes away to occupy her?

No P39 will throw her shoes out the window or throw them across room especially if they are new shoes.

Question 8

Did you witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

No P39 stripes her won clothing off and throws away clothing and shoes.

Question 9

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

No

Question 10

Can you explain the Induction that was in place for the Bohill staff and how this was disseminated to you?

I was just told Bohill said were coming to the ward, no other communication was given to me regarding this. There was no clear guidance given on how to work with the Bohill staff.

Bohill staff did not come at the times they were planned to be on the ward. They would have arrived late in the mornings, could have been 10am, by this time the patients identified for the Bohill were already up and dressed and on occasions would have been at day care. Sometimes the staff from the Bohill would have gone to day care at other times they stayed on the ward and interacted with others. They rarely saw patients getting up in the morning getting washed dressed etc.

Bohill staff also left early, could have left at 6pm, therefore they did not see the patients getting ready for bed. One staff did a night duty on Ennis she arrived after the patients had received their suppers and medication, approx after 10pm, then left at approx 430am, patients would still have been in bed at this time.

Question 11

Was there restrictive practice employed in Ennis?

Doors were locked on the ward but there was always staff in the area. The door to the garden was locked when all the patients were on the ward. If patients were in the garden then this door was open or wedged opened.

A swimsuit was used on P39 for dignity as she keep this on after removing her clothes. We were instructed to put on the swimsuit. Belt was used to keep her trousers up and P39 liked to take this off and play with it. P39 could take the belt off and was not considered as restrictive practise as other people wear a belt.

Were these written in the patients care plans?

I do not know

Question 12

Was there Behavioural Support Plans in place for the patients in Ennis?

Not that I know off not aware of any.

If yes how was this information disseminated to you?

Question 13

Did patients have it identified and noted in their care plans their behaviours such as stripping, making allegations etc.?

I reported these behaviours to the Nurse in Charge but I do not know if it was in the Care Plan

If yes was it documented how staff where to manage these behaviours?

Question 14

Have you attended your MAPA training and updates?

Yes

Question 15

Did you employ MAPA techniques within Ennis Ward?

Yes

If yes can you please give a description of the MAPA techniques employed?

Arms holds on patients P198 and P46 No moves used to move patients at doors

Question 16

How would you describe the atmosphere on the ward within the staff team during this time?

Ennis is a good ward with good staff team. The ward worked short staffed but that became the normal and we got on with it. The staff shortages did annoy some staff.

Question 17

There was environmental changes to the ward Can you please tell us how you were consulted on these changes and what was the outcome of these changes for patients and staff.

Bathroom was converted to a staff toilet and locker room. Clinical room was changed to a a staff room about 4 to 5 years ago.

The Activity room was converted to a second office this was for the Nurse in Charge and staff. The first office was the Ward Sisters Office the only other time I seen it used was for the ward report to be completed at 7am in the morning by the Nurse in Charge.

The Snozelem Room was created when Fairview patients came.

The Activity Room was missed by me. I felt that the patients missed this room as it was used every day for art and craft, footspa, etc. Staff were not consulted re the changes to the ward environment.

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

No

3.019d16

Appendix 16

3020

Notes of Interview **H196**

29th April 2014

Administration Building

Muckamore Abbey Hospital

Question 1

As a Student Nurse in Ennis did you feel supported while working on the ward?

Response

I only worked 8 shifts on Ennis pre allegation

Yes felt supported by

- Opportunity to ask questions
- Given an induction
- Supported by staff team
- Used a buddy system on ward
- Shadowed staff and the Nurse in Charge

Question 2

Did you have a Comprehensive Induction to the ward and where you given pen pictures of the patients on the ward?

Response

Had a good Induction

Cannot remember is she was given pen pictures

Question 3

Did you ever raise any issues with staff in Ennis regarding staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that you were not comfortable with?

Response

No

If yes how were these issues addressed

Question 4

Can you please describe what you recall the evening that it was alleged that a staff member assaulted patient P40 ?

Response

I was in the front office of the ward reading care plans this was to help me do management plans, I worked a PM shift that day. I was asked to give a hand to put away laundry in the back of the ward. Later on I was at the front of the ward with a patient. I spent most of the shift in the office going over care plans.

I was down back of ward putting away laundry I put slippers on one of the girls I cannot remember the patients name or time. I cannot remember anything else.

Question 5

Did B2 request assistance to try and settle patient P40 and if so how did you respond?

Response

Can remember the staff from the Bohill but cannot recall her name. Conversation was that it was B2 s first day. B2 had stated that she had applied for nursing but did not get in.

Cannot remember B2 asking for assistance.

Question 6

Did you witness a member of staff wipe patient P40 's mouth roughly with a mitt?

Response

No

Question 7

Did you hear patient P40 say anything on that evening regarding staff?

Response

No I cannot remember

Question 8

Have you ever heard P40 allege that a member of staff or patient had hit her?

Response

No I cannot remember

If yes how was this addressed?

Question 9

Did you inform patient P40 that she would not get her sweets and lemonade if she did not put her clothes on?

Response

No

Question 10

Have you ever heard staff shout at [redacted] with a raised voice?

Response

No

Question 11

Did you witness staff throwing P39 's shoes away to occupy her?

Response

No

Question 12

Did you witness staff push and/or pull P39 by the waistband of her trousers or any other item of clothing?

Response

No

Question 13

Did you ever witness staff stretching a patient's T-Shirt and tying it between their legs?

Response

No

Question 14

How would you describe the atmosphere on the ward within the staff team during this time?

Response

Cannot comment as duration on ward was short. Cannot remember

Question 15

What was communicated to you about the Bohill staff being on Ennis?

Response

I had attended a resettlement meeting so I knew what Bohill staff were doing on ward. Did not have much involvement with Bohill staff.

Meet a few of the staff but cannot recall their names. Would not have worked with Bohill staff as I was shadowing other staff.

Is there anything that you would like to tell us that you feel would be helpful to the investigation?

Response

No

Notes of Second Interview H196

2nd June 2014

Administration Building

Muckamore Abbey Hospital

Question 1

A number of staff have described the night that P40 alleged that a member of staff had hit her. Staff have stated that you were in this area at this time. Can you please clarify for us what you recall from that evening?

I took laundry down to the back area of the ward. I put slippers on a patient

Question 2

Did you take patient P40 to the bathroom area that evening?

I cannot remember the patients names

Question 3

Did you help staff with patients routines that evening?

Yes I did help with bedtime changes but do not remember who

Question 4

Do you recall the staff on duty that evening?

Cannot remember

3.020 d17

Appendix 17

3.021

Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
9	12	10	2	9	6	5	2	31	38	53	29

3021d18

Appendix 18

Appendix 2 3.022

BELFAST HEALTH AND SOCIAL CARE TRUST

MUCKAMORE ABBEY HOSPITAL

MEMORANDUM

From: Mrs K Murray
Day Care Services Manager

To: Mrs R Scott
Senior Nurse Manager

Ref: **KM**/os

Date 8th May 2014

Re: **Requested Information**

Please see attached information requested regarding Ennis patients' attendance on 7th November 2012 and for the month of November 2012.

Please do not hesitate to contact me if you need further information or clarification.

K. Murray

Kim Murray
Day Care Services Manager

In response to your request for information regarding Ennis patients' attendance on 7th November 2012 and for the month of November 2012, information was gathered from the following sources:-

- Epex
- Duties
- Situation Sheets
- Diary
- Care Plans
- Staff files

In relation to 7th November 2012 the following patients' Day Care was cancelled:-

- P30
- P39
- P41
- P200
- P197

The reason for this cancellation was due to the fact that Moyola had four members of staff on sick leave and one on Jury Service. This, therefore, necessitated the closure of Room 7 and Room 3 affecting the aforementioned patients.

In relation to the other days in November 2012 please see the following:-

Thursday 1st November 2012

No patient Day Care was cancelled, however, both P198 and P40 P40 refused to attend.

Friday 2nd November 2012

All Ennis patients attended.

Monday 5th November 2012

Room 7 in Moyola was closed and the following patients were cancelled:-

- P30
- P39
- P41

The reason for the closure of Room 7 lies with the fact that four staff were on sick leave and one staff was on Jury Service. P198 did not attend on this day and records indicate she was sick.

Tuesday 6th November 2012

P30 P39 and P41 did not attend Day Care on this date. The records indicate that the reason for this was that a ward escort was not available. The following patients were cancelled by Day Care:-

- P42
- P46

The reason for this cancellation was due to four members of Moyola staff being on sick leave and one on Jury Service. P40 did not attend on this day and the records indicate that she refused.

Wednesday 7th November 2012 – as previously outlined.

Thursday 8th November 2012

The following patients' Day Care was cancelled:-

- P198
- P197
- P46
- P42
- P40

The reasons for this cancellation was due to four staff being on sick leave but also records indicated that four Nursing Assistants were sent to the ward on relief. This would have impacted and resulted in closure of Room 4 in the afternoon affecting P46 and P42.

Friday 9th November 2012

The following patients' Day Care was cancelled:-

- P46
- P42
- P45

The reason for this cancellation was due to two Nursing Assistants being sent to the ward on relief due to ward shortages. P40 did not attend due to an appointment.

Monday 12th November 2012 – Friday 16th November 2012

The following patients' Day Care was cancelled for the week:-

- P198
- P197
- P40
- P45
- P41
- P30
- P39

The reason for this cancellation was due to having three members of staff on sick leave for the week.

P44 did not attend on Monday 12th November '12 and records indicate she had an appointment.

Monday 19th November 2012

Day Care was cancelled for the following patients:-

- P43
- P47

The reason for this cancellation was due to three members of staff being on sick leave, one member of staff being on compassionate leave and one member of staff being on Carers' Leave.

Tuesday 20th November 2012

All Ennis patients were in attendance.

Wednesday 21st November 2012

All Ennis patients were in attendance.

Thursday 22nd November 2012/Friday 23rd November 2012

The following patients' Day Care was cancelled:-

- P30
- P39
- P41

The reason for this sick leave was due to three members of staff being on sick leave.

Monday 26th November 2012

The following patients' Day Care was cancelled:-

- P30
- P39
- P41
- P198
- P197
- P40
- P45

The reason for this appears to be three staff members on sick leave as well as one staff getting an emergency annual leave day.

Tuesday 27th November 2012

All Ennis patients attended on this day.

Wednesday 28th November 2012

The following patients' Day Care was cancelled:-

- P198
- P197
- P40
- P45
- P40

The reason for this was due to three staff being on sick leave and one member of staff being on Compassionate Leave.

Thursday 29th November 2012/Friday 30th November 2012

All Ennis patients attended, there were no cancellations.

See attached table with shows an overview of Ennis patients' attendance for November'12

Kim Murray
Day Care Services Manager

Ennis Attendance Numbers for November 2012

Name	T 1	F 2	M 5	T 6	W 7	T 8	F 9	M 12	T 13	W 14	T 15	F 16	M 19	T 20	W 21	T 22	F 23	M 26	T 27	W 28	T 29	F 30
[redacted] P30 P35 P41 P202 P44 P43			RC	WENA	RC			RC								RC	RC	RC				
			RC	WENA	RC			RC								RC	RC	RC				
				WENA	RC			RC								RC	RC	RC				
					F	U	L	L		A	T	T	E	N	D	A	N	C	E			
								APPT										APPT				
													RC									
[redacted] P197 P46 P44 P199 P204 P40 P45 P47	R		S		RC	RC		RC	RC	RC	RC	RC						RC		RC		
					RC	RC		RC	RC	RC	RC	RC						RC		RC		
				RC		RC	RC															
				RC		RC	RC															
					F	U	L	L		A	T	T	E	N	D	A	N	C	E			
					F	U	L	L		A	T	T	E	N	D	A	N	C	E			
	R			R		RC	APPT	RC	RC	RC	RC	RC						RC		RC		
							RC	RC	RC	RC	RC	RC						RC		RC		
													RC									

R-Refused **S-Sick** **WENA-Ward Escort Not Available** **RC- Room Closed** **Appt-Appointment**

3.022 d19

Appendix 19

3.023

Ennis Resettlement Meeting 21/10/2012

Belfast Trust

Present

Dr H50

Dr H194

Rhonda Scott

Mary Mc veigh

B1 (Bohill)

H196 STD N

Catherine O'Callaghan

Liz Moore

Catriona Mulvenna

Bohill Update

The 3 ladies from Erne for Bohill are P199, P43 and P39

Care plans will be discussed with a hope of signing off when amendments have been made.

Timescales will also be discussed.

No concerns from Bohill staff that have been working in Ennis with the 3 ladies.

Timescale discussed for ladies to move W/C 12th November 2012, it is thought that it would be best for all 3 to move together. Staff from Ennis will visit Bohill on a daily basis for the first 2 weeks initially (an Ennis staff member there 24 hrs) but this can be reviewed, H377 has agreed to same.

It was discussed after discussion surrounding behaviours of some female patients that single gender units would be the best way forward.

Restrictive Practices will be discussed further with H92 for his opinion.

Issue with registering with G.P still on-going, B1 is dealing with this at present.

B1 had enquired as to wither a month supply of medications could be prescribed from M.A.H, Dr H194 will enquire with Pharmacy regarding same.

Risk Assessments will be completed for all and monitored 3 monthly.

Advocacy is happy with arrangements.

P199

Care plan was discussed and amendments noted, B1 will make amendments with signing off at a further date.

It was discussed that P199 will need encouragement in the mornings.

Funeral plan, H491 will update when completed and hope that the plan will be finished before the move to Bohill.

P43

Care plan discussed and amendments noted, B1 will update. Discharge summary from Ennis.

Family have visited Bohill, they are still nervous regarding resettlement but were impressed with staff, they are aware that there will be male staff on duty but they will not administer personal care.

Wheel chair is used for P43 s own safety when she has a seizure, this will need to be noted as a restrictive practice and on Bohill's risk register.

P39

Care plan discussed and amendments noted, B1 to update.

Even though seizures are historical the procedure in the community when a seizure occurs is to call 999.

Staff from Bohill had stated they were concerned re P39 removing her clothing as there would be male peers in the same unit it was discussed that P39 wears a swimsuit under her clothing and the possibility of a body suit will be explored, she could also be withdrawn to her bedroom and that every way of managing her behaviour has been explored, for this reason it was discussed that there would be issues surrounding vulnerable adults and restrictive practices, Catherine will refer to B.S.S for further clarification.

At this stage the possibility of single gender units was discussed, B1 will speak to RQIA regarding this issue as B1 felt that RQIA would seem more favourable towards mixed units in the community.

Rhonda will discuss further with H92 issues surrounding vulnerable adults and get his views on the issue.

All updates will be discussed at the next meeting.

3.023d20

Appendix 20

3024

Scott, Rhonda

From: B15 [B15's email address]
Sent: 22 October 2014 16:39
To: Scott, Rhonda
Cc: Gavin OHare-Connolly; Rosemary Dilworth
Subject: RE: Ennis Investigation

Hello Rhonda

The actual date that I was made aware was the 8th November 2012 by the Team Leader at the time.

Kind regards

B15

Home Manager
ore Care

Tel: 028 70 325180
Fax: 028 70 325185
B15's email address

From: Scott, Rhonda [mailto:rhonda.scott@belfasttrust.hscni.net]
Sent: 22 October 2014 14:22
To: B15
Subject: RE: Ennis Investigation

B15

I am keeping well how are you everything good at your end
Thank you for this B15 can you just clarify for us I know the report states the 8th Nov 2012 but what I need you to
ıfirm for me is when you where first alerted to concerns in Ennis
ık you
Rhonda

From: B15 [B15's email address]
Sent: 22/10/2014 13:59
To: Scott, Rhonda
Cc: Gavin OHare-Connolly
Subject: RE: Ennis Investigation

Hello Rhonda

Hope you are keeping well.

The initial report date of allegations are the 8th November 2012.

Kind regards

B15

Home Manager
Amore Care

Tel: 028 70 325180
Fax: 028 70 325185
B15's email address

From: Scott, Rhonda [mailto:rhonda.scott@belfasttrust.hscni.net]
Sent: 22 October 2014 13:23
To: B15
Subject: Ennis Investigation

B15
Can you confirm for me the date that staff at the Bohill raised concerns around the practices in Ennis As you know I am ...pleting the internal investigation and just need clarity on this issue
R. ...da

3.024d21

Appendix 21

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A4

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3025

Week commencing 15th October 2012

	Monday 1st	Tuesday 2nd	Wednesday 3rd	Thursday 4th	Friday 5th	Saturday 6th	Sunday 7th
B7	ERNE 8-8	ERNE 8-8				ERNE 8-8	ERNE 8-8
B14			ENNIS 8-8	ENNIS 8-8	ENNIS 8-8		
B16	ERNE 8-8	ERNE 8-8					ERNE 8-8
B10	ENNIS 8-8	SICK 8-8				SICK 8-8	SICK 8-8
B5			ENNIS 8-8	ENNIS 8-8	ENNIS 8-8		
B13			ERNE 8-8	ERNE 8-8	ERNE 8-8		
B9						ENNIS 8-8	
B17			ERNE 8-8	SICK 8-8	SICK 8-8		
B8	ENNIS 8-8	ENNIS 8-8				ENNIS 8-8	ENNIS 8-8

Week commencing 8th October 2012

	Monday 8th	Tuesday 9th	Wednesday 10th	Thursday 11th	Friday 12th	Saturday 13th	Sunday 14th
B3	ENNIS 8-8	ENNIS 8-8	ENNIS 8-8				
B4		ENNIS 8-8	ENNIS 8-8	ENNIS 8-8			
B16	ERNE 8-8	ERNE 8-8			ERNE 8-8		
B5	ENNIS 8-8				ENNIS 8-8		
B9			ERNE 8-8	ERNE 8-8			ENNIS 8-8
B17					ERNE 8-8	ERNE 8-8	ERNE 8-8
B12			ERNE 8-8	ERNE 8-8		ENNIS 8-8	

Week commencing 15th October 2012

	Monday 15th	Tuesday 16th	Wednesday 17th	Thursday 18th	Friday 19th	Saturday 20th	Sunday 21st
B11				ENNIS 8-8		ERNE 8-8	
B12	8-8	8-8			8-8		
B16	ERNE 8-8	ERNE 8-8			ERNE 8-8		
B13			ENNIS 8-8	ERNE 8-8			ERNE 8-8
B9	ENNIS 8-8	ENNIS 8-8				ENNIS 8-8	ENNIS 8-8
B17			ERNE 8-8		ERNE 8-8	ERNE 8-8	ERNE 8-8
B8	ERNE 8-8	ERNE 8-8	ENNIS 8-8	ENNIS 8-8			

Week commencing 22nd October 2012

	Monday 22nd	Tuesday 23rd	Wednesday 24th	Thursday 25th	Friday 26th	Saturday 27th	Sunday 28th
B7			8-8 Erne		8-8 Erne		
B18							8-8 Ennis
B10		11-11 Ennis		11-11 Ennis	11-11 Ennis		
B5	11-11 Ennis		11-11 Ennis				
B13	8-8 N/D Erne	8-8 N/D Erne				8-8 N/D Erne	8-8 N/D Erne
B17				8-8 N/D Erne	8-8 N/D Erne		ERNE 8-8
B12				8-8 Erne		8-8 Ennis	

Week commencing 29th October 2012

	Monday 29th	Tuesday 30th	Wednesday 31st	Thursday 1st	Friday 2nd	Saturday 3rd	Sunday 4th
B16	ERNE 8-8	ERNE 8-8				ERNE 8-8	ERNE 8-8
B5			8-8 Erne	8-8 Erne	8-8 Erne		
B10	11-11 Ennis	11-11 Ennis				11-11 Ennis	11-11 Ennis
B2	8-8 RATHMULAN						
B13			11-11 Ennis	11-11 Ennis	11-11 Ennis		

Week commencing 5th November 2012

	Monday 5th	Tuesday 6th	Wednesday 7th	Thursday 8th	Friday 9th	Saturday 10th	Sunday 11th
B2			11-11 Ennis				
B10			8-8 Erne	8-8 Erne	8-8 Erne		
B13		8-8 Erne				8-8 Erne	
B6	11-11 Ennis						
B5		ENNIS/N/D 8-8	ENNIS N/D 8-8			SICK	

Week commencing 22nd October 2012

	Monday 22nd	Tuesday 23rd	Wednesday 24th	Thursday 25th	Friday 26th	Saturday 27th	Sunday 28th
B7			8-8 Erne		8-8 Erne		
B14		8-8 Erne					
B18							~~8-8~~ Ennis Patrick G?2
B10		11-11 Ennis		11-11 Ennis	11-11 Ennis		
B5	11-11 Ennis		11-11 Ennis				
B13	8-8 N/D Erne	8-8 N/D Erne				8-8 N/D Erne	8-8 N/D Erne
B17				8-8 N/D Erne	8-8 N/D Erne		
B12				8-8 Erne		8-8 Ennis	

Week commencing 29th October 2012

	Monday 29th	Tuesday 30th	Wednesday 31st	Thursday 1st	Friday 2nd	Saturday 3rd	Sunday 4th
B11							
B4			8-8 Rathmullan	8-8 Rathmullan	8-8 Rathmullan		
B8	8-8 Rathmullan	8-8 Rathmullan				8-8 Rathmullan	8-8 Rathmullan
B5			8-8 Erne	8-8 Erne	8-8 Erne		
B10	11-11 Ennis	11-11 Ennis				11-11 Ennis	11-11 Ennis
B2	8-8 Erne	8-8 Erne				~~8-8 Erne~~	8-8 Erne
B13			11-11 Ennis	11-11 Ennis	11-11 Ennis		

B16

B18

Week commencing 5th November 2012

	Monday 5th	Tuesday 6th	Wednesday 7th	Thursday 8th	Friday 9th	Saturday 10th	Sunday 11th
B2			11-11 Ennis	11-11 Ennis	11-11 Ennis		
B10			8-8 Erne	8-8 Erne	8-8 Erne		
B13	8-8 Erne	8-8 Erne				8-8 Erne	8-8 Erne
B6	11-11 Ennis	11-11 Ennis				11-11 Ennis	11-11 Ennis

3023d22

Appendix 22

3 026

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CONFIDENTIAL

Muckamore Abbey Hospital
2nd Briefing report by M Mannion – 9th January 2013

Actions completed

- Over the Christmas period, I undertook a further two unannounced leadership walk arounds time commitment 4hrs x 2 =8hrs,
- I have completed a review of patient's notes, medical files, and drug kardex, 4 files that were requested to be reviewed by the strategy group and a further 4 files randomly selected from the remaining population of patients on Ennis. Time commitment 18 hrs.
- I have completed analysis of the monitoring forms submitted since the 19th of December taking an inclusive approach by integrating and reviewing previous data from the first briefing completed for the 20th of Dec 2012. Time commitment 10 hours.
- I have completed a review of the learning environment using the Learning and Assessment Standards created and regulated by the Nursing and Midwifery Council NMC. This involved reviewing the student evaluations over the last 2 yrs, requesting if there were any student or external reviewers concerns about the practice environment or behaviours of staff i.e. the NMC annual reviewers, the nursing Practice Education Facilitator the clinical tutors who act as the pre-registration nursing students placement supervisors from Queens University. Time commitment 5hrs.
- Update on the draft improvement plan;
    - Environmental concerns are being addressed cleaning schedules have been improved,
    - Repair of estates issues progressing,
    - Fire safety and environmental issues have been addressed,
    - Admin support officer time increased to support the ward sister,
- Communications with:
    - Executive Director of Nursing and the Director of the Adult Social and Primary Care Directorate,
    - Associate Director of Nursing,
    - Ward Sister and Deputy Ward sister,
    - Monitors present on the ward environment when I was present,
    - Co-Director of the Adult Social and Primary Care Directorate,
    - Service manager of Ennis,
    - Behaviour support officers x 2,
    - Medical staff in the unit,
    - Relatives visiting the unit,
    - Ergonomics trainer,
    - MAPA trainer.

Preparing this briefing paper time commitment 8 hrs.

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Review of patient's notes, medical files, and drug kardex

Documents were reviewed and completed in the care environment and at all times documentation remained in the clinical environment. The information governance policy was respected in this activity.

There were 8 patients files reviewed, 4 named patients as requested by the strategy group and a random selection of files from the other 13 patients. A patient who observed me taking out her records for review asked what I was doing, when an explanation was offered she declined giving her consent for the review to take place, this request was respected. One patient is expected to be discharged within the coming week therefore not selected for review.

There is a corporate commitment for MAPA behavioural strategies to be implemented when appropriate. All of the current patients in Ennis ward are described as presenting with challenging behaviours that on occasion will require the MAPA range of interventions. Registered Nurses, unregistered Health Care Support Workers and Nursing Auxiliaries, are trained in this process. Staff requiring updates are provided with update training which has included observation by a recognised trainer of the staff member when required to use this form of intervention.

There was evidence of an audit conducted in the last year of the MAPA process reported win the patient notes. The audit outcome was positive.

Active promotion of all other prescribed personal life story work i.e. get to know me documentation recorded in each note file reviewed, personal de-escalation strategies particular to individual patients as per care plan is expected and evidence of adherence to this process is recorded within the notes.

I found within my discussion with the MAPA trainer that the moves noted as potential allegations (Allegations were not discussed with the Trainer) could have been MAPA moves designed to protect both patient and others during perceived challenging behaviour episodes.

In my discussion with the Ergonomics trainer, I was advised that staff need to position themselves in such a manner to reduce potential harm to themselves and patients therefore patients with presenting Jerk like behaviours will require a firm and appropriate paced manoeuvre personal to the individual patient. Also it was noted with patients who are potentially unsteady in gait and are perceived or known to be somewhat over weight this must also affect a change of manoeuvres, further acknowledgement of furniture which is set lowly (as it is in Ennis) although comfortable is also a feature of staff when required to assist and support movement of patients, this may appear that some one could be "hauled out of a chair" staff are encouraged to support a patient who has their legs in under their body on a chair to manoeuvre their legs to the floor as a first step, prior to expecting them to stand or be assisted to stand. It was also noted that when moving someone who exhibits rocking movements backwards and forward or side wards rocking that staff are encouraged to move backwards and forward or sideways with them this reduces the risk of falls during dressing and moving activities.

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In my discussion with the behaviour officers it was noted that behavioural plans are regularly reviewed and that the nursing team are engaged in behavioural plans on each shift, it was noted by the 2 staff that much progress has been achieved from previous behavioural base lines in the previous ward environment prior to the transfer to Ennis this they both said was extremely positive yet constant.

In my discussion with the Ward sister regarding resettlement and community integration, she shared the following information. As a team they had been informed that the ward was due to close in March 2013 and that the Resettlement Process commenced in March 2012. All patient Annual Reviews were postponed by the Ward Consultant to facilitate weekly Resettlement meetings.

The Resettlement process began and progressed through the assessments despite working through times when there were unfortunately high levels of staff sick leave. At times the staffing suffered gross shortage ie 4 AM staff plus staff at 9.30AM.

This was highlighted with the Nurse Manager for the ward via emails, conversations and incident reporting. The manager for the ward spoke to me about my concerns.

The nursing staff's interest and morale did not appear to have lessened and every opportunity was still being provided to introduce the patients to the community. During the summer of 2012 a leaving party was held for the patients and their families. With Marquee and a musical entertainment, the patients had a great time on the day. We invited one of our ex patients, who had been successfully resettled in 2011 and she attended with a group of her friends to the dance.

Prior to this Allegation there had been a decision taken amongst patient's families, advocates and Multi disciplinary team that three patients would go to the Bohill Care Home on Trial Resettlement. Assessments have been collated and care plans drawn up. The team leader and manager had visited Ennis and had been in attendance at Resettlement meetings along with R.Scott CIP and Care Managers from the Belfast Trust.
Staff from the Bohill had begun a 6 week period of visiting the patients in Ennis and getting to know them and their needs. Unsettled behaviours of some patients were noted early on and reported to me as ward sister, this was relayed to the Resettlement team. I expressed concern that a period of 6 weeks may be too long if the patients continued to be upset.

At a meeting held in Erne ward to Review the progress of the visiting staff and patients it was requested that the "Bohill staff come to myself if they had any concerns", "I had to redirect member of Bohill staff as a disturbed patient was directing verbal aggression towards them, during their time on the ward".

The staff visits by Bohill had commenced before the ward sister in Ennis had a copy of their duty rota. Staff on duty found this confusing at the time. It was explained that there was problems with the Bohill Care Homes emailing system. The duty received did not reflect the names or numbers of all the staff who reported for duty.

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On one occasion a nurse in charge received four staff who thought they should be in Ennis that day. The staff rotated on a 3 daily basis, two and sometimes three staff together every three days. Induction for this amount of people under the conditions we were working proved to be extremely difficult. The induction process that had been agreed did take place with staff from Bohill but Bohill had sent additional staff without first communicating with the ward sister to inform her of the same. This did result in confusion.
I found evidence of adherence to Trust policy and guidance by the nursing team and active leadership by the ward sister and deputy ward sister.

Documentation review findings;

1. **Patient Nursing notes spanning last two years 2011-2012**

- Roper, Logan and Tierney model care plans in use, fifteen activities of living completed and a review process conducted each six months. This is a person centred care planning process for Nursing Care.
- Named nurse and associate named nurse identified within each set of notes, each record was signed by the nurse recording the information.
- The ward team is actively implementing the need to care for each individual patient in accord with the RCN Dignity Standards;
  - understand my health,
  - respect me,
  - get to know me,
  - having choices,
  - making decisions,
  - feeling safe and promoting my safety.
- Current Patient Protection Plans evident within the notes.
- Patient body charts were used recording bruise/marks noticed, when supporting personal hygiene care, with appropriate medical intervention when required.
- Behavioural plans with Antecedent, Behaviour and Consequences charts, known as ABC charts evident within the plans.
- Contemporary daily care reports written by registered nursing staff.
- Incident reports, Vulnerable Adult forms with associated person centred interventions recorded.
- Personal requests made by patients to be reviewed by the medical team regarding care were recorded.
- Nursing staff concerns relating to aspects of care recorded.
- Not all notes had a current Social Work report but evidence of an historical report.
- I found evidence of basic personal care, personal hygiene, Oral hygiene, fingernail and hand care, toe nail and foot care, hair care and clothing care were all appropriate and respected choice and identified personal preferences of the patients.

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- For some patients there were transitional plans covering moves from the previous clinical environment to the present.
- Multi-disciplinary care reviews were recorded and more recently the integrated community plan meetings were recorded with invitation to family to be involved but not always availed off.
- All patient notes reviewed held the status of delayed discharge from 2007, with many care environments having been assessed and deemed not appropriate or the external providers deeming the patients to be complex and challenging and unsuitable for their environments.
- All files reviewed were consistent with multi professional working relationship, ie the drug kardex was in line with medical review, nursing record and other records. There was evidence of active consultation between members of the multidisciplinary team with record made in the respective notes.
- All patients reviewed had high levels of co-morbidity including learning disability, sensory impairment, communication difficulties, physical ill health, severe and enduring mental illness and challenging behaviours.

2. Drug Kardex

- Pharmacy reviews were present in the files. Current and past documentation evidenced practice adhering to the controlled drugs standards and drug trolley key , storage of drugs, administration of drugs standards by Nursing and Midwifery Council .

3. Medical file which included Allied Health Professionals interventions

- All eight files had Capably Assessment completed in 2010 for access to personal funds; Patient Financial review documentation was not reviewed.
- Regular Blood results.
- ECGs reports.
- Blood test results required for mental health drugs completed at prescribed time frames.
- Dental care, and recorded pre-intervention drug therapy to calm the individual patient were appropriate.
- Foot care.
- Speech and Language Therapist involvement.
- Behavioural plans and review.
- Day care plans and review.
- Other medical interventions and associated documentation recorded concerning physical health issues relevant to individual patients, Heart care, diabetic care, gynaecological care, assessment for dementia.

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Analysis of Monitoring Forms and Evidence of effective care process found in the review of patient files

I thematically reviewed all monitoring forms submitted and the evidence found in the patient files using The Early Indicators of Concern (University of Hull) and the RCN Dignity Standards.

A total of 118 monitoring forms covering 1519 hours of observed practice have been submitted over an eight week period by independent monitors, to observe practice over a 24 hour cycle.

Results from the monitoring form review and direct observation:

All 118 monitoring forms identified many examples of good practice and positive interaction by staff with patients and similar was directly observed.

The positive themes were;

- The monitoring forms and patient files showed that concerns about patients care and wellbeing is a high priority for all staff in Ennis. Each concern is rapidly addressed by appropriate intervention.
- I found evidence from the monitoring forms of proportionate use of supervision and observation. There was evidence that staff were aware of the need for personal privacy for patients and that intrusion must be proportionate.
- I found evidence that the nursing care and the environment encourages;
  - The care of personal processions; where there is minimal family involvement, the named nurse and associate staff promote personal belongings, as appropriate with life story work and individual preferences when possible,
  - Financial care promoting independency in appropriate manner,
  - Supporting patients to care for their personal space promoting self care appropriate to the skill and needs of each patient,
  - Essential records are being kept effectively,
  - Known personal choice/ preferences are supported e.g. country and western music, car outings, garden time, object reference such as bottle tops which supports one patient to self calm herself, time alone, etc.
- Staff anticipating behaviour escalation between patients and defusing the same when and where possible by appropriate intervention. The nursing team actively intervene to prevent challenging behaviours between patients and towards staff. When an incident occurs it is recorded and reviewed to change practice if required.
- I found evidence of a high level of critical appraisal of evidence i.e. analysis of patient behaviour, the aim of which was to understand the behaviour and therefore make an informed decision about care approaches to meet the needs of the individual. This level of attention to the caring process was complimented by

knowledgeable staff who demonstrated understanding of the diverse and complex care needs of the patients in Ennis.

- I found evidence of appropriate AHP input to personal protection plans which were also acknowledged as potential restrictive practice and recorded in patient care plans e.g;
  - Protection plan, that only three patients be present in the lower dining room to facilitate proportionate support for meal time behaviours which promote reduction of risk of choking the promotion of fluid intake and self management of dining cutlery, recommended by Speech therapist,
  - Protection plan, for some patients the requirement of doors being locked near the kitchen area to reduce the risk of self injury,
  - Protection plan, locked doors near the hall way close to the Nursing office as some patients have been assessed as requiring this intervention for self protection,
  - Care plan, promotion of personal dignity by use of bathing suit as an under garment and belt to "divert" i.e. behavioural therapy approach to reduce the behaviour of the removal of clothes.
  - Care plan recorded oral bleeding and ongoing treatment needs for one patient, this bleeding generates distress for the patient and she would be known to scream and cry out when she notices the bleeding. Staff reassures her at these times but often she appears inconsolable. She requires drug there prior to each dental visit and or potential intervention. It is also noted that there is minimal family involvement and desire to be involved in the community integration plan.
  - A patient was diagnosed in 2012 with an emergency condition requiring quick identification and transfer to the local general hospital along with her specific medication kept on the ward. A protection Protocol was developed and is explained to all staff in the practice environment this has facilitated staff intervening appropriately and the patient remains well.
- I found evidence of communication needs from a person centred care perspective for each patient in the care plans e.g. Pictorial support aids, Simple verbal consistent instruction, behavioural redirection, de-escalation strategies, Sensory stimulation or reduction of stimuli. This evidence was complemented by the demonstration of staff knowledge within their skills of communicating with individuals and their correct interpretation of patient's behaviours and what the behaviour may be aiming to communicate. The outcome within their approaches promoted calm and responsive care, both within the monitoring reports and my personal observation.
- I found evidence that involvement with external agencies, relatives, multi-professional staff are all openly facilitated. There is also an unrestricted visiting time freedom for visitors. The ward was an open environment with the daily contact with estate management staff, hotel services staff, administration staff, transport staff and professional staff.
- Patients are encouraged and facilitated to talk to staff and visitors, on the ward and in private. I did not find any example, during direct personal observation, of staff preventing patients speaking to staff or visitors, nor was there evidence of such

Belfast Health and Social Care Trust

restriction on the monitoring returns. Each patient is offered an explanation of who you are and your purpose within the environment, openness is encouraged.

- I found evidence of dietary needs, choices, preferences and consistency of food requirements are individual to each patient and are meet, as far as is possible,
- I found evidence of fluid intake encouragement is promoted and supported no restrictions for patients both observed and recorded.
- I found no evidence of a culture that may be accepting of behaviours or communications that could be defined as abusive or any evidence of systemic abusive practice.
- It has been reported to me by Ester Rafferty has been given 4 induction papers that were jointly signed off as having had the opportunity and completed the induction process by Bohill staff and Ennis staff. This evidence will challenge the comments alleging that no induction took place. Ester Rafferty will report on this matter.

From the 118 monitoring forms only 67 that had identified concerns the key themes were;

- Staff levels at key times in the day impairing the ability to facilitate the needs of patients for activity based interventions,
- The challenge of keeping the curtains up with the frequency of the patients pulling them down,
- The challenge for staff maintaining dignity for some patients with the behaviour of removal of clothes,

Nursing Practice Placement Review

Prior to this practice allegation there have been no concerns with respect to this practice placement area over the last 2 years. This is inclusive of professional staff from Queens University.

Ennis currently has 3 mentors. 2 sign-off mentors and 1 mentor who are registered on the live mentor register.

The ward area was last audited in September 2012.The outcome of the audit agreed two students but reduced to one following temporary move of band 6 to Donegore. A Band 6 nursing position had not replaced by an equivalently experienced nurse at the time of the allegation. This has been resolved in November 2012. This learning environment is audited to facilitate novice to the final placement in management students, this is a commendation for the ward practice area.

The student evaluations themed were all positive about the learning and supportive experience offered them by the nursing staff in the ward some of the quotes were:
"Great support from mentor", "staff supportive", "all my learning outcomes achieved", "the induction to the ward was informative and gave me knowledge about the ward and practice". Progressive development of an orientation pack for students is underway; also a further member of staff will be commencing the mentor training in Sept 2013.

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The ward area is still open for future student placements although the recent student was re-allocated therefore no student currently on placement.

We await the outcomes and recommendations of the investigation before advising Academic Education Institutes (AEIs) of any changes to the area prior to the next QUB allocations. Allocations will take place in January for March students.

Recommendations

- That the current protection plan of continuous monitoring activity be discontinued as there is no evidence that there is a culture tolerant of behaviours that could be defined as abusive or support systemic abuse.
- Complete investigations as rapidly as possible to allow normalisation of the care environment.
- Recommence student allocations to this practice environment for the March students in Queens University.
- That we progress with the improvement plan for staff in the Ennis environment .

Moira Mannion
Co-Director of Nursing: Education and Learning
8th of January 2013

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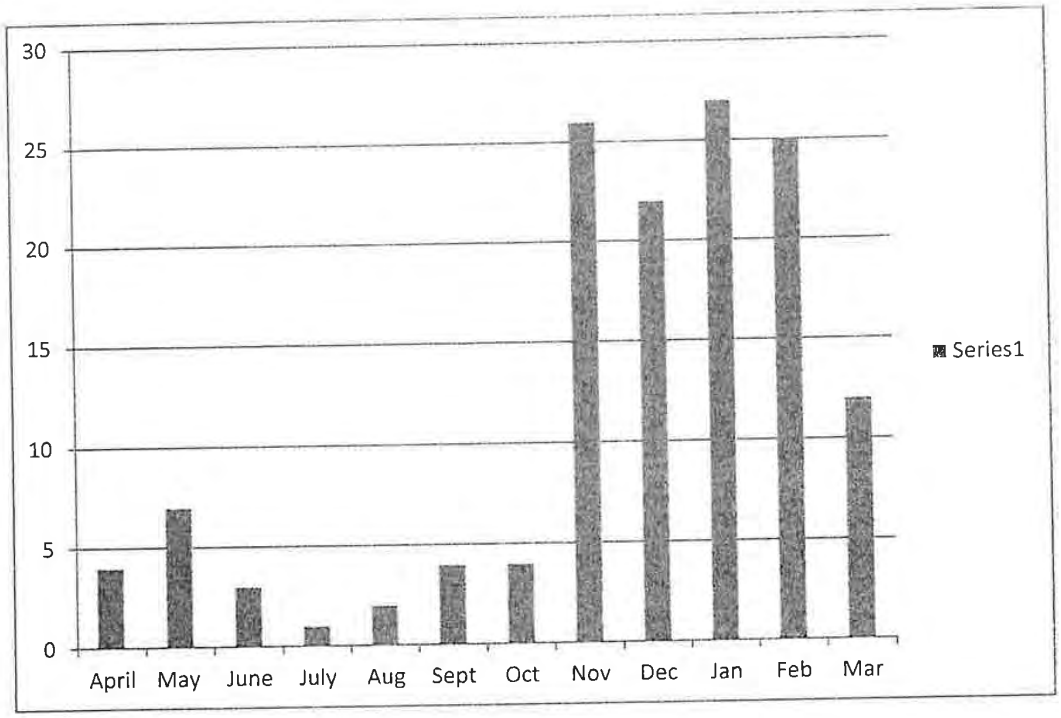
Appendix 23

3 627



Vulnerable Adult Referral 20012 to 2013

April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
4	7	3	1	2	4	4	26	22	27	25	12

Version 4

12.106

Ennis Internal Inspection

Date completed : 12th December 2012

Updated 19th February 2013

Room / Area no.	Issue noted	Suggested resolution	Responsible person/dept	Completion date	Completed	Comments
Front Porch	Unused curtain rail above front door	Remove rail –docket	Estates	Feb 13	Complete	
	Paper sign on inside front door	**Laminate notice – Siobhan to update all notices in ward and laminate as necessary**	Nursing			
	Some notices on notice board out of date i.e. organisational chart	**As above**	Nursing			
	Varnish worn on wooden ceiling	**Re- varnish - docket**	Estates			
Front corridor (right)	Partial picture hook in wall outside room 76	Remove hook - docket	Estates	Feb 13	Complete	
	Floor dusty	Clean floor and audit for a period of 4 weeks	PCSS	21/12/12	complete	Ongoing monitoring
Room 76 (Bedroom)	Curtains partially down	Re hang curtains	PCSS	8/1/13	complete	Ongoing monitoring
	Germazap not working	Fix, remove or replace - docket	Estates			
	Rails available for screens round beds but no curtains	Replace and hang curtains	PCSS	14/1/13	complete	New curtains made. Recommend WM sources disposable type
	2 ceiling lights not working	Replace bulbs	Estates		Completed	

1

Version 4

	(nearest the door)				16/01/13	
Room 77 (Staff room)	Very cluttered	De-clutter	Nursing			**Work in progress – well improved**
	Mirror scratched	Replace mirror - docket	Estates	Feb 13	complete	Mirror removed
	Dirt around base of toilet (at floor)	Clean toilet and audit for a period of 4 weeks	PCSS	23/12/12	complete	Ongoing monitoring
	***Door sign incorrect**	**Siobhan to send a docket to estates**				
	***Holes where mirror has been removed**	**As above**				
Room 82 (bathroom)	**Hole around copper pipe beside toilet**	**Fill hole and repaint –docket**	Estates			**Check?**
	Radiator control on top of unit	Replace control -docket	Estates		Completed 16/01/13	
	Soap dispenser empty	Fill and audit for a period of 4 weeks	PCSS	23/12/12	complete	Ongoing monitoring
	Towel dispenser empty	Fill and audit for a period of 4 weeks	PCSS	23/12/12	complete	Ongoing monitoring
	Cleaning mitt and towels sitting out on ledge	Ensure all tidied away	Nursing	Feb 13	complete	
	Colour coding and **bathroom regulations** on bench	**Put bathroom regulations on wall**	Nursing			**Colour coding on wall, bathroom regulations not available**
	Surround frame on white sheetrock behind shower broken	Fix or replace - docket	Estates	Feb 13	complete	
	Blinds dirty	Clean blinds and audit for a period of 4 weeks	PCSS	08/01/13	complete	Ongoing monitoring

2

Version 4

	***Blinds broken** **Window latch broken** Fan not working Cord pull for light missing Dirt on the lid of the laundry skip ***Commode dirty** ***bathroom cupboards were dirty** ***Bathroom sink was dirty**	**Siobhan speak to Andersons** **Fix latch - docket** Fix or replace - docket Fix or replace - docket Clean laundry skip and audit for a period of 4 weeks **Condemn as this isn't used**	Estates Estates Estates Nursing	Feb 13	Completed 16/01/13 Complete	Ongoing issue with fan re type of fan required for this area
Room 80 (bedroom)	**Floor scuffed** Floor stained and dusty **Redundant slide latches on doors/holes where slide latch has been**	**Capital bid? April 13** Clean floor and audit for a period of 4 weeks **Remove slide latches and cover space with blank face plate – discuss with patient**	Estates PCSS	08/01/13	complete	Brian to follow up with hotel services re the best way to clean this while awaiting capital bid in April 13 Ongoing monitoring
Room 70 (bedroom)	Extra curtain rings on pole **Patches on the walls not painted where holes have been filled in**	Remove curtain rings - Andersons **Paint walls - Docket**	Estates Estates	Feb 13	complete	Linda to discuss with Andersons 21/01/13

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Version 4

	Cup stain on windowsill	Clean windowsills and audit for a period of 4 weeks	PCSS	23/12/12	complete	
Room 75 (day area)	***Table dirty**	**Table dirty at inspection in Feb - Clean table after all meals and audit for a period of 4 weeks**	PCSS	23/12/12	Complete	Ongoing monitoring
	Blind pole on window but no blind	**Remove pole / replace blinds – decision to be made which windows require to be sandblasted - liaise with Brendan – capital bid – April 13**	Estates/nursing			
	Surface peeling off hearth	**Re paint - docket**	**Estates**			Varnish to be applied 17/01/13
	Drawer handle missing - screws exposed	Replace handles - docket	Estates	Feb 13	Complete	
	***Old table in room**	**Condemn**				
	8Screw in wall behind door	**Remove**				
Front Corridor	**Evidence of damp on ceiling outside room 83**	Fix and repaint – docket - **repainted – capital bit 2013**	Estates			
	Cobwebs on wall outside 118 and above fire door	Remove cobwebs and audit for a period of 4 weeks	PCSS	02/01/13	complete	Ongoing monitoring
	2 curtain rails on large windows, only 1 curtain hanging	Remove redundant curtain pole and re-hang curtains - Linda to decide which windows require to be sandblasted - Linda to arrange a visit from Andersons, liaise with Brendan – **capital bit April 13**	Estates/PCSS/Nursing			Linda to discuss with Andersons 21/01/13
	Fire doors scuffed	Fill holes and repaint- pending outcome **of capital bid meeting Apr 13**	Estates			Brian to assess and do what is possible pending the capital bid April 13

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Version 4

Room 83 (Toilet)	**Evidence of damp on walls**	Clean and re-paint toilet area- Estates will paint this toilet within next few weeks – **rub down and treat walls – repainted but walls bubbling and damp coming through again**	Estates		Completed 16/01/13	
	Faeces on toilet seat	Clean toilet seat and audit for a period of 4 weeks – random checks	Nursing		Completed 16/01/13	
	Large hole in wall – copper pipe exposed	Fill hole and repaint- pending outcome of capital bid meeting Jan 13	Estates		Completed 16/01/13	
	Nurse call button missing	Repair or replace with blank face plate - Linda to submit a docket	Estates		Completed 16/01/13	
	3 anti ligature hooks missing	Replace- Linda to submit a docket	Estates		Completed 16/01/13	
	Sock bag hanging in toilet	Remove	Nursing	21/12/12	Completed	Ongoing monitoring
	Cobwebs on walls and ceiling	Remove cobwebs and audit for a period of 4 weeks	PCSS	21/12/12	completed	Ongoing monitoring
	Floor dirty especially at join with walls	**Clean floor and audit for a period of 4 week – floor dirty – feb 13**	PCSS			
Room 118 (Linen store)	Copper pipe at room 120	Remove pipe and valve off - Linda to submit a docket – **fill hole where pipe was removed**	Estates		Completed 16/01/13	
	Store untidy	Tidy store	Nursing	Feb 13	Complete	
	Floor cluttered	Remove everything from floor onto shelves	Nursing	Feb 13	Complete	
	Floor dirty and scuffed	Clean floor and audit for a period of 4 weeks	PCSS	09/01/13	completed	Floor buffed

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Version 4

	***hole in wall behind door**	**Fit door stop to the wall**				
Room 85 (store)	Floor cluttered Rust on floor at front of filing cabinets, floor dirty ***Floor dirty**	Remove everything from floor to shelves Clean floor and audit for a period of 4 weeks – docket to Estates **Clean floor**	Nursing PCSS Estates	Feb 13 PCSS-Floor scrubbed 09/01/13	complete	Floor scrubbed & buffed. PCSS unable to remove rust stains requires Estates to rectify
Room 84 (store)	**Room cluttered** **Floor very dirty** Sticky labels on walls and shelves Paper notice on wall ***Holes in ceiling**	**Work in progress – continue to De-clutter room**, i.e. condemn water cooler - removed Clean floor and audit for a period of 4 weeks Remove and replace with laminated labels Laminate **Fill and repaint**	Nursing PCSS Nursing Nursing	 09/01/13 Feb 13 Feb 13 – Notices removed	 Complete Complete Complete	Floor scrubbed & buffed
Main Office	Paper notices on filing cabinets Floor scuffed and dirty Tarifold broken at back of desk ***Holes in wall where tarifold was**	Laminate Clean floor and audit for a period of 4 weeks Order replacement - Linda to submit a docket to have the bracket removed **Fill holes and repaint**	Nursing PCSS Nursing/Estates	Feb 13 Floor, moped scrubbed and buffed 16/01/13	Complete complete Completed 16/01/13	

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Version 4

	Sheetrock coming away from the wall in various places **Temperature in room very high** Large split between wall and ceiling **Window dirty – inside** ***Blue tack on ceiling**	**Remove and repaint - docket** **Regulate temperature and seal cover - Linda to submit a docket** Fill space and re-paint- Docket **Clean windows and audit for a period of 4 weeks** **remove**	Estates Estates Estates PCSS	09/01/13	complete	**Brian to assess feasibility of installing a thermostat** Ongoing monitoring
Room 89 (day space)	Stains on windowsill and floor **Blind pole but no blind** **Chair fabric damaged on all chairs**	Clean floor and windowsill - audit for a period of 4 weeks **Remove or replace - decide which windows require to be sandblasted - liaise with Brendan** **Re-upholster or replace**	PCSS Estates/nursing Nursing	21/12/12	complete	Ongoing monitoring Linda to discuss with Andersons 21/01/13
Kitchen store	**Needs to be painted** Floor, windowsill and skirting dirty Top of freezer sticky and dirty Large food remnants in window frame when window opened	Clean floor, windowsill and floor, audit for a period of 4 weeks Clean freezer, audit for a period of 4 weeks Clean window frame, audit for a period of 4 weeks	PCSS PCSS PCSS	21/12/12 Cleaned 21/12/12 PCSS Cleaned 21/12/12	complete complete complete	Ongoing monitoring Ongoing monitoring Ongoing monitoring

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	Open bottle of water on windowsill	Dispose of bottle – keep in fridge	PCSS	Disposed of 21/12/12	Complete 21/12/12	Ongoing monitoring
	Opened biscuits on shelf	All opened food stuff should be in sealed containers	PCSS Nursing	Disposed of 21/12/12	Complete 21/12/12	Nursing should also be storing opened foods in containers
	Staff food, individual patient food and communal food all in same area – **staff food still stored in patients fridge**	Separate storage areas for staff and patient food **Remove to staff storage area**	Nursing	Ongoing		A Staff room is available - staff food should not be stored on shelving or top of fridge. The Food store is for patients food only
	lollipops		Nursing	Feb 13	Complete	These belong to pts
Dining Room	~~Old stains on surface of cupboard inside door~~	Clean surfaces after every meal, audit for a period of 4 weeks	PCSS	Cleaned Daily	Complete	Ongoing monitoring
	Old stains on floor	Clean floor, audit for a period of 4 weeks	PCSS	Cleaned Daily	complete	
	Ground in (old) food debris on radiator cover	Clean area after every meal, audit for a period of 4 weeks	PCSS	Cleaned daily	complete	
	Broken window latch	Replace or fix – docket	Estates	Feb 13	Complete	
	No curtains or blinds on the windows	Replace curtains or blinds - Linda to decide which windows require to be sandblasted - Linda to arrange a visit from Andersons, liaise with Brendan	Estates	Curtains hung 11/1/13	Complete	PCSS made curtains for interim until new a re purchased. Linda to discuss with Andersons 21/01/13
	Old stains on top of bin	Clean surfaces after every meal, audit	PCSS	cleaned	complete	Ongoing monitoring

		for a period of 4 weeks		21/12/12		
	Unit at servery – top and drawers dirty	Clean surfaces after every meal, audit for a period of 4 weeks	PCSS	Daily	complete	Ongoing monitoring
	Walls marked at both sides of white roll dispenser	**Clean and re-paint - Docket**	Estates			
	Old food stains on inside of door leading to the dining room	Clean surfaces after every meal, audit for a period of 4 weeks	PCSS	Cleaned 21/12/12	Complete	Ongoing monitoring
	Sellotape on window frame	Remove and clean, audit for a period of 4 weeks	PCSS	removed 08/01/13	complete	
	PVC window frame cracked	**Fix or replace window frame – Capital bid – April 13**	Estates			
	Gorge out of the reveal at window	**Fill hole and repaint**	Estates			
	Wood on inside of 2nd door badly damaged	**Fix and re-paint or replace - pending outcome of capital bid meeting Apr 13**	Estates			Brian to assess damage and if not fixable – capital bit April 13
Room 98 (Dayroom)	Food stuff? / faeces? on the ceiling	Remove and clean, audit for a period of 4 weeks - Docket	PCSS Estates	PCSS removed 16/1/13	Complete	Requires estates o touch up p/work
	Germazap not working	Repair, remove or replace - docket	Estates	Feb 13	Complete	
	Fireplace not secured to wall – brackets broken	Secure safely- docket	Estates	Feb 13	Complete	
	Gouges out of door	Fill and re paint- docket	Estates	Feb 13	Complete	Brian to assess damage and if not fixable – capital bit April 13

	Faeces on chair **Damaged upholstery on all chairs**	Remove and clean, audit for a period of 4 weeks **Fix / replace**	Nursing Nursing	Feb 13	Complete	
Multi-sensory room	Paint work damaged Mirrors dirty	Re paint - Docket Clean mirrors, audit for a period of 4 weeks	Estates PCSS	Feb 13 Cleaned 2/1/13	complete complete	Ongoing monitoring
Dirty Laundry room	**Cluttered – boxes round the floor** Floor stained and dirty	**Declutter** Clean, audit for a period of 4 weeks	Nursing PCSS	Floor scrubbed 9/1/13	complete	Floor scrubbed & buffed
Clinical Room	Blue tack on walls Cobwebs in corner of room Door slow release removed – hole remains No medium gloves available Stains on doors and on floor around bottom of the doors Floor dirty Rust on floor below the O2 cylinder 2 O2 cylinders	Remove and clean Remove and clean, audit for a period of 4 weeks Fix door frame – Docket Replace gloves - is this included in nursing cleaning schedules as a task Remove and clean, audit for a period of 4 weeks Clean, audit for a period of 4 weeks Docket Are these both needed? yes	PCSS PCSS Estates Nursing PCSS PCSS Estates Nursing	21/12/12 21/12/12 Feb 13 Feb 13 21/12/12 21/12/12 Feb 13	complete complete complete complete complete complete complete Complete	Ongoing monitoring Ongoing monitoring Ongoing monitoring Cage to be built to house the O2 off the floor

				16/01/13	
2 suction machines	Send old machine to stores	Nursing	Feb 13	complete	Linda to send big suction machine to stores
No hibiscrub in dispenser	**Replace**	Nursing			
Tubes attached to suction machine	These should be sealed and readily available but not attached	Nursing	Feb 13	complete	
Suction machine on floor	Should be on a shelf - docket	Estates	Feb 13	complete	
Face broken on scales	Fix or replace – docket	Estates	Feb 13	complete	
Some leaflets/notices missing	Leaflets displayed should include: • NPSA cleaning colour coding poster available for nursing and hotel services staff • Poster for dilution rates of Antichlor plus tablets • Information re the management of sharps injuries • Information leaflets re MRSA and Clostridium Difficile	Nursing	Feb 13	complete	Jenni posted 25/2/13
Action in emergency notice out of date	**Display up to date notice**	Nursing			
Front of drug trolley dirty	**Clean, audit for a period of 4 weeks**	Nursing			Burn bin not opening
Drug packaging in burn bin	**Remove and dispose of appropriately – burn bin for medication only**	Nursing			
***Burn bin not opening**	**Order new bin**	Nursing	Feb 13	complete	
Sharps box not closed					

Version 4

	properly	Close after use				
Room 107 (Toilet)	No plug in sink		Estates		Complete 16/01/13	Decision made not to replace the plug as patients persistently remove it – this is a hand washing sink and does not require a plug
	Faeces on toilet seat	Clean, audit for a period of 4 weeks	Nursing			
	Walls damp	Treat / clean and re paint – pending outcome of capital bid meeting Jan 13	Estates		Complete 16/01/13	
	***Walls painted but pain bubbling and damp coming through**	**Treat and repaint**				
	Bare plaster on walls where something has been removed and not repainted	Re paint - pending outcome of capital bid meeting Jan 13	Estates		Complete 16/01/13	
	Sheetrock coming off outside toilet door	Fix or replace 0 Docket	Estates		Complete 16/01/13	
Back Hall	Ceiling needs to be re-varnished	Re-varnish ceiling - Docket	Estates	Feb 13	complete	
	Damage to radiator cover	**Fix or replace cover – Docket – Source new cover form closed ward**	Estates			
	Door handles dirty	Clean, audit for a period of 4 weeks	PCSS	Cleaned 21/12/12	Complete	Ongoing monitoring
	Unused shelf brackets on wall	**Remove**	Estates			
	Sellotape stain on key lock	Clean, audit for a period of 4 weeks	PCSS	cleaned	complete	

	***Finger guard on door damaged**	**Replace finger guard**		2/1/13		
Room 115 (bedroom)	Floor stained Partial blinds missing **Hooks in wall**	Clean, audit for a period of 4 weeks Replace or remove blinds - ?sand blast – capital bid April 13 **Remove**	PCSS Estates	Cleaned 2/1/13	complete	Linda to discuss with Andersons 21/01/13
Room 109 (bedroom)	Inside windows dirty **Missing lock keepers on chest of drawers**	Clean, audit for a period of 4 weeks **Replace**	PCSS Estates	10/1/13	complete	Ongoing monitoring
Room 114 (bedroom)	Holes on windowsills Ariel lead not covered in **Floor gouged** Key operated light switch not working ***Blinds partially missing**	Fill and re-paint - docket Cover - docket **Fix or replace – docket – capital bid April 13** Repair - Docket **Andersons/sandblasting**	Estates Estates Estates Estates	Feb 13 Feb 13 Feb 13	Complete Complete complete	
Room 110 (bedroom)	**Blinds partially missing** Wardrobes scuffed	**Replace blinds – sand blast? Capital bid April 13** Replace/repair	Estates Estates	Feb 13	Ongoing	Linda to discuss with Andersons 21/01/13 Replace with surplus as patients are discharged
Room 111 (bathroom)	Incorrect signage on door	Replace signage – docket	Estates	Feb 13	complete	Remove signage for now on this door - capital bid to replace all signage

	Lid on laundry skip dirty	Clean, audit for a period of 4 weeks	Nursing	Feb 13	complete	
	Sticky labels in hygiene cupboard	Remove and replace with wipe clean labels (laminated)	Nursing	Feb 13	complete	Ongoing monitoring
	Shelves dirty	Clean, audit for a period of 4 weeks	PCSS	Daily	complete	
	Mirror marked	Clean, audit for a period of 4 weeks	PCSS	Daily	complete	Ongoing monitoring
	Fan dirty and dusty	Clean, audit for a period of 4 weeks	PCSS/estates	Exterior cleaned		
	Shower head dirty	Clean, audit for a period of 4 weeks	PCSS	10/1/13	complete	
	Inside window dirty	Clean window	PCSS	10/1/13	complete	
	Screens dirty, rusty and dusty **Still dusty**	Replace **Clean**	Nursing			Linda to get new screens from stores
	Blind pull missing	Replace - docket	Estates	Feb 13	complete	
	Wipes container broken	Replace	Nursing	Feb 13	complete	
	Pull cord in bathroom broken	Replace pull cord - docket	Estates	Feb 13	complete	
	***bathroom rules**	**Display**				
Front office	Computer dusty	Clean computer	Nursing	Feb 13	complete	
General - relevant to all ward	Paintwork on skirting boards, windowsills, doors, door frames, windowsills, ceilings and handrails chipped	Paint all skirting boards, door frames, handrails, windowsills, ceilings and doors - pending outcome of capital bid meeting Apr 13	Estates			
	Paint flaking on the ceilings	Clean off flaking paint and paint ceilings - pending outcome of capital bid meeting	Estates			

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		Apr 13				
	Plaster gouged on walls	Fill holes and repaint - pending outcome of capital bid meeting Apr13	Estates			
	Chipped paint on walls in dayrooms, bedroom and corridors	Repaint all dayrooms, bedrooms and corridors - pending outcome of capital bid meeting Apr 13	Estates			
	Redundant slide latches on doors/holes where slide latch has been	**Remove slide latches and cover space with blank face plate**	Estates			
	Surfaces, ledges, furniture, window frames, inside notice boards, behind hand rails, inside phone cupboards, top of wardrobes, top of TV cabinets and skirting boards dusty	Dust surfaces and audit for a period of 4 weeks	PCSS	Ongoing	complete	
	Notice boards unlocked/locks broken in some instances	**Order new notice boards for the ward**	Estates/Nursing			order new notice boards and submit a docket to have them put up when they arrive in ward
	Plaster work around door frames cracked	Remove plaster, re plaster and repaint - pending outcome of capital bid meeting Apr 13 - docket	Estates			Brian to assess and do what's possible pending capital bid April 13
	Holes in walls due to screws etc being removed	Fill holes and repaint - Docket	Estates			
	Screws/nails in walls Hooks in ceilings	Remove screws, nails and hooks, fill holes and paint - Docket	Estates			
	Cracks in walls	Fill cracks and repaint - pending outcome of capital bid meeting Apr 13	Estates			

	All light shades are dirty and have debris in	Clean lampshades and audit for a period of 4 weeks	PCSS/Estates			
	Door signage paint marks and dirty	Clean or replace - pending outcome of capital bid meeting Apr 13	Estates			Programme of cleaning all light fittings started 2/1/13 Brian to follow up with Rosemary
	Taps in bedroom sinks not working	Remove sinks – docket ***Replaster where sinks have been removed and repaint**	Estates			Brian to assess if an interim solution is possible pending capital bid Apr 13
	All handles on windows dirty and sticky	Clean handles and audit for a period of 4 weeks	Estates			Handles cleaned, Sticky residue left from glue being removed by Estates
	Hand washing signage missing from some hand washing sinks	**Check**	Nursing			
	Inside radiator covers dirty	Remove covers and clean - docket	Estates/PCSS	Feb 13	complete	
	Soap dispensers missing in some toilet areas	**Check**				Programme starting 23/1/13 Brian to follow up with Rosemary
	Paper towel dispensers missing in some toilet areas	**Check**	Estates			
	No bins in some toilets	**Check**	Estates			Bins should be bought out of ward budget - request WM to order – Linda to discuss with Rosemary
	Outside windows dirty	How often are these cleaned?		3x per year		
	Walls damaged from door handles	Fit door stops/fill holes in walls and repaint - docket				Contractor not due to clean windows until

	Wardrobes damaged and grubby	Clean and audit for a period of 4 weeks -			Complete 16/01/13	04/13 Brian to assess for a solution Furniture cleaned 2/1/13 Replace with surplus as patients are discharged

- Linda – to write a list of all work requiring dockets and discuss with Brian the best way to submit the work