1.001

Belfast Health and Social Care Trust

Ennis Report

Investigation into alleged incidents reported on 8th November 2012

CONTENTS

List of Appendices

Appendix 1	Summary allegations from the Safeguarding Report
Appendix 2	H198 's written statement
Appendix 3	H870 written statement
Appendix 4	Interview and responses with Ward Sister H491
Appendix 5	Interview and responses with Senior Nurse Manager H377
Appendix 6	Interview and responses with B4 Bohill
Appendix 7	Interview and responses with B7 Bohill
Appendix 8	Interview and responses with B5 Bohill
Appendix 9	Interview and responses with B6 Bohill
Appendix 10	Interview and responses with H197 Bank Nurse Ennis
Appendix 11	Interview and responses with H159 Health Care Support Worker Ennis
Appendix 12	Interview and responses with H205 Health Care Support Worker Ennis
Appendix 13	Interview and responses with H869 Health Care Support Worker Ennis
Appendix 14	Interview and responses with H203 Health Care Support Worker Ennis
Appendix 15	Interview and responses with H206 Health Care Support Worker Ennis
Appendix 16	Interview and responses with H196 Student Nurse Ennis
Appendix 17	Adverse Incidents/ Accident Reports
Appendix 18	Day Care Attendances from Ennis
Appendix 19	Minutes of Resettlement Meetings
Appendix 20	Confirmation from B15 (Bohill) on date of allegations
Appendix 21	Duty Rotas for Bohill Staff
Appendix 22	Briefing Report by M Mannion January 2013
Appendix 23	Vulnerable Adult Referrals April 2012 to May 2012

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

•To investigate matters regarding the treatment of patients in Ennis ward following a complaint of alleged abuse of patients by staff received from a visiting staff member from Priory Group, Bohill Care Home. (Bohill)

•To investigate managerial processes i.e. that the ward had been managed in a safe and effective manner particularly in relation to the day to day running of staff rosters, the daily activities of the ward and the environment requirements, prior to the Adult Safeguarding Investigation.

•To immediately report to the Trust any matter which may undermine the objectivity or robustness of the investigation. Referring any issue of concern, not directly relevant to the terms of reference, to the appropriate senior manager for action as appropriate.

•To make recommendations on what action if any should be taken in relation to the matters investigated. This should include a recommendation on whether the case should be referred to a disciplinary hearing.

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:

4. **To investigate the following matters regarding the treatment of patients in Ennis ward following a complaint of alleged abuse of patients by staff received from a visiting staff member from Priory Group.**

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. The investigation team noted themes in the allegations and have grouped these in this report.

36. Unnamed Staff (but again described as usually [H159] would put [P39] [P39] s belt on over her clothes, just under her breasts and tie it tight to stop her stripping. [B10] Bohill Staff, said to MAH staff that it looked tight but staff said that [P39] would be fine. When [B10] took [P39] to be changed, she would loosen the belt but again when she came back from her tea break, the belt would be tightened again. (Source: [B10] Bohill Staff)

[H159] (Ennis) interviewed. Question 10, Response: [P39] *can display very challenging behaviours. She is obsessed with food, strips 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? Response: *"Staff tried to amuse* [P39] [P39] *with soft balls, toys that sang or played music, this helped her to behave. Staff constantly redressed her.* [P39] *s behaviours usually got worse between lunch and tea time. New or strange staff was 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."*

[H197] (Ennis) interviewed. Question 19, Response: *"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? Response: *"Do not know. The nurse in charge was aware of all of these."*

[H206] (Ennis) interviewed. Question 11, Response: *"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 open. A swimsuit was used on* [P39] *for dignity as she kept 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."*

H205 (Ennis) interviewed. Question 10, Response: *"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."*

H869 (Ennis) interviewed. Question 11, Response: *"Bottom half of ward was locked. Garden area was secure/enclosed. Kitchen was locked. Level 3 observations. Patient* P43 *has drop attacks and 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."*

H203 (Ennis) interviewed. Question 10, Response: *"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."*

B6 (Bohill) interviewed. Question 10, Response: No

B5 P39 (Bohill) interviewed. Question 10, Response: *"I was commencing night duty and 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."*

When asked if she was made aware of how and why this was done she responded: *"I did not say anything as I was not sure if two staff were needed this was the only occasion."*

B7 (Bohill) interviewed. Question 10, Response: *"Cannot remember"*

Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager)

The investigation team concluded that P39 did wear a belt but that the tightness of the belt could not be determined. The investigating team were unable to substantiate this allegation.

45. Staff would fasten P39 (patient) belt as tight as possible to stop her removing her clothes. (Source: B5 Bohill Staff)

Refer to Allegation Number 36 above.

The investigation team concluded that P39 did wear a belt but that the tightness of the belt could not be determined. The investigating team were unable to substantiate this allegation.

48. H205 early 50's Description of H205 (MAH Staff) and a 2nd staff member (care assistant) in her 20's, small, thin, dark hair down past her shoulders and was different colours all the time (MAH Staff). Think her name began with S. P39 (patient) was making crying noises and care assistant stood up from her chair and put both her hands on P39 's mid back and pushed her away. P39 came back, happened quite a few times, then P39 started taking her trousers down. Care assistant was getting agitated – could tell by the tone of her voice. She said – that's enough – went towards P39 and was trying to get her belt tightened but P39 was moving about. An older care assistant came over and held P39 P39 had her hands on the arm of the chair and was bent over. Older care assistant held P39 by her hips of top half of the body while the younger care assistant yanked at her belt forcefully pulling it and fastening it. Her belly was all pushed up and hanging over her belt. She looked really uncomfortable. (Source: B5 Bohill Staff) another belt allegation

Refer to allegation 36

The investigation team concluded that P39 did wear a belt but that the tightness of the belt could not be determined. It is noteworthy that B5 stated during interview that her query was in relation to why two staff had been required to put on P39 's belt and that nothing untoward had occurred in relation to the tightness of the belt.

The investigating team were unable to substantiate this allegation.

1. H159 – MAH Staff – pulled P39 (patient) from the sofa P39 was sitting on, by the hem of her trousers, onto the floor and was verbally condescending (Source: B2 Bohill Staff)

H159 interviewed re allegation. H159 stated that at no time did she or did she ever witness staff push or pull P39 by any item of clothing, she has denied this allegation. She confirmed that staff needed to be assertive and due to the noise levels in the environment you had to raise your voice to be heard, she said that at no time did she ever shout at patients.

H197 interviewed re the allegation. She confirmed that staff did not shout but would have used a firm tone with her P39 when she was about to hit another patient to prevent her continuing with this behaviour, P responded to this firmer tone and it would have prevented her from hitting another patient. H197 stated that she had not witnessed staff push or pull P39 by any item of clothing. Staff would have turned P39 away from an area by putting their hands on her shoulders and turning her away.

B7 B5 and B6 (Bohill) all interviewed and stated that they had not witnessed staff pull P39 by items of clothing or use abusive language to the patients.

H206 H205 H869 H203 Band 3 Support Workers within Ennis, H H491 Ward Sister of Ennis and H196 Student Nurse on placement in Ennis at this time all interviewed. All staff stated that they had not raised any issues regarding any staff attitudes, treatment of patients, unprofessional conduct or any issues regarding staff practices that they were not comfortable with.

Investigating team unable to interview B2 (Bohill staff), 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.

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.

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.

26. Unnamed Staff – rough handling of P39 staff grabbing/ pulling at her when redressing. Mostly just 2 staff (care assistants) doing this. (Source: B5 B5 Bohill Staff)

Refer to allegations 45 and 48

The investigating team concluded that there is no allegation.

2. H159 MAH Staff, spoke in an inappropriate manner such as, 'get out of my way'/you're doing my head in', to patients in general. (Source: B2 Bohill Staff)

H159 interviewed re allegation. She confirmed that staff needed to be assertive and firm to be heard in the noisy and challenging environment but she denied shouting or speaking to any patients in an inappropriate manner.

Other relevant staff interviewed re: this allegation and responses as follows:

H869 interviewed, Question 6, response: *"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."*

H206 interviewed, Question 6, response: *No*

H203 interviewed, Question 6, response: *"Not shouting at her, staff may have used a firmer tone if P39 was displaying Challenging Behaviour."*

H196 interviewed, Question 10, response: *No*

H205 interviewed, Question 6, response: *"Not in a raised voice but in a firm voice when P39 was displaying her behaviours. This was not in an angry way."*

B7, B5 and B6 staff from the Bohill interviewed and all stated that they had not witnessed staff speak to patients inappropriately or use abusive language.

Investigating team unable to interview B2 (Bohill), B1 (Bohill Manager) H198 (Ennis) 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 made by B2 could not be substantiated.

11. H159 MAH staff, entered the day room where there were two patients, shouting something like 'would you behave, that's enough'. (Source: B2, Bohill Staff)

Refer to allegation 2.

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

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*

I [redacted] *the other staff was blond and called* [redacted] *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* [redacted] *at the Bohill the next day; this was then reported to* [redacted]. *The next thing the CID came to the Bohill to interview me."*

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

[redacted] interviewed and denied the allegation.

[redacted] 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."*

[redacted] and [redacted] (Bohill) interviewed and no issues/concerns raised d by any of these staff.

[redacted] and [redacted] from Ennis were asked:

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

Investigating team unable to interview [redacted] (Bohill) or [redacted] (Bohill Manager).

In relation to the allegation above, made by [redacted] or [redacted] the investigating team concluded that during interview [redacted] re-stated that this incident had occurred. The investigation team contacted Bohill on the 20th February 2015 @ 4pm to speak to [redacted] to seek her cooperation to proceed with this allegation. [redacted] informed the investigation team that [redacted] had a "*panic attack*" when informed that they wished to speak to her. [redacted] spoke to [redacted] and she reported on [redacted]'s behalf that [redacted] 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 [redacted] and [redacted] worked in Ennis during the 7th 8th and 9th October 2012. [redacted] stated during interview that she had reported this to her manager [redacted] the following day. The allegations were reported to the hospital on the 8th November 2012. The investigation team contacted the manager of the Bohill, [redacted] she has confirmed via e mail that these allegations were reported on the 8th November 2012 (Appendix 20)

18. Unnamed MAH Staff said to patients generally 'these girls are here to get rid of you', referring to Bohill Staff. (Source: [redacted] or [redacted], Bohill Staff)

[redacted] and [redacted] (Bohill) interviewed and raised no issues/ concerns re: this allegation.

[redacted] (Ennis) interviewed and all staff stated that this type of communication did not happen.

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

The investigating team concluded that the allegation could not be substantiated

19. Unnamed MAH Staff – everyone shouting at P39 (patient) with raised voices usually after day care when she stripped off. (Source: B8 Bohill Staff)

Refer to allegations 1, 2, 11, 16 & 38.

An allegation, taken from the Adult Safeguarding Investigation Report, was made by B2 B2 Bohill staff that H198 Nurse in Charge, had come out of the office in response to increased noise levels and shouted into the day room 'I'm fed up with the lot of you, you're doing my head in'

Investigating team unable to interview B8 (Bohill), B2 (Bohill), B1 B1 (Bohill Manager) or H198 (Ennis), however, H491 (Ennis Ward Sister) interviewed re any concerns raised. Question 3, Response: *"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."* H491 reported that this person was a Band 5 Nurse and following reporting, addressing this with the staff member and monitoring, no further incidents of this nature appeared.

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

37. H159 MAH Staff – said 'thank God you are taking her, she's a pain/ pest/ hard work', referring to P39 (patient). Not known if this was said within earshot of patients. (Source: B10 Bohill Staff)

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

B5 (Bohill) interviewed. Question 13, Response: *"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."*

No reference was made during any of the interviews that comments between staff were derogatory about patients.

Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

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

38. Unnamed staff (described as most staff) – responded to P39 (patient) when she would try to get keys by shouting at her 'don't be…', 'don't push…' no attempt to distract. (Source: B10 Bohill Staff) put with other shouting allegations

Refer to allegations 1, 2, 11, 16 & 38.

Ennis staff H206 H203 H869 and H205 all stated that they never heard staff shout at P39 but a firm tone would be used to distract her from her behaviours.

Bohill staff interviewed B7 B5 B4 and B6 and they did not raise any issues regarding this.

The Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigating team concluded that the allegation could not be substantiated

51. Comments between staff often derogatory about patients. (Source B4 B4 Bohill staff)

Refer to allegation 16

B4 interviewed re this allegation she stated during interview she had heard one staff use abusive language to a patient however did not raise any concerns about staff often being derogatory about patients.

The investigating team concluded that the allegation could not be substantiated

59. Anyone who spoke to me about P39 was very negative. Source: B8 Bohill Staff, PSNI Interview

Refer to allegation 16 & 51

The Investigating team unable to interview B8 (Bohill) or B1 (Bohill Manager).

The investigating team concluded that the allegation could not be substantiated

61. Some staff raised their voices at P39 asking her to 'stop it' or 'go away'. Source: B8 Bohill Staff

Refer to allegation 16 & 51

The Investigating team unable to interview B8 (Bohill) or B1 (Bohill Manager).

The investigating team concluded that the allegation could not be substantiated

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, 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 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

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

Refer to allegation 5

H197 s statement from interview re: this allegation as follows: *"On the day of this allegation* 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."*

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 Bohill staff, police report)

This was investigated by the PSNI.

During interview H197 denied this allegation

Bohill staff interviewed B7 , B5 and B6 and they did not raise any issues 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.

The investigating team concluded that the allegation could not be substantiated

22. Unnamed staff – staff would push P39 (patient) back by putting two hands on her shoulders. This occurred during the process of letting patients in and out of the dining room when P39 would try to push in. (Source, B8 Bohill Staff)

B7 (Bohill) interviewed. Question 7, Response: *"I didn't have concerns when I was there the only thing was the pads which was more of a query than a concern."*

B7 (Bohill) Question 8, Response: *"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."*

B5 (Bohill) interviewed re: this and no issues/ concerns raised.

B6 (Bohill) stated that she saw staff push patients away from dining room door although she reported that she wasn't sure if this was right or wrong. She felt that it wasn't abusive although stated that staff did not explain what they were doing and why when they were working with the patients. She stated that she discussed this with her Line Manager the next time they met but was informed that concerns had already been raised about Ennis at this stage. When asked if she would have raised this as a concern had other issues not been raised and she replied *"No I did not think it was abusive practice."*

B4 (Bohill) was asked about her understanding of how the Meal Time routine was managed. Response: *"The patients were taken in small groups, three I think at a time, this was organised.* 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."*

Investigating team unable to interview B8 Bohill) or B1 (Bohill Manager).

The investigation team were unable to substantiate the allegation however it is noteworthy that the description of how P39 may have been moved is in keeping with Manual Handling.

23. Unnamed Staff – an unnamed patient was 'more than guided', grasped around the wrist, some force used, wasn't resisting. (Source, B8 Bohill Staff)

B7, B5, B4 and B6 (Bohill) were interviewed re: this and no issues/concerns were raised.

H869 (Ennis) interviewed re: this and described how she would have put her hand on a patients elbow and her other hand on their wrist to move them safely with guidance.

Investigating team unable to interview B8 (Bohill) or B1 (Bohill Manager).

The investigation team were unable to substantiate the allegation however they noted that the description given is in keeping with Manual Handling.

24. Unnamed Staff – P39 (patient) put into a chair. P39 sat with legs up. Staff sat with back to her on the same chair. P39 usually kicked staff away to get out of chair. (Source: B9 Bohill Staff)

B7, B5, B4 and B6 (Bohill) all interviewed re: this allegation and reported no issues/ concerns.

Investigating team unable to interview B9 (Bohill) or B1 (Bohill Manager).

The investigating team was unable to identify any staff member or members in relation to this allegation and were therefore unable to substantiate the allegation.

25. Unnamed staff (short, spikey dark hair) – P39 (patient) trying to get into the kitchen – staff firmly put hands on shoulders from behind and moved her away. (Source: B9 Bohill Staff)

Refer to allegation 30

Investigating team unable to interview B9 (Bohill) or B1 (Bohill Manager). Unable to identify who the staff was.

The investigation team were unable to substantiate the allegation however it is noteworthy that the description of how P39 may have been moved is in keeping with Manual Handling.

30. Unnamed Staff – pushing patients away from dining room door rather than say excuse me. (Source: B6 Bohill Staff)

Refer to allegation 22 & 25

B6 (Bohill) stated that she saw staff push patients away from dining room door although she reported that she wasn't sure if this was right or wrong. She felt that it wasn't abusive although stated that staff did not explain what they were doing and why when they were working with the patients. She stated that she discussed this with her Line Manager the next time they met but that concerns had already been raised about Ennis at this stage. When asked if she would have raised this as a concern had other issues not been raised and she replied *"No I did not think it was abusive practice."*

The investigation team concluded that there is no allegation.

54. Clients fed as quickly as possible, brought out again without wiping their faces. Source: B6 Bohill Staff. (worked 11am-11pm on 5/11/17)

Refer to allegation 22, 25, & 30

B6 during interview did not raise this as a concern

The investigation team concluded that there is no allegation

55. Patients crowding at the door – pushed out of the way without speaking to them or saying excuse me.
Source: B6 Bohill Staff, PSNI Interview (worked 11am-11pm on 5/11/17)

Refer to allegation 22, 25, 54 & 30

The investigation team concluded that there is no allegation

32. Unnamed Staff (described as usually long standing staff) pulling/ dragging unnamed patients off sofa. Example given – female patient had just laid down on sofa when a staff member reached for her feet, swung her legs around and reached for her wrist and elbow and pulled her out of the chair with force. (Source: B10 Bohill Staff)

The interviews conducted questioned staff generally on moving interventions employed and observed.

Refer allegation 1.

H197 (Ennis) interviewed. Question 23, Response: 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 *"*

H159 (Ennis) interviewed. Question 22, Response: *"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* P39 *and* P41 *."*

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

"Ergonomics trainer advised that 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."

Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigation team were unable to substantiate the allegation however they noted that the description given is in keeping with Manual Handling.

34. Unnamed staff (but including H159) – would reach for P39 (patient) by the shoulders from behind and pull her backwards into a chair, then staff would sit in front of her to stop her moving. (Source: B10 Bohill Staff)

Refer to allegation 1 & 32

Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigation team were unable to substantiate the allegation.

60. Staff would place 2 hands on P39 s shoulders and push her away from trying to get into the drinking room – not forcefully Source: B8 Bohill Staff.

Refer to allegation 1, 32 & 34

Investigating team unable to interview B8 (Bohill) or B1 (Bohill Manager).

The investigation team were unable to substantiate the allegation.

3. H159 MAH Staff, hit P40 (patient). P40 observed coming from the bathroom naked screaming and shouting "I hate her. I hate her, I hate H159 H159 she hit me". P40 very distressed and blood was coming from her mouth. (Source: B2 Bohill Staff)

H159 interviewed. Question 8, response: *"the ward was short staffed; I was there on my own. I decided to start self-care earlier than usual straight after tea. I did not change P P40 she was in the toilet having a bowel movement and was screaming and yelling. I heard her I did not see her. Student Nurse H196 came to help after 10 mins with the patients self care. I started changing the girls between 6.15pm and 6.30pm and bringing them to the dayroom. At 7pm I finished, locked the bathroom door and commenced the patient's suppers. Patient J P43 was soiled so I took her to the bathroom. Student Nurse H196 brought patient P40 to the bathroom, she was naked. B2 came down to the bathroom when I was changing P43 . I asked her to get fresh pyjamas for P P40 and then take her back to the dayroom. I did not see blood and I did not complete P P40 s oral hygiene that night. No staff had made me aware of anything P40 had said that evening."*

Other relevant staff interviewed re: this allegation and responses as follows:

H196 interviewed. Questions 4, 5 6, 7, and 8:

Question 4, 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, 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, response: "*No*"

Question 7 response: "*No I cannot remember*"

Question 8 response: "*No I cannot remember*"

H197 interviewed re: allegation. Question 8, response: *"I was in the day room and then went with the Student Nurse to administer an enema on patient* P41 . P40 *was in the day room Student Nurse went to get pyjamas for her. I did not change any patients that evening.* P40 *alleges these things all the time. I do not recall as she says these things all the time."*

H196 called to attend a second interview 2nd June 2014.

Question 1, response: *"I took laundry down to the back area of the ward. I put slippers on a patient."*

Question 2, response: *"I cannot remember the patients' names"*

Question 3, response: *"Yes I did help with bedtime changes but do not remember who"*

Question 4, response: *"Cannot remember"*

H869 interviewed, Question 6, response: *"No never."*

H206 interviewed. Question 5, response: *"Yes ,* P40 *would say this about other patients never heard her say this about a member of staff."*

How was this addressed? Response: *"If we had not witnessed anything we would have reported this to the Nurse in Charge."*

H203 interviewed. Question 5, response: *"Frequently alleged that other patients had hit her e.g.* P44 *or* P43 *If she said that* P43 *had hit her then this would be true".* H H203 did not think that P40 ever alleged that staff had hit her. When asked how her behaviours were addressed she responded: P40 *would be comforted by staff a bit like when you sooth a toddler. We would have reported this to the Nurse in Charge or another trained staff member that day."*

H205 interviewed. Question 5, response: *"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.* P P40 *would have alleged this a lot." When asked how this behaviour was addressed she responded: "I asked patient were she had been hit and I identified that the patient was not on the ward at the time."*

Sr H491 interviewed. Question 10, response: *"Patients* P197 *and* P40 *make allegations, this should be in their care plan. Patients who strip should have this in their Care plans"*

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

H196 Student Nurse on Ennis ward at this time was unable to provide any further information regarding this allegation. Staff in Ennis gave varying perceptions as to whether P40 would make allegations regarding staff; H205 , H203 H206 and H869 stated they had not heard her say this about staff. Sr H491 stated that P40 would make allegations and that this should have been documented in her care plan. The investigation team examined P40 's care plan and there is reference that she does make allegations but does not state if this is against patients and/or staff.

P40 was referred to the Dentist immediately following this incident and it was noted that she had an abscess in her mouth at the time.

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

4. H196 MAH Staff, told P40 (Patient) that she wouldn't get her sweets and lemonade if she didn't put her nightdress on. P40 sitting naked for a period of time. (source: B2 Bohill Staff)

H196 interviewed re allegation and she denied that this had occurred.

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.

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)

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

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 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 o substantiate H197 s account.

17. H159 MAH Staff, told Bohill Staff they could not bring P43 (patient) in from where she was sitting outside on the wet grass or get her something to sit on. (Source: B3 or B4 , Bohill Staff)

B4 's confirmed in her interview that this incident had occurred. When asked who the staff was she responded: H159 *I think was her name."*

When asked who the patient was she stated: "P39 "

She was asked to describe the clothing the patients had on and responded: "P39 *was wearing a hoodie and Jeans."*

When asked if she made any attempt to bring the patient back in she responded: *"No* B3 B3 *brough her back in immediately I did not say anything."*

B7 B5 and B6 (Bohill) interviewed. Responses: No issues/ concerns raised by any of these staff.

H159 interviewed re: allegation. Question 13, Response: *"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. P P43 was only out in the garden if the weather permitted this and was observed by staff. P P39 did not go out unless staff were with her she was never put out."*

H197 interviewed re: allegation. Question 18, Response: P43 *loved 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."*

H205 and H869 from Ennis were asked if there was scope for patient engagement in activities apart from day-care. Both staff stated that the garden was used.

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 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. 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.

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)**

Refer to allegation 13

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 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."

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. Meeting 9th October 2012 in Erne with Community Integration Officer, ward sister of Erne ward sister Ennis Care Manager and Dr H194 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 13

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.

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 7 there is some evidence to discredit it.

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 feel 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

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.

53. P43 (patient) would have sat outside by herself without any staff going out with her or checking her. B3 told staff the grass was damp but they told her this was normal. (Source B3 Bohill Staff, worked 8am -8pm on 8/10/12).Refer allegation 14 and 23

Refer to allegation 50

The investigating team is unable to substantiate the allegation

15. H198, MAH Staff, failed to provide induction for B2 Failed to ensure appropriate supervision and care of patients. (source: B2 Bohill Staff)

H198 has retired from MAH since this allegation was made. She declined the opportunity of an interview however she sent a letter to the investigation team on 8th April 2014 - H198 stated in her letter that the person from the Priory (Bohill) commenced duty at approx. 10am on the day of the allegation. H198 stated that she did not give this person an Induction but introduced her to the staff she would be working with and asked them to keep her informed. H198 stated that the ward was extremely busy and that they worked short of staff for the day. This was further compounded by day care sessions being cancelled. H198 has stated in her letter that when she did her hand over to the night staff at the end of the day there was no concerns, issues reported (Appendix 2).

H491 (Ward Sister Ennis) interviewed: Question 5, Response: *"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. When Bohill staff arrived on the 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."* She also stated that the Bohill staff asked to work with patients who weren't identified for their service and that the patients' behaviour changed when the new 'faces' arrived on the ward.

H203 (Ennis) interviewed. Question 11, Response: *"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 P P39 They spent most of their time with patient 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."*

H205 (Ennis) interviewed. Question 11, Response: *"When they came onto the ward they were introduced to the staff they were to shadow 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 e.g. P202 The manager of the Bohill arrived on the ward to talk to the staff and they were outside with patient P202 the three of them stayed outside during this time. I worked quite a bit with the Bohill staff and never saw them work with patient P 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 day care by the time they*

arrived. The Bohill staff would then have gone to day care 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."

H869 (Ennis) interviewed. Question 10, Response: *"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."*

H206 (Ennis) interviewed. Question 10, Response: *"I was just told Bohill 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."*

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.

B7 (Bohill) interviewed. Question 2, Response: *"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"*

B5 (Bohill) interviewed. Question 2, Response: *"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."*

B4 (Bohill) interviewed. Question 2, Response: *"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 likes 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* B 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.*

B6 (Bohill) interviewed. Question, Response: "*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.*"

Investigating team unable to interview B2 (Bohill) or H198 (Band 5 Staff Nurse Ennis).

The investigation team from reviewing duty rotas for Ennis and Bohill staff can confirm that H H198 was the nurse in charge of Ennis on this day, 7th November 2012. H198 has stated in her letter that due to staff shortages that day and day care sessions being cancelled that she did not complete an Induction for the Bohill staff. The investigation team confirmed that the ward was short staffed that day and that day care sessions had been cancelled.

The investigation team is unable to confirm who the nurse in charge was was the day that B B7 stated she did not have much of an Induction. On reviewing the duty rotas for the Bohill staff there is no Saturday that the three staff B7 named worked in Ennis together.

In relation to the allegation made above by B2 that H198, MAH Staff, failed to provide induction for B2 the investigating team found enough evidence to uphold this allegation.

20. Unnamed MAH Staff – all staff – when P39 (patient) would take her shoes off, staff threw them away and said they did this to occupy her as she went after them. (Source, B8 Bohill Staff)

B5 (Bohill) interviewed re: any concerns. Question 11, Response: *"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."*

B6 and B7 (Bohill) interviewed re: concerns in relation to this and none raised.

B4 (Bohill) interviewed and she did not during interview raise any issues regarding staff taking P39 's shoes off and throwing them away to occupy her.

H206 (Ennis) interviewed. Question 7, Response: *"No.* P39 *will throw her shoes out the window or throw them across room herself especially if they are new shoes."*

H205 (Ennis) interviewed. Question 7, Response: *"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."*

H869 (Ennis) interviewed. Question 7, Response: *"No,* P39 *liked her shoes, she could take these off. She would have thrown her own clothing and shoes out the window on occasions."*

H203 (Ennis) interviewed. Question 7, Response: No

Investigating team unable to interview B8 (Bohill) or B1 (Bohill Manager).

The investigating team concluded that P39 's (patient) shoes were removed by both herself and staff but were unable to find evidence of any abusive practice in relation to this.

47. A care assistant, really thin, short brown hair about 50 – said if P39 (patient) was on the ground, they would throw them across the floor to distract her. (Source: B5 , Bohill Staff)

Refer to Allegation 20

B5 (Bohill) interviewed. Question 11, Response: "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."*

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

The investigating team concluded that there is no allegation

61. Staff would sometimes LIFT P39 's shoes and throw them away from her; (Source B8 Bohill Staff)

Refer to allegation 20 & 47

The investigation team unable to interview B8 or B1 Bohill)

The investigating team concluded that there is no allegation

29. Unnamed Staff – staff would push P39 (patient) away when she came up and held B6 's (Bohill Staff) hand, saying to P39 'leave her alone'. (Source: B6 , Bohill Staff)

B6 (Bohill) interviewed. Question 12, Response: *"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? Response: *"This did not happen. No one took* P39 *'s hand away I allowed her to hold my hand."*

B6 during interview did not raise this as a concern.

The investigating team concluded that this allegation is void.

57. Standing in the day room talking to the younger nurse H206 when P39 approached me and wanted to take my hand. Another patient whose name I don't know was walking up behind P39 P39 was turned away by H206 but not roughly. Then the night nurse (different staff member) pushed the other patient into the chair without much care causing her to flop on the couch. She said 'sit back down'.
Source: B6 Bohill Staff, PSNI Interview (worked 11am-11pm on 5/11/17)

Refer to allegation 29

The investigating team concluded that this allegation is void

58. P39 approached me again and took me by the hand and brought me around the ward. The night nurse said that I was rewarding P39 for bad behaviour by letting her bring me round the ward.
P39 was redirected away from me a lot, by the nurse and H206. H206 wasn't rough but the night nurse was pushing at her. She was very abrupt. She is quite a stocky lady so I don't know if she meant to be so rough but she would push them at arm's length abruptly. She was quite tall with reddish brown short hair, in her mid 50's – talked about retiring.
Source: B6 Bohill Staff, PSNI Interview (worked 11am-11pm on 5/11/17)

Refer to allegation 29 & 57

The investigating team concluded that this allegation is void

21. Unnamed MAH Staff- P39 (patient) standing naked in the hallway every morning at 8am when B8 Bohill Staff, arrived on shift. (Source, B8 B8, Bohill Staff)

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

H197 H159 H206 H869 H203 (Ennis) interviewed and all stated that P P39 stripped off her clothing frequently and that this was one of her behaviours that needed to be managed.

H491 (Ward Sister Ennis) interviewed in relation to management of behaviours on the ward and she stated that behaviour such as stripping should be documented in the patient's care plan. When asked if strategies to manage behaviours were documented in the care plans she replied: *"Yes it was expected to be. The Ward Manager monitored care plans. If new behaviours occurred I would check the care plan to see if this was documented – if this was not documented I would either add this myself or leave a message for Named Nurse to do this."* She also informed the investigation team that the evaluation sheets were read every day and that care plans were audited by the EQC Resource Nurse who recently offered additional training and support for care plans.

Investigating team unable to interview B8 (Bohill) or B1 (Bohill Manager).

The investigation team reviewed duty rotas for B8 working in Ennis. Records show that she worked on the 1st 2nd 6th and 7th October 2012 from 8am to 8pm.

Due to the reported and documented frequency of stripping behaviour by P39 the investigation team can conclude that this allegation is possible.

56. Took a break from 6.30 – came back at 7pm, all patients in their pyjamas – don't think possible to wash and change all patients in half an hour told bedtime routine started at 7.30pm.
Source: B6 Bohill Staff (worked 11am-11pm on 5/11/17)

B6 (Bohill) interviewed re: this and no issues/concerns raised.

The investigating team concluded that this allegation is void

27. Unnamed Staff – staff were putting 2 pads on at a time on unnamed patients. When B7 Bohill Staff queried this she was told patients were wetting too much. (Source: B7 Bohill Staff)

B7 (Bohill) interviewed re: this allegation. Question 16, Response: *"This was not said by a member of staff in Ennis, it was said by a member of staff in Erne I believe when I was talking about it in that ward."* Ms B7 went on to report that when she asked staff about patients wearing 2 pads she was informed that some patients are incontinent and pass large volumes of urine. She informed the investigation team that she had no concerns re: this explanation.

B7 stated clearly during interview that this conversation did not take place in Ennis.

The investigating team concluded that this allegation is void.

28. Unnamed Staff told B7 Bohill Staff, if you offer too much attention, they will want it all the time. (Source: B7, Bohill Staff)

B7 (Bohill) interviewed; Question 15, Response: *"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."*

B7 during interview did not raise this as a concern.

The investigating team concluded that this allegation is void.

31. Unnamed Staff – 2/3 staff were putting a delivery away and patients were in the day room unsupervised – 2 patients emptied out all the laundry bags. Staff came in and shouted aggressively 'who did this?' staff then made an assumption as to who it was and told other staff angrily '…….. did this'. (Source: B6 Bohill Staff)

B6 (Bohill) interviewed. Question 14, Response: *"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? Response: *"Don't know"*

Who were the members of staff? Response: *"Don't know, I didn't see."*

What did the other staff in Ennis do when a staff member made the assumption that a patient had done this? Response: *"I was walking towards bottom of ward when I heard this I couldn't see."*

What did you do when you heard staff shout aggressively at patients? Response: *"I walked on past."*

B6 informed the investigation team that she did not report this alleged incident to anyone at the time. Her statement to the investigation team that she did not see either staff or patients involved is contradictory to the detail in the original allegation.

The investigating team is unable to substantiate the allegation.

33. Unnamed staff member (described as a care assistant, having short, dark, spikey hair, aged in her 40's, average weight) – P44 (patient) didn't get up for tea as she said she had a sore head – staff member said if your head is sore you won't want your dinner and scraped it into the bin. P44 asked for a tablet for her headache, staff said she wasn't allowed one as she hadn't eaten her dinner. (Source: Natasha Blair, Bohill Staff)

Below information taken from the Adult Safeguarding Investigation

Interview with P44 (held on11/1/13)
P44 was interviewed in relation to allegations made that a member of staff said to her "If your head is sore you won't want your dinner "and scraped it into the bin. P44 asked for a headache tablet, staff said she wasn't allowed one as she hadn't eaten her dinner.

The use of direct and closed questions was required during the interview as per the advice of Rosalind Kyle (Speech and Language Therapist) who advised on P44's communication needs.

P44 did relate an incident when her dinner was scraped into a bin by a staff member. P44 said this was because she didn't like the dinner and refused to eat it. P44 reported that she was refused a sandwich as an alternative.

It is believed that her dinner was scraped into the bin. However it is unclear what the context was or whether this was an appropriate response from staff.

At no point during interview did P44 report that she had a headache at this time.
She was unable to identify any staff member.

Investigating team unable to identify who the staff member was. Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigating team is unable to substantiate the allegation

35. Unnamed staff (but described as H159 usually) – would stretch P39 P39 (patient) T-shirt between her legs and tie it in place. (Source: B10 Bohill Staff)

H159 (Ennis) interviewed. Question 17, Response: Never

H197 (Ennis) interviewed: Question 17, Response: No

H206, H205 and H203 (Ennis) interviewed. Question 9, Response: No

H869 (Ennis) interviewed. Question 9, Response: *"No some of the patients wore vests with poppers at the bottom."*

Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigating team were unable to substantiate the allegation

39. H159 – very set in routines – e.g. P39 gets changes at these times only – no need to take her now. (Source: B10 Bohill Staff)

Bohill staff interviewed B7, B5, B4 and B6 did not raise any issues regarding this.

The Investigating team unable to interview B10 (Bohill) or B1 (Bohill Manager).

The investigating team were unable to substantiate the allegation

41. Unnamed Staff – lack of induction, orientation and information sharing for Bohill Staff. (Source: 6 Bohill Staff)

Refer to Allegation Number 15

The investigation team is able to uphold the allegation in relation to H198 as it has been identified that she did not give B2 an Induction and it would indicate that B7 received a poor induction also.

42. Unnamed Staff – lack of staff engagement/ interaction with patients. (Source: 5 Bohill Staff)

B7 (Bohill) interviewed: Question 17, Response: *"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."* B7 also reported that the Ward was very un-stimulating.

B5 (Bohill) interviewed. Question 15, Response: *"Staff were good. Patients were not left sitting staff interacted with them. Staff were very calm and made an effort."*

B4 (Bohill) interviewed. Question 14, Response: *"Staff spoke to the patients but there was not a lot of interaction as the staff were very busy on the ward. 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."*

B6 (Bohill) interviewed. Question 17, Response*: "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. 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."*

H159, H197, H206, H205 and H869 (Ennis) all stated that the ward was short of staff and they worked as a team to meet the needs of the patients. Some have said that there was stress on the ward due to the workload especially in the mornings but everyone worked together.

H203 (Ennis) interviewed. Response: *"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."

The Investigating team unable to interview [redacted] (Bohill Manager).

The investigation team concluded that Ennis was short staffed and the team were under pressure to complete care tasks. This would appear to be more evident in the morning shift when staff demands were at their highest.

The investigation team concluded that due to demanding care needs, low staffing levels, cancelled day care and reported staff stress that a lack of staff engagement/ interaction with patients was very likely. The allegation is therefore upheld.

43. Unnamed Staff – lack of adequate staffing, patients left unsupervised. (Source: 4 Bohill Staff)

It is evident from all the interviews completed and from looking at staffing resources that the ward was short staffed.

The Investigating team unable to interview [redacted] (Bohill Manager).

The investigation team concluded that this allegation can be upheld.

44. Unnamed Staff – atmosphere/ culture on ward described as dull, unstimulating, institutionalised, dark, gloomy, lacking in warmth etc. (Source: 6 Bohill Staff)

[redacted] (Bohill) interviewed. Question 19, Response: *"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."*

[redacted] (Bohill) interviewed. Question 17, Response: *"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."*

[redacted] (Bohill) interviewed. Question 14, Response: *"The ward was very busy. Atmosphere was quite dull the ward décor was outdated with not much colour. Atmosphere between staff was quite good; 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."*

[redacted] (Bohill) interviewed. Question 19, Response: *"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 clique 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."*

[redacted] (Ennis) interviewed. Question 24, Response: *"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."

When asked about the environment H197 responded: *"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."*

H159 (Ennis) interviewed. Question 24, Response: *"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 were staff shortages."*

H196 (Ennis) interviewed. Question 14, Response: *"Cannot comment as duration on ward was short. Cannot remember."*

H205 (Ennis) interviewed. Question 17, Response: *"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. 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."*

When H869 (Ennis) was asked if she would like to highlight anything during interview that may be beneficial to the investigation she responded: *"I always found it a good team we were short staffed but we got on with our work. I was not stressed re this. I have worked with these girls (patients) so long and I am really attached to them that if I thought anyone hurt them I would speak up immediately I would not hide anything."*

H203 (Ennis) interviewed. Question 17, Response: *"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."*

H206 (Ennis) interviewed. Question 16, Response: *"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."*

H491 interviewed re: the ward environment and any changes made to the ward environment and responded as follows:

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 – one staff did not like this but I felt this was improvement for patients and staff Ward was over-crowded

The Investigating team unable to interview B1 Bohill Manager).

The investigation team acknowledge that the Bohill staff were coming from a newly built, bright, spacious, physical environment in contrast to an older style hospital ward.

The investigation team concluded that at the time of the allegation that the ward environment was un-stimulating and not conducive to easily managing challenging behaviours. Generally a good atmosphere was reported between staff in spite of this.

46. Nothing in P39 s care plan to tell anyone how to manage stripping behaviour and no instruction from staff on how to manage it. (Source: B5 B5 Bohill Staff)

B5 (Bohill) interviewed. Question 5, Response: *"Yes I was on night duty one night and read the care plans. They gave good detail and insight into the patients. Staff were really informative. Staff kept me updated as we went along and worked with the patients."*

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

The investigating team concluded that there is no allegation.

63. Ennis Ward a horrible place-based on 20 years care experience. (source B8 B8 Bohill Staff)

Refer allegation 22

The Investigating team unable to interview B8 or B1 (Bohill Manager).

The investigation team acknowledge that the Bohill staff were coming from a newly built, bright, spacious, physical environment in contrast to an older style hospital ward.

The investigation team concluded that at the time of the allegation that the ward environment was un-stimulating and not conducive to easily managing challenging behaviours. Generally a good atmosphere was reported between staff in spite of this.

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).

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).

This was investigated separately and a conclusion was reached, it was therefore not re-investigated.

14. H198 MAH staff, came out of the office in response to increased noise levels and shouted into the dayroom, "I'm fed up with the lot of you, you're doing my head in."

This was investigated separately and a conclusion was reached from this investigation

40. H198 – grabbed P42 by the scruff of her neck and took her to her bedroom

This was investigated separately and a conclusion was reached, it was therefore not re-investigated.

5. 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 investigate that managerial process, had been adequately managed in a safe manner concerning the day to day running of staff rosters, the daily activities of the ward and the environment requirements, prior to the Vulnerable Adults Investigation.

6. Induction processes

There is disparity between Bohill staff and MAH staff about the level of induction that was provided to Bohill staff. Allegation number 12 was upheld by the investigation team and it is thought that the same Band 5 Nurse (H198) was responsible for B7 s statement of a poor 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.

7. Training

The investigation team reviewed staff training records within Ennis. The majority of staff in Ennis have completed their mandatory training to include Management of Actual or Potential Aggression. Not all staff had attended their Adult Safeguarding training on the 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.

Health Care Support Workers had no formal 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.

8. 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.

9. 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.

10. 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.

11. Resources

The investigation team noted from interview with Mr 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.

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.

12. 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: these are the allegations classed as 'void'. One allegation was strongly re-iterated by B4 (Bohill) during interview in relation to H197 (Allegation 16) 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. B 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. 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 to discipline both H197 and H159 remain valid.

13. 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 LMcC 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.

14. Signatures

Signed_____

Rhonda Scott,

Senior Nurse Manager,

Learning Disability Manager

Date_____

Signed_____

Geraldine Hamilton

Service Improvement Manager

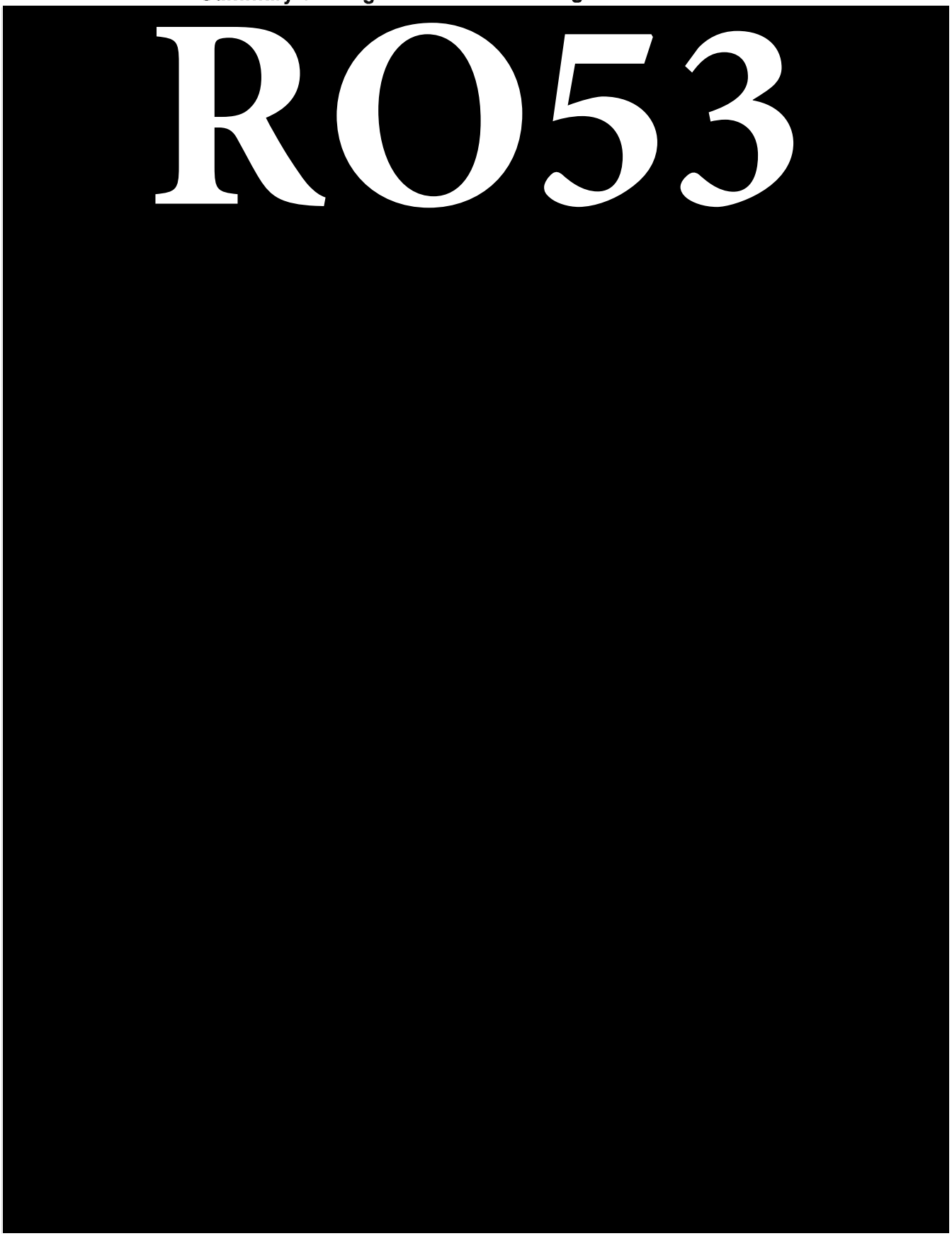
Mental Health and Learning Disability

Date_____

1.COnd1

Appendix 1

Summary of Allegations under Investigation



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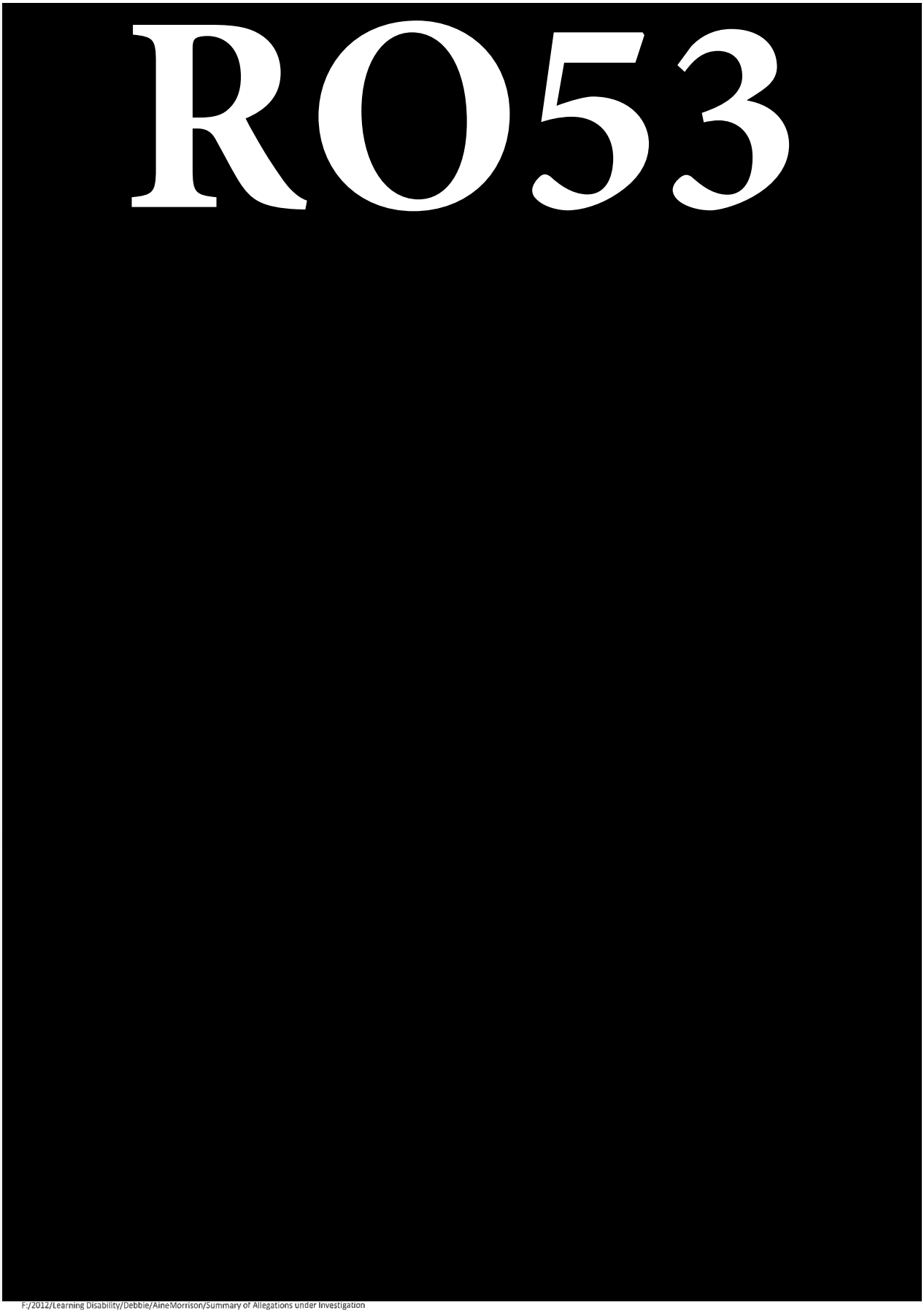
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F:/2012/Learning Disability/Debbie/AineMorrison/Summary of Allegations under Investigation

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Appendix 2

1.006

[redacted]
H198's address

Rhonda,

I will not be attending the disciplinary meeting on 16/4/14 as I no longer work for the Belfast trust at 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 forewarding to yourself a Statement of events for 7/11/12.

Kinds Regards.

[redacted]
H198

(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 9.30pm

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

The Student commenced her own studies working in the front office. I introduced the Privy nurse to the staff down at the back end of the ward and asked them to keep the Privy 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 remainder 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 medications Another one occured 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 quieter. I worked on some

(2)

Peices for the resettlement programme. The primary 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 evalution 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 primary staff were supernumary but did help after tea time at my request.

Another inc occured @ 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 md. $\frac{4}{17}$ 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

1.006d3

Appendix 3

[redacted]
H870's address

Dear Rhonda Scott,

From what I can recall on the day of question I was working in Ennis ward, on relief from oldstone. I think the hours I spent in Ennis wee 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 superuise 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 employee 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 [redacted]
H870

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 [redacted] 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: [redacted] P39 & [redacted] 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 ([redacted] P201 & [redacted] 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 [redacted] 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

[redacted] (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 H77 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

3.006

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 in 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

1.00805

Appendix 5.

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

Mr 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.

1.009d6

Appendix 6

1,015

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

1.010d7

Appendix 7

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.

1.011d8

Appendix 8

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

1,012d9

Appendix 9

Interview Questions [redacted]

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 [redacted] and worked with her and one day with [redacted] 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 s 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

1.013d10

Appendix 10

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 ?

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 P41 If I had been called I would not have been in a position to help as I could not leave P41

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 loved 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

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.

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Appendix 11

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. B2 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 P40 P40 ?

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 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.

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 P39 and P41

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 B2 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 12

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.

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Appendix 13

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 liked 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 level 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. (H833 is very passionate about these patients it is clearly evident)

1.017d14

Appendix 14

Notes of Interview H203 [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

1.018d15

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

1.019d16

Appendix 16

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 P39 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

3.219

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

1.020d17

Appendix 17

1.021

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

1.021d18

Appendix 18

Appendix 3

BELFAST HEALTH AND SOCIAL CARE TRUST

MUCKAMORE ABBEY HOSPITAL

M E M O R A N D U M

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
- P345

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
- P39
- 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

K. Murray

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 P20 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] P19 P46 P42 P199 P27 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**

1.022019

Appendix 19

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.

H199

Care plan was discussed and amendments noted, B1 will make amendments with signing off at a further date.

It was discussed that H199 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.

1.023d/20

Appendix 20

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
firm for me is when you where first alerted to concerns in Ennis
Thank 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 npleting the internal investigation and just need clarity on this issue
Rhonda

1.024d21

Appendix 21

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					
B718							~~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		
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
B16 B2	8-8 Erne	8-8 Erne				~~8-8 Erne~~	8-8 Erne
B13			11-11 Ennis	11-11 Ennis	11-11 Ennis		

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

1.025 of 22

Appendix 22

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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

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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

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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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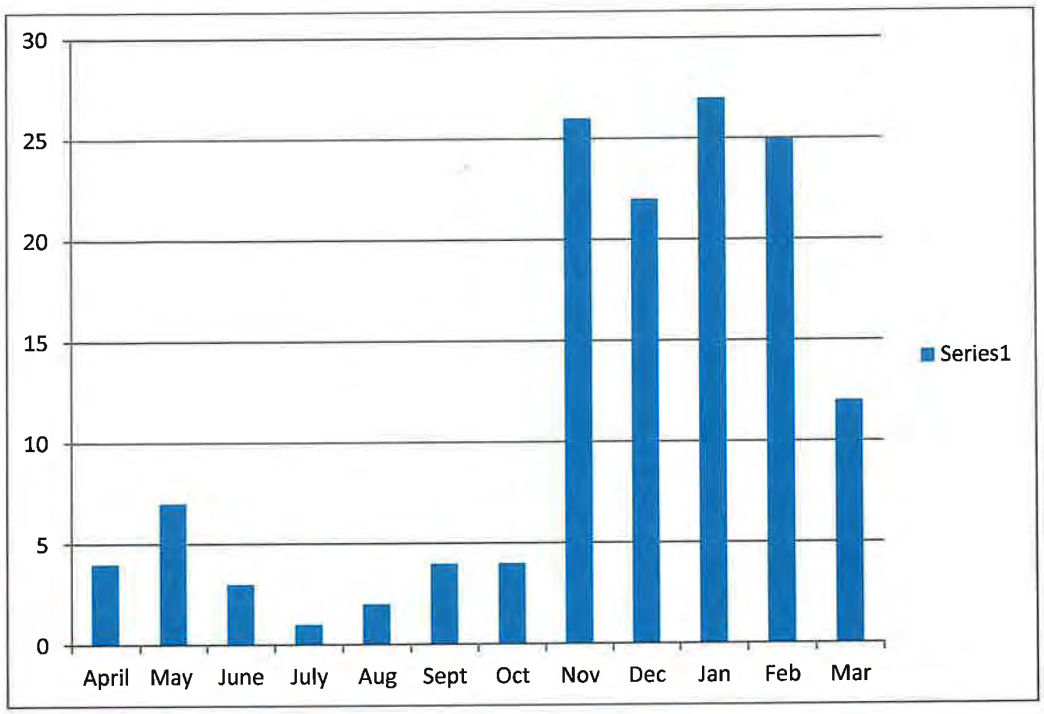
Appendix 23



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

Final Report of Independent Assurance Team

Muckamore Abbey Hospital

19th September 2018

Confidential

Contents: Page No:

1. Background

In autumn 2017, serious safeguarding concerns were identified at Muckamore Abbey Hospital. A range of actions were put in place by the Belfast Health and Social Care Trust (BHSCT) and one of these actions was the establishment of an Independent Assurance Team in December 2017 by the Director of Nursing and Director of Adult Social and Primary Care. The purpose of the Independent Assurance Team is to independently review the response of the Trust and the Learning Disability service and provide a report to the Trust Directorate Level Governance and Improvement Board. This final report follows on from a draft report provided to the Director of Nursing and Director of Adult Social and Primary care, on the 4th April 2018, which by then had also been shared with the Senior Nursing Management Team at Muckamore Abbey Hospital.

In taking forward this work the Independent Assurance Team worked with the Senior Management Team in Muckamore Abbey Hospital in relation to the agreed areas of work, which have been agreed by the lead Director and Directorate Level Governance and Improvement Board.

The observations as set out within this report are based on the information provided to the Independent Assurance Team between December 2017 and 4th April 2018. The range of information provided and reviewed by the members of the Independent Assurance Team is listed in Appendix 1. It is recognised that some further information may become available as further information regarding the safeguarding concerns at Muckamore Abbey Hospital continues to evolve. Due to ongoing PSNI and Safeguarding investigations it was not appropriate for the members of the Independent Assurance Team to speak directly with staff involved in the incidents.

2.0 Objectives

i) To provide a level of independence and transparency in relation to key decision making processes.

ii) To provide an independent view on specific key decisions that have been made to date in relation to staff moved to other facilities, precautionary suspensions or restricted duties of staff involved in identified incidents.

iii) To offer advice and support to lead Director(s) and were appropriate to constructively challenge and/or make recommendations.

iv) To support the Co-Director in terms of service improvement and modernisation.

In addition, the Independent Assurance Team specifically reviewed: -

- BHSCT policies related to agreed areas listed in Table 1. These policies were reviewed as these were directly related to the incidents and decision making being reviewed by the Independent Assurance Team.
- A draft workforce paper (Learning Disabilities) was provided to the Independent Assurance Team in December 2017.

The specific areas of work and actions taken to progress the work is set out in Table 1 below.

Table 1. Specific areas of work undertaken by Independent Assurance Team

Area	Actions
Review interim decisions re named staff who are subject to precautionary suspension or restricted duties	Reviewed CCTV and decision making processes in relation to identified incidents in which staff were placed on precautionary suspension or placed on restricted duties.
Review of BHSCT policies related to agreed areas	The following policies were reviewed: • Levels of Supervision/Observations within Learning Disability In-Patient Services November 2013 (should have been reviewed 2016) • Seclusion within Learning Disability In-Patient Services (Children's and Adults) Procedure November (2016) • Use of Restrictive Interventions for Children and Adult Services (does not appear to be Learning Disability specific) (May 2015) • Implementation of CCTV within Muckamore Abbey Hospital to assist with Investigations related to Adult Safeguarding.
Review draft workforce paper	Reviewed draft workforce paper (November 2017) provided in relation to staffing levels and staffing model

3.0 Assurance Review Team membership

Yvonne McKnight, Adult Safeguarding Specialist, BHSCT

Frances Cannon, Senior Professional Officer, NIPEC

Owen Barr, Professor of Nursing and Intellectual Disabilities, Ulster University

4.0 Review of decisions made in relation to staff moved to other facilities, the precautionary suspensions and restricted duties arrangements of nursing staff

The Independent Assurance Team were asked to review the decision-making process and implementation of precautionary suspension or restricted duties of staff in relation to identified safeguarding incidents which occurred at Muckamore Abbey Hospital on the 15th and 16th August 2017, in the Intensive Care Unit (ICU), an incident on 1st October 2017 in Sixmile Ward and a number of incidents associated with the swimming pool at Muckamore Abbey Hospital.

In response, the Independent Assurance Team specifically reviewed information relating to six staff including two Registered Nurses Learning Disabilities (RNLDs) that were placed on precautionary suspension and a further six staff, including 5 RNLDs, placed on restricted duties as part of the interim protection plans of staff.

4.1 Staff Moved to another Facility (Sixmile)

Two staff that had been moved from the Intensive Care Unit to Sixmile had allegedly directly observed safeguarding incidents and failed to report these. There was a level of uncertainty regarding how much the other staff present had observed. The rationale provided verbally to the Independent Assurance Team for moving two staff to Sixmile was underpinned by a focus on safety. It was considered by the senior management that the people with learning disability in Sixmile would themselves be able to raise concerns if an incident arose. This was believed to the situation because all people in Sixmile were considered vocal in terms of raising issues about their care and had done so in the past and were therefore considered be able to communicate any concerns that may arise.

It was explained to the members of the Independent Assurance Team that there was a concern that one of the staff initially moved from the Intensive Care Unit to Sixmile had expressed a view that their move may be linked to them reporting a safeguarding concern and they viewed it as punitive. The senior management team in Muckamore Abbey Hospital were concerned about this perceptio.

The Independent Assurance Team were informed verbally that in light of this stated perception by the member of staff that the decision to move both Registered Nurses to Sixmile was reviewed and within this a number of factors were considered including:

- the perception of the staff member
- the Ward Manager in ICU knew the individuals very well and therefore would be well placed to provide on-going supervision
- other staff placed on restricted duties remained on their respective wards

The decision was reviewed and it was decided that the two Registered Nurses should be moved back to ICU. It was also agreed that they both should remain on restricted duties which was the interim protection plan and continue to receive weekly supervision from the Charge Nurse in ICU.

4.2 Precautionary suspensions

The rationale provided to the members of the Independent Assurance Team for placing people on precautionary suspension, was that there were concerns regarding these staff in relation to the following:-:

- Two Healthcare support Workers identified via CCTV footage viewing as having been directly involved in safeguarding incidents
- A Registered Nurse was identified through escalation of a concern by a colleague after a report by the person with learning disability
- A Nurse in Charge failed to report safeguarding concerns and a clear distinction was made between them and other Registered Nurses on duty due to their role and overarching responsibilities at that time.
- One person allegedly actively discouraged a member of staff who wished to escalate a safeguarding concern.
- One person allegedly directly involved in safeguarding incidents.

It was reported and supported by written evidence provided that those individuals on precautionary suspension have had follow up through:

- Initial letters confirming the suspension and further follow up letters
- Telephone contact every two weeks from a designated manager.

4.3 Restricted duties

It has been explained to the Independent Assurance Team that the people were placed on restricted duties as opposed to being placed on a precautionary suspension because: -

- They failed to report a safeguarding issue
- They were present but did not appear to be 'actively involved' in the incidents that occurred
- There was uncertainty regarding how much of the incidents these staff may have directly observed.

The restrictions included

- not to take charge of the ward at any time
- only work in one ward
- only permitted to undertake a bank shift in that ward
- receive on-going support and weekly supervision with the Ward Manager.

4.4 Review of decision making process involved

In seeking to review the decision-making processes involved in relation to the precautionary suspension or placing staff on restricted duties, members of the Independent Assurance Team requested notes of meetings at which these decisions were made and other correspondence relevant to these decisions that was available in order to be clear about the rationale involved. The information reviewed included information about staffing levels, the Nurses in Difficulties policy, internal HSCT emails relating to the suspension of staff or the staff on 'restricted' duties, records from Designated Contact Person of ongoing contact with staff who were on precautionary suspensions, records of the dates of weekly supervision with staff on 'restricted' duties and the BHSCT Disciplinary Procedure (April 2017).

The three members of the Independent Assurance Team also met with the Hospital Manager, Senior Nurse Managers, Charge Nurses from Sixmile and Intensive Care Unit and the manager of Day Services. A summary of the key points raised by these staff, within the meetings, has been themed and is available at Appendix 1.

As noted, interim decisions around precautionary suspension and restricted duties needed to be made in real time and it would be expected these would have been initially reviewed within an agreed time frame and four weekly thereafter - in keeping with Belfast HSCT HR Disciplinary procedures and Nurses in Difficulties policy.

It was reported to the members of the Independent Assurance Team that this has been done monthly by the Hospital Manger and Senior Nurse Manager. The Independent Assurance Team were provided very limited written material in relation to the review of the decisions. The documents provided focused on communicating or reinforcing the decisions that had been made and were limited formal notes of meetings. The information provided did not provide any outline of the range of factors considered, how these were weighed up in making the decision or the range of options for the decision making considered. Therefore, members of the Independent Assurance Team are unclear as to who was involved in these discussions each time and what specific factors are considered in reaching the decisions in relation to each person.

4.5 Observations of Assurance Team on the initial decisions taken

It is recognised by the members of the Independent Assurance Team that decisions about the precautionary suspension of staff or placing staff on restricted duties needed to be in real time and must be based on the information available at the time to people making the decisions. These are viewed as interim decisions that should be underpinned by patient safety, be taken in consultation with HR Department and should have a clear calendar date set for review. This date was not provided or clearly stated in any documentation provided to the Independent Assurance Team. It is further recognised that the interim decisions mentioned above needed to be made by a senior

BHSCT manager with responsibility for the service provided, who may not be directly working within the service at Muckamore Abbey Hospital.

The complexity involved in making these decisions promptly and based on the limited information that may be available is appreciated by members of the Independent Assurance Team. It is our view that the interim decisions taken at the time to place staff on precautionary suspension appear appropriate. The Independent Assurance Team noted one Registered Nurse who failed to report a safeguarding concern was placed on precautionary suspension, the verbal rationale given to the Independent Assurance Team was that as the nurse in charge of that shift, the obligation to intervene to safeguard and report was greater than other Registered Nurses on duty, given the level of responsibility related to that operational role. The Independent Assurance Team were not provided with written information which definitively outlined the rationale the for decision making.

4.6 Observations of Assurance Team in relation to the implementation and ongoing review of the precautionary suspension

The members of the Independent Assurance Team have seen evidence of the letters and logs of telephone contacts with staff as noted within Appendix 1. For each of the staff on presecautionary suspension there was a designated contact person and we have seen notes of ongoing contact between this member of staff and the person on precautionary suspension. No set template or proforma was used to keep a record of this ongoing contact. There is variation in the nature of the records kept relating to this ongoing contact in respect of the format (some handwritten, some typed), the detail of the notes made and the way in which these notes of contact were signed by the staff member.

The records made in relation to contact with staff members on precautionary suspension were held by the designated contact person and at the time of this review these records of contacts had not been placed in individual staff personal files.

In discussions with the designated contact staff, they stressed the emotional impact on those staff on precautionary suspension both professionally and personally. They also emphasised how difficult it was for them personally to fulfil the role of a

'designated contact' person. In interviews, it was highlighted that this is a very challenging role as there was an expectation by the staff member on precautionary suspension that information updates would be provided to them, when in reality the role as the designated contact staff as they understood it, was meant to focus on support to the staff member and sign posting to other resources. It was also reported that given the length of time the suspensions are ongoing that contact can be difficult to sustain when there is no new information and little to discuss with staff.

Additionally, it was reported that contacts can be affected by the level of information the designated contact person has, i.e.

- one person reported that the lack of detail hindered conversation with the member of staff on precautionary suspension
- another reported that having too much detail of safeguarding incidents at times created awkwardness in conversations.

4.7 Observations of Independent Assurance Team in relation to on the supervision of staff on restricted duties

The members of the Independent Assurance Team viewed evidence of the letters and follow-up emails confirming to the staff members they were placed on restricted duties and what this entailed. They also viewed records of the dates of supervision meetings provided by the Charge Nurses who were the identified people to provide supervision. Given the personal nature of the supervision, the records of meetings were not reviewed.

Through interviews with the Charge Nurses and other managers (See Appendix 2), it was apparent that supervision sessions were tailored to the care environment and needs of the individual to be able to work in that setting and did not involve discussing any allegations about the member of staff. The Independent Assurance Team are of the view that information provided during interviews confirmed that the arrangements for supervision were appropriate in the circumstances.

The Independent Assurance Team noted that email communication they were provided which related to a number of staff within the same email. The Independent Assurance Team recognise this may have occurred in the initial stages due to several

staff being involved in each incident, however, this 'clustering' of communication made it difficult to establish the rationale underpinning the decisions made relating to individual staff.

There was evidence of decisions made and communication with staff about those decisions. Contained within emails there is limited evidence of the rationale for decisions (i.e. it related to a safeguarding concern). However, there was no written evidence of an explicit analysis of the information underpinning the decisions nor explicit exploration of the range of potential options for decisions that could be made. This detail would have been expected within these notes.

As noted, interim decisions about placing restrictions on the practice of some staff needed to be made in real time. It would be expected these interim decisions would be reviewed within an agreed time frame. With the exception of the two staff moved back from Sixmile, the Independent Assurance Team were provided with limited records in relation to reviews of the decisions to apply restrictions on practice. The Independent Assurance Team are of the view that whilst adult safeguarding and patient safety underpinned the interim decisions, due to the lack of documentation relating to the review of these decisions it is unclear as to who was involved and what factors were considered in each case e.g. impact on people with learning disability, impact on service delivery and impact on staff.

In the feedback received in the interviews with the Charge Nurses, the Independent Assurance Team members were informed that the Charge Nurses, who were providing supervision to the staff members on restricted duties, did not perceive that they had been formally engaged in review of these decisions. They highlighted the impact the decision to place people on restricted duties had on service delivery, including the reduction in services available to people with learning disability within Muckamore Abbey Hospital and other people who may use facilities within the hospital.

Through the interviews with the Charge Nurses and reviewing the notes of the Listening Group it is evident that demands on the Ward Sister/Charge Nurse from:

- within the ward (i.e. ward manager/counted as member of the core team to provide care) and
- outside of the ward (to regularly provide cover of the Nursing Office)

are highly challenging and should be urgently reviewed in order to prioritise the leadership role of the Charge Nurses/Ward Sister at ward level.

4.8 Recommendations

I. Decisions in relation to the precautionary suspension of staff or placing staff on restricted duties should first and foremost fully take into account the expected professional conduct of all staff involved and the professional expectations of behaviour from the Nursing and Midwifery Council or other relevant professional regulators. If other factors, such as the operational role the person may have be fulfilling at the time are taken into account, the analysis of these differing factors must be clearly stated, analysed and documented in the decision making process.

II. There should be a template aligned to the HR Policy to record the initial decisions taken and any subsequent review of that decision - this template should include notes on:

- the context
- explicit analysis of the relevant factors
- the people consulted
- the actions considered
- the rationale for final decision taken
- a specified calendar date for review of the decision
- the document should be signed and dated by all people involved in the making the decision.

III. Records relating to staff on precautionary suspension or restricted duties, including email correspondence between Trust managers should relate to one individual at a time, i.e. comments relating to several staff members should not be clustered in one email. This would facilitate clearer communication about individual decisions and also the filing of this information in the files of individual staff members.

IV. There should be a standardised approach to the review of decisions which proactively considers the relevant factors with a recognition of the possibility of amending the interim decisions.

V. When decisions are being reviewed, both the intended and unintended consequences of interim decisions, for people with learning disability, service delivery and staff members should be actively considered and reflected in the notes of the review of the decision.

VI. Senior Management would benefit from more proactive and ongoing support from HR in relation to all aspects of precautionary suspensions and restrictions on practice.

VII. The role of the Ward Sister/Charge Nurse should be reviewed in order to prioritise the leadership aspect of the role at ward level (e.g. consideration should be given to supernumerary status of the Ward Sister/Charge Nurse)

VIII. There should be clear guidance for staff in the policy about undertaking the role of the 'designated contact persons' to include the areas to be covered in discussion with staff and proformas to be completed as a record of the contact.

IX. In developing this guidance, the opportunity should be taken by HR to explore with 'designated contact persons' across the BHSCT, what information and preparation would have assisted them in undertaking this role in this service and other learning opportunities in the Trust.

X. 'Designated contact people' providing ongoing contact to staff on precautionary suspension or on restricted duties should be formally included in the process of reviewing these decisions and their participation and views in the review of decisions should be noted in the record of the meeting.

5.0 Review of Policies

In the process of undertaking the independent assurance exercise the members of the Independent Assurance Team reviewed the policies below as these emerged as relevant to considering the incidents and decisions made about staff.

- *Levels of Supervision/Observations within Learning Disability In-Patient Services November 2013 (should have been reviewed 2016)

- *Seclusion within Learning Disability In-Patient Services (Children's and Adults) Procedure November (2016)
- Use of Restrictive Interventions for Children and Adult Services (does not appear to be Learning Disability specific) (May 2015)
- *Implementation of CCTV within Muckamore Abbey Hospital to assist with Investigations related to Adult Safeguarding (2016).

5.1 Key observations by the Independent Assurance Team

Whilst the team recognise that polices highlighted with an asterisk above are due to be updated and this is detailed in the Action Plan for the Protection of Patients in Muckamore Abbey Hospital, it was specifically noted that the Seclusion within Learning Disability In-Patient Services (Children's and Adults) Procedure should have been reviewed in November (2016) and this was not completed. This should have been undertaken almost a year before any of the current concerns about safeguarding were identified at Muckamore Abbey Hospital.

The following overall comments below should be considered when reviewing these policies.

- It is a major concern that aspects of the key "evidence base" used to underpinned these policies was out of date when the policy was written; e.g. NMC and NICE Guidelines
- Several of the key source materials referred to in the development of the policies were inadequately referenced at the end of the policy, meaning it was not possible to be sure which editions of documents were consulted when the policy was being developed.
- The language used within policies reviewed was largely task orientated and depersonalised.
- It is a major concern that the policy on - Levels of Supervision/Observations within Learning Disability In-Patient Services November 2013 was not reviewed in November 2016 and it should have been. Therefore, guidance on this critical area of care was out of date and to the understanding of the Independent Assurance Team, this policy has still not been reviewed, 19 months after this was required to be reviewed.

- Equality Impact Assessment boxes were not ticked on two policies (Levels of Supervision / Observations within Learning Disability In-Patient Services (November 2013) and Seclusion within Learning Disability In-Patient Services (Children's and Adults) Procedure (November 2016). Therefore, it was not clear if these Equality Impact Assessments had ever been undertaken.
- There was no clear evidence of consultation with people with learning disabilities/families/carers/key organisations for people with a learning disability in the development of these policies. It was noted by the members of the Independent Assurance Team that 'CAUSE' is related to mental health not services for people with learning disabilities. Given the task orientated and depersonalised language within these policies, it is of the view of the members of the Independent Assurance Team that people with learning disabilities and family members were unlikely to have been actively involved in the development or review of these policies.
- There is an unacceptable lack of clarity within the policies and vagueness in timeframes for actions to be taken, as noted in terms such as:
    - 'as soon as practicable'
    - 'as appropriate'
    - 'regular'
- Despite the stages of development these policies went through within the BHSCT, there is no explicit evidence of external review or the involvement of people with learning disabilities, family, carer representatives in the development of the policies reviewed. Whilst it is accepted that this may not be required for all policies, specific rationale should be provided for why it is not necessary. The members of the Independent Assurance Team expected to see this level of involvement specifically in relation to policies that may involve physical interventions or potential deprivation of liberty of people with learning disabilities.

5.2 Recommendations

I. National guidelines and the documents related to professional regulators used to underpin policies must be the current versions and policies should be reviewed if the requirements of professional regulators change during the term

of the policy. People signing off policies at different levels within the BHSCT should seek written assurance that this is the position for all evidence used.

II. Consideration should be given to reviewing the policies below into a single policy document, thus creating an overarching policy based on a person-centred approach and Positive Behavioural Support:

- Levels of Supervision/Observations within Learning Disability In-Patient Services (November 2013 – now out of date)
- Seclusion within Learning Disability In-Patient Services (Children's and Adults) Procedure (November 2016)

III. Use of Restrictive Interventions for Children and Adult Services (May 2015). Policies that cover both Children and Adult services should provide clear direction on the specific and uniquely different requirements in relation to children and adults, where applicable and necessary. At present, there is no clear distinction made within the policies reviewed relating to either the use of seclusion within learning disability in-patient services or the use of restrictive interventions for children and adult services across the BHSCT. It is the view of the Independent Assurance Team that the needs of children and adults being placed in seclusion or restrictive interventions are different and specific guidance should be provided for each.

IV. With specific reference to the BSHCT Use of Restrictive Interventions for Children and Adult Services (May 2015), on p8 of 22, it specifically highlights that the BHSCT Management of Aggression Team are not involved in training within Muckamore Abbey Hospital. The training within Muckamore Abbey Hospital appears to be provided solely by the MAPA Training Team. To encourage collaborative working across the BHSCT, reduce the potential organisational and geographical isolation of staff in Muckamore Abbey Hospital from colleagues in similar services in the BHSCT, and the sharing of information and good practice, it is recommended that the MAPA Training team at Muckamore Abbey Hospital should be integrated into the BHSCT Management of Aggression Team.

V. It is also recommended that the title of the 'Management of Aggression Team' should be reviewed to reflect a person centred ethos and recognition of the

distress that people who present challenges to services and staff responding may be experiencing at that time.

VI. Active engagement with people with learning disabilities, family, carer representatives should be considered as a starting point when developing policies and an explicit rationale provided when the decision is taken not to involve these people in BHSCT policy development.

VII. In discussions, members of the Independent Assurance Team have become aware that the same room is used in the Intensive Care Unit for both 'Low Stimulation' and Seclusion. It is felt that from the perspective of the person with learning disabilities that the use of the same room for two different interventions, potentially results in mixed messages and confusion. It is recommended that separate areas are used for 'Low Stimulation' and Seclusion.

VIII. All BHSCT policies relating to people with learning disabilities should be reviewed and updated within the specified timeframe. When there is an anticipated or actual delay in the review of a BHSCT policy, this should be formally escalated to the BHSCT Director who signed the policy and a robust plan should be put in place to review the policy within an agreed revised timeframe. There should be explicit communication to staff in the BHSCT that the previous policy remains in place until the new policy is signed off.

6.0 Staffing/Workforce Review

The members of the Independent Assurance Team were asked to review a draft paper on staffing levels in Muckamore Abbey Hospital. This paper provided figures for the funded, actual and required number of staff for each ward within Muckamore Abbey Hospital. It also provided information on the number of 'bank hours' used within each ward, as well as information on specific levels of enhanced supervision that were being provided in specific wards. The figures provided related to November 2017. The Assurance Team are aware that there have been a number of workshops held to review staffing levels and skill mix on the wards. At the time of writing this report an updated paper had not been provided to the Independent Assurance Team.

6.1 Feedback on the draft paper reviewed relating to staffing levels on wards

The members of the Independent Assurance Team accepted that the paper they had been asked to review was a draft and the comments provided below are offered as points to consider in finalising the paper on staffing levels.

a. No ward has funded and actual numbers matching, with the figures provided indicating that staff levels are mostly below funded numbers at band 5 and band 3.
b. Large number of bank hours are being used, and from the information provided it was not clear what grades of staff were involved or how this process is managed.
c. Variation in absence rates were noted across bands and wards.
d. "Required numbers" contained within the draft paper were mainly higher than those present or funded. No explanation was provided within the paper as to how the figure for 'required' numbers had been calculated. If a specific methodology was undertaken it should be explicitly stated and a rationale for the selection of this methodology provided.
e. There appeared to be staffing implications for Muckamore Abbey Hospital staff in providing 'outreach support'. The remit of Muckamore Abbey Hospital staff in providing outreach support was not explicitly stated and no information on the funding model for this was contained within the draft paper.
f. The members of the Independent Assurance Team had concerns about the language used within some aspects of the draft paper to articulate the abilities and needs of people with learning disabilities. Whilst this appeared to be an attempt to profile the needs of patients on the wards it was not explicit how it was expected to be taken into the consideration in relation to making decisions about staffing levels. For example, comments about 'patient's abilities and needs', 'level of aggression', 'levels of capacity' and the making of 'previous allegations'.

6.2 Key observations by the Independent Assurance Team

Discussions evolving from the review of the draft workforce paper highlighted long term concerns about staffing levels and the Independent Assurance Team saw evidence that issues relating to concerns about staffing levels have been documented

on the BHSCT Risk Register since 2014. There were also emails noted in relation to concerns regarding staffing levels with information provided in E Rostering and use of Bank (Appendix 1). Staffing level concerns were also confirmed in the interviews with staff who highlighted that adequate staffing levels in Muckamore Hospital is reliant on the use of bank and agency staff (including agency staff from England) to cover nursing shifts on a day to day basis.

The Independent Assurance Team noted with concern the comments within the Listening Paper relating to the impact of staff shortages including ..."lack of staff to allocate to take patients out on social outings", "cancelled training sessions resulting in poor compliance with mandatory training updates". The Independent Assurance Team acknowledge the importance of the feedback received from the "Listening Group" but recognise further data of the numbers of staff involved in the process would help clarify the robustness of this feedback.

Staff interviewed also highlighted that this situation has been compounded by short term workforce planning. It was reported that a significant number of staff who had secured posts/positions in Muckamore Abbey Hospital in the past had been offered temporary contracts, as there was a view that due to resettlement and contraction of the hospital, the posts would not be required in the longer term. However, as soon as permanent positions became available elsewhere a significant number of staff moved on. There was a sense of a real missed opportunity in these situations. There was also a strength of opinion that workforce planning in the past focused on short term needs rather than medium to long term requirements. These observations highlighted the needs for urgent action at BHSCT Senior Management level for address this matter. It was reported by the Hospital Manager that hospital management team action plan moved to permanent recruitment of all staff to ward in August 2016.

6.3 Recruitment

The Trust reported they are committed to ensuring that staffing levels and skill mix on wards are appropriate and are engaged in a number of pieces of work in relation to this:

- A number of advertisements, have been placed on HSC Recruit for band 3 Health Care Support Workers since September 2016. This has included advertisements

in Magherafelt and Antrim's local newspapers in late 2017. There has also been a local advertisement placed for band 5 Nurses in the Antrim Guardian and a further HSC Advert.

- A rolling programme for recruitment of band 5 and band 3 staff for Muckamore Abbey Hospital is in place and a Recruitment Fair took place in late March 2018
- A pilot with HR has also commenced where staff leaving are being asked to participate in face to face exit interviews with HR. This is part of a strategy for improving staff retention.

On the 24th March 2018, Muckamore Abbey Hospital had a one day "walk –in" recruitment event. At this event applicants who were previously short listed for interview were fast tracked through the interview process – this involved Access NI, Occupation health checks and interviews being conducted on the same day. The Independent Assurance Team note that on the 29th March 2018 due to the success of the event a number of staff were being interviewed as additional applicants presented on the day of the event which required additional arrangements to meet the need. The members of the Independent Assurance Team were informed that 31 band 3 and 15 band 5 posts have been offered by the 4th April 2018.

6.4 Workforce Planning

The senior management team within Muckamore Abbey Hospital held an initial workshop on 31 January 2018 to review staffing levels and skill mix on the wards. The Public Health Agency attended, along with ward representatives. The members of the Independent Assurance team were invited to attend these workshops but were unable to do so due to the short notice provided of the dates The workshop focused on analysing the complexity of patient needs on each ward to gain a fuller understanding of the staffing levels and skill mix required per ward. A second workshop took place on the 21st March 2018. A final report of the findings and recommendations will be submitted to the Directors for consideration. This report has not been shared with the members of the Independent Assurance Team at the time of writing this report.

The Independent Assurance Team would strongly recommend that the findings and recommendations stemming from these workshops should be progressed as a matter

of urgency. Additionally, this work should be linked into the regional Delivering Care/Safe Staffing PHA Project.

6.5 Recommendations

I. The Independent Assurance Team recommend the need for clear processes for escalating concerns about staffing levels and ability to provide safe nursing care directly to the Director of Nursing and Director of Social and Primary Care.

II. The Trust should purposefully continue to actively recruit nursing staff through high profile regional and a rolling local recruitment campaigns.

III. Clear information about the role, function and planned future of Muckamore Abbey Hospital, together with information on the complexity of abilities and needs of the people cared for in Muckamore Abbey Hospital should be articulated to support and inform workforce planning.

IV. Senior managers should as a matter of urgency explore current actions aimed at retaining staff – including local induction, preceptorship for new registrants, regular supervision, career development opportunities and using staff skills for specialist practice roles for which they have been prepared.

V. In order to further understand why staff have left Muckamore Abbey Hospital, exit interviews should be conducted with all staff leaving Muckamore Abbey Hospital and Learning Disability Services in the BHSCT. These interviews should be conducted by a person who was not involved in the management of the staff member. It is recommended that independent exit interviews are conducted retrospectively with all staff who have left Muckamore Abbey Hospital and Learning Disability Services in the BHSCT to work elsewhere in the past 3 years.

VI. It is the view of the Independent Assurance Team that it would be good practice to support rotation of newly qualified staff across practice areas/care environments within Muckamore Abbey Hospital in a planned and transparent manner, to support professional development and development of skills and competencies. Consideration should also be given the rotation of staff between hospital and community services in a planned and transparent manner.

VII. It is apparent that due to the shortage of RNLDs in post, Muckamore Abbey Hospital actively recruit nurses from Mental Health Nursing and others fields of practice to fill vacancies, the impact of this on services provided needs to be monitored and evaluated.

VIII. The BHSCT should formally escalate concerns directly to the DOH regarding the number of commissioned places on the pre-registration nursing - learning disabilities and specialist practice programmes and request consideration of increasing the numbers of places as soon as possible.

IX. A Task and Finish Group should be established to review and analyse the use of E rostering, this should include robust arrangements for monitoring of staff working over contacted hours.

X. The recommendations of the "Listening Groups" should be progressed with agreed timeframes.

7.0 Conclusion

The members of the Independent Assurance Team have provided the observations and recommendations within this report to assist in the development of services for people with learning disabilities and the development of staff at Muckamore Abbey Hospital as a future vision for the hospital is articulated. We have shared our observations with members of the Serious Adverse Incident Panel, chaired by Margaret Flynn and recognise that panel will be making further recommendations.

The members of the Independent Assurance Team believe urgent action is needed to address the observations within this report and the recommendations made in order to address important aspects of the operational culture within Muckamore Abbey Hospital. Key to taking forward these recommendations is prompt and direct action to reduce the observed geographical and organisational isolation from the wider BHSCT of the people using these services and staff working in Muckamore Abbey Hospital.

Appendix 1: Themed Feedback from Interviews with Staff at Muckamore Abbey Hospital on 28th March 2018

Number of staff interviewed = 5
Roles staff interviewed: included:- Charge Nurses/ Manager/ Manager Day Opportunities, Acting Hospital Manager.

Staff in difficulty policy

- Recurring theme that staff were not aware of "Staff in difficulty" policy
- Need for supervision & training to act as designated contact person
- It would be helpful to have questions to support role
- It would be help to have a pro-proforma/process to follow
- Difficult to support staff without information
- Do have access to senior nurse meeting which is helpful – but still very much in the dark
- Ward sister /Charge Nurse /designated officers not included in the reviews
- Difficult to maintain – as little to talk about
- The person/s on precautionary suspension only want to hear about what is happening in relation to their situation … "….we don't have that level of information – in fact we know very little" "Expected to have conversations out of context" , "Fear of reprisal if you say anything wrong"

Staffing

- Too many temporary posts in hospital – circa 100 temporary posts – this needs rectified
- Over use and reliance on Bank and Agency staff – hospital uses e-roster and use a red alert system if a staff member is doing too many Bank hours.
- "The hospital depends on Bank staff – couldn't run without Bank staff shifts"
- Use of Agency from outside of Northern Ireland
- RNLDs who have completed their NMC recorded Specialist Practice programmes are not supported to practice as Specialist Practitioners.
- Sense of lack of career development opportunities

Supervision

- No template for use for supervision sessions
- Supervision is specific to area of practice

Medical Cover

- Lack of medical cover

Service/patient impact

- Due to staff shortages and restricted duties- patients access to social activities impacted – access to the swimming pool drastically reduced

Paper prepared
April 2018

Belfast Health and Social Care Trust
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Interim Protection Plans: Review of Progress of Supervision and Training Element

As a result of the historical CCTV investigation some staff have been placed on an interim protection plan. Some of the incidents that have been viewed have had individual learning themes identified. These themes then form the basis of the training and supervision element of the interim protection plan.

This process is to be used to review the training and supervision element of the Interim protection plan. Completion of the training and supervision element does not mean that the interim protection plan ceases or is stepped down. The interim protection plan will remain in place and is subject to review by the DAPO and DN. ***Please refer to the Interim protection plan review process (stage 4).***

Roles and Responsibilities
Supervisor - The Supervisor should be at least a band higher than the individual and not part of the investigation and should have appropriate experience and training to perform this role. - Training, based on identified themes, should be completed in line with the evidence matrix - Minimum of one personal and insightful reflection per theme - Evidence in supervision of discussion around the personal reflection - Evidence should include any good practice/reflections/feedback - Supervisor will determine if evidence of supervision and training has reached a threshold for verification and record this decision making
Support from Verifier - As an additional level of assurance, the evidence of supervision and training will be verified. - The verifier will be registrant of at least band 7, not undertake the role of supervisor and not part of the investigation. - The Verifier will review all evidence provided, in line with the evidence matrix - Verifier will complete Evidence Matrix Checklist - Verifier will then determine if supervision and training can progress through the assurance process or identify areas in which further focus is required by individual supervisee.
Assurance Process
Step 1. Review by DN - Evidence file will be reviewed by the DN - DN will review all documentation /evidence in line with initial themes identified by Senior Nurse Advisors and DAPO

Version (01) 07.07.21
Version (02) 15.07.21
Version (03) 27.07.21
Version (04) 29.07.21
Version (05) 13.09.21
Version (06) 27.09.21
Version (07) 28.09.21
Version (08) 02.11.21
Version (09) 02.12.21

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- DN will determine if there is sufficient evidence of learning against the themes identified.
Step 2. IPP review (training and supervision element of IPP review) - DAPO and DN meet to review Interim Protection Plan - DN will provide assurance in relation to evidence of learning. Evidence folder will be available to assist assurance process. - Decision to move to Trust assurance. Review outcome documented
Step 3. Trust Assurance - Divisional Nurse will present an overview of staff for whom it has been agreed have completed their training and supervision to the MAH Assurance Group - Final decision made and documented. - **Interim Protection plan will remain in place** and will be reviewed on an agreed basis by DAPO and DN with updates provided to the MAH assurance meeting.
Step 4. Operational Meeting - Divisional Nurse will present an overview of staff for whom it has been agreed have completed their training and supervision to the Operational Group. - **Interim Protection plan will remain in place**

Time scales
This is not time bound to allow for sufficient time for completion by the individual. However, it should not take any less time than 12 months.

The MAH Historic Investigation remains a live Adult Safeguarding Joint protocol Investigation. Interim Protection Plans including Supervision and Training Elements remain subject to change, and new learning themes may need to be added if new incidents are viewed.

Version (01) 07.07.21
Version (02) 15.07.21
Version (03) 27.07.21
Version (04) 29.07.21
Version (05) 13.09.21
Version (06) 27.09.21
Version (07) 28.09.21
Version (08) 02.11.21
Version (09) 02.12.21

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Review of Supervision and Training Aspect of Interim Protection Plan

Review Date:	
Attendees to the Review:	
Staff Member's Name:	
Date Interim Protection Plan (IPP) commenced:	
Date IPP agreed at Operational Meeting:	
Confirmation from line manager that the Interim Protection Plan has been in place: Yes / No	
Relevant additional information or any new Adult Safeguarding concerns raised about the staff member's practice:	
Evidence available of engagement in supervision:-	
Evidence available of training and reflective learning in relation to each theme:	
Agreed Interim Protection Plan which will remain in place:-	
Responsible Divisional Lead for on-going assurance of IPP:	

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Recorded by:		Date:	

Appendix 2

Information provided and reviewed by the members of the Independent Assurance Team

- Nurse Management Structure and Responsibilities Review (diagram)
- E rostering – bank utilisation reports
- Staffing Levels
- Staff in Difficulty - Policy
- Internal Trust emails relating to Suspensions and Restrictions
- Current Suspensions record
- Letters & Emails to Staff
- Staff on Restrictions – Weekly Supervision records
- Precautionary Suspensions / Contacts with Staff
- Disciplinary Procedure
- Listening sessions – Report
- Draft Workforce Paper
- Policies

➢ Levels of Supervision/Observations within Learning Disability In-Patient Services November 2013 (should have been reviewed 2016)

➢ Seclusion within Learning Disability In-Patient Services (Children's and Adults) Procedure November (2016)

➢ Use of Restrictive Interventions for Children and Adult Services (does not appear to be Learning Disability specific) (May 2015)

➢ Implementation of CCTV within Muckamore Abbey Hospital to assist with Investigations related to Adult Safeguarding.

 5.050 cc corresponded

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3 November 2017

Mr Sean Holland/Mrs Charlotte McArdle
Chief Social Work Officer/Chief Nursing Officer
Castle Buildings
Stormont Estate
Belfast. BT4 3SQ

Dear Charlotte/Sean

Thank you for your letter of 20th October 2017 in which you set out your concerns regarding the delays in timely reporting of serious safeguarding incidents and breaches in the Serous Adverse Incident and Early Alert procedures.

The incidents reporting timeline has been subject to detailed scrutiny and challenge and it is evident that there were clear failures both internally and externally in respect of these requirements. Incident reporting in Learning Disability Services is a key quality indicator and the management and leadership behaviours in this area will be subject to further investigation and action. Please accept my unreserved apology for our shortcomings in this regard and for the concern this has raised about patient safety and the quality of service provided to these most vulnerable individuals in our care. I will ensure that the learning from our scrutiny of the timelines and around reporting both internal and external is applied in the future

I can confirm that the incidents which are subject to ongoing and further analysis fall into three broad areas of concern :

- 2 incidents of physical assault and several incidents which suggest the inappropriate use of physical restraint and seclusion.
- Neglectful practices specifically the lack of meal supervision with vulnerable patients and a apparent lack of meaningful engagement with patients
- A range of concerns regarding nursing practices, for example sleeping on duty and professionally qualified staff apparently observing some of these practices which were not subsequently reported.

To date the incidents have occurred out of hours and the actual incidents are confined to the members of staff already suspended. However the investigative processes are still at an early stage and this is an evolving picture.

I have provided a summary timeline of the incidents and actions below, I have also outlined the additional structures and actions the Directors are putting in place in order to provide the clear assurances you require about patient safety both now and in the future. In addition the footage collected during the test period has and may continue to highlight other incidents which will be reported to the Department of Health in a timely way.

Trust Headquarters, A-Floor, Belfast City Hospital
Lisburn Road, Belfast. BT9 7AB

Summary Timeline

- The incidents of the 12 August 2017 were not reported by ward staff until 21 August 2017; when reported it was immediately referred to Adult Safeguarding and the PSNI. The staff member involved was place on precautionary suspension. At this stage the PSNI informed the Trust that a single agency approach was being followed for this incident.

- At the time of the incident the CCTV monitoring system that had been installed to assist with Adult Safeguarding concerns was not due to become a live system until 11 September 2017.

- On the 29 August 2017 the Trust became aware that test footage may be available and sought legal advice to view the footage as part of the investigation into the allegations.

- On 6 September 2017 legal advice confirmed that the test footage could be viewed in line with the Trust policy and the information was shared with the PSNI. Contact was made with the CCTV installation company to arrange for Senior Staff to view the footage for 19 September 2017.

- The viewing centred on the incident of the 12 August 2017 and at this viewing a number of other safeguarding concerns were identified involving the staff member already on precautionary suspension and another Healthcare Support Worker. The incidents involved two patients in the Psychiatric Intensive Care Ward (PICU)

- The Trust immediately identified that the member of staff was not on duty and followed this up with a precautionary suspension. This was part of the protection plan.

- An urgent senior strategy meeting was convened by the Director of Adult and Social Primary Care on 22nd September 2017 when she was notified the incidents. After this meeting, an Early Alert update was issued and followed up with an SAI Level 3 notification, which was sent to HSCB and RQIA.

- The Staff Nurse in Charge of the ward on 12 August 2017 was also placed on precautionary suspension for failure to report and protect the patient on the ward. Two further staff nurses were transferred to another ward pending review of available information and delays in reporting safeguarding concerns.

- On 27 September 2017 a verbal update was given to the Department of Health Learning Disability Unit followed by a written submission on 28 September 2017 in response to the Department of Health queries about the incidents. A further update was completed on 20 October 2017.

- On 1 October 2017 a patient on Sixmile Ward reported that a Staff Nurse on night duty physically assaulted him. It was immediately escalated to managers who put in place and interim protection plan, and required the Staff Nurse not to report for night duty the following night. This was discussed and agreed with the Regional Emergency Social Work Service and followed up on 2 October 2017.

- On 2 October 2017 CCTV was viewed and whilst the complaint made by the patient could not be viewed on the CCTV as cameras are not installed in patients' bedrooms, images showed the Staff Nurse kicking the bedroom door of the patient at 5.20am before entering the room and this was considered highly significant as a safeguarding issue. The Staff Nurse was place on precautionary suspension on 4 October 2017.

- On 3 October 2017 the Trust held an Adult Safeguarding Strategy meeting with PSNI and RQIA. A decision was reached that the investigation should be a joint agency approach for all incidents.

- On 4 October 2017 the HSCB, PHA and DoH were verbally updated and a Serious Adverse Incident Form was submitted. The Early Alert should have been updated at this stage and I acknowledge and apologise for this error. Again, we will learn from this.

- Professional alerts have been submitted to the CNO for the two registrants on precautionary suspension.

Assurance

Directors have put in place additional structures and resources to provide clear direction, co-ordination and assurances across all the following investigative and management processes.

- Adult Safeguarding multi-agency strategic management group under Adult Safeguarding Procedures and the Memorandum of Understanding (2013)

- Level 3 Fully Independent Serious Adverse Incident Investigation

- Adult Safeguarding Investigation

- Police investigation under Regional Joint Protocol Procedures (Sept 2016)

- Disciplinary and Professional Procedures.

- Wider commissioning issues regarding discharge delays

- Liaison with RQIA

- Communication Strategy

- A full time Senior Safeguarding experienced officer external to Learning Disability who will be responsible for the effective co-ordination and reporting on all aspects of this investigation

- This individual will be supported by a dedicated team.

- A system of enhanced monitoring and escalation to ensure that the onsite teams are clear about expectations, responsibilities and accountabilities. This includes additional staff and real-time monitoring of CCTV.

- CCTV is being requested for wards who do not have them installed
- Ongoing random sampling of previous CCTV
- Ongoing announced and unannounced monitoring of wards by external senior Trust staff. This will be sensitive to the needs of patients.

I hope this above information provides sufficient information and assurance at this stage.

I recognise that further more comprehensive information will be required in the coming weeks and this will be provided.

Yours sincerely

Mr Martin Dillon
Chief Executive

Cc: Mrs Marie Heaney, Director of Adult Social and Primary Care Service
Miss Brenda Creaney, Director of Nursing and User Experience

Trust Headquarters, A-Floor, Belfast City Hospital
Lisburn Road, Belfast. BT9 7AB

Action Plan Re: Incidents In Muckamore Abbey Hospital

Action	Lead Person	Timescale for Completion	Completion Comment or Follow Up Required
Establish a secure electronic file for collation of all information relating to Incidents in PICU	Brendan Ingram	6th October 2017	To be accessible by Mairead Mitchell, Esther Rafferty, Brendan Ingram, Marie Heaney, and Rhoda McBride
Provide Initial timeline of incidents in PICU	Esther Rafferty	Esther to provide Date	Information sent to Director, Co-Director and filed in Secure file
Initial Viewing of CCTV Imagery in PICU by Senior Staff	Esther Rafferty	20th to 25th September 2017	Information sent to Director, Co-Director and filed in Secure file
Early Alert of initial incident	Mairead Mitchell	7th September 2017	Sent through Early Alert Process
Early Alert update following further incidents being noted in PICU	Esther Rafferty	22nd September 2017	Sent through Early Alert Process
Notification to DHSSPS, HSCB and RQIA	Mairead Mitchell Esther Rafferty	Mairead and Esther to provide dates	All agencies have been informed and notifications in secure file
Notification to Northern and Belfast Trust	Esther Rafferty	Esther to provide e-mails/phone call details etc to Brendan for secure file	Filed in Secure File
Safeguarding Joint Protocol Initiated	Rhoda McBride	On-Going	Information held by Safeguarding Team
Safeguarding meeting with PSNI< RQIA< and BHSCT	Rhoda McBride	3rd October 2017	Agreed to meet again once staff interviews have been completed – to be completed 4 – 6 weeks. Rhoda to provide minutes of all meetings
High Level Senior staff meeting to determine actions required as a result of Safeguarding concerns	Marie Heaney Barney McNeany	26th September 2017	Notes filed in secure file – Follow up meeting agreed for 3rd October 2017
Advice sought from DLS re viewing CCTV Footage	Esther Rafferty		Filed in Secure file
CCTV Guidance to be drawn up	Brendan Ingram	3rd October 2017	Filed in Secure file
CCTV Log to be drawn up	Brendan Ingram	3rd October 2017	Filed in Secure file

August – October 2017

Action Plan Re: Incidents In Muckamore Abbey Hospital

Contact with families agreed as one person	Amanda Burgess	11th October 2017	Information held by Safeguarding Team
Contact to be made with families by Co-Director	Mairead Mitchell	5th October 2017 Mairead to forward brief details to Brendan for secure file	Information held in Secure File
CCTV Viewing Team to be agreed	Mairead Mitchell Brendan Ingram	5th October 2017	Team members notified, list held in Secure File
All Ward/Dept managers to be notified within Muckamore Abbey Hospital of safeguarding concerns and the use of CCTV	Mairead Mitchell	5th October 2017	All wards/depts. informed – Meeting content held in secure file
Enhanced Monitoring visits to PICU	Esther Rafferty	On-Going Monitoring forms to be sent to Amanda Burgess/Rhoda McBride to forward to Brendan Ingram for secure file	Dates of visits held in secure file
SAI Notification form to be completed for PICU Incidents	Jacqui Austin	25th September 2017	Copy of notification held in Secure File
SAI Notification form to be completed for Sixmile Incident	Jacqui Austin	5th October 2017	Copy of notification held in Secure File
Monitoring Visits to include all wards on site	Esther Rafferty	3rd October and On-going Monitoring forms to be sent to Amanda Burgess/Rhoda McBride to forward to Brendan Ingram for secure file	Dates and times of visits held in Secure file
Nominate an independent Chair for Level 3 SAI review for PICU Incidents, Prepare TOR's for same and agree Panel Members	Mairead Mitchell	9th October 2017	Dr Milliken to contact Potential Chair
Staff involved in incidents Suspended/Redeployed Notified to Nurses in Difficulty	Esther Rafferty	25th October 2017 Esther to forward copies of e-mails etc to Brendan for secure file	Completed

August – October 2017

Action Plan Re: Incidents In Muckamore Abbey Hospital

Further Meeting held with Senior Staff to brief Mairead Mitchell on return form leave	Marie Heaney	3rd October 2017	Notes held in secure file
Set up a schedule of meetings to update senior staff on progress of action plans	Mairead Mitchell	On-Going	Fortnightly meetings have been established and placed in appropriate staff schedulers
Preparation of a Press Release if required	Mairead Mitchell	5th October 2017	Copy sent to Bronagh Dalzell in Corporate Communications and copy held in Secure file
Preparation of list of all staff who have had previous allegations made towards them	Esther Rafferty	To be completed by 12th October 2017 Esther to forward Brendan copy of same once completed for secure file	List of staff names held in Secure File
Chief Executive and Exec Board Updated	Marie Heaney	4th October 2017	Held In secure file

August – October 2017

Action Plan for Protection of Patients in Muckamore Abbey Hospital – November 2017

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
1 ENHANCED MONTORING					
CCTV Installation	Implement on all wards. Killead and Donegore	Estates/Brendan Ingram	Will be installed and live on wards Constraint – contractor timescale	To be determined contractor	Amber
CCTV preservation of 90 equivalent days	To preserve and secure the footage already gathered from March 2017	IT/Brendan Ingram	CCTV will be preserved	Completed 11 Nov	Green
CCTV Viewing Centre	Viewing screens to be moved off ward to location on Admin Building	Estates/Brendan Ingram	Viewing will be discreet and allow for improved viewing Constraint – contractor timescale	Completed 11 Nov	Green
CCTV live viewing	Intermittent live viewing of three shifts per day. Monitoring form will be completed and submitted to Brendan Ingram/Jacqui Austin for verification. Reporting of any concern issue re nursing to Service Manager and Head of Learning Disability. Concerns re safeguarding immediately to Rhoda McBride social work lead or Safeguarding Officer and Out of Hours to RESWS.	Brendan Ingram	A daily log report will be analysed to provide assurance on patient care and safety. Constraint. Sustainability of staff to do this And policy implications.	November and Ongoing	Green
CCTV sample of past footage 1st Aug – 2nd October 2017	A 25% sample of footage which includes the three shifts on the 4 wards to be viewed to determine any further safeguarding concerns. Rhoda McBride	B Ingram	Independent monitoring with staff from outside of hospital. Monitoring template depicting concerns or good practice.	To be completed 15 November	Green

Action Plan for Protection of Patients in Muckamore Abbey Hospital – November 2017

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
	social work lead and Esther Rafferty nursing lead to analyse				
2					
Enhanced ward monitoring by senior staff.	Senior Nurse Managers moved to the wards to support ward teams and monitor nursing practice. A comprehensive monitoring form is completed by ward manager weekly, discussed with Senior Nurse Manager. The Service Manager and Senior Nurse Manager then review at weekly supervision. Any concerns are escalated to Co-Director immediately by Service Manager.	Esther Rafferty Service Manager Esther Rafferty Service Manager	All 8 wards will have weekly comprehensive report which outlines, complaints, incidents, safeguarding and staffing. Escalation of concerns will be improved and actioned quicker.	November 2017 – Ongoing	Green
External Staff monitoring	Senior Staff across directorate are intermittently doing patient safety walk around to wards unannounced. A report is collated from the walkaround.	Brendan Ingram	Reports from walkaround is sent to Esther Rafferty Nurse Lead and Rhoda McBride Social Work Lead for analysis and escalation of concerns to Head of Learning Disability.	October 2017- Ongoing	Green
3					
Senior Nurse Managers responsibilities to enhance ward presence and monitoring	Wards to be reallocated to Senior Nurse Managers to ensure equity of workload, enhanced monitoring,	Esther Rafferty – lead Service Manager	Better division of workload for Senior Nurse Manager Allows for peer support Enhances support for ward staff	November 2017 completed	Green

Action Plan for Protection of Patients in Muckamore Abbey Hospital – November 2017

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
	presence on ward and to provide support for ward staff				
4					
Review of Management Responsibility and Reporting	Hospital Social Work staff will move to Social Work Lead for Learning Disability and reporting will be through Social Work line to ensure accountability and professional practice. Behaviour Nurses will report directly and be managed by Psychology Services.	Rhoda McBride Siobhan Keating	Improved professional Governance Arrangements Direct line of accountability to Social Work Lead Safeguarding arrangements enhanced Ensure behaviour nurses will be core to implementing Positive Behaviour Support Psychology led behaviour plans for patients Ensure behaviour staff are not used for other duties.	November 2017 completed November 2017 completed	Green
5					
Review of Hospital Staff profile	To monitor incidents, complaints and safeguarding issues in relation to staff and determine if trends	Mairead Mitchell	Ensure patient safety	November 2017	Green
6 IMPROVING STAFFING					
Enhance staffing for multidisciplinary teams	Two new posts for Behaviour Nurse Therapists Band 6 Two new Social Worker Posts Band 6 Pharmacy cover for Hospital 0.5wte	Siobhan Keating Rhoda McBride Esther Rafferty	Ensure each ward has a behaviour nurse and will lead on implementation of Positive Behaviour Support Ensure that each MDT has Social Work Input and ward based to help with Safeguarding Issues. Ensure patient safety to reduce medication errors. Pharmacist to	November 2017 November 2017 December 2017	Amber

Action Plan for Protection of Patients in Muckamore Abbey Hospital – November 2017

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
	GP sessions twice weekly	Dr Colin Milliken	review PRN Medications and antipsychotic medication and its use Ensure patients have appropriate physical medical care and screening	December 2017	
7 COMMUNICATION					
Communication of patient safety concerns to all ward staff	Full implementation of ward based safety briefings on all wards MDT Attendance and ward based PCSS Staff Record of safety briefing to be sent to Senior Nurse Manager for analysis. Senior Nurse Manager to attend at least one safety briefing per ward per week.	Esther Rafferty	All staff aware of issues and actions to be taken regarding patients. Reduce incidents Allow for good working relationships with all ward staff.	November 2017	Green
8 REFLECTION AND LEARNING					
Reflective Practice and Learning	All ward staff to have opportunity to attend reflective practice sessions. An independent psychologist from outside Learning Disability will lead the implementation. Trend analysis being completed of complaints, SAIs, incidents and safeguarding in the past two years of Hospital. This will highlight correlation and learning.	Siobhan Keating Jacqui Austin/Fiona Davidson`	Culture of wards to be of learning and reflection Reflective practice embedded in MDT Enhance Patient Safety Learning for all staff Identify trends and actions required	November 2017 December 2017	Amber

Action Plan for Protection of Patients in Muckamore Abbey Hospital – November 2017

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
9					
Implementation of Positive Behaviour Support	Full implementation of Positive Behaviour Support for all wards First phase – PICU Killead and Donegore Awareness training for all staff including PCSS staff Full RAID Training for MDT Team	Sarah Meekin	Reduction in intensity of incidents Reduction in use of seclusion Reduction in PRN medication Constraint will be staffing levels.	November 2017	Amber
10					
Safety Quality Initiatives SQ Belfast Projects	Medical led IMPACT Projects which focus on Delayed Discharges Safety Briefs Medication errors Support from Senior Management Team for the Project Staff undertaking SQB Belfast. Projects identified -use of seclusion -physical health of patients – Cranfield.	Dr Colin Milliken Senior team	Improvement in patient care in the areas identified. Multidisciplinary input and improved communication Staff training in Quality Improvement Methodology Project outcomes that will impact and improve patients care	Sept and ongoing Sept and ongoing	Green
11					
Communication and engagement with staff on Hospital issues	Monthly meetings with Ward Sisters/Charge Nurses/Deputies/Head of	Mairead Mitchell	Better communication to all staff Value staff Involvement of staff	September 2017 and ongoing	Green

Action Plan for Protection of Patients in Muckamore Abbey Hospital – November 2017

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
	Departments and Consultant Staff		Enhanced Patient care		
	Task and Finish Group implementation of action plan	Mairead Mitchell		December 2017	Amber
12					
Communication with carers	Your voice counts sessions to be rolled out bi monthly and action brought to attention of Head of Learning Disability	Brendan Ingram	Carers views to improve patient care Engagement with carers	September 2017 and bi-monthly	Amber
13					
Communication with patients	To request TILII Muckamore group to gain views of patients re care and safety with the help of advocates	Esther Rafferty	Patient views that will impact on improved care.	November 2017 – ongoing	Amber
14					
Securing of information	Set up a secure file of all information regarding current safeguarding, SAI and disciplinary.	Brendan Ingram	Ensure all information preserved for the future. Allow information to be on hand to Senior Management Team at all times	September and ongoing	Green

Action Plan for P. ection of Patients in Muckamore Abbey Hospital –December 2017

Progress Update as at 30th January 2018

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
1 ENHANCED MONTORING					
CCTV Installation	Implement on all wards. Killead and Donegore To review CCTV Policy	Estates/Brendan Ingram Mairead Mitchell/Brendan Ingram	Will be installed and live on wards Constraint – contractor timescale Revised Policy **Installation in Killead/Donegore to be complete by end of January – Commence works in the swimming pool and Moyola following this.** **CCTV policy to be completed by end of February 2018**	To be determined contractor January 2018	Amber
CCTV preservation of 90 equivalent days	To preserve and secure the footage already gathered from March 2017	IT/Brendan Ingram	CCTV will be preserved	Completed 11 Nov	Green
CCTV Viewing Centre	Viewing screens to be moved off ward to location on Admin Building	Estates/Brendan Ingram	Viewing will be discreet and allow for improved viewing Constraint – contractor timescale	Completed 11 Nov	Green

Action Plan for P. ..ection of Patients in Muckamore Abbey Hospital –December 2017

Progress Update as at 30th January 2018

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
CCTV live viewing	Intermittent live viewing of three shifts per day. Monitoring form will be completed and submitted to Brendan Ingram/Jacqui Austin for verification. Reporting of any concern issue re nursing to Service Manager and Head of Learning Disability. Concerns re safeguarding immediately to Rhoda McBride social work lead or Safeguarding Officer and Out of Hours to RESWS.	Brendan Ingram	A daily log report will be analysed to provide assurance on patient care and safety. Constraint. Sustainability of staff to do this And policy implications.	November and Ongoing	Green
CCTV sample of past footage 1st Aug –4th November 2017	A 25% sample of footage which includes the three shifts on the 4 wards to be viewed to determine any further safeguarding concerns. Rhoda McBride social work lead and Esther Rafferty nursing lead to analyse	Brendan Ingram	Independent monitoring with staff from outside of hospital. Monitoring template depicting concerns or good practice. 540 hours completed	To be completed end November	Green

Action Plan for Protection of Patients in Muckamore Abbey Hospital –December 2017

Progress Update as at 30th January 2018

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
Request from DoH to extend CCTV viewing	To determine what is required for further viewing, ? 1st August to 4th November which equates to 1500 hours or March/April to 1st August which equates to 5000 hours	Mairead Mitchell	Completion of viewing will need to be independent from the hospital. Constraint – Availability of suitably qualified staff **Mencap unable to provide any support** **Contact being made with suitably qualified staff who have recently retired and also with a number of associates from the BMC** **Guidance and flowchart drawn up for this.**	Proposal paper sent to directors oversight group	Amber
Previous allegations of Adult Safeguarding Incidents	To review CCTV footage back to March/April for any previous safeguarding incidents by those staff with current allegations against them	Mairead Mitchell/Brendan Ingram	To determine if any further safeguarding incidents have occurred	December 2017	Amber
Review of Policies	Zero Tolerance Policy Implementation process within Muckamore Abbey Hospital	Esther Rafferty/Colin Milliken/Jacqui Austin	To ensure full implementation of policy throughout all wards and depts. **The Divisional Nursing Team within the Belfast Trust has set up a group to look at the zero tolerance policy** **Alongside this there is a regional policy review**	December 2017	Amber

Progress Update as at 30th January 2018

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
			Ward Sister Frances Maguire is completing a survey with staff and is on the Trust Zero Tolerance Review Group.		
	Rapid Tranquillisation Policy Consider whether this should be included on the ASPC Directorate Register Also to form part of the PBS Action Plan	Colin Milliken	To provide updated policy **Dr Milliken happy to provide reassurance that the policy is followed, but will demonstrate this through audit. We will consider training/awareness for staff, and this could be included and audited as part of induction for all staff. The ID service would wish to be involved in Trust review of the policy.**	To provide updated policy	Red
	Adult Safeguarding Presentation of the Adult safeguarding Process and the development of a flow chart for all wards and departments outlining the main steps to follow in reporting safeguarding incidents	Rhoda McBride	Presentation to staff in Muckamore Abbey Hospital and develop a flow chart for all wards and depts. to follow	December 2017	Green

Action Plan for Protection of Patients in Muckamore Abbey Hospital –December 2017

Progress Update as at 30th January 2018

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
	Patient Supervision/Observation Policy To review current policy to ensure that content remains current and relevant	Esther Rafferty	Revised Policy **The group continues to meet and is updating the current policy and this will take approximately six weeks to complete**	December 2017	Red
	Seclusion Policy To review use of seclusion with support from Royal College of Psychiatry and Psychology	Colin Milliken	Produce a new revised pathway for use of seclusion Dr Arun Subramanian, Royal College of psychiatry and Clinical Director Southern Trust has been engaged to support this work. **First meeting to review this policy took place on Friday 26th January 2018 – Further meetings currently being planned.**	June 2018	Amber
	CCTV Policy To review current policy as a result of learning to date from installation of CCTV in Cranfield and Sixmile	Brendan Ingram	To review CCTV policy incorporating any learning to date since installation of CCTV in Cranfield and Sixmile Wards **First meeting arranged for 7th February 2018**	January 2018	Amber
2					
Enhanced ward monitoring by senior staff.	Senior Nurse Managers moved to the wards to	Esther Rafferty	All 8 wards will have weekly comprehensive report which	November 2017 – Ongoing	Green

Progress Update as at 30th January 2018

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
	support ward teams and monitor nursing practice. A comprehensive monitoring form is completed by ward manager weekly, discussed with Senior Nurse Manager. The Service Manager and Senior Nurse Manager then review at weekly supervision. Any concerns are escalated to Co-Director immediately by Service Manager.	Esther Rafferty Sarah Meekin	outlines, complaints, incidents, safeguarding and staffing. Escalation of concerns will be improved and actioned quicker. Complete staff survey using Survey Monkey and establish a focus group to ensure staff engagement in monitoring visits and to also highlight any opportunities for improvement		
External Staff monitoring	Senior Staff across directorate are intermittently doing patient safety walk around to wards unannounced. A report is collated from the walk around.	Brendan Ingram	Reports from walk around is sent to Esther Rafferty Nurse Lead and Rhoda McBride Social Work Lead for analysis and escalation of concerns to Head of Learning Disability.	October 2017-Ongoing	Green
3					
Senior Nurse Managers responsibilities to enhance ward presence and monitoring	Wards to be reallocated to Senior Nurse Managers to ensure equity of workload, enhanced monitoring, presence on ward and to provide support for ward staff	Esther Rafferty	Better division of workload for Senior Nurse Manager Allows for peer support Enhances support for ward staff	November 2017 completed	Green
4					
Review of Management Responsibility and Reporting	Hospital Social Work staff will move to Social Work Lead for Learning Disability and reporting will be through	Rhoda McBride	Improved professional Governance Arrangements Direct line of accountability to Social Work Lead	November 2017 Completed	Green

Action Plan for Protection of Patients in Muckamore Abbey Hospital –December 2017

Progress Update as at 30th January 2018

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
	Social Work line to ensure accountability and professional practice. Behaviour Nurses will report directly and be managed by Psychology Services.	Rhoda McBride Siobhan Keating	Safeguarding arrangements enhanced A presentation update for all staff on site on safeguarding process Ensure behaviour nurses will be core to implementing Positive Behaviour Support Psychology led behaviour plans for patients Ensure behaviour staff are not used for other duties.	7th November 2017 November 2017 completed	
5					
Review of Hospital Staff profile	To monitor incidents, complaints and safeguarding issues in relation to staff and determine if trends	Mairead Mitchell	Ensure patient safety	November 2017	Green
6 IMPROVING STAFFING					
Enhance staffing for multidisciplinary teams	Two new posts for Behaviour Nurse Therapists Band 6	Siobhan Keating	Ensure each ward has a behaviour nurse and will lead on implementation of Positive Behaviour Support Interviews for Band 6 Behaviour Nurse Posts now completed and staff will take up post quite shortly Band 4 PBS Assistant to go out to interview prior to Christmas.	December 2017	Green

Action Plan for Protection of Patients in Muckamore Abbey Hospital –December 2017

Progress Update as at 30th January 2018

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
	Two new Social Worker Posts Band 6	Rhoda McBride	Work Input and ward based to help with Safeguarding Issues. **All requisitions now raised and Both Posts approved through Scrutiny. To come off waiting list**	January 2018	Amber
	Pharmacy cover for Hospital 0.5wte	Esther Rafferty	Ensure patient safety to reduce medication errors. Pharmacist to review PRN Medications and antipsychotic medication and its use **Funding confirmation from level 3 co-director to proceed**	January 2018	Amber
	GP sessions twice weekly	Dr Colin Milliken	Ensure patients have appropriate physical medical care and screening Meeting scheduled for 4th December 2017 to take recruitment process forward Criteria now agreed and post to go to Recruitment	January 2018	Green

Action Plan for Protection of Patients in Muckamore Abbey Hospital –December 2017

Progress Update as at 30th January 2018

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
			Meeting arranged with HR for 1st February 2018 to discuss process for recruitment		
7 COMMUNICATION					
Communication of patient safety concerns to all ward staff	Full implementation of ward based safety briefings on all wards MDT Attendance and ward based PCSS Staff Record of safety briefing to be sent to Senior Nurse Manager for analysis. Senior Nurse Manager to attend at least one safety briefing per ward per week.	Esther Rafferty	All staff aware of issues and actions to be taken regarding patients. Reduce incidents Allow for good working relationships with all ward staff.	November 2017	Green
8 REFLECTION AND LEARNING					
Reflective Practice and Learning	All ward staff to have opportunity to attend reflective practice sessions. An independent psychologist from outside Learning Disability will lead the implementation.	Siobhan Keating	Culture of wards to be of learning and reflection Reflective practice embedded in MDT Enhance Patient Safety PICU and Killead wards agreed as the two wards in 1st Phase	To commence December 2017	Green
	Trend analysis being completed of complaints, SAIs, incidents and safeguarding in the past two	Jacqui Austin/Fiona Davidson`	Learning for all staff	December 2017	Green

Progress Update as at 30th January 2018

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
	years of Hospital. This will highlight correlation and learning.		Identify trends and actions required		
9					
Implementation of Positive Behaviour Support	Full implementation of Positive Behaviour Support for all wards First phase – PICU Killead and Donegore Awareness training for all staff including PCSS staff Full RAID Training for MDT Team	Sarah Meekin	Reduction in intensity of incidents Reduction in use of seclusion Reduction in PRN medication Constraint will be staffing levels. We are now in week 4 of implementation. An implementation group has been established led by Psychology. A training plan has been developed and is currently being implemented. Further resource has been made available through PHA and this is being followed up by Sarah Meekin	November 2017	Green
10					
Safety Quality Initiatives SQ Belfast Projects	Medical led IMPACT Projects which focus on Delayed Discharges Safety Briefs Medication errors Support from Senior Management Team for the Project Staff undertaking SQB Belfast.	Dr Colin Milliken Senior team	Improvement in patient care in the areas identified. Multidisciplinary input and improved communication Staff training in Quality Improvement Methodology Project outcomes that will impact and improve patients care	Sept and ongoing Sept and ongoing	Green

Action Plan for Protection of Patients in Muckamore Abbey Hospital –December 2017

Progress Update as at 30th January 2018

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
	Projects identified -use of seclusion -physical health of patients – Cranfield.				
11					
Communication and engagement with staff on Hospital issues	Monthly meetings with Ward Sisters/Charge Nurses/Deputies/Head of Departments and Consultant Staff	Mairead Mitchell	Better communication to all staff Value staff Involvement of staff Enhanced Patient care Has been changed to weekly meetings	September 2017 and ongoing	Green
	Task and Finish Group implementation of action plan	Mairead Mitchell	Presentation on outcomes of listening groups has been completed and an action plan is currently being developed with staff Presentation to Director's Oversight Group 11th December 2017	December 2017	Green
12					
Communication with carers	Your voice counts sessions to be rolled out bi monthly and action brought to attention of Head of Learning Disability	Brendan Ingram	Carers views to improve patient care Engagement with carers **Next Meeting to take place with relatives on 15th February 2018**	September 2017 and Quarterly Next meeting to take place January/February 2018	Amber
13					

Action Plan for Protection of Patients in Muckamore Abbey Hospital –December 2017

Progress Update as at 30th January 2018

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
Communication with patients	To request TILII Muckamore group to gain views of patients re care and safety with the help of advocates	Esther Rafferty	Patient views that will impact on improved care. Louise Hughes (ARC) has been contacted and will facilitate additional sessions for patients in order to gain their views on their care and treatment **Esther has requested an update from ARC and meeting scheduled with Bryson House (This for both patient and carer advocacy)**	November 2017 – ongoing	Amber
14					
Securing of information	Set up a secure file of all information regarding current safeguarding, SAI and disciplinary.	Brendan Ingram	Ensure all information preserved for the future. Allow information to be on hand to Senior Management Team at all times	September and ongoing	Green
15 Plan for ASG and Disciplinary investigations					
To establish a Strategy Group to take forward ASG and Disciplinary investigations.	To establish processes, schedules, timetables and appropriate documentation in preparation of ASG and Disciplinary Investigations	Rhoda McBride	Strategy meeting has taken place and further meeting organised.	December and On-going	Green
16 Liaison with HR Staff	Convene a meeting with HR to agree how the ASG and	Rhoda McBride Yvonne McKnight	Meeting took place with Marie Cullen and Claire Nellis in HR on 24/11/17 and agreement reached	November and On-going	Green

Progress Update as at 30th January 2018

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
	Disciplinary Processes can be taken forward together		that both processes can proceed simultaneously. **Rhoda has e-mailed Marie Curran for the names of the disciplinary team from the Beeches. Orla Tierney 8A NDL Lead has also been appointed.**		
17 Disciplinary Team to be appointed	Appropriate staff to be appointed to complete disciplinary process	Mairead Mitchell Rhoda McBride HR Staff	Disciplinary team to complete process simultaneously with ASG Process **Same as above**	January 2018	Red
18 Establish TOR for Disciplinary and ASG Teams	Terms of Reference to be agreed with Disciplinary Team, Adult Safeguarding and Human Resources	Mairead Mitchell Rhoda McBride HR Staff	Agreed TOR for disciplinary and ASG teams to follow **No update as yet as waiting information on team memberships**	January 2018	Red
19 Preparation of an interview schedule to include all staff and their TU representatives/other	Interview schedule to be set up with staff, Trade Unions/Other	Chair of Disciplinary Panel Rhoda McBride	An agreed interview schedule for all staff and their TU representatives/other **No update as yet as waiting information on team memberships**	January 2018	Red
20 Agree interview questions	Proposed interview questions to be agreed	Rhoda McBride	List of agreed interview questions for Disciplinary Procedure **No update as yet as waiting information on team memberships**	January 2018	Red

Action Plan for Protection of Patients in Muckamore Abbey Hospital –December 2017

Progress Update as at 30th January 2018

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
21 Information required for ASG and Disciplinary Investigations	Collate and gather all information required to complete ASG and Disciplinary Investigations	Brenda Ingram	Have available all of the following information • ASG file • Care Plans • Case Notes • Seclusion Policy • CCTV Policy • CCTV Footage • Whistleblowing Policy • NMC/NISCC Standards/Codes • ASG Policy – including Joint Protocol • Observation Policy • Staff Training Records • Staff Supervision records • Datix Incidents • Previous Historical concerns re all staff and patients • TOR • Interview Schedule • Templates for Interviews/Minute	January 2018	Red

Progress Update as at 30th January 2018

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
			Taker/Interviewer/MAPA etc. • Any witness statements etc • List of staff • List of patients and their care plans etc **Work has commenced on pulling together this information – further information to be collated as and when required by the SAI Panel.**		
22 ASG report and Recommendations	ASG team will complete a separate ASG report and make recommendations	ASG Lead	Production of final report with recommendations	February/March 2018	Red
23 Disciplinary report and recommendations	The Disciplinary team will write a separate report and make recommendations	Disciplinary Lead	Production of final report with recommendations	February/March 2018	Red
24 'keeping yourself safe'	Roll Out "Keeping yourself safe" programme for all patients in PICU and Sixmile initially	Danielle McIlroy	Roll out "Keeping yourself safe" for all patients in all wards across the hospital site **Work has commenced but lead for this work has now returned to former post. Update report**	February 2018	Amber

Progress Update as at 30th January 2018

Assurance Step	Action to be Taken	Responsible Lead Person	Outcome Measure or Constraint	Timescale	RAG Rating
			available of what has been completed to date.		

Recommendations	Action to be taken	By Whom	Timescale For Action		Date Action Achieved
1. The Independent Assurance Team recommend the need for clear processes for escalating concerns about staffing levels and ability to provide safe nursing care directly to the Director of Nursing and Director of Social and Primary Care.	• Roster utilisation and compliance training • Reset Roster rules • Retaining staff in process of employment on line • Booking bank shifts returned to central Bank office • External agency contracts managed by central Bank office • Agreed communication regarding escalation flow chart to nurse in charge, Ward sister/Charge nurse Bank office, Lead nurse, service manager to co-director • 2 wards(D&K) joining to become 1 ward area now Ardmore • Action plan for monitoring and accountability to be re-established communication with senior staff including ward sister/charge nurses	MM, BC, Roster & bank MM, BC MMCB,RS,FM	Sep2018-Jan 2019 Jan – March 2019	Training has taken place on all areas – some wards identified as non-compliant – supported to meet Trust policy guidance. All wards informed of the changes required to Roster utilisation. Weekly Ward sister and charge nurse meeting re-established and Staff appointed to oversee the roster in each area. Progress monitored at weekly meeting in line with Trust policy. All issues directly discussed with Senior Nurse Leads.	January 2019
2. The Trust should purposefully continue to actively recruit nursing staff through high profile regional and a rolling local recruitment campaigns.	• Recruit exercise on site • Retained recruitment function returned to the central workforce office	SC MM, AP,FM	2018 Oct 2018	Attendance at central nursing workforce meeting	Dec 2018 Nov 2018

	• Engage in Trust recruitment working group • Rolling add on the HSC website • Bank recruitment for Bank only staff • Staff planning to retire who stated they wished to retain set hours contract explored	MM, AP,BC, FM BC, Monica Molloy	Dec 2018 Jan- March 2019	Attendance at Recruitment group Rolling Trust Advert online Exploring with HR contracts for alternative approached to retirement	Jan 2019
3. Clear information about the role, function and planned future of Muckamore Abbey Hospital, together with information on the complexity of abilities and needs of the people cared for in Muckamore Abbey Hospital should be articulated to support and inform workforce planning.	• Business meeting • Regional meetings • New Governance site meeting • Review of the workforce plan	MH Director and Divisional team Brenda C, Moira M, AP	ongoing	Weekly business meeting Regional meetings planed Governance meeting has commenced	2020
4. Senior managers should as a matter of urgency explore current actions aimed at retaining staff – including local induction, perception of new registrants, regular supervision, career development opportunities and using staff skills for specialist practice roles for which they have been prepared.	• Staff open listening sessions • HR exit interviews be reviewed • Bwell and here4u communication to staff also Contacts for staff include: Staff Care, site counselling and psychology service • Review induction programme • Review preceptorship programme • Review education commissioning activities • Review delivery of education programmes CPD, Positive	MM,MM,BC,MM FM,RS,MMCB,SC	Aug 2018- feb 2019	B well, Here4u, staff care, counselling and psychology in place and have been communicated to all staff Positive behavioural Support remains mandatory and requires formal education for staff to	

	Behavioural Support Mandatory training • Review Supervision CNO standards compliance • Review staff development review compliance			gain better understanding All other standards continue to on-going monitoring and reported upon to the SNMT meeting with Exec DoN	
5. In order to further understand why staff have left Muckamore Abbey Hospital, exit interviews should be conducted with all staff leaving Muckamore Abbey Hospital and Learning Disability Services in the BHSCT. These interviews should be conducted by a person not involved in the management of the staff member. It is recommended that independent exit interviews are conducted retrospectively with all staff who have left Muckamore Abbey Hospital and Learning Disability Services in the BHSCT to work elsewhere in the past 3 years.	• Staff open listening sessions • HR exit interviews be planned See first report attached	Deputy Director of nursing Trade union colleagues HR	ongoing		
6. It is the view of the Independent Assurance Team that it would be good practice to support rotation of newly qualified staff across practice areas/care environments within Muckamore Abbey Hospital in a planned and	• Staff engaged in night duty only be reviewed and supported to be on days as per Trust policy for their development opportunities	Lead nurses on site Lead nurses & A Pelan	Ongoing 2019	 Commence Review opportunities for	Ongoing 2020

transparent manner, to support professional development and development of skills and competencies. Consideration should also be given the rotation of staff between hospital and community services in a planned and transparent manner.	• Review opportunities for rotation across the hospital and community service for nurses			rotation across the hospital and community service for nurses develop a plan	
7. It is apparent that due to the shortage of RNLDs in post, Muckamore Abbey Hospital actively recruit nurses from Mental Health Nursing and other fields of practice to fill vacancies, the impact of this on services provided needs to be monitored and evaluated.	• Retained recruitment function returned to the central workforce office • Engage in Trust recruitment working group • Rolling add on the HSC website • Bank recruitment for Bank only staff • Engagement in Trust recruitment planned activities • Engagement in curriculum development in HEI pre-registration programmes • Engagement in the Future Nurse and New NMC proficiencies for Learning disabilities • Engagement in the Learning Disability collaborative NI • Engagement in the regional DERS working group implementing DOH policy and commissioning intentions	Nov 2018	Ongoing	All HEI partnership engagement	2020

8. The BHSCT should formally escalate concerns directly to the DOH regarding the number of commissioned places on the pre-registration nursing – learning disabilities and specialist practice programmes and request consideration of increasing the number of places as soon as possible.	• Escalated concern regarding Learning Disability Nursing figures to CNO numbers increased this education year 2018 • Requested consideration of the priority of Learning disability within the Delivering care work strand via CNO • Open university be commissioned to deliver a Learning disability programme aim to increase population of Learning disability nurses • CEC commissioned programmes, CPD and mandatory training compliance • Learning needs analysis completed to influence ECG for incoming year	EDoN Brenda Creaney, Moira Mannion MM,SC, EMCD, CC	Sep 2018 Sep-Dec 2018		Ongoing developmer activities Ongoing developmer activities
9. A Task and Finish Group should be established to review and analyse the use of E rostering, this should include robust arrangements for monitoring of staff working over contracted hours.	• Established work strand Aug –Dec 2018 • Re-training and automatic Roster rule review • Training regarding employment on line to self-manage bank shifts for own employees • Roster rules reset and agreed accountability refreshed • Operational manager in place and lead nurse with Ward sisters/charge nurse to be accountable for this system		Aug- Dec 2018		Ongoing activities

10. The recommendations of the "Listening Groups" should be progressed with agreed timeframes.	Launch Health and safety stress assessment by training facilitators, who will conduct focus groups and the outcome of which will be a Trust action plan generated by the themes in line with the HSC health and safety standards	Health and safety Trust team-facilitators	Feb 2019		

Presentation Given To Trust Board Nov 19

Muckamore Abbey Hospital

A Review of Safeguarding at Muckamore Abbey Hospital

SAI Report Findings and Recommendations

Belfast Trust Immediate and Medium Term Actions

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Background Detail

- August 2017 father of patient in PICU raised concerns with his MP about incidents involving his son and concern that information was being withheld. MP wrote to DOH who contacted Trust 30/8/2017
- AS incidents had occurred in PICU on 12/8/17, not reported to hospital managers until 21/8/17 who then notified AS and PSNI. Staff member suspended. Minimal detail provided
- Not considered by the Division to reach SAI threshold
- CCTV monitoring system due to go live on 11/9/17 was discovered to have been running as a test phase.
- This was viewed on 19/9/17 and revealed further incidents and involving another staff member who was suspended.
- Early alert to DOH on 7/9/17
- Directors not notified until 22/9/17 6 weeks after incident occurred. Urgent senior meeting occurred same day, revised early alert and SAI Level 3 notification to HSCB and RQIA.
- 01/10/17 – further assault incident alleged by patient in Sixmile. This incident was appropriately reported, staff member suspended.
- Total of 4 staff on suspension, 2 alleged witnesses placed on enhanced supervision
- Incident reporting in LD services is an important quality indicator and immediately gave rise to questions about the leadership in the hospital, the Trust by the DOH and Trust Board

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Immediate Actions

- All family carers were contacted to inform them and provide the maximum amount of information possible and offered individual meetings.
- All available CCTV footage was preserved, from 1 March 2017 until 30 September 2017.
- An enhanced monitoring and escalation system was put into place which consisted of, real time monitoring of CCTV where it was in place, senior nurses were relocated from the central office to allocated ward areas, senior staff from across the directorate were appointed to undertaken unannounced leadership visits.
- A Directors Oversight Group was established which met initially weekly, then fortnightly at Muckamore Abbey Hospital. This meeting is still in place. Its role was to receive reports from enhanced monitoring systems, provide an open door to all staff to speak directly to Directors confidentially on any matter and to provide support and advice to the senior leadership team.
- Directors met directly with all groups of staff at Muckamore Abbey Hospital to outline the serious nature of the allegations and the steps required to address the root causes as well as to listen to feedback.
- Terms of reference were developed for a fully independent level 3 SAI Investigation. Work commenced to identify a suitable expert panel to include a family carer. This is nearing completion and will then be submitted to HSCB.
- An adult safeguarding investigation commenced immediately in partnership with the PSNI under the Joint Protocol. This remains on-going To date there have been over a hundred incidents relating to 9 patients from the historical viewing of the CCTV in PICU. Majority of these have been referred to the PSNI for consideration.

- A team of 10 retired social workers and nursing staff experienced in Adult Safeguarding work were recruited to undertake the viewing of the historical CCTV material, alongside an experienced learning disability nurse with expertise in MAPA techniques. This team received training, protocols were developed and they commenced this work on 30 April 2017. This work is expected to complete by end of September. The footage is from four areas of the hospital:-
  - Psychiatric Intensive Care Unit
  - Cranfield 1 & 2 wards
  - Six mile ward.
- The installation of CCTV was commissioned for all wards the swimming pool area and the day care centre. This has now been completed and is live with the exception of Erne ward where asbestos problems are being addressed first.
- An assertive recruitment exercise was undertaken which has had positive results with 46 posts offered. These staff are being phased in from July onwards.
- The Trust appointed an independent assurance group
- The terms of reference for this group were to review decisions regarding staff who were subject to precautionary suspension or restricted duties as part of a protection plan.
- To review specific policies around seclusion, supervision, observations, restrictive interventions and implementation of CCTV.
- To review draft workforce paper.
- A series of senior multi-agency meetings involving PSNI, Trust, HSCB, RQIA, DOH, Northern Trust and Public Health Agency were convened and minuted.
- Professional alerts were undertaken for all registrars and NMC referrals made.
- Disciplinary investigations were initiated where permitted by PSNI.
- Director of Adult Social and Primary Care provided briefings to the Directors in HSCB, Northern and South Eastern Trust.

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Terms of Reference

The Terms of Reference

1. To undertake a level 3[1] investigation that:

Reviews the effectiveness of:

i. the identification and timely reporting of adult safeguarding incidents in Psychiatric Intensive Care Unit (PICU) and Six Mile in August 2017 & October 2017, and subsequent communication and reporting of these incidents between the Trust, PHA / HSCB and Department of Health

ii. adult safeguarding and the subsequent investigations in Muckamore Abbey Hospital from 2012 – 2017

iii. adult safeguarding protection plans in Muckamore Abbey Hospital

iv. the current advocacy arrangement in Learning Disability services

v. governance and quality assurance and controls in relation to quality, safety and user experience of care in Learning Disability Services from 2012 – 2017

vi. the implementation of previous recommendations following SAI, Adult Safeguarding investigations and RQIA reports in relation to Muckamore Abbey Hospital from 2012 – 2017

vii. using the RQIA assessment definitions of Well-Led[2] assess the leadership within Muckamore Abbey Hospital to include:

- Delivery of Safe, Effective and Compassionate Person-Centred Care[3]
- Clinical supervision
- Training
- Multi-professional audit
- Communication
- Learning and improvement

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2. Identifies areas of good practice both at Muckamore Abbey Hospital and in related services elsewhere with a view to proposing a programme of improvement and development associated with the outcomes of the investigation.

3. Advises on, with a view to consideration of, any other relevant matters that may arise during the investigation.

The Review Team was advised of matters which were outwith the Terms of Reference and these were directed to the Hospital's managers [4]

[1]That is, a review of serious adverse incidents which are particularly complex involving multiple organisations; have a degree of technical complexity that requires independent expert advice and are very high profile…attracting a high level of both public and media attention. Section 5.3 of Health and Social Care Board (2016) Procedure for the Reporting and Follow up of Serious Adverse Incidents, Version 1.1

[2]That is, Effective leadership, management and governance which creates a culture focused on the needs and the experiences of service users in order to deliver safe, effective and compassionate care

[3]That is, Avoiding harm and preventing harm to service users from the care, treatment and support that is intended to help them. The right care at the right time, in the right place with the best outcome. Service users are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support

[4]The Review Team was advised of matters which were outwith the Terms of Reference and these were directed to the Hospital's managers

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Methodology

In order to orientate the Review, the Trust provided safeguarding files spanning 2012-2017 concerning:

- 69 hospital patients
- 61 RQIA reports of inspections of Hospital wards
- 12 *Patient Experience Interviews*
- A history of the Hospital.
- Information concerning staff absence rates
- Staff recruited and those leaving
- Patient mortality
- Referrals to safeguarding
- Seclusion reports
- Governance structure
- Patient self-advocates and facilitation

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SAI Level 3 Independent Expert Panel

- Dr Margaret Flynn, Chair of the Review Team and Chair of Wales' National Independent Safeguarding Board
- Mrs Mary Bell, parent and independent advocate
- Professor Michael Brown, Queen's University, Faculty of Medicine, Health and Life Sciences
- Mr Bryce McMurray, former Director of Mental Health and Learning Disability and former Executive Director of Nursing at the Southern Health and Social Care Trust
- Dr Ashok Roy, Consultant Psychiatrist at Coventry and Warwickshire Partnership Trust and outgoing Chair of the Faculty of Intellectual Disability Psychiatry, Royal College of Psychiatry

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Findings

The Review Team found that:

- Safeguarding events cannot be seen in isolation. Without exception, discussions concerning safeguarding gave way to patients' compromised lives at the Hospital, their chronic boredom and the failure to create and offer them high quality community services
- Hospital patients have a 1:4 chance of being harmed by their peers
- Irrespective of the considerable quantity of paperwork associated with safeguarding, the Review Team could not determine how closely Hospital practice aligned with the safeguarding protocol and procedures
- The CCTV in the Hospital's Psychiatric Intensive Care Unit – with the highest staffing levels and ratios of qualified staff – shows patients being harmed by staff and yet no safeguarding referrals were made and no members of staff spoke out
- Patients' families are distressed and angry that nobody intervened to halt the harm and that even the possibility of patients being harmed was denied and deemed implausible by Hospital Managers and the RQIA
- There was a culture of tolerating harmful and disproportionately restrictive interventions
- Many families wanted to emphasise that harmful practices co-existed with skilled and compassionate practices and that there are excellent staff at the Hospital whose work is highly valued
- The CCTV evidence triggered staff suspensions, an investment in viewing many hours of CCTV footage and acknowledgement that relations with patients and their families had to be restored
- There is confusion about safeguarding "concerns" and "complaints"
- The use of seclusion was not monitored. Its intensive use by a small number of patients is anti-therapeutic
- Over a third of safeguarding files state that patients have "a history of making allegations" which sacrifices patients' credibility

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- Reference to patients' mental capacity adopts an all or nothing approach with some clinicians determining whether or not patients may contribute to investigations and even attend "Keeping Yourself Safe" training
- Communications with families about alleged safeguarding incidents and potential investigations were vulnerable to being construed as seeking permission to undertake safeguarding investigations
- The routine (and discontinued) practice of involving the Police Service of Northern Ireland in all safeguarding discussions is bewildering
- Advocacy at the Hospital is not as uncomfortably powerful as it should be
- Place-hunting for Hospital patients is not working
- Leadership is distributed and not being used to benefit Hospital patients
- Northern Ireland's services are poorly equipped to support infants and children with learning disabilities, autism and complex medical challenges – whose families do not view the Hospital as their future
- The Hospital is not being used for short term admissions and treatment. It has been historically relied upon by Trusts as the "default placement" – placing distressed and chronically bored patients together. Safeguarding at the Hospital has to be seen against this backdrop

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Lessons

The Review Team has identified the following lessons:

- Safeguarding practice at the Hospital involves negotiating too many obstacles
- The Hospital's senior managers must support staff who report harmful events and practices
- Patients' and their families must be treated as equal partners and have to be heard on a continuous basis. Episodic contact is unhelpful
- The Hospital requires focus with regard to its role and pace in the future of Learning Disability services in NI. This focus has to be endorsed by all staff and managers, Trusts, the Department of Health and the Legislative Assembly
- A life course perspective is required to understand and realise the aspirations of patients and their families.

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Recommendations

The Review Team offers two recommendations:

- Evidence of a renewed commitment (i) to enabling people with learning disabilities to have full lives in their families and communities and (ii) to services which understand that ordinary lives require extraordinary supports – which will change over the life course.
- An updated strategic framework for NI's citizens with learning disability and neuro developmental challenges which is co-produced with self-advocates with different kinds of support needs and their families. The transition to community based services requires the contraction and closure of the Hospital and must be accompanied by the development of local services. The Review Team suggests that elements of the latter include purposefully addressing the obstacle cited by so many, that is, "there are no community services." A life course vision of "age independent pathways," participative planning, and training for service development for example remains to be described. Elements of the contraction and closure include individual patient relocation, staff consultation and participation, and maintaining quality and morale.
- Long term partnerships with visionary housing associations, including those with experience of developing shared ownership, for example, is crucial to closing and locking the "revolving door" which enables existing community services to refuse continued support to former patients in group living, residential care or nursing home settings. If a young person or adult has their own home or settled tenancy, there is no question about where their destination will be if they have required Assessment and Treatment.

- The "feedback sessions" endorsed the Review's findings and additional recommendations were identified – some of which were emailed after the events. These include repairing relationships and trust; challenging the custom and practice of seclusion; deploying specialist skills; leading values-driven transformation; clarity of services' purpose; and halting "default admissions" to Muckamore Abbey Hospital

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Families recommended that:

- Hospital staff at all levels must invest in repairing and establishing relationships and trust with patients and with their relatives as partners
- Families and advocates should be allowed open access to wards and living areas
- There is an urgent need to (i) invest in valued activities for all patients and (ii) to challenge the custom and practice concerning the improper and excessive use seclusion at the Hospital
- The use of seclusion ceases
- The perception that people with learning disabilities are unreliable witnesses has to change
- People with learning disabilities and their families are acknowledged to have a critical and ongoing role in designing individualised support services for their relatives
- The Hospital's CCTV recordings are retained for at least 12 months
- Families are advised of lawful practices the Hospital may undertake with (i) voluntary patients and (ii) sectioned patients
- Families are given detailed information, perhaps in the form of a booklet, about the process of making a complaint on behalf of their relatives
- Families receive regular progress updates about what happening as a result of the review
- A family was advised by a clinician seeking to section their relative that "It doesn't sit easy using seclusion on a voluntary patient"

Staff recommended that:

- An enhanced role for specialist nursing staff is set out
- Responses to safeguarding incidents and allegations are proportionate and timely
- All safeguarding documentation is substantially revised

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Regional Directors recommended that:

- A shared narrative is set out
- Commissioners specify what "collective commissioning" means
- The transformation required in learning disability services must be values driven and well led
- The purpose of all of our services is clear
- All Trusts should invest in people-skills and be cautious about focusing solely on learning disability nursing
- The default "Friday afternoon and weekend admissions" to Muckamore Abbey Hospital have to stop
- Time limited and timely Assessment and Treatment become the norm
- Trusts and Commissioners must be knowledgeable about the "user experience" and that of their families
- Trusts and Commissioners should set out the steps required in the Department of Health's post Bamford plan: in the short and medium term
- At the time of the feedback events, the Hospital was addressing its low threshold for admissions
- For example, it may be helpful to distinguish the recommendations and points made in the review which may be addressed in the short term and in the medium term. For example, in the short term:
- The three main stakeholders – people with learning disabilities, their families and advocates; the Learning Disability service providers in NI and commissioners should work as equal partners so that the service can be transformed - perhaps as an accountable group
- The flow of admissions - especially readmissions - into the hospital should be restricted to halt the "revolving door" phenomenon. The hospital is being used inappropriately to respond to a wide range of situations which would need to be managed locally if community services are to begin designing services around individuals
- Existing patients need to spend time in and be visible in the community
- Families and advocates should be allowed open access to wards and living areas
- Monitoring and reporting of all restrictive practice - the use prn medication, physical restraint and seclusion must be strengthened

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In the medium term:

- Trusts should begin to build "all age care pathways" which bring together children's and adult services, hospital and community services and health and social care and education services
- Out of hours services should be enhanced using strengthened community learning disability and mental health teams as well as the hospital team to support families and service providers for all age groups
- The professional development of all front line staff must be prioritised using educational approaches based on providing better care rather than on formal course based approaches
- New approaches to enhance housing capacity need to be accelerated to deal with ever increasing demand

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Good practice

- The Hospital has made real progress in relocating hundreds of patients since the 1980s and 1990s. The Hospital and community services have demonstrated that they are well placed to contribute to the next larger scale cycle of change.
- It was the introduction of Positive Behaviour Support workers that led to a significant reduction in the number of incidents at Iveagh
- 24 LD nurses have trained as HVs and feedback from families is really positive
- Killead explicitly recognised the importance of engaging in interesting and enjoyable activities
- The initiative of a ward sister to document a conflict resolution approach. This is an effective alternative to a safeguarding investigation. Acknowledgement and documented the felt and expressed harm.

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Medium Term Actions for Belfast Trust

1. Development of a Governance Board including patients, family carers, Trusts, Advocates – **under discussion**
2. Co-production of a meaningful Advocacy model
3. Development of meaningful therapeutic activity programme 7 days per week with each patient - **underway**
4. Development – clear measurable KPIs for inpatient service - **underway**
5. Establishment of robust governance system within MAH which meets the requirements set out in the SAI report - **underway**
6. Prospective audit of reasons for new admissions from August 2018 to inform planning - **underway**
7. Development of regionally agreed admission protocol - **completed**
8. Evidence clear treatment and care plans
9. All policies require review within a Human Rights Framework and using co-production approaches.
10. Urgent review of seclusion using co-production approaches
11. Urgent review of Adult Safeguarding approaches and outcomes – **Task and Finish group to commence in November**
12. Development of Positive Behaviour Support to all wards – **appointment of BSN to every ward completed**
13. Development of health care service on site – **under discussion**
14. Appointment of a Temporary 8c Transformation Manager to drive forward Belfast and Regional actions – **funding agreed**

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Progress of Investigative and Oversight Processes to date

Adult Safeguarding Disciplinary and PSNI

- The viewing of the historical CCTV material in PICU has revealed a large number of incidents of inappropriate treatment of patients including alleged incidents of physical abuse by a number of staff. The task of viewing all of the preserved footage from PICU, Cranfield 1 and 2 and 6 Mile has not completed yet.
- This has resulted in further staff being placed on precautionary suspension which is a total to date of 13 staff. A further 26 staff who appeared to witness incidents and did not report them or intervene will be subject to both PSNI and Trust investigation.
- As a consequence of anonymous whistleblowing allegations from the staff at Muckamore Abbey Hospital and evidence contained within the SAI report two senior managers have been relocated from their roles in Muckamore pending an investigation into leadership behaviours and management practices in Muckamore Abbey Hospital.
- Adverse media publicity has been generated by the investigations at Muckamore Abbey Hospital in particular Irish News, Belfast Telegraph as well as Belfast Live and other social media platforms.
- The Trust issued a comprehensive media statement in August and is planning a further media briefing in the coming weeks.
- PSNI have submitted 2 files to PPS
- PSNI have agreed that the Trust can proceed with their internal disciplinary processes. This has commenced.

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Regional Actions

- **Regional Directors Learning Disability Improvement Board** established – terms of reference and Workstreams being worked up
- Review of Learning Disability Model of Care and Funding underway by HSCB
- Priority areas agreed for Improvement and Development
    1. Extended crisis response services
    2. Supported Housing/Provider Engagement
    3. Short Breaks
    4. Review of delivery of models of acute care
    5. Workforce

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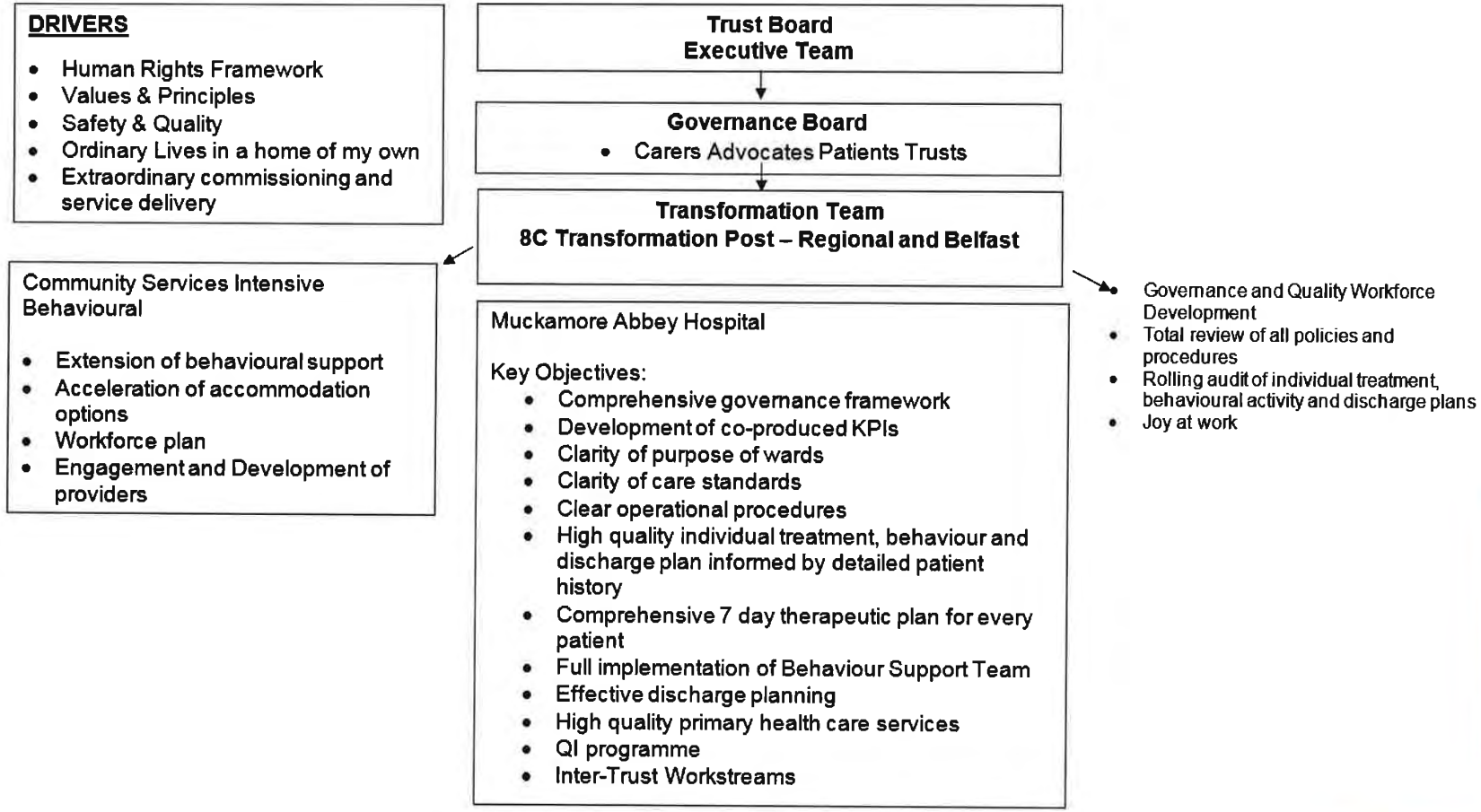

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Appendix one

SUMMARY REPORT

ASPC Directorate, Muckamore Abbey Hospital (MAH)

Modernisation & Workforce Planning Team

Human Resources

16 August 2018

January 2019 first action update

1. Introduction

Management within Adult Social Primary Care Directorate requested support from the Modernisation and Workforce Planning Team (M&WFP Team) within Human Resources in relation to concerns regarding the number of staff leaving voluntarily from Muckamore Abbey Hospital (MAH) through resignation or retirement.

Within the Trust all staff processed as leavers (with the exception of Medical and Dental) and who leave voluntarily are invited to undertake an Exit questionnaire on the Human Resources Payroll Travel and Subsistence (HRPTS) system via Employee Self Service.

An action of the Muckamore Abbey Task and Finish Group was that exit interviews would be undertaken on a pilot basis by the (M&WFP) Team as an alternative to completion of the Exit Questionnaires on HRPTS.

The pilot took place during the period December 2017 – April 2018. The (M&WFP Team) conducted eleven exit interviews with staff. All interviews took place with the agreement of staff on an anonymised basis and were conducted either in person at MAH or McKinney House, with one interview conducted by telephone.

Information obtained was gained through open and honest discussion with staff using an Exit Interview questionnaire. The Exit Interview Questionnaire, designed for this exercise, is attached as **Appendix 1**.

2. Analysis of information from Exit Interviews

Quantitative Analysis

Of the eleven staff interviewed seven resigned and four retired.

One member of staff interviewed was from the Administrative and Clerical occupational group with the remaining 10 being Band 5 nurses. Seven of these nurses resigned and three retired.

All of the seven nurses who resigned secured Band 5 posts with other HSC Trusts. It is worth noting that five of these staff went to the South Eastern Trust in areas outside of Learning Disability Nursing.

45% of staff (5 headcount) cited wellbeing and safety at work as the main reason for leaving. It is also worth noting that a further three staff cited wellbeing and safety at work as a contributory reason to their decision to leave. Three members of staff cited "Retirement" as the main reason for leaving, one member of staff cited "Not Satisfied in Job Role" as a main reason for leaving, one person citing "Lack of training and development" and another staff member citing "Unsuitable location".

"Working relationship with manager", "not satisfied in job role" and "wellbeing and safety at work" as highlighted earlier, featured as contributory reasons for leaving and was selected by multiple staff.

64% would not recommend MAH as a place to work, however, 82% would recommend Belfast Trust as a place to work, with 18% undecided/cannot comment.

Qualitative Analysis

Below is a synopsis of the issues identified. Selected quotes from staff are displayed overleaf with a comprehensive listing provided in **Appendix 2**.

- Patient Safety/Governance

- Well Being and Safety at Work
- Physical Aggression
- Stress/low morale

- Management of Staff
- Investigations/Safeguarding
- Lack of support from line management/senior management
- Lack of presence of senior management on site (8B and above)
- Work/life Balance
- Communication
- Induction, Training
- Job Satisfaction

January 2019 first action update

Quotes from Staff Interviewed

Insufficient/dangerous staffing levels

Mental scars from violence

New band 5 staff are leaving as they are thrown into the deep end

If there is an incident of challenging behaviour there is not enough staff to respond in a timely manner

Registration at risk

Poor staff morale affects mental health

Feel burnt out, exhausted

I submitted around 50 IR1 forms, never was there any follow up or debrief or learning

Staff are falling off their feet have not ate meals, and are pulled for having a drink of water on the wards

Blame Culture

Inappropriate use of cameras

Preceptorship not getting completed due to staffing levels

Feel I have not been listened to previously or have confidence that something will happen

Only one 1:1 meeting with manager in two and a half years

Recommendations

From the findings of the Exit interviews it is clear that an action plan needs to be developed to address some of the concerns cited as the reasons why staff left. Based on the findings to date the M&WFP team recommend the following actions be implemented.

- Adequate induction programme to support newly qualified band 5 staff.
- Ensure staff complete preceptorship in a timely manner.
- Review of new staff at quarterly intervals.
- Time to reflect on practice where incident of challenging behaviour occurs.
- Awareness on appropriate use of CCTV.
- Feedback process on all IR 1 forms.
- Identify what safe staffing levels are for all shifts and ensure ward is adequately resourced.
- Demonstrate a cohesive management approach by senior managers within the hospital.
- Increased visibility on an ongoing basis of Senior Management on site.

Conclusions

The exit interviews carried out with the staff in Muckamore Abbey Hospital to date have been invaluable. They have helped to identify a wide range of issues that can be addressed by management. This exercise, together with the implementation of the recommendations should help to retain staff in the future and to engage staff in the process of improving their working experience within Muckamore Abbey Hospital which ultimately will result in an improved client experience.

Appendix 1

Exit Interview Questionnaire

Muckamore Abbey

HSC Belfast Health and Social Care Trust
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Questionnaire to be completed by Modernisation & Workforce Planning Team within Human Resources and will be used flexibly and adapted to the circumstances of the interview.

1. Personal Details:

First Name: _____ Date: _____

Surname: _____ Completed by: _____

Staff Number: _____

Band: _____

Job Title: _____ Trained in _____

Ward: _____

Line Manager: _____

Last Day of Service: _____

* Job Family:

2. Reason for Leaving:

2.1 On what basis are you leaving the Trust?

☐ Resignation

☐ Retirement

☐ Temporary Contract

2.2 Please select your main reason for leaving? (Select one)

☐	Working relationship with manager	☐	Unsuitable location
☐	Working relationship with colleagues	☐	Return to Education
☐	Lack of Training and Development	☐	End of Fixed Term Contract
☐	Promotion prospects / Career prospects	☐	Retirement
☐	Flexible working / Work life balance		
☐	Wellbeing and safety at work		
☐	Not satisfied in job role		
☐	Pay / Terms and Conditions		
☐	Other (Reason)		

Explore response further

2.3 Please select any other reasons which contributed to you deciding to leave the Trust? (Select a maximum of two)

☐	Working relationship with manager	☐	Unsuitable location
☐	Working relationship with colleagues	☐	Return to Education
☐	Lack of Training and Development	☐	End of Fixed Term Contract
☐	Promotion prospects / Career prospects	☐	Retirement
☐	Flexible working / Work life balance		
☐	Wellbeing and safety at work		
☐	Not satisfied in job role		
☐	Pay / Terms and Conditions		
☐	Other (Reason)		

Explore response further

3. * Do you feel anything could have been done to encourage you to stay?

4. What have you enjoyed whilst working in Muckamore Abbey?

5. What have you found challenging whilst working in Muckamore Abbey?

6. Would you recommend Muckamore Abbey as a place to work?

YES Explore

NO Explore

**** 7. Would you recommend Belfast Trust as a place to work?***

YES Explore

NO Explore

8. Where are you going?:

8.1 Have you secured a job within another organisation?

YES

NO (please progress to 7.3)

8.2 What sector is your new job in?

HSC Organisation

- ☐ Northern Trust
- ☐ South Eastern Trust
- ☐ Western Trust
- ☐ Southern Trust
- ☐ BSO
- ☐ NIBTS
- ☐ Other NHS Organisation (Please Specify) _____

** What AFC band is your new position?* _____

Other Public Sector

Private Sector

Voluntary Sector

Other (Please Specify) _____

8. 3 On leaving are you joining a bank within the Trust?

YES

NO

Thank you for your co-operation. *

Appendix 2

Synopsis of Issues listed Related quotes from staff
Patient Safety/Governance
• Clients need time, attention and consistency. Client group has changed dramatically, now more forensic and challenging, if there is an incident of challenging behaviour there is not enough staff to respond in a timely manner
• Continuity of care fractured due to number of bank and agency staff
• Not enough staff for the numbers of patients and their needs
• Insufficient/dangerous staffing levels, staff need to be MAPPA trained, so use of agency staff is therefore not a realistic option as they are

unfamiliar with the clients and not a true replacement for staff on the ward
• A lot of expectations in terms of restraining but without the staffing levels to deliver
• Registration at risk, there are not the resources to deliver
• I submitted around 50 IR1 forms, never was there any follow up or debrief or learning yet in one of these incidents 3 people were injured
• No nursing supervision
• Insufficient staffing levels resulting in clients not getting enough attention and potential for medication errors
Well Being and Safety at Work
○ Physical Aggression
○ Daily risk of physical harm
○ Mental scars from violence
○ Incidents of completely unexpected aggression
○ Staff just going through the motions of their role as everyone feels compromised due to investigations
○ Made to feel guilty if you have to go home as a result of an injury
Stress/morale low
▪ Morale at an all time low
▪ Poor staff morale affects mental health
▪ Increasingly challenging more recently, even difficult to get toilet and meal breaks
▪ Moved from pillar to post

▪ Staff are falling off their feet have not ate meals, and are pulled for having a drink of water on the wards (following surveillance on CCTV)
▪ Staff feel vulnerable
▪ Expected to do 10 things at once
▪ Muckamore used to be a community, that is no longer the case
▪ Feel burnt out, exhausted
▪ Poor staff morale due to agency staff paid enormous wages but not fulfilling full role (undertaking one to ones).
▪ 20-25 nurses started in Muckamore from my university class approximately only 2 remain working here
Management of Staff
Investigations/Safeguarding
➢ Inappropriate use of cameras
➢ No support regarding safeguarding
➢ Everyone is under suspicion
➢ Blame Culture
➢ Spot checks feel like spying
➢ Investigations take too long
Lack of support from management/senior management
❖ Not appreciated
❖ Senior managers were not working as a team. Conflict filtered down and arguments from senior managers filtered down - power struggle
❖ Never see management unless something is wrong. Senior Management (8B & above) never seen on the ground.

❖ No support from senior management
❖ Managers are available but afraid to roll up their sleeves
❖ Band 6 staff are counted in the skill mix but not involved in direct patient care and should be able to assist in times of need
Worklife Balance
• No flexibility with Rotas, rotas not completed 4 weeks in advance so cannot arrange childcare
Induction, Training
○ Feel I have not been listened to previously or have confidence that something will happen
○ No feedback or checking from senior management if ok following injury
○ Only one 1:1 meeting with ward manager in two and a half years
○ Managers highlight all the wrongs there is a lack of positive feedback
○ New band 5 staff are leaving as they are thrown in at the deep end
Communication
○ Mandatory basic induction not completed, not aware of what to do when sick for example
○ Insufficient support following on from induction
○ Nurse in charge within my first month, not prepared as new to the post and first post from university, didn't feel there was enough support in place and didn't feel comfortable being put in position.

○ First day on duty really taken aback at the way staff on the ward were spoken to by management, staff were really upset and ended up in tears.
Job Satisfaction
▪ Qualified nurses are not used to their full potential. Extremely understaffed resulting in me completing B3 duties as opposed to B5
▪ Preceptorship not getting completed due to staffing levels not being utilised as a B5 nurse, spends a lot of time undertaking B3 role, escorting etc. as a result, my nursing qualification and training are wasted. Can't take charge, can't do care plans, feel like a spare part
▪ A lot of nursing time spent on computers/paperwork taking time away from engaging and interacting with patients

BELFAST HEALTH AND SOCIAL CARE TRUST

Muckamore Abbey Hospital
Update for Department of Health
19 April 2018

This paper provides a further update on the actions and progress on matters relating to Muckamore Abbey Hospital. The report focuses on providing an update in relation to the adult safeguarding investigation, which forms part of the current SAI Review.

Adult Safeguarding update

On 27 March 2018, during CCTV viewing relating to 7 August 2017, staff were observed with pillows and blankets and appeared at times to be sleeping on duty. The Trust is arranging an independent HR investigation in relation to this. Increased monitoring of night duty has been put in place.

The SAI relates to incidents viewed on CCTV on 12 August, 15 August and 16 August 2017 in PICU and the incident on 1 October 2017 relating to Six Mile and the swimming pool incidents. The incident of 7 August 2017 regarding staff appearing to sleep on duty in PICU will be dealt with separately.

The Trust continue to apply a very low threshold for reporting to adult safeguarding as part of an assurance process.

Adult Safeguarding/HR Disciplinary Investigation

The Disciplinary team and the Safeguarding Investigation team have viewed relevant CCTV. A further meeting including HR and DLS was held on 19 April 2018 to address some emerging issues, related to interpretation of the footage.

Update from PSNI

On 17 April 2018 PSNI provided a further update in relation to the incidents which they had been investigating which formed part of the SAI. There is now greater clarity regarding those incidents that can proceed to the joint disciplinary and adult safeguarding investigation.

Update re Screening Interviews with patients/relatives in PICU and Sixmile Wards

The Belfast Trust took responsibility for completing screening interviews with all service users identified in PICU and Sixmile wards who continue to be patients within Muckamore Abbey Hospital. Each Trust took responsibility for their own service users who had returned to their Trust area. The screening interviews focused around twelve questions covering five key areas:

- Likes and dislikes of the hospital including their perception of others experiences
- Patient experiences of the care they received from staff
- Patient experience of staff conduct and attitude
- The activities that were offered to patients

- How safe and confident patients felt in sharing their experiences as well as what they felt could be done better.

To date 18 screening interviews have been completed. Overall, patient responses have been positive.

The majority of service users have described a very positive experience of the care they have and are receiving from Muckamore Abbey Hospital. Almost all patients described a very supportive relationship with at least one member of staff. In a small number of cases some issues were shared in relation to previous experiences and these patients were provided with an opportunity to have this looked into again.

To date 19 screening interviews have taken place with relatives. Again, overall feedback has been positive and any issues raised will be followed up. The plan going forward is to conduct screening interviews with all current patients and relatives across all wards on the hospital site.

Installation of CCTV

CCTV has now been installed in Killead/Donegore, Moyola Daycare, and the swimming pool. Final connections are still awaited as there were problems detected with the underground ducting system, these are being addressed and final stage will be to apply fibre connectors at both ends of each system in the facility within which the system is located. Anticipated live switch on before end of May 2018.

The CCTV Policy has been reviewed and currently going through a process of consultation with all relevant parties. This will include Staff side, patients and relatives.

Retrospective viewing of CCTV

Planned viewing of historical CCTV viewing is to commence on Monday 30 April. Induction has now been completed for all 10 individuals who will be assisting with the process and currently contracts are being prepared for these individuals to sign. It has been agreed that the viewing team will begin by viewing the CCTV for the entire month of August 2017 in PICU and will also look at night shifts.

Staffing

The Nurse Service Manager post in Muckamore Abbey Hospital was advertised on a temporary basis following the appointment of the current Manager to the post of Divisional Nurse for Learning Disability. Interviews have taken place and a temporary appointment has been made. The new temporary Manager is now in post.
Work in relation to developing a Staffing Model for Muckamore is ongoing. The second workshop planned for March 2018 took place and a further workshop has since been held. A report on the outcome of these workshops will be provided to the Directors for consideration.

Muckamore undertook an extensive recruitment drive which included use of the local media. This resulted in 47 applications being shortlisted for interview. On Saturday 24 March 2018 the hospital held a recruitment walk-in event. This event included fast-tracking of shortlisted applicants, where Access NI, Occupational Health checks and interviews were conducted on the same day. A number of additional applications were also made on the day of the event. To date there have been 31 band-3 and 15 band-5

positions offered. The success of the event resulted in a number of interviews being carried forward into the following week. It is anticipated that some of the successful band-3 candidates will take up post mid to end May 2018. It is recognised that a comprehensive recruitment and retention strategy for Muckamore Abbey Hospital is required. Turnover of staff continues to be high with 25 staff left in previous six months.

Assurance – monitoring arrangements in place – internal and external

Monitoring internally by Senior Nurse Managers continues. This involves viewing of CCTV for 15 minutes, three shifts per day. Senior Nurses also complete daily walk arounds and provide weekly monitoring reports to the Service Manager.

External monitoring arrangements remain in place, with safeguarding and senior managers external to the hospital providing this. A monitoring report is completed and forwarded to Safeguarding Lead and Project Manager for collation.

Directors' Oversight

In this reporting period there was a further Directors on-site drop-in session held in Muckamore on 17 April 2018, however no staff attended. The Directors Oversight group will continue to convene at Muckamore Abbey Hospital fortnightly to meet with the Collective Leadership Team to support the cultural and service transformation required.

External Assurance Group

The Assurance Group have submitted their report and is currently under consideration.

Serious Adverse Incident (SAI) Review

The SAI Panel met again in Muckamore from 4-6 April 2018. This is the fourth time the Panel have met in Muckamore. The Panel have reviewed the RQIA reports for the last five years and are currently reviewing adult safeguarding case files. The Panel have also undertaken a series of meetings. These have included meetings involving (1) Head of Learning Disability; (2) Nurse Service Manager and senior Nursing team; (3) Consultants; (4) Adult Safeguarding; (5) relatives/carers. Work is also being progressed outside of these Panel meetings and the plan for an August completion of the work remains in place. The Panel are next due to meet in Muckamore from 14-18 May 2018 and the timetable will include further meetings.

Meeting with Regional Directors with responsibility for Learning Disability

Marie Heaney is meeting with the two Directors with responsibility for Learning Disability and who place patients in Muckamore Abbey Hospital to share thinking about models of assessment, treatment and crisis response.

Trust Board

Updates continue to be provided to Trust Board in relation to Muckamore. Last update report provided to Trust Board on 4 April 2018.

From:
Mark McGuicken
Director of Disability & Older People

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

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Tel: 028 9052 0561

Email: mark.mcguicken@health-ni.gov.uk

Our Ref:

Date: 6 October 2022

Dr Cathy Jack
Chief Executive
Belfast Health and Social Care Trust

cathy.jack@belfasttrust.hscni.net

Dear Cathy

The Belfast Trust advised the Department in 2018 that it had appointed an External Assurance/Support Team, whose membership comprised Professor Owen Barr (Ulster University), Frances Cannon (NIPEC) and Yvonne Mc Knight.

I understand the purpose of the team was to provide independent assurance to the Trust Director level Governance and Improvement Board in relation to the Learning Disability service area response to the serious safeguarding concerns in Muckamore Abbey Hospital.

I would be grateful if you would arrange for the Department to be provided with an update on this work and its outcomes, including a copy of any final report produced by the team and any response from the Trust.

Yours sincerely

MARK McGUICKEN
DIRECTOR OF DISABILITY & OLDER PEOPLE

MAHI - STM - 107 - 1271

Position plan in response to the Report of Independent Assurance Team MAH 2018

Completed by Owen Barr and Yvonne McKnight

Recommendations	Actions	RAG
1. The Independent Assurance Team recommend the need for clear processes for escalating concerns about staffing levels and ability to provide safe nursing care directly to the Director of Nursing and Director of Social and Primary Care	ERoster is in place with safe staffing levels Workforce achievement against staffing model is reviewed weekly and shared within Trust and DOH	
2. The Trust should purposefully continue to actively recruit nursing staff through high profile regional and a rolling local recruitment campaigns	Several recruitment events have taken place in 2019, 2021 and 2022 Recruitment has remained a challenge in line with the future of the hospital 7 new registrants took up post 2022 who will all have a rotation of hospital and community to prepare for future workforce Stable staffing achieved via Agency. 85% of staffing in MAH are agency.	
3. Clear information about the role, function and planned future of Muckamore Abbey Hospital, together with information on the complexity of abilities and needs of the people cared for in Muckamore Abbey Hospital should be articulated to support and inform workforce planning.	Resettlement plans in place for the majority of individuals that remain on site DOH consultation on the future of MAH closed 24 January 2023 Workforce review for LD services across the region underway led by DOH BHSCT Organisational change process ready to progress when decision about the future of MAH made regarding the consultation underway to realign workforce to community and intensive intervention support service.	

Position plan in response to the Report of Independent Assurance Team MAH 2018

4. Senior managers should as a matter of urgency explore current actions aimed at retaining staff — including local induction, preceptorship for new registrants, regular supervision, career development opportunities and using staff skills for specialist practice roles for which they have been prepared	Nursing structure in place, structure attached which has more Lead Nurses and Senior Nurses than would be normal for wards of this size. The 2 Senior Nurse Mangers and 3 Lead Nurse posts whilst having specific line management roles also have briefs for assurance around staff support, post incident learning and debrief, adult safeguarding nurse champions, safety interventions oversight and resettlement. Local Induction is in place for any new bank or agency staff, there is a day one checklist for staff to complete to ensure safety. For staff that are starting in MAH for block booking they are given a more comprehensive additional induction with a mentor. All newly qualified Registrants have been given Preceptorship that covers the hospital and community in the first year with an allocated Perceptor. An upskilling programme in place for mental health nurses to access specific training on Positive behaviour support, communication, relational security, this has been delivered face to face but is also rolled out via coaching and on the ward mentoring. The most recent RQIA inspection reported that they could see the evidence of this training and coaching on the wards. Safety Interventions training (previously MAPA) which is trauma informed also incorporates Positive Behaviour Support awareness and safeguarding awareness training. All staff have routine supervision and post incident debriefs.	

Position plan in response to the Report of Independent Assurance Team MAH 2018

5. In order to further understand why staff have left Muckamore Abbey Hospital, exit interviews should be conducted with all staff leaving Muckamore Abbey Hospital and Learning Disability Services in the BHSCT. These interviews should be conducted by a person who was not involved in the management of the staff member. It is recommended that independent exit interviews are conducted retrospectively with all staff who have left Muckamore Abbey Hospital and Learning Disability Services in the BHSCT to work elsewhere in the past 3 years	Reports based on leaving interviews completed in 2018 & 2019 Both reports are attached, the recommendations were shared with Hospital Management at the time. Also an enhanced pay rate of 15% was introduced to retain staff but was discontinued due to having limited impact on retention. Retention of substantive staff continues to be an issue, recent leavers have stated the uncertainty of the future of the hospital and career development opportunities in BHSCT, NHSCT and SHSCT as reasons for leaving. BHSCT has a core of contracted agency staff most of whom have been working at MAH for a number of years. In June 2022 staffing hit a critical unsafe level – the actions taken at that time: • workforce appeal to all Trusts resulted in the securing of regular part time nursing staff as follows: <u>South Eastern Trust:</u> Band 5 x2 Band 4 x2 Band 3 x 2 <u>Northern Trust:</u> Band 3 x 2 • increase in contracted agency staff • MAH retention rate of 15% enhanced salary reintroduced • MAH enhanced critical care rate for bank staff introduced The outcome of these actions has stabilised the nursing workforce to meet the needs of the current inpatient population in process of resettlement.	

Position plan in response to the Report of Independent Assurance Team MAH 2018

6. It is the view of the Independent Assurance Team that it would be good practice to support rotation of newly qualified staff across practice areas/care environments within Muckamore Abbey Hospital in a planned and transparent manner, to support professional development and development of skills and competencies. Consideration should also be given the rotation of staff between hospital and community services in a planned and transparent manner	Rotation and support plans in place for new Registrants for hospital and community. Starting October 2022 each new Registrant who took up post in 2022 has a yearlong preceptorship delivered 6 months in the hospital and 6 months in the community with allocated preceptors and weekly support from a jointly appointed Clinical Nurse Lecturer. MAH continues to be an assessed learning placement for student nurses and Trainee Doctors – the feedback from these placements continues to reflect positive learning experiences and meeting the Audit requirements for the placing universities. This is supported also by the Practice Education Facilitator.	
7. It is apparent that due to the shortage of RNLDs in post, Muckamore Abbey Hospital actively recruit nurses from Mental Health Nursing and others fields of practice to fill vacancies, the impact of this on services provided needs to be monitored and evaluated	Up skilling programme in place for RNs (Mental Health) who are currently working in MAH. The evaluation has been extremely positive regarding skills in communication related to learning disabilities, understanding behaviours that challenge and Positive Behaviour Support. This is supported by role modelling and coaching from staff in all disciplines. This is monitored by supervision and performance management. The staffing model is monitored weekly against the workforce plan, with 85% agency staff consistently for the past year. However overall staffing is approx. 90% against safe staffing plan.	
8. The BHSCT should formally escalate concerns directly to the DOH regarding the number of commissioned places on the pre-registration nursing - learning disabilities and specialist practice programmes and request consideration of increasing the numbers of places as soon as possible	The number of commissioned places in preregistration nursing is reviewed yearly with UU, QUB and OU. The recently appointed Nurse Consultant in Learning disability has a current role regionally in future educational planning for LD Nursing in line with future Model.	

Position plan in response to the Report of Independent Assurance Team MAH 2018

9. A Task and Finish Group should be established to review and analyse the use of E rostering, this should include robust arrangements for monitoring of staff working over contacted hours	ERostering is in place and all hours worked are monitored and managed.	
10. The recommendations of the "Listening Groups" should be progressed with agreed timeframes	There are ongoing regular listening sessions with Staff and Senior Leadership Team. There are Bi weekly “keeping in Touch” sessions chaired by Co Director for all staff on site including all disciplines, estates, PCSS, administration staff.	
11. Decisions in relation to the precautionary suspension of staff or placing staff on restricted duties should first and foremost fully take into account the expected professional conduct of all staff involved and the professional expectation of behaviour from the Nursing and Midwifery Council or other relevant professional regulators. If other factors, such as the operational role the person may have been fulfilling at the time are taken into account, the analysis of these differing factors must be clearly stated, analysed and documented in the decision making process.	A clear process is in place regarding the decision making process which is proportionate to patient and staff safety. This is recorded and shared with the relevant individual. The process for individuals is reviewed at assurance and operational meetings specific to this process.	
12. There should be a template aligned to the HR policy to record the initial decisions taken and any subsequent review of that decision – this template should include notes on: • **The context** • **Explicit analysis of the relevant factors** • **The people consulted** • **The actions considered** • **The rationale for final decision taken** • **A specified calendar date for review of the decision**	A template is in place and in use by the Human Resources Historical investigations team	

Position plan in response to the Report of Independent Assurance Team MAH 2018

• **The document should be signed and dated by all the people involved in making the decision**		
13. Records relating to staff on precautionary suspension or restricted duties, including email correspondence between Trust managers should relate to one individual at a time, i.e. comments relating to several staff members should not be clustered in one email. This would facilitate clearer communication about individual decisions and also the filing of this information in the files of individual staff members.	In place in line with GDPR.	
14. There should be a standardised approach to the review of decisions which proactively considers the relevant factors with a recognition of the possibility of amending the interim decisions	A process to review interim protection plans is in place. See attachments process for implementation and review.	
15. When decisions are being reviewed, both the intended and unintended consequences of interim decisions, for people with learning disability, service delivery and staff members should be actively considered and reflected in the notes of the review of the decision	A process to review interim protection plans is in place . See attachments process for implementation and review.	
16. Senior management would benefit from more proactive and ongoing support from HR in relation to all aspects of precautionary suspensions and restrictions on practice	Support process and framework for meetings is in place for managers and HR	

Position plan in response to the Report of Independent Assurance Team MAH 2018

17. The role of the Ward Sister/Charge Nurse should be reviewed in order to prioritise the leadership aspect of the role at ward level (e.g. consideration should be given to the supernumerary status of the Ward Sister/Charge Nurse	Nurse structure attached. Lead Nurse role developed for each ward to support the ward sister/Charge nurse in each area. These posts are supernumerary to the shift numbers and allow direct support, coaching and guidance in direct patient care and communication with Families.	
18. There should be clear guidance for staff in the policy about undertaking the role of the 'designated contact persons' to include the areas to be covered in discussion with staff and proformas to be completed as a record of the contact	Designated contact person is in place and is assigned with HR department who keep regular contact with those staff who are under precautionary suspension.	
19. In developing this guidance, the opportunity should be taken by HR to explore with 'designated contact persons' across the BHSCT, what information and preparation would have assisted them in undertaking this role in this service and other learning opportunities in the Trust	There is a designated contact person in place within Human Resources.	
20. 'Designated contact people' providing ongoing contact to staff on precautionary suspension or on restricted duties should be formally included in the process of reviewing these decisions and their participation and views in the review of decisions should be noted in the record of the meeting	In place, as above.	
21. National guidelines and the documents related to professional regulators used to underpin policies must be the current versions and policies should be reviewed if the requirements of professional regulators change during the term of the policy. People signing off policies at different levels within the BHSCT should seek written assurance that this is the position for all evidence used.	Standards and guidelines process in place for the approval of Trust policies.	

Position plan in response to the Report of Independent Assurance Team MAH 2018

22. Consideration should be given to reviewing the policies below into a single policy document, thus creating an overarching policy based on a person-centred approach and Positive Behavioural Support: • **Levels of Supervision/Observations within Learning Disability In-Patient Services (November 2013 – now out of date)** • **Seclusion within Learning Disability In-Patient Services (Children's and Adults) Procedure (November 2016)**	• Levels of Supervision/Observations within Learning Disability In-Patient Services reviewed 2019 for further review 2026 • Seclusion within Learning Disability In-Patient Services reviewed 2021 with a new policy in line with national standards for further review 2026	
23. Use of Restrictive Interventions for Children and Adult Services (May 2015). Policies that cover both Children and Adult services should provide clear direction on the specific and uniquely different requirements in relation to children and adults, where applicable and necessary. At present, there is no clear distinction made within the policies reviewed relating to either the use of seclusion within learning disability in-patient services or the use of restrictive interventions for children and adult services across the BHSCT. It is the view of the Independent Assurance Team that the needs of children and adults being placed in seclusion or restrictive interventions are different and specific guidance should be provided for each.	Restrictive practice policy for adults and children reviewed and updated 2022, **as attached.**	
24. With specific reference to the BSHCT Use of Restrictive Interventions for Children and Adult Services (May 2015), on p8 of 22, it specifically highlights that the BHSCT Management of Aggression Team are not involved in	The two safety interventions teams for the BHSCT were managed under separate Licences with the Crisis Prevention Institute (CPI), this was a legacy issue predated RPA.	

Position plan in response to the Report of Independent Assurance Team MAH 2018

training within Muckamore Abbey Hospital. The training within Muckamore Abbey Hospital appears to be provided solely by the MAPA Training Team. To encourage collaborative working across the BHSCT, reduce the potential organisational and geographical isolation of staff in Muckamore Abbey Hospital from colleagues in similar services in the BHSCT, and the sharing of information and good practice, it is recommended that the MAPA Training team at Muckamore Abbey Hospital should be integrated into the BHSCT Management of Aggression Team.	There is a current plan in place to integrate the trainers however this will require additional resource as one team will then have the responsibility for the whole trust. In the interim there will be a SOP in place for the management of all CPI registered trainers based at MAH to be managed in line with a single licence. The BHSCT has one Restrictive Practice policy and SI Training that covers Adult and Children – see attached.	
25. It is also recommended that the title of the 'Management of Aggression Team' should be reviewed to reflect a person centred ethos and recognition of the distress that people who present challenges to services and staff responding may be experiencing at that time	The team are now called the safety interventions team	
26. Active engagement with people with learning disabilities, family, and carer representatives should be considered as a starting point when developing policies and an explicit rationale provided when the decision is taken not to involve these people in BHSCT policy development.	Ongoing patient and carer forums for MAH and the community in place bi monthly attended by Advocacy groups, TILI and supported carers, patients and Service Users . These groups engage around current issues, Quality improvement and service development to engage patients service users and family in all new developments. BHSCT have a full time Carer engagement lead who assists with the involvement and participation in service progression..	
27. In discussions, members of the Independent Assurance Team have become aware that the same room is used in the Intensive Care Unit for both 'Low Stimulation' and Seclusion. It is felt that from the perspective of the person with learning disabilities that the use of the same room for two different interventions, potentially results in mixed messages and confusion. It is recommended that separate areas are used for 'Low Stimulation' and Seclusion	There is a revised policy regarding this and the area of seclusion. Each ward has its own low stimulus area.	

Position plan in response to the Report of Independent Assurance Team MAH 2018

28. All BHSCT policies relating to people with learning disabilities should be reviewed and updated within the specified timeframe. When there is an anticipated or actual delay in the review of a BHSCT policy, this should be formally escalated to the BHSCT Director who signed the policy and a robust plan should be put in place to review the policy within an agreed revised timeframe. There should be explicit communication to staff in the BHSCT that the previous policy remains in place until the new policy is signed off.	All policies are reviewed in line with set timeframes	

Belfast Health and Social Care Trust

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SUMMARY REPORT

ASPC Directorate, Muckamore Abbey Hospital (MAH)

Modernisation & Workforce Planning Team

Human Resources

16 August 2018

1. Introduction

Management within Adult Social Primary Care Directorate requested support from the Modernisation and Workforce Planning Team (M&WFP Team) within Human Resources in relation to concerns regarding the number of staff leaving voluntarily from Muckamore Abbey Hospital (MAH) through resignation or retirement.

Within the Trust all staff processed as leavers (with the exception of Medical and Dental) and who leave voluntarily are invited to undertake an Exit questionnaire on the Human Resources Payroll Travel and Subsistence (HRPTS) system via Employee Self Service.

An action of the Muckamore Abbey Task and Finish Group was that exit interviews would be undertaken on a pilot basis by the (M&WFP) Team as an alternative to completion of the Exit Questionnaires on HRPTS.

The pilot took place during the period December 2017 – April 2018. The (M&WFP Team) conducted eleven exit interviews with staff. All interviews took place with the agreement of staff on an anonymised basis and were conducted either in person at MAH or McKinney House, with one interview conducted by telephone.

Information obtained was gained through open and honest discussion with staff using an Exit Interview questionnaire. The Exit Interview Questionnaire, designed for this exercise, is attached as **Appendix 1**.

2. Analysis of information from Exit Interviews

Quantitative Analysis

Of the eleven staff interviewed seven resigned and four retired.

One member of staff interviewed was from the Administrative and Clerical occupational group with the remaining 10 being Band 5 nurses. Seven of these nurses resigned and three retired.

All of the seven nurses who resigned secured Band 5 posts with other HSC Trusts. It is worth noting that five of these staff went to the South Eastern Trust in areas outside of Learning Disability Nursing.

45% of staff (5 headcount) cited wellbeing and safety at work as the main reason for leaving. It is also worth noting that a further three staff cited wellbeing and safety at work as a contributory reason to their decision to leave. Three members of staff cited “Retirement” as the main reason for leaving, one member of staff cited “Not Satisfied in Job Role” as a main reason for leaving, one person citing “Lack of training and development” and another staff member citing “Unsuitable location”.

“Working relationship with manager”, “not satisfied in job role” and “wellbeing and safety at work” as highlighted earlier, featured as contributory reasons for leaving and was selected by multiple staff.

64% would not recommend MAH as a place to work, however, 82% would recommend Belfast Trust as a place to work, with 18% undecided/cannot comment.

Qualitative Analysis

Below is a synopsis of the issues identified. Selected quotes from staff are displayed overleaf with a comprehensive listing provided in **Appendix 2**.

- Patient Safety/Governance

- Well Being and Safety at Work
- Physical Aggression
- Stress/low morale

- Management of Staff
- Investigations/Safeguarding
- Lack of support from line management/senior management
- Lack of presence of senior management on site (8B and above)
- Work/life Balance
- Communication
- Induction, Training
- Job Satisfaction

Quotes from Staff Interviewed

From the findings of the Exit interviews it is clear that an action plan needs to be developed to address some of the concerns cited as the reasons why staff left. Based on the findings to date the M&WFP team recommend the following actions be implemented.

- Adequate induction programme to support newly qualified band 5 staff.
- Ensure staff complete preceptorship in a timely manner.
- Review of new staff at quarterly intervals.
- Time to reflect on practice where incident of challenging behaviour occurs.
- Awareness on appropriate use of CCTV.
- Feedback process on all IR 1 forms.
- Identify what safe staffing levels are for all shifts and ensure ward is adequately resourced.
- Demonstrate a cohesive management approach by senior managers within the hospital.
- Increased visibility on an ongoing basis of Senior Management on site.

Conclusions

The exit interviews carried out with the staff in Muckamore Abbey Hospital to date have been invaluable. They have helped to identify a wide range of issues that can be addressed by management. This exercise, together with the implementation of the recommendations should help to retain staff in the future and to engage staff in the process of improving their working experience within Muckamore Abbey Hospital which ultimately will result in an improved client experience.

Appendix 1

Exit Interview Questionnaire

Muckamore Abbey

Belfast Health and Social Care Trust
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Questionnaire to be completed by Modernisation & Workforce Planning Team within Human Resources and will be used flexibly and adapted to the circumstances of the interview.

1. Personal Details:

First Name: _____ Date: _____

Surname: _____ Completed by: _____

Staff Number: _____

Band: _____

Job Title: _____ Trained in _____

Ward: _____

Line Manager: _____

Last Day of Service: _____

* Job Family:

2. Reason for Leaving:

2.1 On what basis are you leaving the Trust?

☐ Resignation

☐ Retirement

☐ Temporary Contract

2.2 Please select your main reason for leaving? (Select one)

☐	Working relationship with manager	☐	Unsuitable location
☐	Working relationship with colleagues	☐	Return to Education
☐	Lack of Training and Development	☐	End of Fixed Term Contract
☐	Promotion prospects / Career prospects	☐	Retirement
☐	Flexible working / Work life balance		
☐	Wellbeing and safety at work		
☐	Not satisfied in job role		
☐	Pay / Terms and Conditions		
☐	Other (Reason)		

Explore response further

2.3 Please select any other reasons which contributed to you deciding to leave the Trust? (Select a maximum of two)

☐	Working relationship with manager	☐	Unsuitable location
☐	Working relationship with colleagues	☐	Return to Education
☐	Lack of Training and Development	☐	End of Fixed Term Contract
☐	Promotion prospects / Career prospects	☐	Retirement
☐	Flexible working / Work life balance	☐	
☐	Wellbeing and safety at work	☐	
☐	Not satisfied in job role	☐	
☐	Pay / Terms and Conditions	☐	
☐	Other (Reason)	☐	

Explore response further

3. * Do you feel anything could have been done to encourage you to stay?

4. What have you enjoyed whilst working in Muckamore Abbey?

5. What have you found challenging whilst working in Muckamore Abbey?

6. Would you recommend Muckamore Abbey as a place to work?

YES Explore

NO Explore

**** 7. Would you recommend Belfast Trust as a place to work?***

YES Explore

NO Explore

<u>8. Where are you going?:</u>

8.1 Have you secured a job within another organisation?

YES

NO (please progress to 7.3)

**** 8.2 What sector is your new job in?***

HSC Organisation

- ☐ Northern Trust
- ☐ South Eastern Trust
- ☐ Western Trust
- ☐ Southern Trust
- ☐ BSO
- ☐ NIBTS
- ☐ Other NHS Organisation (Please Specify) _____

** What AFC band is your new position?* _____

Other Public Sector

Private Sector

Voluntary Sector

Other (Please Specify) _____

8. 3 On leaving are you joining a bank within the Trust?

YES

NO

Thank you for your co-operation. *

Appendix 2

Synopsis of Issues listed Related quotes from staff
Patient Safety/Governance
• Clients need time, attention and consistency. Client group has changed dramatically, now more forensic and challenging, if there is an incident of challenging behaviour there is not enough staff to respond in a timely manner
• Continuity of care fractured due to number of bank and agency staff
• Not enough staff for the numbers of patients and their needs
• Insufficient/dangerous staffing levels, staff need to be MAPPA trained, so use of agency staff is therefore not a realistic option as they are unfamiliar with the clients and not a true replacement for staff on the ward
• A lot of expectations in terms of restraining but without the staffing levels to deliver
• Registration at risk, there are not the resources to deliver
• I submitted around 50 IR1 forms, never was there any follow up or debrief or learning yet in one of these incidents 3 people were injured
• No nursing supervision
• Insufficient staffing levels resulting in clients not getting enough attention and potential for medication errors
Well Being and Safety at Work
o Physical Aggression
o Daily risk of physical harm
o Mental scars from violence
o Incidents of completely unexpected aggression
o Staff just going through the motions of their role as everyone feels compromised due to investigations
o Made to feel guilty if you have to go home as a result of an injury
Stress/morale low
▪ Morale at an all time low
▪ Poor staff morale affects mental health
▪ Increasingly challenging more recently, even difficult to get toilet and meal breaks
▪ Moved from pillar to post
▪ Staff are falling off their feet have not ate meals, and are pulled for having a drink of water on the wards (following surveillance on CCTV)
▪ Staff feel vulnerable
▪ Expected to do 10 things at once
▪ Muckamore used to be a community, that is no longer the case

▪ **Feel burnt out, exhausted**
▪ **Poor staff morale due to agency staff paid enormous wages but not fulfilling full role (undertaking one to ones).**
▪ **20-25 nurses started in Muckamore from my university class approximately only 2 remain working here**
Management of Staff
Investigations/Safeguarding
➢ **Inappropriate use of cameras**
➢ **No support regarding safeguarding**
➢ **Everyone is under suspicion**
➢ **Blame Culture**
➢ **Spot checks feel like spying**
➢ **Investigations take too long**
Lack of support from management/senior management
❖ **Not appreciated**
❖ **Senior managers were not working as a team. Conflict filtered down and arguments from senior managers filtered down - power struggle**
❖ **Never see management unless something is wrong. Senior Management (8B & above) never seen on the ground.**
❖ **No support from senior management**
❖ **Managers are available but afraid to roll up their sleeves**
❖ **Band 6 staff are counted in the skill mix but not involved in direct patient care and should be able to assist in times of need**
Worklife Balance
• **No flexibility with Rotas, rotas not completed 4 weeks in advance so cannot arrange childcare**
Induction, Training
o **Feel I have not been listened to previously or have confidence that something will happen**
o **No feedback or checking from senior management if ok following injury**
o **Only one 1:1 meeting with ward manager in two and a half years**
o **Managers highlight all the wrongs there is a lack of positive feedback**
o **New band 5 staff are leaving as they are thrown in at the deep end**
Communication
o **Mandatory basic induction not completed, not aware of what to do when sick for example**
o **Insufficient support following on from induction**

o **Nurse in charge within my first month, not prepared as new to the post and first post from university, didn't feel there was enough support in place and didn't feel comfortable being put in position.**
o **First day on duty really taken aback at the way staff on the ward were spoken to by management, staff were really upset and ended up in tears.**
Job Satisfaction
▪ **Qualified nurses are not used to their full potential. Extremely understaffed resulting in me completing B3 duties as opposed to B5**
▪ **Preceptorship not getting completed due to staffing levels not being utilised as a B5 nurse, spends a lot of time undertaking B3 role, escorting etc. as a result, my nursing qualification and training are wasted. Can't take charge, can't do care plans, feel like a spare part**
▪ **A lot of nursing time spent on computers/paperwork taking time away from engaging and interacting with patients**

Belfast Health and Social Care Trust

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SUMMARY REPORT

Muckamore Abbey Hospital (MAH)

(For the period October to December 2019)

Modernisation & Workforce Planning Team
Human Resources
31st December 2019

1. Introduction

Management within the Adult Social Primary Care Directorate requested support from the Modernisation and Workforce Planning Team (M&WFP Team) within Human Resources relating to the increasing number of staff leaving Muckamore Abbey Hospital (MAH) through resignation or retirement.

Within the Trust all staff processed as leavers (with the exception of Medical and Dental) who leave voluntarily are invited to undertake an Exit questionnaire on the Human Resources Payroll Travel and Subsistence (HRPTS) system via Employee Self Service. As there has been a poor completion response rate on HRPTS it was agreed that as an alternative face to face interviews would be undertaken by the M&WFP Team with staff exiting Muckamore Abbey Hospital.

Face to face interviews took place from the end of October 2019 to December 2019. Whilst 22 names were given to the M&WFP Team, three staff had already left the service and only six others had handed in their notice. As a result, during this period Exit interviews were undertaken with the agreement of the six staff on an anonymised basis at Muckamore Abbey Hospital.

Information obtained was gained through open and honest discussion with staff using an Exit Interview questionnaire. The Exit Interview Questionnaire used for this exercise, is attached in **Appendix 1**.

2. Analysis of information from Exit Interviews

The following section summarises the responses to the questions contained in the Exit Questionnaire.

Question 2. Reason for Leaving

Of the six staff interviewed five resigned and one retired. Five staff were from the Nursing occupational group – two were Band 5 Staff Nurses and three staff were Band 3 Healthcare Support Workers. Four of these staff resigned and one is retiring. One staff member was from the Medical and Dental occupational group.

Two staff cited “Wellbeing and Safety at work” as the main reason for leaving. It is worth noting that both of these staff were Band 3 Healthcare Support Workers (HCSW) and one further staff member cited “Wellbeing and Safety at work” as a contributory reason for their decision to leave. The other HCSW Band 3 and one of the Staff Nurses Band 5 cited “Career/Promotion prospects” as the main reason for leaving. One Staff Nurse Band 5 cited “Retirement” as a main reason for leaving, however, it should be noted that this staff member stated that they had decided to retire much earlier than intended and had taken voluntary early retirement resulting in them receiving a reduced HSC pension and lump sum. The remaining member of staff cited “Flexible working/Work life balance” as their main reason for leaving.

“Other Reason/s” featured as the contributory reason for leaving and was selected by multiple staff.

Question 3. Could anything have been done to encourage you to stay at MAH?

Of the six staff interviewed, five confirmed there was nothing that could have been done to encourage them to remain working at MAH, the remaining member of staff stated that they would have had no issues remaining at Muckamore, however, they had already given a commitment to move to another Trust on improved flexible working arrangements.

Question 4. What have you enjoyed whilst working in MAH?

All staff responded it was the great team of staff and working with the patients.

Question 5. What have you found challenging whilst working in MAH?

Below is a synopsis of the issues identified:

- Exposure to Physical Aggression;
- Dealing with extremely challenging behaviour;
- Pressure put on staff to return to work after sustaining work place injury;
- Very stressful environment;
- Staff feeling very vulnerable, under constant scrutiny;
- Qualified staff - fearful for their registration;
- Low morale;
- Negative publicity & public perception of the hospital and care delivered to patients;
- Endeavouring to maintain good relationships with relatives as a result of the negative publicity;
- Lack of certainty regarding future of Muckamore;
- Need to secure alternative employment due to vulnerability of MAH's future;
- Unsafe staffing levels – pressurised environment;
- High levels of agency staff;
- Pay of Agency staff in comparison to Trust staff;
- Management of agency staff (who are on significantly higher salaries than those having to manage them);
- Balancing work and caring responsibilities;
- Lack of support by line management for staff left on the wards following suspension of other staff involved in hospital safeguarding investigations;
- Lack of presence of new senior management team on the wards.

Question 6. Would you recommend MAH as a place to work?

Four of the six staff stated they would not recommend MAH as a place to work as a result of the issues identified in response to question 5 above.

The other two staff made the following comments:

- Staff were friendly
- Workplace was improving
- Interesting work

Question 7. Would you recommend the Belfast Trust as a place to work?

One staff member stated they would recommend the Belfast Trust as a place to work, however, they also commented that when things become difficult, the Trust is slow to respond. The others either stated that they would not recommend the Belfast Trust as a place to work as they felt the Investigation at MAH had been badly handled by the Trust, or, they felt unable to comment as they had not experienced working elsewhere in the Trust.

Question 8.1. Have you secured a job in another organisation (If yes, where)?

The five staff who resigned have all obtained employment within the HSC sector. One B5 Staff Nurse has obtained a promotion within the Northern Trust. One staff member is moving to a job share post in the Southern Trust. Of the three Healthcare Support Workers, one has taken a significant reduction in hours to take up a post in an Adult Resource Centre in the South Eastern Trust, one member of staff has taken a lower banded post as a HCSW Band 2 (outside of learning disability) within the Northern Trust and the other HCSW has obtained a B3 post in Oldstone, a residential unit for patients from MAH within the Belfast Trust.

Question 8.2. On leaving, are you joining a 'Bank' within the Belfast Trust?

Three staff stated they would not be joining the 'Bank', whilst one indicated that they were joining the Agency that supplies staff to MAH. The remaining three staff were already on the Trust 'Bank', with only one indicating that they would consider continuing to work on the 'Bank' in Muckamore Abbey Hospital.

3. Conclusion

The Exit interviews carried out with the staff in Muckamore Abbey Hospital have been invaluable. It should be noted that a number of the staff interviewed were very emotional and deeply regret that they felt they had no alternative but to either resign or retire from their posts.

It is hoped that the above responses and the actual staff comments contained in **Appendix 2** identify a range of issues that can be addressed by management and assist in the future retention of staff at Muckamore Abbey Hospital.

Appendix 1

Exit Interview Questionnaire

Muckamore Abbey

Belfast Health and Social Care Trust
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Questionnaire to be completed by Modernisation & Workforce Planning Team within Human Resources and will be used flexibly and adapted to the circumstances of the interview.

1. Personal Details:

First Name: _____ Date: _____

Surname: _____ Completed by: _____

Staff Number: _____

Band: _____

Job Title: _____ Trained in _____

Ward: _____

Line Manager: _____

Last Day of Service: _____

* Job Family:

2. Reason for Leaving:

2.1 On what basis are you leaving the Trust?

☐ Resignation

☐ Retirement

☐ Temporary Contract

2.2 Please select your main reason for leaving? (Select one)

☐	Working relationship with manager	☐	Unsuitable location
☐	Working relationship with colleagues	☐	Return to Education
☐	Lack of Training and Development	☐	End of Fixed Term Contract
☐	Promotion prospects / Career prospects	☐	Retirement
☐	Flexible working / Work life balance		
☐	Wellbeing and safety at work		
☐	Not satisfied in job role		
☐	Pay / Terms and Conditions		
☐	Other (Reason)		

Explore response further

2.3 Please select any other reasons which contributed to you deciding to leave the Trust? (Select a maximum of two)

☐	Working relationship with manager	☐	Unsuitable location
☐	Working relationship with colleagues	☐	Return to Education
☐	Lack of Training and Development	☐	End of Fixed Term Contract
☐	Promotion prospects / Career prospects	☐	Retirement
☐	Flexible working / Work life balance	☐	
☐	Wellbeing and safety at work	☐	
☐	Not satisfied in job role	☐	
☐	Pay / Terms and Conditions	☐	
☐	Other (Reason)	☐	

Explore response further

3. * Do you feel anything could have been done to encourage you to stay?

4. What have you enjoyed whilst working in Muckamore Abbey?

5. What have you found challenging whilst working in Muckamore Abbey?

6. Would you recommend Muckamore Abbey as a place to work?

YES Explore

NO Explore

**** 7. Would you recommend Belfast Trust as a place to work?***

YES Explore

NO Explore

<u>8. Where are you going?:</u>

8.1 Have you secured a job within another organisation?

YES

NO (please progress to 8.3)

**** 8.2 What sector is your new job in?***

HSC Organisation

- ☐ Northern Trust
- ☐ South Eastern Trust
- ☐ Western Trust
- ☐ Southern Trust
- ☐ BSO
- ☐ NIBTS
- ☐ Other NHS Organisation (Please Specify) _____

** What AFC band is your new position?* _____

Other Public Sector

Private Sector

Voluntary Sector

Other (Please Specify) _____

8. 3 On leaving are you joining a bank within the Trust?

YES

NO

Thank you for your co-operation. *

Appendix 2

Quotes from staff
• Never thought I would ever leave Muckamore having dedicated so many years of my career here, but it's too stressful and the pressure is too great.
• Feel at risk of physical harm on a daily basis, have been assaulted in the past and feel unable to put up with attacks on me – just can't take it anymore.
• Mental scars from physical assault, worried in case I totally over react if assaulted again.
• Incidents of completely unexpected aggression, feel targeted as it's never done in front of other staff.
• Patient profile has changed dramatically. As a result patients are displaying much more challenging behaviour which is putting everyone under a great deal of stress and strain. On occasions when the ward has been short staffed, I'm left with the one patient with extremely challenging behaviour for all of the 12 hour shift.
• Feeling of isolation as patients are in individual Pod's so you spend a lot of the shift on your own with the one patient.
• Not enough staff for the number of patients.
• Too stressful after all that's happened over the past year. Lack of staff and high number of agency staff who are not a true replacement for permanent staff on the ward. An awful lot expected despite the current situation.
• Feel as though you not only have to look after the patients but also the agency staff as they aren't familiar with the patients and you are trying to ensure their safety also.
• Stressful being in charge of a ward and managing agency staff who are getting paid more than the other qualified nurses on the ward.
• Poor staff morale due to agency staff paid enormous wages but not fulfilling full role.
• Bad publicity really taking its toll as many of us come from small communities and you feel it is reflecting on you as an individual.
• Ward staff feel very unsupported - member of team came into ward to advise they had just been suspended and to collect their belongings but staff on duty were left really upset and shell shocked – had a massive impact on everyone, but were just left to get on with it. Absolutely nothing was said to the ward staff by line management and acted as if nothing had happened. Think someone should have at least spoken to the ward staff to reassure and support everyone. It's a very stressful environment to be working in.
• Muckamore Abbey Hospital won't exist in the future, they are looking to close it. As a result there is no job security.
• Taking up a post with reduced pay/ hours but anything is better than continuing to work here.

• Poor staff morale due to agency staff paid enormous wages but not fulfilling full role.
• Only two trained Band 5 nurses on duty per shift. Other M/H Units I have worked in have 2-3 Band 6's on duty on each shift.
• Trained staff spend so much time on paperwork taking time away from engaging and interacting with patients. Feel guilty and ward staff feel they are not being supported.
• Made to feel guilty if you have to go home as a result of an injury. Being put under pressure to get back to work as soon as possible.
• There is nothing on site to occupy the patients in the evenings which leads to frustration and boredom.
• Despite informing managers that things were very difficult and demands of the job were causing me stress, nothing was done until after I had to take sick leave.
• Ward staff haven't met new senior management team, it would be great to see them on all of the wards.
• When things go wrong it takes the Trust too long to address and respond to issues.

Belfast Health and Social Care Trust
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Muckamore Abbey Hospital
Leadership & MDT Structure
March 2023

Working together · Excellence · Openness & Honesty · Compassion

Peter Sloan Director

Billie Hughes
Co Director

Dr Paul Devine Clinical Director

Roisin McMahon
Divisional Nurse

Colette Johnston
Divisional Social Worker

Sam Warren
Senior Nurse Manager
Training and development Assurance & ASG Nurse Lead

Dr Ken Yeow Consultant Psychiatrist
Dr Michael Kingsley Physical health

Colette McCorry - Hotchkiss
Senior Nurse Manager
MAH resettlement Assurance & support and engagement Plans

Hilary Hassan
Assistant Service Manager/Lead Nurse

Killead & Donegore Ward
Ward Sister– Vacant
Deputy WS – Frances McGlone
Deputy CN – Richard Mensa

Moyola Therapeutic Services vacant
Site Coordinators
Sarah Kwinika, Rosie McBride, Kerry Murray, Patricia Lennon

Occupational Therapists:
Jenny Toland
Adeline Fox
Sarah Hewitt
Chrissie McClean

Physiotherapy:
Keri Kenny
Lindsay Duncan
Mary Gribben
Jill Lynas

ASG
Ciara Rooney
SM
Hilda McGrann

Pharmacist:
Deirdre Murray

Involvement lead:
Dolores Atkinson

Social Work:
Michelle Shannon
SSWP Eimear McGeown
SW Mary Keown

Paul Magowan
Assistant Service Manager/lead Nurse

Rhonda Scott
Assistant Service Manager/Lead Nurse

Sixmile Forensic Service
Ward Sister – Helen Ward

Cranfields One & Two
Ward Sister – Sophie Jarvis

Resettlement leads:
ChloeJade McDonald
Brian Gribben

Speech & Language:
Rosalind Kyle
Carol Hunter
Emma Loughran

Psychology:
John Ferguson
Siobhan Keating

Michelle Curran - Nurse Consultant
Theresa Green - Clinical Lecturer
Vacant - Nurse Development Leads
Helen Crawford – Practice Education Facilitator

Grainne Healey Lead for BPS Behavioral Practitioners:
Jenny Doherty
Rebecca Boyd
Fiona Magee
Ruth Sheridan

Belfast Health and Social Care Trust
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Policy Code: BHSCT/PtCtCare (06) 2021

Title:	**Restrictive Practices Policy for Adults and Children**		
Policy Author(s)	Neil Walsh, Advisor/Trainer on Management of Aggression Tel: 028 950 42050 Neil.Walsh@belfasttrust.hscni.net Samuel Warren, Advisor/Trainer on Management of Aggression Tel: 028 961 55783 Samuel.Warren@belfasttrust.hscni.net		
Responsible Director:	Jacqui Kennedy, Human Resources and Organizational Development Director		
Policy Type: (tick as appropriate)	*Directorate Specific ☐	Clinical Trust Wide ☒	Non Clinical Trust Wide ☐
If policy type is confirmed as ***Directorate Specific** please list the name and date of the local Committee/Group that policy was **approved**			
Approval process:	Standards and Guidelines Committee Executive Team Meeting	**Approval date:**	01/02/2022 09/02/2022
Operational Date:	February 2022	**Review Date:**	February 2023
Version No.	4	**Supercedes**	V3.1 – May 2015 – October 2020
Key Words:	Restrictive Practices, Restrictive Intervention		
Links to other policies	BHSCT Being open policy – Saying sorry when things go wrong (2020) TP 80/11 BHSCT Your right to raise a concern (whistleblowing) policy (2018) TP 22/08 BHSCT A zero tolerance approach to the prevention and management of aggression and violence towards staff in the workplace (2019) TP 02/08 BHSCT Policy and procedure for the management of comments, concerns, complaints and compliments (2020) TP 45/08 BHSCT Policy to be followed when obtaining consent for examination, treatment or care in adults or children (2015) SG 27/13 BHSCT Rapid tranquillisation guideline for the immediate pharmacological management of violent and aggressive behaviour in adults, children and young people in inpatient units (2017) SG 44/12 BHSCT Procedure for reporting and managing adverse incidents (2018) TP 94/14 BHSCT Risk management strategy 2020 – 2021 TP 58/08 BHSCT Adult safeguarding policy and procedure 2020 (SG 20/19)		

	Assurance Framework – Sub-Committee Structure 2018 BHSCT Core child protection regional policy and procedures (2017) SG 38/17

CONTENTS

**** POLICY DISCLAIMER**

Throughout the policy those known to the Trust as; clients, individuals, patients, residents etc. will be referred to as service user (s)

1.0 INTRODUCTION

The Belfast Health and Social Care Trust acknowledge that restrictive practices take place and is committed to reducing restrictive practices and applying least restrictive principles to all aspects of the Trusts service delivery. The use of restrictive practices is based on the philosophy of Eliminate, Minimise, and Make Safe. The ideal is to deliver services and supports which are free from restrictive practices. However, if restrictive practices are necessary to maintain the safety of the service user, staff or members of the public, each service area should ensure that there are robust legal grounds for the restriction, it is reviewed regularly and a person centred approach is adopted when considering the treatment of each individual. When restrictive practices are used they are as a last resort when all other less restrictive measures have been exhausted and applied in a manner that ensures privacy and dignity.

- Restrictive practices are those that limit a person's movement, day to day activity or function. (RCN, 2017)

This can also be viewed as depriving a person of choices, controlling them through not permitting them to do something, making them do something or setting limits on what they can do, without physically intervening. It includes the use of threats and coercion. (Restraint Reduction Network, 2019)

- Restrictive interventions are a specific subset of restrictive practices. They are deliberate acts on the part of other person (s) that restrict a person's movement, liberty and/or freedom to act independently in order to: take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken and end or reduce significantly the danger to the service user or others. (DOH, 2014)

2.0 SCOPE OF THE POLICY

The Belfast Health and Social Care Trust is committed to delivering the highest standards of care in conjunction with the Trust Values: Excellence, Openness & Honesty, Compassion and Working Together.

The Trust as a statutory responsibility to safeguard the welfare of children, young people and adults in need of protection, including members of staff.

This policy includes definitions, the Trusts objectives and duties/responsibilities of key staff.

This policy sets out the overarching framework for the use of restrictive practices within the Trusts services.

This policy includes details of legislative framework and guiding principles within which all staff should work.

This policy is supported by subordinate policies and protocols that provides further detail and guidance on safe, lawful and legitimate use of specific forms of restrictive interventions.

The Trust considers that the management of behaviours that challenge is a process requiring openness & honesty, compassion, dignity & respect for the rights of the service user, acting in their best interests and balanced against the risk of harm to themselves, staff and members of the public.

The Trust considers that restrictive interventions should be reasonable and proportionate to the risk presented, least restrictive for the least amount of time and used as a last resort.

The Trust recognises that a service user's behaviour can escalate to the point where restrictive interventions may be needed to protect the service user, staff or other users of the Trust from significant injury or harm, even if all best practice to prevent such escalation is deployed.

2.1 Types of Restrictive Interventions and/or Practices

Environmental Intervention:

The use of obstacles, barriers or locks to prevent a person from moving around freely.

Psychological intervention:

Depriving a person of choices, controlling them through not permitting them to do something, making them do something or setting limits on what they can do.

Coercion:

The practice of persuading someone to do something by using force or threats.

Observation:

A minimally restrictive intervention of varying intensity in which a member of healthcare staff observes and maintains contact with a person to ensure the person's safety and the safety of others.

Physical Restraint:

Any direct physical contact where the intervener prevents, restricts or subdues movement of the body, or part of the body of another person.

Clinical Holding:

The use of physical holds to assist or support a person who lacks capacity to consent to receive clinical or personal care or treatment.

Chemical restraint:

The use of medication, which is prescribed and administered for the purposes of controlling or subduing acute behavioural disturbance, or for the management of on-going behavioural disturbance.

Mechanical restraint:

The use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control.

Seclusion:

The confinement of a person in a room or area from which free exit is prevented.

Refer to Appendices 1 for 'Procedural and further guidance on Restrictive Interventions'

2.2 Three Steps to Positive Practice Framework

All areas of the organisation that are required to use restrictive interventions must embed the Three Steps to Positive Practice Framework when considering and reviewing the use of restrictive interventions.

The *Three Steps to Positive Practice* are designed to encourage careful consideration and reflection on the use of any potentially restrictive practice, before it is implemented, and throughout the entire timeline when the restrictive practice may be used. It is applicable at the points of assessment, implementation, evaluation and review, and in situations where the use of restrictive practices have been in place for some time or are associated with a particular environment.

The three steps are intended to assist staff to ensure that the decision they make and the actions they take are consistent with legal, ethical and professional accountability frameworks, every time a decision is made or an action is taken. (RCN, 2017)

Refer to Appendices 3 for link to 'The RCN Three Steps to Positive Practice Framework'

2.3 Proactive and Preventative Strategies

The Regional Policy on the use of Restrictive Practices in Health and Social Care Settings highlights the need that all local organisational policies must adopt positive approaches in the delivery of care, support and treatment plans that deliver proactive and preventative strategies, to better support the people using services and improve outcomes that a support a better quality of life.

The use of positive and proactive interventions will support the development of a therapeutic relationship between staff and those that they care for. The benefit of an established therapeutic relationship aids communication, promotes recovery and supports the development of skills building to allow people to express themselves appropriately, therefore reducing the likelihood of behaviours of concern.

2.3.1 Communication

Effective and person centred communication is key in supporting a person and their family to be part of their care and treatment.

These five key themes must be evident in practice:

- Transparency
- Trust and Relationship building
- Compassion, dignity and respect
- Supporting and managing expectations
- Consistency in communication

A partnership approach to care and wellbeing is essential. Underpinning a rights based approach and developing the positive relationships required to ensure that people feel protected, treated fairly, listened to and respected.

Where required, staff should have access to appropriate communication support tools and must be appropriately trained to empower and support the people that they work with to communicate effectively.

Refer to Appendix 2 'Methods of Reducing Restrictive Interventions'

3.0 ROLES AND RESPONSIBILITIES

3.1 Trust Board

The Trust board is responsible for ensuring that a policy is in place that governs the safe use of restrictive interventions via its governance arrangements and that all staff working in the trust are aware of, and operate within the policy.

3.2 The Chief Executive

Has overall responsibility and accountability for the health, safety and welfare of all service users, staff and others affected by the activities of the Trust and is responsible for the following:

- Fostering a framework within which the Trust can develop a culture and ways of working that focuses on restraint reduction and will reduce the need for restrictive interventions. When restrictive interventions are used it will be in the least restrictive way for the minimum amount of time and as a last resort.

- Appointing a senior manager at director level to take the lead responsibility for restrictive intervention reduction programmes.

3.3 Director of Human Resources and Organisational Development

Has overall delegated responsibility for service user and staff safety with an emphasis on compassionate person centred care and treatment, and is responsible for the following:

- Ensuring that appropriate arrangements are in place to demonstrate the Trusts commitment to reducing the use of restrictive practices as detailed in the policy purpose. Leadership, Performance measurement, Learning and Development, Providing personalised support, Communication and Person-Centred Focus and Continuous improvement.

- Ensuring communication of The Restrictive Practices Policy and review where appropriate.

- Ensuring adequate arrangements are in place to meet training needs identified through the regional strategy.

3.4 Co-Director of Human Resources and Organisational Development

Supports the Human Resources and Organisational Development Director and has responsibility for the following:

- Assisting the Human Resources and Organisational Development Director in the communication and ongoing review of the Trust Restraint Reduction Framework, Policy on Restrictive Practices and associated structures.

- Managing the process of reporting and monitoring incidents involving the use of restrictive practices and ensuring that managers and relevant agencies are kept informed of any significant implications highlighted and shared learning.

- Alerting other senior managers to significant risk issues in relation to the use of restrictive practices.

3.5 Directors and Co-Directors

Are responsible for the following:

- Ensuring compliance with The Restrictive Practices Policy and associated strategies.

- Ensuring that the development or review of local procedures in relation to the use of restrictive practices within their directorate reflects the ethos of this policy.

- Ensuring that where the use of restrictive practices is reasonably foreseeable in their service area that their staff teams are equipped with the knowledge and skills to understand and prevent crisis behaviour, make evidence based decisions regarding the use of restrictive practices to facilitate clinical procedures, and provide staff training in the key competencies that supports the view that restraint is used as a last resort to manage risk behaviour associated with aggression, violence and acute behavioural disturbance.

- Ensuring the use of restrictive practices within their service groups is appropriately recorded.

- Ensure that all incidents involving the use of restrictive practice are appropriately reported, investigated and monitored in line with the Trust's incident reporting procedure and that learning outcomes are implemented and shared across the Trust.

- Responsible for high level monitoring of incident patterns, to identify high-risk areas, and the subsequent development of relevant management strategies.

- Authorising and approving commissioned training in relation to restrictive practices and restrictive interventions which is provided by external / licenced providers.

3.6 Managers

- Managers of services (at all levels) will ensure that services are resourced appropriately and that their staff teams are able to access training, supervision and support to enable them to practice in a manner that complies with the relevant legislation and guidance.

- Managers will design staff structures to minimise restrictive practice by maintaining a consistent workforce with the right values, attitudes and skills and in the right numbers.

- Managers will ensure that all areas have regular forums and opportunities for service users, their families and advocates to contribute to the design, delivery and evaluation of services with specific reference to reducing the need for restrictive practices.

- Managers will ensure that post-incident reviews and debriefs take place so that lessons are learned from incidents occurring wherein restrictive practices have had to be used. This includes gathering the views of the service user and the experience of restraint or restriction placed on them, why this occurred and their understanding of the situation.

- Managers will ensure that all their employees are complying with this policy and that measures are in place to release staff for the appropriate training.

- Managers will ensure that data is collected for audit purposes.

- Managers will ensure that there are systems in place for appropriate reporting, recording and monitoring of safeguarding incidents involving adults, children or young people.

- Managers will ensure that their staff are offered the appropriate training for their area of work and assessments and training needs are completed for their type of work and working environments.

3.7 All Staff

- Have individual responsibility to ensure they work within the legal and ethical framework that pertains to their practice and interventions that would be defined as restrictive with a pro-active response to poor practice.

- Must ensure they comply with the Trust policy relating to restrictive practice and contribute to activities designed to support a reduction or elimination of restrictive practices.

- Must ensure they are competent within their role and within the setting in which they are employed in order to meet the needs of the service user being cared for.

- Must ensure that any gaps in knowledge, skills or practice in the area of restrictive practices and/or restrictive interventions are raised swiftly to their manager.

- Must ensure they attend the appropriate training in relation to this policy.

- Must take reasonable care of their own health and safety and that of others.

- Are responsible for risk assessing the wearing of personal protective equipment (PPE) in the use of restrictive interventions.

- Must ensure they report all incidences of restrictive practices and/or interventions.

3.8 Training associated with the use of Restrictive Interventions and/or Practices

Training must be identified using a 'Training Needs Analysis' for each service area.

An example can be found in the BHSCT Zero Tolerance Policy. Human Resources Learning and Development and be contacted for support.

Training in the use of restrictive interventions must be accredited and provided by a certified training organisation.

The philosophy, lessons and skills trained to staff must align with the BHSCT values, with a focus on proactive, preventative and evidence-based strategies. The training provided must be guided by BHSCT policies and procedures relating to restrictive practices and restrictive interventions, relevant legal and regulatory frameworks and professional standards for best practice.

Refer to Appendices 5 for link to 'Zero Tolerance Risk Assessment and Training Needs Analysis'

4.0 CONSULTATION

During this policy review, the following groups were consulted: CAUSE, The Management of Aggression Team, The Trust Joint Health and Safety Committee, Trade Unions, Occupational Health, Consultant Psychiatry, Senior Managers in Emergency Department, Mental Health, Learning Disability Services, Pharmacy, Children's services, Security and Peer Support, Restrictive Practices Task and Finish Group.

5.0 POLICY STATEMENT/IMPLEMENTATION

5.1 Dissemination

This policy applies to all services and their staff involved in caring for service users receiving treatment or care within the Trust.

Any concerns regarding the implementation of this policy should be addressed with your senior manager or further clarification can be sought from the author.

Training queries should be directed to the appropriate training provider.

5.2 Resources

This policy will be made available on the policies and guidelines page on the Trust intranet.

5.3 Exceptions

There will be no exceptions, as the policy will apply to all staff.

5.4 Implementation

It is the responsibility of the multidisciplinary team to ensure that the relevant assessments have been completed in areas where staff are expected to engage in any form of restrictive practice as defined within the policy. This must be done in conjunction with relevant legislation identified within this policy.

This assessment and subsequent management plan should include service specific preventative strategies, safe systems of work, training, support and supervision for staff, which is sensitive to the needs of the service user.

These assessments will require regular audit to determine their acceptability and efficiency.

5.5 Legal and Professional Issues Related to the Use of Restrictive Practices

5.5.1 Principles

Belfast Trust is committed to delivering safe, high quality and compassionate services. Employees are expected to deliver services and behave in a manner that is compatible with this commitment. Belfast Trust expects all employees to treat others with dignity and respect whether it be service users, carers, visitors or colleagues.

Belfast Trust is committed to carrying out its functions in line with the core principles and values that underline human rights legislation namely Freedom, Respect, Equality, Dignity and Autonomy (FREDA). Staff should use FREDA principles to red flag any behaviour that is not compatible with the Trust ethos of delivering safe, quality and compassionate care or which violates our equality and human rights statutory commitments.

All employees will make every effort to ensure that human rights are protected, that respect for human rights, is part of day to day work and that human rights are an integral part of all actions and decision making. The Trust will keep human rights considerations, relevant legislation and previous judicial reviews at the core of decision-making.

5.5.2 Human Rights Act 1998

In addition to anti-discrimination legislation Belfast Health and Social Care Trust employees have a duty to deliver services in a manner that meets our statutory equality, human rights and good relations duties. These duties include:

Section 75 of the NI Act 1998

- Promotion of Equality of Opportunity in relation to the nine equality categories.
- Promotion of Good Relations between persons of different religious belief; political opinion; and racial group.

Section 49A of the Disability Discrimination Act 1995

- Promotion of positive attitudes towards disabled persons.
- Encouraging the participation by disabled persons in public life.

Duty to respect, protect and fulfil rights outlined in the Human Rights Act 1998 including:

- Article 2 - the right to life.
- Article 3 - the right not to be tortured or inhumanly or degradingly treated or punished.
- Article 5 - the right to liberty and security of the person.
- Article 8 - the right to respect for one's private and family life, correspondence and home.
- Article 14 - protection from discrimination.
- United Nations (UN) International Covenant on Economic, Social and Cultural Rights (ICESCR) [UK ratification 1976], which includes the right to the highest attainable standard of health.
- The Trust is committed to upholding the principles of the UN Convention on the Rights of Persons with Disability (UNCRPD), which seeks to promote, protect and ensure full and equal enjoyment of all human rights and fundamental freedoms by all service user's with disabilities and to promote respect for their inherent dignity.
- Use of restrictive interventions must be undertaken in a manner that complies with the Law, Health and Safety Legislation, Human Rights Act 1998 and the relevant rights in the European Convention on Human Rights.

(For further information, please visit website The Human Rights Act | Equality and Human Rights Commission (equalityhumanrights.com)

5.6 The Safe and Ethical use of all forms of Restrictive Interventions

Restrictive interventions should never be used to punish or for the sole intention of inflicting pain, suffering or humiliation.

There must be a real possibility of harm to the service user or to staff, the public or others if no action is undertaken.

The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm.

Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need.

Any restriction should be imposed for no longer than absolutely necessary.

What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent.

Restrictive interventions should only ever be used as a last resort.

People who use services, carers and advocate involvement is essential when reviewing plans for restrictive interventions (DOH, 2014).

5.6.1 Duty of Care

Duty of care is a legal obligation to:

- Always act in the best interest of individuals and others.
- Not act or fail to act in a way that results in harm.
- Act within your competence and not take on anything you do not believe you can safely do.

5.6.2 Mental Capacity Act (NI), 2016 – Deprivation of Liberty Safeguards Code of Practice (2019)

The statutory principles are:

- Principle 1: a person is not to be treated as lacking capacity unless it is established that the person lacks capacity in relation to the matter in question.
- Principle 2: the question if a person is able to make a decision for himself or herself can only be determined by considering the requirements of the Act and no assumptions can be made merely on the basis of any condition that the person has or any other characteristics of the person.

- Principle 3: a person is not to be treated as unable to make a decision for himself or herself unless all practicable help and support to enable the person to make the decision has been given without success.

- Principle 4: a person is not to be treated as unable to make a decision merely because the person makes an unwise decision.

- Principle 5: any act done, or decision made, must be made in the person's best interests.

(For further information, please visit website Mental Capacity Act | Department of Health (health-ni.gov.uk)

5.6.3 The Children (Northern Ireland) Order, 1995

A range of legislation provides legal basis for how social services and other agencies deal with issues relating to children. This legislation has been introduced so that all individuals looking after children, in the workplace are aware of how children should be looked after and legally protected.

Whilst different legislation may give greater or lesser focus on the use of restrictive practices, there is a universal expectation that the use of any force should be a last resort, reasonable and proportionate to the circumstances.

The overall aim is to protect the child or young person from harm. This range of legislation aims to make sure the care children and young people receive is well supported, of high quality and tailored to their needs whilst also improving their educational experience and achievements.

(For further information, please visit website The Children (Northern Ireland) Order 1995 (legislation.gov.uk)

5.6.4 The Mental Health Order (NI), 1986

Mental health legislation covers the reception, care and treatment of mentally disordered persons. The Mental Health Order aims to provide stronger protection for service users and clarify roles, rights and responsibilities. This includes:

- Involving the service user and, where appropriate, their families and carers in discussions about the service users care at every stage.

- Providing personalised care.

- Minimising the use of inappropriate blanket restrictions and restrictive interventions including medication, physical restraint and seclusion.

(For further information, please visit website The Mental Health (Northern Ireland) Order 1986 (legislation.gov.uk)

6.0 MONITORING AND REVIEW

This policy will provide a framework whereby the Trust will develop Key Performance Indicators in relation to restrictive practices.

All services must have a robust monitoring process in place and ensure that their governance arrangements enable them to demonstrate that they have taken all reasonable steps to prevent the misuse and misapplication of restrictive practices.

The monitoring process will include audit on the use of restrictive practices. An example of an audit tool that could be used is the RRN Reducing Restrictive Practices Checklist.

Refer to Appendix 4 for link to 'The Restraint Reduction Network's Reducing Restrictive Practices Checklist'

The use of restrictive practices and interventions must be reported in line with divisional assurance frameworks. Feedback from patients, families, carers and advocates will be used to review and monitor use of the policy.

The service must discuss the use of restrictive practices and interventions through regular reports and reviews with attention to statistical data.

The policy will be reviewed on a five yearly basis as a minimum or sooner should there be changes in legislation or best practice.

6.1 Support Mechanisms

Following the use of restrictive practices and/or restrictive interventions it is essential to address any immediate needs of the service user, bystanders, family members, or staff who have been involved.

A post incident review or debrief must take place as soon as reasonably possible, providing an opportunity for learning and support for staff and the service user involved. This process must include the service user's view and thoughts about the incident as well as the staff members involved.

This process must include:

- Basic facts - What happened? When? Why? Where? Who else has been affected?

- Patterns in behaviours, triggers or precipitating factors and patterns in staff responses.

- Alternatives to the behaviours - what can be done differently next time? How to strengthen staff responses.

- What changes can be made to avoid future occurrences.

- Negotiate future approaches and expectations.

- What has been learned? Changes to risk assessments and care plans / individual approaches.

7.0 EVIDENCE BASE/REFERENCES

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Royal College of Psychiatrist's (2018) Prescribing Observatory for Mental Health

Royal College of Nursing (2010) Restrictive physical intervention and therapeutic holding for children and young people: Guidance for nursing staff

Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016) Trauma-informed mental healthcare in the UK: What is it an how can we further its development? Mental Health Review Journal, 21 (3), 174-192. Doi: 10.1108/MHRJ-01-2015-006

8.0 APPENDICES

Appendix 1: Procedural and further Guidance on Restrictive Interventions
Appendix 2: Methods of Reducing Restrictive Interventions
Appendix 3: RCN Three Steps to Positive Practice – Link
Appendix 4: Reducing Restrictive Practice Checklist (RNN, 2019) - Link
Appendix 5: Zero Tolerance Risk Assessment and Training Needs Analysis - Link

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in the **Restrictive Practices for Adults and Children Policy** where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and Indirect Supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.

- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

10.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening

exercise to ascertain if the policy has potential impact and if it must be subject to a full impact assessment. The process is the responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this **link**.

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality and Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the equality screening for the policy is:

Major impact	☐
Minor impact	☒
No impact	☐

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018, the Trust considers the impact on the privacy of individuals and ways to mitigate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality and Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the Data Protection Impact Assessment screening for the policy is:

Not necessary – no personal data involved	☒
A full data protection impact assessment is required	☐
A full data protection impact assessment is not required	☐

12.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this link.

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality and Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

13.0 REASONABLE ADJUSTMENT ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.
The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

01/02/2022
_____ **Date:** _____
Policy Author

01/02/2022
_____ **Date:** _____
Director

APPENDIX 1

PROCEDURAL AND FURTHER GUIDANCE ON RESTRICTIVE INTERVENTIONS

1. NICE guideline (NG10) 2015: Violence and aggression: short-term management in mental health, health and community settings

Overview | Violence and aggression: short-term management in mental health, health and community settings | Guidance | NICE

2. The Restraint Reduction Network Training Standards 2019

The Restraint Reduction Network Training Standards - Restraint Reduction Network

3. Department of Health: Positive and Proactive Care: reducing the need for restrictive interventions

Helping health and care services manage difficult patient behaviour - GOV.UK (www.gov.uk)

APPENDIX 2

METHODS OF REDUCING RESTRICTIVE PRACTICES

Recovery-based Approaches

Recovery means working in partnership with service users to improve their clinical and social outcomes. Recovery models are consistent with contemporary service philosophies across wider health and social care setting and include the promotion of human right based approaches, enhancing personal independence, promoting and honouring choices and increasing social inclusion.

Recovery is possible for everyone. Each person can achieve satisfying and fulfilling life, in keeping with their own preferences, goals and aims, through empowerment, self-determination and unconditional engagement with wider communities and society more generally (DOH, 2014).

Positive Behaviour Support (PBS)

PBS provides a framework that seeks to understand the context and meaning of behaviour in order to inform the development of supportive environments and skills that can enhance a service user's quality of life. Evidence has shown that PBS based approaches can enhance quality of life and also reduce behaviours that challenge, which in turn can lead to a reduction in the use of restrictive interventions.

PBS provides a conceptual framework, which recognises that service users may engage in behaviours that challenge because they have challenging or complex needs that are not being met. These can be associated with unusual needs and personal preferences, sensory impairments, or mental or physical health conditions (DOH, 2014).

Primary Preventative Strategies:

- Deliver services that focus on person-centred, trauma-sensitive care and support
- Providing positive and rewarding social environments
- Give structure to the day and provide meaningful occupation and activities
- Addressing health inequalities
- Improving levels of independence
- Enhancing quality of life
- Improving communication skills
- Helping service users manage their own conditions by enhancing coping skills or adapting their environment
- Helping service users to exercise or sleep

Primary interventions is part of a specific approach including PBS and the Six Core Strategies. This may also include individualised approaches such as cognitive behavioural therapy, dialectic behaviour therapy and other psychological

interventions. Fundamentally, primary intervention is based on person-centred approaches, which aim to provide the 'right fit' between the services available and the needs of the service user (Restraint Reduction Network, 2019).

Secondary Preventative Strategies:

Secondary prevention focuses on early intervention and aims to minimise escalation in behaviour, which may lead to the use of restrictive practices, this includes:

- An assessment of the presenting behaviour so that a targeted approach can be used which may include the removal of immediate triggers
- Making changes to the environment
- Self-regulation techniques such as relaxation, breathing exercises, mindfulness, and meditation techniques
- Effective verbal and non-verbal approaches such as limit setting and distraction techniques
- Reinforcement of alternative positive behaviours
- The use of appropriate medication either to address underlying psychiatric symptoms or to alleviate anxiety (Restraint Reduction Network, 2019).

Tertiary Strategies:

These are reactive strategies aimed at addressing the needs of service user's where primary and secondary preventions has failed in order to help the service user to regain control. Tertiary strategies can be non-restrictive or restrictive. They aim to bring about immediate behavioural change in the service user by enabling staff to manage the situation and eradicate or minimise the risks. It is important to recognise that crisis approaches or risk management approaches and not designed or intended to achieve any long-term or lasting behavioural change (Restraint Reduction Network, 2019).

Person Centred, Trauma-Informed Care

Trauma is the experience of violence and victimisation including sexual abuse, physical abuse, severe neglect, loss, domestic violence and/or the witnessing of violence, terrorism or disaster.

The earlier in life trauma happens, the more profound the impact on brain development. People who have experienced trauma in early childhood often struggle to self-regulate and seem to always be in a state of high alert to protect themselves from remembered harmful experiences. This is their automatic, learned response and not signs of pathology, rather they are survival strategies that have helped them cope with terrible pain and challenges.

Trauma-informed care involves universal precautions based on an assumption that the people who use services have a history of trauma, which can present behavioural in many ways including anxiety/depression, substance abuse, self-injury, eating problems, poor judgment, flashbacks, nightmares, terror, auditory hallucinations, difficulty problem solving and aggression (this list above not exhaustive).

Trauma-informed care focuses on 'what happened to the person' instead of 'what's wrong with the person' and helps understand how the person's behaviour developed, how this impacts on the person now, and how to help the person develop new coping strategies.

When taking a trauma-informed approach, it is important for staff to reflect on their own behaviours and responses to individuals, being aware of how their approach may adversely impact on the person (Sweeney, 2016)

The Six Key Restraint Reduction Strategies

The use of coercive and restrictive interventions can be minimised, and the misuse and abuse of restraint can be prevented. The first steps in doing so are to set expectations across the BHSCT.

- Strategy 1: Leadership
  The organisation develops a mission, philosophy and guiding values, which promote non-coercion and the avoidance of restraint. Executive leaders commit to developing a restraint reduction plan, which is implemented and measured for continuous improvement.

- Strategy 2: Performance Measurement
  The organisation takes a 'system' approach and identifies performance measures, which determine the effectiveness of its restraint reduction plan and which measure key outcomes for service users.

- Strategy 3: Learning and Development
  The organisation develops its staff with the knowledge and skills to understand and prevent crisis behaviour. Training is provided which gives staff the key competencies and supports the view that restraint is used as a last resort to manage risk behaviour associated with aggression, violence and acute behavioural disturbance.

- Strategy 4: Providing Personalised Support
  The organisation uses restraint reduction tools, which inform staff, and shape personalised care and support to service users.

- Strategy 5: Communication and Service User Focus
  The organisation fully involves service users in a variety of roles within the service, identifies the needs of service users and uses these to inform service provision and development.

- Strategy 6: Continuous Improvement
  The principle of post-incident support and learning is embedded into organisational culture (Restraint Reduction Network, 2019).

APPENDIX 3

THE RCN THREE STEPS TO POSITIVE PRACTICE

Three steps to positive practice | Royal College of Nursing (rcn.org.uk)

APPENDIX 4

RESTRAINT REDUCTION NETWORK'S REDUCING RESTRICTIVE PRACTICES CHECKLIST (RNN, 2019)

https://restraintreductionnetwork.org/wp-content/uploads/2016/11/Reducing-Restrictive-Practices-Checklist.pdf

(For further information, please visit website: Restraint Reduction Network)

APPENDIX 5

ZERO TOLERANCE RISK ASSESSMENT & TRAINING NEED ANALYSIS

Please go policy below: pages 20-25 for Zero Tolerance Risk Assessment & Training Need Analysis:

BHSCT A zero tolerance approach to the prevention and management of aggression and violence towards staff in the workplace (2019) TP 02/08

Belfast Health and Social Care Trust
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20 June 2019

Professor Charlotte McArdle
Chief Nursing Officer
Department of Health
Room C5.4
Castle Buildings
Stormont
Belfast
BT4 3SQ

Dear Charlotte

Thank you for your letter dated 31 May 2019 in which you asked for information on the following:

Current staffing ratio and skill mix available to patients, taking account of differing levels of observations:

The staff ratio in Muckamore Abbey Hospital is funded at 113.9 WTE Registrant staff and 117.23 WTE Non Registrant Nursing Support staff. Additional funding was provided by Commissioners in recognition of delayed discharges of complex patients approximately four years ago to provide a total of 158.05 WTE Registrant staff and 180.4 WTE Non Registrant Nursing Support staff. This ratio is further augmented by bank and agency staff dependent on assessed patient need by the Ward Sisters and Lead Nurses.

Below is listed real-time staffing per ward dependent on assessed patient need by the ward sisters and lead nurses.

Table 1: Care delivered Period 29th April - 26th May

Skill Mix for Roster	
Ward	Skill Mix
Ardmore	35/65
Cranfield 1	38/62
Cranfield 2	33/67
Sixmile	46/54
Erne	30/70
Site	**36.4/63.6**

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Table 2: Planned staffing before all available resources allocated.

Skill Mix for Roster Period 27th May - 23rd June	
Ward	Skill Mix %
Ardmore	32/68
Cranfield 1	40/60
Cranfield 2	29/71
Sixmile	46/54
Erne 1	39/61
Site	**37.2/62.8**

Presence of a senior clinical decision maker (ie Band 6 or above) on each ward 24 hours per day, 7 days per week:

The presence of a senior clinical decision maker (i.e. Band 6 or above) on each ward 24-hours a day, 7 days per week is not presently included in the FSL. In line with the delivering care methodology, we are planning to uplift Band 5 to Band 6 to provide senior clinical decision-making and aim to achieve a minimum of three per ward. (6 more)

Presently, there are 4 x Band 7 Night Coordinators (senior nurses out of hours), 6 x Sisters/Charge Nurses on daytime roster with a minimum of 1 x Ward Sister/Charge Nurse on at the weekend. There are 13 x Deputy Ward Sisters/Charge Nurses; 1.00 WTE vacancy with a recruitment plan in place. They are rostered across 24x7 days per week across the five wards providing senior decision-making skills including leadership across the wards/site.

Current number of nurse vacancies and actions taken to fill same:

There is a FSL of 115 Band 5 staff and FSL of 160 Senior Nursing Assistants; there are 180 Senior Nursing Assistants in post (additional recurrent funding by the PHA to address levels of observations required by patient need).

Registered Nurses

Funded Staff	Staff in Post
115	71

Maternity	Sickness	Suspensions	Vacancy Post	Backfill
7	9	11	44	45

Non-Registrants

Funded Staff	Staff in Post
160	180

Maternity	Sickness	Suspensions	Vacancy	Backfill
2	33	9	0	43

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There is also the following:
1 x Nurse Development Lead Band 7
1 x MAPA Coordinator Band 7
1 x Governance Lead Band 6

Action Taken:
Recruitment activity
To provide stability to the workforce and to reduce backfill, we continue to recruit to Band 3 Senior Nursing Assistants and anticipate a number of new starts over the summer months. This will also provide service continuity for those who are unavailable to work.

A Recruitment Fair took place in March 2018 with 28 final year students from Queens University been offered a post, 7 staff took up their posts between October 2018 until present, explanations by those that didn't take up the job offer were positions closer to home, several job offers therefore change of mind with choice. Attendance at Job Fairs in QUB, UUJ, Dublin, Dundee, RCN Congress Liverpool and Belfast Open Day on the 11 May 2019. We have offered 8 Final Year Student Nurses from QUB, 3 of who want to work in Iveagh with 5 choosing to work in Muckamore.

We continue to hold an open file on HSC recruit for recruitment purposes; we are presently planning a further recruit event for Learning Disability nurses in the summer months.

We have requested staff to consider been redeployed from other host HSC Trusts to work within Muckamore which resulted in one individual. The reason for this is that other Trusts have challenges in this area and the lack of staff in this field.

We have recruited registrants N=35 both Learning Disability, Mental Health and Nurses with Forensic external off contracted agencies, initially for six to eight months with monitoring and review processes. This is in addition resource available through the Trust Nurse Bank. The organisations meet the Trust's contracts specifications. The staff are fully prepared with MAPA training and induction to policies and practice expectations prior to commencing within the wards. They have local induction to the ward environment and the population so patients they will be contributing to their care.

As stated above we are recruiting additional senior decision makers per ward to stabilise the workforce and provide visible clinical leadership.

The substantive Service Manager Nursing post has been approved for permanent recruitment alongside 2 x Band 7 Practice Development nursing posts to progress the creating caring cultures agenda. The development of the Home Treatment model will progress a minimum of 3 x Band 6/7 nursing positions.

We are also supporting a secondment to the regional work-stream for the development of Regional Learning Disability Pathway Band 8A of 1.00 WTE nurse.

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Number of new permanent WTE that have commenced employment in Muckamore Abbey Hospital since 1 March 2019:

The Trust has ongoing recruitment activities outlined above and commencement dates are anticipated from 1st July onwards in line with the Trusts Strategy of Corporate Welcome and Induction. There will be 2 x Band 3 and 1 x Band 6 coming into the Trust within the next 2 months.

Number of new permanent WTE nurses that have left employment in Muckamore Abbey Hospital since 1 March 2019

January –April 2019, 8 x registered staff have left employment within the above period.

Number of anticipated WTE nursing appointments over the next two months

1 x Band 6 registrants
2 x Band 3 non-registrants

The steps taken to ensure that all current and former patients involved in the ongoing investigation have had their biopsychosocial needs assessed and reviewed in light of the allegations regarding their care and treatment while in Muckamore including the provision for addressing associated trauma.

Continuous review through each wards multidisciplinary team in collaboration with the patient and their Next of Kin, care plans have being updated on biopsychosocial model.

The expansion of Psychological Services across Muckamore site, in terms of an increased applied psychology workforce and an increase in Behaviour Therapy workforce, will provide increased psychological attention towards the needs of the patients. This includes increased focus on formulation, cascading a positive behaviour support approach to delivering care and the provision of psychological therapies with an emphasis on impact of trauma and attachment issues. A pilot recruitment of adding Behavioural Assistant posts onto wards is commencing through Psychological Services towards end of June 2019. They will supplement the work of Behaviour Therapists.

We continue to explore additional resources to address the complex needs of the presenting patient population and are engaged in regional work to identify other therapeutic interventions which could be of value.

The nursing care provided within all wards in Muckamore Abbey Hospital is conducive to the delivery of safe, effective, therapeutic and compassionate care:

We can confirm that a daily review of 'Is Care Safe Today' has been introduced including Safety Briefs and Safety Huddles with a weekly 'live' governance meeting. This important development included monthly, weekly and on-occasions daily review of staffing complement to meet the prescribed care needs of the patient population.

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The current nursing governance arrangements for staff working in Muckamore Abbey Hospital

The Ward Sister/Charge Nurse have a daily review of 'Is Care Safe Today' has been introduced. Daily Safety briefs and Safety Huddles which inform the weekly 'live' governance meeting.

Daily review of staffing across the wards is undertaken by the Service Manager and Senior Nurse Managers and they contribute to the nursing element of the weekly SITrep report submitted to the Director.

Senior Manager Leadership walk around daily and weekly.

- Director of AS&PC
- Executive Director of Nursing
- Deputy Director of Nursing
- Co- Director
- Divisional Medical Chair
- Divisional Social Worker
- Divisional Psychologist
- Clinical Medical Lead
- Carer Consultant
- Service Manager Daily
- Senior Nurse Manager Daily
- Nurse Development Lead Weekly
- Practice Education Facilitator – In-reach and Governance monitoring of NMC learning and assessment standards supporting mentors, sign off mentors and students.
- University Link Lecturers supporting students on placement
- Governance Lead Nurse weekly
- Business & Governance Manager weekly
- Safeguarding Lead for Learning Disability

Application of roster policy one month in advance. Regular communication with Bank Office and Roster team when required.

The arrangements to ensure that senior nurses are available to frontline staff 24 hours per day, 7 days per week, and confirmation that all frontline staff are aware of how to contact senior nurses to escalate concerns. BHSCT are supporting promoting staff wellbeing:

The Trust can confirm that senior nurses are available to frontline staff 24-hours per day 7-day per week. We can also confirm that it has been communicated to all staff the Internal Escalation Process for Raising Concerns.

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How BHSCT are supporting, promoting and monitoring nursing staff wellbeing and morale in Muckamore Abbey Hospital and the impact of this?

The following are actions to support staff to promote their wellbeing and to improve morale:

- Along with a Lead Nurse, Human Resources support staff who are absence to meet staff and understand 'What's to them" and to see how the Trust can support the individual to return to work. This is also done in collaboration with colleagues from Occupational Health. This approach has reduced staff absence.
- Massage Therapists have been commissioned to provide sessions for staff. Staff have engaged in this activity with very positive feedback.
- Counselling Services are on site each week. Staff are fully engaged in this service.
- There is also psychological support from the Occupational Health Department
- Head of Psychological services who is currently acting as Divisional Psychologist has made contact with a number of staff as requested.
- All information around staff care have being shared with staff
- Ward sisters have weekly meeting with Operational Manager
- Ward team meetings are held monthly
- Monthly feedback sessions on site for improved communication
- B-well Health Fair has taken place on the Muckamore site for all staff with the relaunch of Rehydrate, Refuel Stations.
- Stress assessment workshops to be facilitated by Health and Safety team in BHSCT
- Listening Sessions for staff.
- Engagement with Staff-side for information sessions, updates and facilitating staff support with their respective Staff side.
- The publication of first Care Consultant Newsletter for the site and Carers was published.
- Creating and Caring Cultures continues to be supported which focused on joy at work and delivering compassionate care. Creating Caring Culture an exciting nursing led development programme supported by FONS. The programme has a keen focus upon learning from within the organisation and from external sources.
- There are two Quality Improvement projects taken place in two of the ward environments.
- Day care services have extended their hours for patients with additional activities, i.e. Art therapy, music therapy and available Day Care staff on wards to facilitate patients to undertake meaningful activities.

The opportunities for nursing staff to deliver evidence based therapeutic interventions in line with NICE guidance:

All nursing staff are trained to manage and de-escalate behaviours that challenge and the model in use is accredited with British Institute of Learning Disability and this model is in use in all Trusts in Northern Ireland and UK. Training is available via the CEC and BHSCT Trust Trainers. (MAPA)

Evidence based Therapeutic Interventions are planned and delivered as part of an MDT assessment of need. There is close working between nursing, medical psychological, behavioural and AHP staff in developing and implementing care plans, positive behaviour

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support plans, including communication assessments and sensory assessments which may lead to development and delivery of interventions such as social stories, using talking mats, activity schedules.

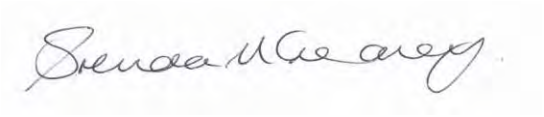
Dialectical Behaviour Therapy as a specific psychological intervention is delivered in groups and individually across the site by Psychological Services in partnership with the MDT. Where workforce issues allow this is supported by Nursing Staff – included in the support of a "DBT Skill for the week" on wards and with specific patients. Positive Behaviour Support (PBS) as a culture of care is being rolled out across the site, although this has been challenging due to workforce difficulties. Additional workshops are planned for PBS and also in Compassionate Care and leadership for the autumn and are led by Psychological services.

How nursing staff are being kept appraised and updated on service developments and actions including outcomes of RQIA recommendations and outcomes:

- Engagement with Staffside for information sessions, updates and facilitating staff support with their respective Trade Unions
- Ward Sister/Charge Nurses have weekly meeting with Operational Manager
- Ward team meetings held monthly
- Monthly feedback sessions on site for improved communication

Please do not hesitate to contact me should you require any further information.

Yours sincerely



Miss Brenda Creaney
Executive Director of Nursing and User Experience

Copy to: Mr M Dillon
Dr C Jack
Mrs M Heaney
Mrs M Mannion

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A Review of Safeguarding at Muckamore Abbey Hospital

A Way to Go

November 2018

Margaret Flynn,

Mary Bell,

Michael Brown,

Bryce McMurray and

Ashok Roy

CONTENTS

THE REVIEW TEAM

Dr Margaret Flynn, Chair of the Review Team and Chair of Wales' National Independent Safeguarding Board

Mrs Mary Bell, parent and independent advocate

Professor Michael Brown, Queen's University, Faculty of Medicine, Health and Life Sciences

Mr Bryce McMurray, former Director of Mental Health and Learning Disability and former Executive Director of Nursing at the Southern Health and Social Care Trust

Dr Ashok Roy, Consultant Psychiatrist at Coventry and Warwickshire Partnership Trust and outgoing Chair of the Faculty of Intellectual Disability Psychiatry, Royal College of Psychiatrists

From the Review Team's experience of services elsewhere as advocates, practitioners, clinicians, researchers and managers, the members brought a wide range of independent perspectives and expertise in service provision for people with learning disabilities and autism.

The Review Team takes the view that people with learning disabilities should not have to live at Muckamore Abbey Hospital and that the management and practitioner skills and efforts required to effect modest changes in patients' lives are better spent in creating high quality community services.

EXECUTIVE SUMMARY

1. A team of five was appointed to review safeguarding at Muckamore Abbey Hospital between 2012-2017.
2. The Review Team read patients' files concerning safeguarding incidents; associated documents; Northern Ireland's safeguarding protocol and procedures; and the Regulation and Quality Improvement Authority's (RQIA) inspection reports concerning the Hospital's wards. The Team met patients, their relatives, Hospital staff and managers.
3. During the Review, "Briefing Papers" were drafted and shared with the Hospital's managers, the Belfast Health and Social Care Trust (which commissioned the Review) and the RQIA. These feature in the Appendices. A draft report was shared with Hospital Managers, the Trust and the RQIA to ensure that it was factually correct. On 24 and 25 September 2018 the Review Team led a series of "feedback sessions" with a view to (i) presenting and discussing the findings with patients' families, the Hospital's staff and managers, and the Trusts responsible for placing people at the Hospital, and (ii) generating recommendations.

4. The Review Team found that:
    - Safeguarding events cannot be seen in isolation. Without exception, discussions concerning safeguarding gave way to patients' compromised lives at the Hospital, their chronic boredom and the failure to create and offer them high quality community services
    - Hospital patients are significantly likely to be harmed by peers
    - Irrespective of the considerable quantity of paperwork associated with safeguarding, the Review Team could not determine how closely Hospital practice aligned with the safeguarding protocol and procedures
    - The CCTV in the Hospital's Psychiatric Intensive Care Unit – with the highest staffing levels and ratios of qualified staff – shows patients being harmed by staff and yet no safeguarding referrals were made, and no members of staff spoke out
    - Patients' families are distressed and angry that nobody intervened to halt the harm and that even the possibility of patients being harmed was denied and deemed implausible by Hospital Managers and the RQIA
    - There was a culture of tolerating harmful and disproportionately restrictive interventions
    - Many families wanted to emphasise that harmful practices co-existed with skilled and compassionate practices and that there are excellent staff at the Hospital whose work is highly valued
    - The CCTV evidence triggered staff suspensions, an investment in viewing many hours of CCTV footage and acknowledgement that relations with patients and their families had to be restored
    - There is confusion about safeguarding "concerns" and "complaints"
    - The use of seclusion was not monitored. Its intensive use by a small number of patients is anti-therapeutic

- Over a third of safeguarding files state that patients have "a history of making allegations" which sacrifices patients' credibility
- Reference to patients' mental capacity adopts an all or nothing approach with some clinicians determining whether patients may contribute to investigations and even attend "Keeping Yourself Safe" training
- Communications with families about alleged safeguarding incidents and potential investigations were vulnerable to being construed as seeking permission to undertake safeguarding investigations
- The routine (and discontinued) practice of involving the Police Service of Northern Ireland in all safeguarding discussions is bewildering
- Advocacy at the Hospital is not as uncomfortably powerful as it should be
- Place-hunting for Hospital patients is not working
- Leadership is distributed and not being used to benefit Hospital patients
- Northern Ireland's services are poorly equipped to support infants and children with learning disabilities, autism and complex medical challenges – whose families do not view the Hospital as their future
- The Hospital is not being used for short term admissions and treatment. It has been historically relied upon by Trusts as the "default placement" – placing distressed and chronically bored patients together. Safeguarding at the Hospital should be seen against this backdrop

5. The Review Team has identified the following lessons:
    - Safeguarding practice at the Hospital involves negotiating too many obstacles
    - The Hospital's senior managers must support staff who report harmful events and practices
    - Patients' and their families must be treated as equal partners and must be heard on a continuous basis. Episodic contact is unhelpful
    - The Hospital requires focus regarding its role and pace in the future of Learning Disability services in NI. This focus must be endorsed by all staff and managers, Trusts, the Department of Health and the Legislative Assembly
    - A life course perspective is required to understand and realise the aspirations of patients and their families.

6. The Review Team offered two recommendations underlining the importance of understanding that ordinary lives require extraordinary supports; and that a life course vision of services for people with learning disabilities and autism is required.
7. The "feedback sessions" endorsed the Review's findings and additional recommendations were identified – some of which were emailed after the events. These include repairing relationships and trust; challenging the custom and practice of seclusion; deploying specialist skills; leading values-driven transformation; clarity of services' purpose; and halting "default admissions" to Muckamore Abbey Hospital.

INTRODUCTION

1. During January 2018, the Belfast Health and Social Care Trust (the 'Trust') set out Terms of Reference for a review of safeguarding activities at the Hospital. The Trust asked the Review Team to identify the principal factors responsible for historic and recent safeguarding incidents at the Hospital. The team is independent of the Hospital.

THE TERMS OF REFERENCE

To undertake a level 3[1] investigation that:

2. Reviews the effectiveness of:
    (i) the identification and timely reporting of adult safeguarding incidents in Psychiatric Intensive Care Unit (PICU) and Six Mile in August 2017 & October 2017, and subsequent communication and reporting of these incidents between the Trust, Public Health Agency (PHA)/Health and Social Care Board (HSCB) and Department of Health
    (ii) adult safeguarding and the subsequent investigations in Muckamore Abbey Hospital from 2012 - 2017
    (iii) adult safeguarding protection plans in Muckamore Abbey Hospital
    (iv) the current advocacy arrangement in Learning Disability services
    (v) governance and quality assurance and controls in relation to quality, safety and user experience of care in Learning Disability Services from 2012 - 2017
    (vi) the implementation of previous recommendations following Serious Adverse Incidents (SAI), Adult Safeguarding investigations and Regulation and Quality Improvement Authority (RQIA) reports in relation to Muckamore Abbey Hospital from 2012 - 2017
    (vii) using the RQIA assessment definitions of Well-Led[2] assess the leadership within Muckamore Abbey Hospital to include:
        - Delivery of Safe, Effective and Compassionate Person-Centred Care[3]
        - Clinical supervision
        - Training
        - Multi-professional audit
        - Communication
        - Learning and improvement

[1] That is, a review of *serious adverse incidents* which *are particularly complex involving multiple organisations; have a degree of technical complexity that requires independent expert advice* and *are very high profile…attracting a high level of both public and media attention.* Section 5.3 of Health and Social Care Board (2016) *Procedure for the Reporting and Follow up of Serious Adverse Incidents,* Version 1.1

[2] That is, *Effective leadership, management and governance which creates a culture focused on the needs and the experiences of service users in order to deliver safe, effective and compassionate care*

[3] That is, *avoiding harm and preventing harm to service users from the care, treatment and support that is intended to help them. The right care at the right time, in the right place with the best outcome. Service users are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support*

3. Identifies areas of good practice both at Muckamore Abbey Hospital and in related services elsewhere with a view to proposing a programme of improvement and development associated with the outcomes of the investigation.
4. Advises on, with a view to consideration of, any other relevant matters that may arise during the investigation [4].

REVIEW METHODOLOGY

5. To orientate the Review, the Trust provided safeguarding files spanning 2012-2017 concerning 69 hospital patients; 61 RQIA reports of inspections of Hospital wards; 12 *Patient Experience Interviews*; *Adult Safeguarding: Prevention and Protection in Partnership* (Department of Social Services and Public Safety and Department of Justice, 2015), *Protocol for Joint Investigation of Adult Safeguarding Cases* (HSCB 2016), *Adult Safeguarding Operational Procedures: Adults at Risk of Harm and Adults in Need of Protection* (HSCB, 2016); and a history of the Hospital. In addition, the Review Team requested information concerning staff sickness absence rates; the staff recruited and those leaving; patient mortality; the referrals to safeguarding; seclusion reports; the governance structure; patient self-advocates and facilitation (from the Association for Real Change); the Society of Parents and Friends of Muckamore Abbey Hospital; and Advocacy meetings.
6. Between January and June 2018, the Review Team met with Hospital managers and staff: the Learning Disability Director, Clinical Director, the Head of Psychology Services, the Service Improvement and Governance Manager, Senior Nurse Managers, Service Managers, an Operations Manager, a Community Integration Coordinator, the Designated Adult Protection Officer, a social worker with responsibility for adult safeguarding, ward managers, the Lead Behaviour Nurse Therapist, the Day Services Manager, the Nurse Development Lead, Psychologist, Speech and Language Therapist, and the Parents and Friends Group, Hospital patients, advocates and facilitators and patients' relatives. Further, the Review Team met the Assistant Director of the Northern Trust, the Director Commissioner of the Belfast Trust and the Director/Commissioner of the Southern Trust, individuals responsible for reviewing the Hospital governance, Inspectors and the Assistant Director, Mental Health and Learning Disability of the Regulation and Quality Improvement Authority. The Police Service of Northern Ireland discussed its experience of safeguarding at the Hospital by telephone.
7. **The RQIA inspection reports and *Patient experience interviews* do not provide a single overview of Muckamore Abbey Hospital. They present dispersed and sequential information about individual wards and the observations of some patients**.
8. Review Team members wondered about the information that the families of prospective patients to the Hospital might access, that is, information which does not arise directly from the Hospital. The answer is the independent inspection reports of the RQIA[5]. The Review Team could have compared and contrasted the RQIA's ward-specific recommendations and

[4] The Review Team was advised of matters which were outwith the Terms of Reference and these were directed to the Hospital's managers

[5] Reference to the RQIA's website sets out the role, methods, powers and responsibilities of the RQIA, https://www.rqia.org.uk/ (accessed 31 October 2018).

the resulting action planning of the wards. However, since **it is difficult to draw conclusions from 61 narrative texts and hundreds of recommendations**, the process would reveal more about repeated recommendations than in understanding the Hospital as a whole, its contexts and the explanatory frameworks of involved parties than about ways of abating or controlling abuse and harm. So, a different approach was negotiated which placed patient experience, safeguarding practice and the related topic of recording information, centre stage.

9. **The reviewers intentionally selected quotations to illustrate the typical as well as an array of examples from the Hospital wards' inspection reports. The reports proved to be a rich source of themes to which additional ones were added as they emerged**.
10. The Review Team watched *Muckamore Abbey in days gone by*[6] and three Review Team members watched 20 minutes of the CCTV footage which resulted in the suspension of six staff members during November 2017.
11. The Review Team's *Briefing Papers* were shared with Hospital managers and Board members once the content was agreed. These feature in the Appendices with the RQIA's feedback concerning the themes abstracted from its reports. Finally, the Review Team offered to facilitate multi-agency events including senior Hospital managers and Trust members to discuss the findings and test out potential recommendations.
12. The Review Team acknowledged the relevance of Mike Nolan's work concerning the *Senses Framework* (see Appendix 1). Since this has played an important role in raising the status, profile and quality of care environments for people with dementia there is merit in adopting its use to underpin environments in which everyone experiences the *senses.*
13. The Review Team's discussions - both person to person and email debriefing - and reflections on emerging Briefing Papers characterised its work. These were shaped by contact with patients and families – and a clear picture of the alternative opportunities and services required in Northern Ireland.

DESCRIPTION OF THE CASE

14. **During November 2017, it was reported in the media that staff had been suspended from Muckamore Abbey Hospital** (the 'Hospital').[7] Their "precautionary exclusion" enabled a joint adult safeguarding investigation of allegations of abuse of patients with learning disabilities. The media coverage acknowledged that there was CCTV data relating to the allegations and that six people had been suspended.[8] It was noted also that staff morale had hit "rock bottom."[9]

CONTEXT TO THE FINDINGS (and *other relevant matters*)

15. The findings are prefaced with this context because the provision and use of the Hospital have featured in the Review Team's meetings and discussions. That is, **without exception, the topic**

[6] https://www.youtube.com/watch?v=vQ6QjxB9UQQ (accessed 15 April 2018)
[7] http://www.bbc.co.uk/news/uk-northern-ireland-42058205 (accessed 30 January 2018);
[8] http://www.irishnews.com/news/2017/11/30/news/two-more-staff-suspended-from-co-antrim-hospital-amid-police-probe-into-ill-treatment-of-patients-1199982/ (accessed 30 January 2018)
[9] http://www.antrimguardian.co.uk/articles/news/61988 (accessed 30 January 2018)

of safeguarding gave way to discussions about ways in which services might establish conditions conducive to improving the lives of people with learning disabilities in the Hospital and in Northern Ireland.

16. The history of the Hospital is pertinent to this Review since it provides a basis for understanding the world of Muckamore Abbey. Appendix 2 reveals its wider relevance in terms of milestones and themes. **From its early expansion providing quasi-permanent living and training placements in a self-contained "village community,"[10] the Hospital's decline was associated with becoming rundown, understaffed, overpopulated and obsolete as a model of service provision. However, the Hospital survived closure headwinds** with familiar claims: the relocation of patients would be traumatic since they have long standing ties with the place; it would painfully revisit and reverse the decision of parents and families to secure a hospital placement; and community services are absent and/or poorly equipped to address the support needs of patients whose behaviour is difficult to manage.
17. **An undated "Business Case" for Muckamore Abbey Hospital envisaged a "core hospital…to provide in-patient element of the Assessment and Treatment of people with a severe learning disability and an additional mental disorder** as defined in the Mental Health (Northern Ireland) Order 1986." This heralded the closure of "the in-patient children's assessment and treatment unit (16 beds)…with an alternative service being re-provided in the community[11]…[and] a 115 bedded in-patient specialist psychiatric assessment and treatment service for people with a learning disability from the Northern and Eastern Health and Social Services Board areas and a Regional Specialist Treatment service…to meet Commissioning Board's target inpatient specialist assessment and treatment bed requirements as follows: Eastern Board, 70 beds; Northern Board 35 beds; Western Board 5 beds; Southern Board 5 beds." The Business Care referenced a "seclusion room with lobby" without elaboration.
18. Currently the Hospital provides services to between 80-90 patients, some of whom have lived there for decades. People's initial admissions were involuntary. During the 1960s the Hospital served many purposes, for example, a home for life; education, "treatment through training," respite for families, nurse training and teacher training. Five decades later, there are connections with these historical themes in terms of:
    - the Hospital's purpose
    - its adjustments to the demands arising from patients' support needs, including physical health care
    - the safe grouping of patients
    - the availability of crisis response and respite services in community settings
    - the destabilising effect of protracted uncertainty for patients, their families and staff
    - the severity of challenging behaviours being over-estimated, and the relevance of ordinary opportunities and accommodation underestimated.
19. **The law** is pertinent since it can safeguard and protect adults with learning disabilities from neglect and abuse. The Review Team sought to understand the context of references to

[10] https://www.youtube.com/watch?v=vQ6QjxB9UQQ (accessed 15 April 2018)
[11] http://www.belfasttrust.hscni.net/about/1615.htm (accessed 17 August 2018)

consent and mental capacity in information concerning the Hospital's safeguarding investigations. Northern Ireland is a distinct legal jurisdiction:

In the absence of specific adult safeguarding legislation, the last ten years in NI has seen the development of a range of policies and procedures which have determined the scope and nature of safeguarding practice*…Safeguarding Vulnerable Adults: regional adult protection policy and procedural guidance (DHSSPS, 2006), established the concept of a "vulnerable adult" and…included a reporting and investigation protocol and processes for monitoring professional practice. This was followed in 2010 by "Safeguarding Vulnerable Adults: a shared responsibility" (Volunteer Now 2010/2012) which provided advice and procedural guidance for voluntary and community sector organisations in recognising and responding to situations of alleged or suspected abuse…every incident requires a response; each response must allow for flexibility and individualised decision-making. Where an adult is deemed to be at risk,* [an] *investigation process is followed, progressing through stages of screening, investigation and assessment, implementation and protection planning, monitoring and reviewing and closure. Where a crime is suspected or alleged "The Protocol for the Joint Investigation of alleged and suspected cases of abuse of vulnerable adults" (Health and Social Care Board 2003,2009) provides procedural guidance"* (Montgomery and McKee, 2017, p201-202).

20. Adult Safeguarding in Northern Ireland has five ***underpinning principles***:[12]
    (i) *A **rights-based** approach: to promote and respect an adult's right to be safe and secure; to freedom from harm and coercion; to equality of treatment; to the protection of the law; to privacy; to confidentiality; and freedom from discrimination*
    (ii) *An **empowering** approach: to empower adults to make informed choices about their lives, to maximise their opportunities to participate in wider society; to keep themselves safe and free from harm and enabled to manage their own decisions in respect of exposure to risk*
    (iii) *A **person-centred** approach: to promote and facilitate full participation of adults in all decisions affecting their lives taking full account of their views, wishes and feelings and, where appropriate, the views of others who have an interest in his or her safety and well being*
    (iv) *A **consent-driven** approach: to make a presumption that the adult has the ability to give or withhold consent; to make informed choices; to help inform choice through the provision of information and the identification of options and alternatives; to have particular regard to the needs of individuals who require support with communication, advocacy or who lack the capacity to consent; and intervening in the life of an adult against his or her wishes only in particular circumstances, for very specific purposes and always In accordance with the law*
    (v) *A **collaborative** approach: to acknowledge that adult safeguarding will be most effective when it has the full support of the wider public and of safeguarding partners*

[12] *Adult Safeguarding: Prevention and Protection in Partnership* (DHSSPS and DOJNI, 2015)

across the statutory, voluntary, community, independent and faith sectors working together and is delivered in a way where roles, responsibilities and lines of accountability are clearly defined and understood. Working in partnership and a person-centred approach will work hand in hand (p8-9).

21. The *Adult Safeguarding Operational Procedures* set out the *main forms of abuse,* that is, physical abuse, sexual violence and abuse, psychological/emotional abuse, financial abuse, institutional abuse, neglect, exploitation, human trafficking/modern slavery and hate crime.
22. **The Mental Capacity Act (Northern Ireland) 2016** represents a potential approach to mental capacity and mental health law. Its origins reside in the Bamford Review of Mental Health and Learning Disability (2002-2007). The latter sought to combine service modernisation and a coordinated approach to legal provision, which in turn were informed by the principles of human rights and equality. However, the Act **has not been fully implemented** because the cost considerations remain to be determined (Harper, C. *et al* 2016). Although patients' mental capacity is a key element of the Hospital's safeguarding investigations, it cannot be determined from documentation how closely Hospital practice aligns with the spirit of the Mental Capacity Act (Northern Ireland).
23. The Review Team is advised that the compulsory admission of most of the Hospital's patients arises from the Mental Health (Northern Ireland) Order 1986.[13] However, **the Hospital is plagued by *mental health delayed discharges,* that is, although a clinical/multi-disciplinary decision has been made that a patient is ready to be discharged and the patient is safe to be discharged, the Hospital's delayed discharges are compromising its capacity to provide assessment and treatment**. While the reasons behind the delayed discharges are multi-factorial, patients subjected to protracted waiting for non-acute hospital provision are likely to deteriorate.
24. The Hospital's own *High-Level Analysis of Incident, Complaint and Serious Adverse Incident Investigations* spanned 1 November 2015-1 November 2017, and sought to triangulate Hospital records. The Analysis stated that, *"There were **4385** adverse incidents recorded…*
    - *Abuse of patient by staff, a total of **22** incidents*
    - *Abuse of staff by patient, a total of **3067** incidents*
    - *Abuse of patient by patient, a total of **1037** incidents*
    - *Abuse - Other, a total of **259** incidents."*
25. The outcome of the analysis, "*identified that Killead and Cranfield ICU have high levels of incidents of abuse and aggressive behaviour, particularly incidents where patients are abusive to staff. Erne ward recorded 8 incidents of staff abuse towards patients but when this was discussed with ward staff it was identified that one patient habitually alleges abuse by staff and these incidents are screened out and closed by the safeguarding process. The largest number of complaints[14] were in relation to quality of treatment and care."*

[13] https://rqia.org.uk/RQIA/files/4e/4ee9f634-be47-4398-afc9-906a20ff3198.pdf (accessed 19 April 2018)

[14] The complaints addressed by the Hospital since 2012 include: the negative effect of remaining a patient at the Hospital; cancelled appointments with a psychologist; delays in securing post hospital accommodation; RQIA recommended that windows should be covered – relatives state that bedrooms are now "like a prison;" comment of staff member; no support for family re discharge planning; the length of the safeguarding

26. These numbers illuminate:
    (i) the limitations of safeguarding referral data insofar as there is no backstory including reference to the links between combinations of patients/staffing/ward/hospital attributes and people's behaviour. The fact that a single patient may be associated with many incidents underlines the necessity of asking questions about context and data
    (ii) and the fact that patients at this Hospital share a common plight – the likelihood of being harmed by their peers.
27. The Review Team was informed that the high numbers of referrals to the PSNI (including those arising from peer to peer assaults) led to the Daily Mail describing the Hospital as the most violent location in the UK.

FINDINGS

"I'd rather be out and about in a place in the community" (RQIA, Donegore 2015).

The following sections begin with quotations from RQIA reports. The free-standing quotations were gathered during interviews and meetings. They are mostly unattributed.

(a) Adult safeguarding incidents in PICU and Six Mile

Cranfield can be a stressful environment to work in…many of the restrictive practices in use were not documented…and were not under regular review…completed restriction checklists were not available (Cranfield 2013);

11 patients had completed inpatient treatment and were waiting to move out…detrimental to individuals no longer requiring treatment…a step-down facility would allow patients to move out of ward to smaller, more home like environments (Six Mile 2013);

the rationale or therapeutic aim was not clearly documented…did not always justify the level of restrictive intervention (Cranfield 2013);

no bus runs or annual patient holiday…" they stopped the gardening programme without telling us" (Six Mile 2017).

We had no concerns until the CCTV came to light. It was disappointing that it was nine days before it was reported.

investigation process; delayed discharge; premature discharge; no [playground] swing for patient; the care at PICU; [historical] verbal threat by staff member; unsafe grouping of patients; failure to provide appropriate care and treatment x 7; information shared with relative without the permission of patient; relative not informed of an accident; patient left too long in wheelchair, clean laundry mixed with dirty laundry, low temperature in patient's bedroom; high temperature of ward; capacity to manage money; alleged abuse at the Hospital; poor communication with family re assault endured by relative; poor condition of bedroom; staff shortages x 2, inattention to a patient potentially eating cigarettes, the possibility of absconding; outcome of an abuse investigation not known to family/diagnosis sought; detention following a period as a voluntary patient; medication left out; different practice re administering medication at home and at the Hospital; patient made to clean faeces from a toilet; patient refused another consultant; patient's weight loss and eating habits

28. Between April 2012 and September 2017, there were:
    - 22 allegations of physical abuse (one of which also alleged psychological abuse) concerning staff working on **Cranfield**. Eight of these allegations were referred to the police. Two allegations concerned psychological abuse and one concerned sexual abuse. Eleven allegations were *screened out,* three were *closed* and the outcomes of others included, *SVA meeting…historical…happened during Physical Intervention… witnesses say did not happen…later retracted…unsubstantiated…protection plan put in place* for example;
    - four allegations of physical abuse concerning staff working on **Six Mile**, and one concerning psychological abuse. Three of the physical abuse allegations were referred to the police. The outcomes included, *closed… injured during Physical Intervention… screened out…investigated and closed…witness said it did not happen.*
29. The Review Team takes the view that individual patient files about safeguarding events implicating staff are a valuable paper-trail. They provide information about the allegation and safeguarding activities and processes which cannot be observed. Potentially they provide a behind the scenes look at the work and decisions of safeguarding investigators within specific contexts. The files have been assembled solely for the purposes of the review. Collectively, they contain forms such as: Adult Safeguarding Designated Officer Records; Decision to Close Adult Protection Investigation; Pre-Interview Assessment; Procedures for the Protection of Vulnerable Adult from Abuse and Exploitation; Witness Statement; Closure/Transfer Summary; Minutes of Initial Case Conference; Protection Plan Report; and Adult Protection Clarification Discussion.
30. However, there is little consistency across the files. The photocopied forms contain very many incomplete pages, for example, a section on Human Rights is rarely completed. Some forms contain signatures without reference to the role/designation of the signatory. Many of the files contain forms with handwritten information, some of which are illegible. Thus, **it cannot be determined how closely Hospital safeguarding practice aligns with *Adult Safeguarding Operational Procedures*.**
31. Appendix 3 sets out the principal findings arising from the safeguarding files and highlights those arising from Cranfield and Six Mile wards.
32. **The Review Team was advised of the presence of staff who are related at the Hospital, including families who have worked there for generations**. Also, since *some staff are very comfortable in each other's presence…the likelihood of peer challenge is constrained// There's an awful lot of nepotism at Muckamore…it's not healthy// It might say "confidential", but you can guarantee that everyone knows everything in no time!* **This is a relevant backdrop since the primary loyalties of people who are related or in intimate relationships are unlikely to be to the patients. There was no reference to *conflict of interest declarations* in any file.**
33. RO14 [redacted]

RO14

34. RO14

RO14

[redacted]

RO14

35. Within a week of the CCTV evidence coming to light the process of suspending staff began and the Police Service of NI, the RQIA, the Chief Nursing Officer and the Department of Health were informed. Over the following weeks a team of social workers (not Hospital employees) scrutinised a sample of the CCTV evidence. At the request of the DH, the Hospital commissioned rotas of retired social workers and mental health workers to watch all the CCTV recordings (of over 5,000 hours) and cross reference events seen on screen with dates and times. The team of social workers cross referenced this information with individual patient care records, records of staff rotas and handovers, and other records to generate "historical" safeguarding referrals – albeit almost two years after the events occurred.
36. Although the Hospital promptly mobilised the Trust and senior DH officials, it was aware of the delay between the written recording of an incident and the response of a senior manager and informing the families whose relatives were placed on these wards. **So, from a position that appeared secure in terms of responding to allegations of harm to patients, senior Hospital managers were caught off guard.** The fact that no one had intervened to halt the harm and take charge was shattering. However, this time lag between the event and the response, as well as the inadequacy of the warning systems, are familiar to crises. The Hospital

might have discredited itself immediately by claiming that: "Everything is under control – it's business as usual". Relevant information was gathered very quickly.

37. All information had to be analysed with care and during this process the status of the recently installed CCTV was considered. The CCTV was contracted to go "live" during September 2017 and it is remarkable that senior Hospital managers appeared unaware that filming had commenced. The relatives of patients in the Psychiatric Intensive Care Unit are offended that events which came to light via the CCTV coverage were denied and even claimed to have been implausible. Such imprudent responses mean that new relations must be established with patients' families.
38. In addition to viewing specific events identified by rotas of viewers, the social work team scrutinised the associated records. For example, one patient had required hospital treatment having sustained fractures during physical restraint. The minutes associated with this "untoward event" stated that a series of physical interventions resulted from "behaviour influenced by the present environment" and concluded that the patient required a higher level of staff support and structure "to reduce the risk of boredom," that is, in the Hospital ward with the largest complement of staff. The minutes concluded "the staff involved in the process to be commended for collaboration and timely manner… [in which] witness statements etc. completed."
39. If these minutes were shared with the Hospital's executives and with the RQIA, it is disappointing that an intervention which resulted in operative treatment to re-set a fracture, was recorded as worthy of commending the staff involved and was not challenged. The physical interventions resulted in a patient's painful injury and yet there was no suggestion that the actions of the staff involved were so harmful that their practice of restraint required urgent attention. The way in which this mini-crisis was tackled and recorded by the Hospital conveys something of the corporate culture that governs communications.
40. Some records are missing. These include the records of staff who had been previously subject to disciplinary processes.
41. **The CCTV viewers have alerted the social work team to many examples of staff behaviour which resulted in the foreseeable suffering of patients**.[15]
42. The damage arising from such events lingers and will persist. However, the arrangements which gave rise to the damage are being faced. The responses of the Hospital and the Belfast Health and Social Care Trust were shaped by the *Protocol for Joint Investigation of Adult Safeguarding Cases* (2016), which *aims to provide a framework within which HSC Trusts, PSNI and RQIA can work in partnership to ensure adults at risk and in need of protection have equal access to the justice system when harm/abuse constitutes a potential crime* (para 1.2).
43. Necessarily the police investigation involved and continues to involve the scrutiny of the CCTV evidence and written records concerning events. It has required immersion into the circumscribed world of a learning disability hospital, for example whether the physical interventions seen on screen arose from accredited training. Additionally, the known distress-

[15] Examples have been removed for the purposes of the PSNI investigation

behaviour of some patients poses challenges for potential prosecution: it was *reported that it was a normal pattern for X to be distressed and challenging and then X would need…to vomit to aid his calming down. If this is normal behaviour it is difficult to claim that X suffered harm from being locked in room.*

44. In terms of patients' Protection Plans, these included staff suspension; reporting to the Nursing and Midwifery Council; reporting to the Trust's, *Nursing in Difficulty* – a means of tackling poor practice; being placed on restrictive duties; not being left in charge of a ward; weekly supervision; being supervised by a qualified member of staff when on duty; changing the times of monitoring visits during the night; "CCTV monitoring of 15 minutes per shift by senior nurses;" and ensuring that staff who were sleeping on duty were not on duty at the same time. Further, in the light of the inappropriate use of a "weighted blanket"[16] these have been removed from general use at the Hospital.
45. The files reveal the impact of the emergence of revelations and the decisions of the Public Prosecution Service on patients' families. One overwhelmed relative requested that information should be directed at a sibling on learning that what had happened to their relative did not meet the threshold for prosecution. Another family wondered if their non-verbal relative had "tried to tell" them about possible physical hurt by rubbing their arm or leg during visits. Discussing this with staff at the time, speculating that he might have been hurt, resulted in responses such as, "I don't think so. I wasn't on duty."
46. The social work team have negotiated with these families their favoured way of hearing about the events revealed by the CCTV. They are noted to be relieved that the staff associated with harmful practices are no longer working with their relatives. They are feeling disgusted, disbelieving, disappointed and angry – as well as guilty that they had imagined that their relatives would be safe at the Hospital. One family noted that, *I knew RQIA was rubbish, but I still had to use the procedure…I have been told every reason why what happened* [to my relative] *couldn't be true…once they realise that we are stirring the pot they get their act together…It's clear it's not a one off. There was a culture.*
47. The Review Team endorses the view about culture. **There was indeed a culture - a tolerated set of norms or work practices - which were harmful and disproportionate. It was shaped by the use of power, relationships and place in which the wards were "closed;" visitors – relatives as well as professionals - were advised whether or not they could visit due to "unsettled" patients; individual staff members were comfortable working with certain staff; and "cut and paste" records concerning the use of seclusion, for example, were not challenged.**
48. The fine-grain viewing, reading and analysis of the social work team has contributed to the Hospital's response. That is, as far as the police permit, information being shared with the relatives of patients who are known to have been harmed – and more generally a process of checking with 27 families[17] of patients who were placed in PICU and Six Mile Wards between March 2017 and January 2018. They were asked about their past and current *concerns about*

[16] Which should provide gentle, deep pressure touch
[17] At the time of writing

the standard of care, and how these *were addressed;* their experience of the ways in which staff have *spoken to or treated* their relatives; whether or not their relatives are *treated with dignity and respect;* the individuals to whom they would address their *worries…about anything in Muckamore;* what might *improve the quality and standard of care* at the Hospital; and the availability of staff to discuss their relative's care.

49. **The fact finding illustrates the juxtaposition of neglectful, harmful, disrespectful and valued practice**. For example, families want it to be known that there are some Hospital staff who conscientiously provide compassionate care and treatment: *kept my son alive// grade 3 staff go the full hog to meet needs// staff are fantastic.* Events were recalled that suggest critical pressure points for the Hospital, e.g. *lack of exercise and activity// relative putting on too much weight// clothing/money going missing// not protected from others// staffing shortages…busyness, long shifts* and the use of bank staff// *RQIA not fulfilling role// slow to attend to patients' physical health needs* and adverse *incidents//* a patient's *physical assault by staff had resulted in two court cases// the Ward Manager did not return calls// abuse between patients not taken seriously// quality would only be improved by closure// better planning for discharge.*
50. Fact finding with 18 of the 42 patients placed in PICU and Six Mile for the relevant period (21 from Belfast HSCT, nine from Northern HSCT, ten from South Eastern HSCT and two from Southern HSCT) hinged on their experience of being at the Hospital, the staff, the activities available, whether they felt safe and how the Hospital might be improved. It was noted that although some patients found it difficult to understand the questions, two people expressed frustration at being unable to leave and six were unhappy about the behaviour of other patients/unsafe grouping of patients, the majority were uncritical of the Hospital. Activities were valued when they were available, and one person acknowledged the help he had received to prevent self-harming.
51. Other assurance activities include maintaining patients' protection plans; sustaining links with patients' families; staggering the night-time monitoring visits to wards; recruiting two out-of-hours supervisors; increasing the availability of behavioural support nurses; enhancing the monitoring of the wards with unannounced visits; recording the start and end time of staffs' night-time breaks; increasing senior management oversight of wards; reviewing the staff who were suspended or subject to restrictive practice each month; offering these staff the support of Occupational Therapy and Psychology services; installing CCTV in all other wards; safeguarding training for staff and patients; monthly Assurance Meetings involving the Trust, the PSNI and Human Resources; hosting Memorandum of Understanding meetings for the Trusts, the PSNI, the RQIA, the Board and the Department of Health; releasing a media statement by the Trust, the Board and the PSNI; and, most recently, responding to the leakage to the media concerning the content of the CCTV.[18]
52. The CCTV has given the Hospital a decisive edge. Visual evidence of assaults endured by patients who cannot describe what has happened was an impetus for the crisis management

[18] https://www.bbc.co.uk/news/uk-northern-ireland-44984924 (accessed 29 July 2018)

response. Senior Hospital managers took charge and the families of patients had person to person contact with Hospital staff. Moreover, the patients required information, assistance and respect. Viewing the extensive CCTV evidence has resulted in decisions concerning staff suspensions, questions concerning the adequacy of internal and external scrutiny and renewed consideration of options for the Hospital's future.

53. **Inherent in crises is the task of looking for information. The social work team has highlighted, *inter alia,* that patients were not the priority of certain staff members; that the focus of the Psychiatric Intensive Care Unit was lost; that "most events" occurred during weekends and "never" on Tuesdays when audit visits and similar activities took place; that signatures were omitted from certain records; the power of certain unregistered practitioners; and that critical documents and records have been "lost." Although the viewing has also highlighted examples of sensitive and compassionate exchanges with patients, the durability and legitimacy of these are regrettably lost in the urgency of the harms endured**.
54. Such relevant information has emerged gradually. What Hospital managers have sought to understand are the overall dynamics that so quickly socialise staff into deprioritising the treatment, safety and comfort of patients. The recent challenge facing the Hospital because of the information leakage includes the fact that although it has taken charge, unknowns remain, that is, from the as yet unseen CCTV evidence. However, to date it has demonstrated openness and a desire to assist in securing criminal justice results at such a difficult time. Importantly, its specific actions are complemented with attention to the long term and necessarily this requires engagement with the external agencies. Muckamore Abbey is a regional Hospital and regional solutions are required to address the fact that "the majority of admissions are after hours" and it is just too easy to admit and re-admit patients.

(b) Adult safeguarding and investigations since 2012

Significant number of vulnerable adult referrals (Ennis 2012);
increased number of incidents…not disproportionate (Killead 2016);
no evidence that capacity to consent to care and treatment was being monitored regularly (Cranfield 2014).

55. Between April 2012 and September 2017, the Hospital recorded 128 allegations concerning staff working on PICU, Six Mile, Killead, Ennis, Oldstone, Greenan, Cranfield, Mallow, Donegore, Moylena and Erne. Over 92 of these allegations concerned "physical abuse," and 102 (80%) concerned physical abuse combined with "institutional abuse, psychological abuse, verbal abuse, verbal and psychological/emotional abuse." **Thus, the most typical type of allegation concerning staff is physical abuse.**
56. **The language used by practitioners reflects that of the policy and procedures. However, language explains, and obscures and "concerns" are non-specific and barely capture the harms endured by some patients**. "Complaints" also feature in the safeguarding vocabulary

and this features in the Referral/Screening Information template, that is, *the victim has capacity to make an informed decision and does not want to make a complaint to PSNI/or the victim does not have sufficient capacity and the next of kin does not wish to make a complaint on their behalf.* Potentially this conflates the complaints and the safeguarding processes (see footnote 14). The Review Team questions how a complaint concerning safeguarding differs from one in relation to the quality of patient care and treatment.

57. **The Review Team was told that, *there is no monitoring of seclusion and, regardless of the policy, it seems to be the first option. We have scenarios of people who are not detained, who have capacity, who are being secluded – and there is no form of appeal…The seclusion room is not fit for purpose. It contains a chair…*** What information was provided to the architects concerning a "seclusion room with lobby?"
58. Hospital data for 2015 records 21 patients subject to 859 seclusion episodes with three people accounting for almost 90% of these. One patient was subject to seclusion on 78 occasions in a single month. During 2016, 20 patients were subjected to 575 episodes of seclusion, with two patients accounting for 55% of these – that is, two of the three people who were the most frequently secluded during 2015. During 2017, 15 patients were subjected to 616 episodes of seclusion with the same two people highlighted in 2015 and 2016 accounting for 75% of all frequent seclusions. One of these people was subject to 75 seclusions in a single month.
59. The Belfast Health and Social Care Trust's policy says, "Use of interventions are not seen as a long-term solution in the management of service user behaviour…" It is not clear why the practice persists for two people since their intensive use of seclusion over a three - year timeframe appears wholly disproportionate. The Team questions the prevailing assumptions concerning the use of seclusion. Was its use always a "last resort" and/or an unequivocal emergency? Current scrutiny of practice would suggest that the use of seclusion was not benign in all circumstances. The 20-minute viewing of CCTV evidence prompts the Team to question the adequacy of furnishing in the seclusion room and the physical comfort of patients placed there. How was the room designed to minimise injury? For example, is there protruding beading around the doors and windows?
60. Appendix 3 confirms that the allegations of assault comprise the lion's share[19] of safeguarding referrals. The allegations include hair-pulling, being pushed, thrown, nipped, scratched, dragged and bruised. However, the contexts and *factors precipitating referral,*[20] are generally suggested, e.g. *very unwell at present.*
61. **The statement, "Has a history of making allegations" features in almost a third of the safeguarding files**. Such an assertion risks compromising scrutiny of events since it potentially sacrifices people's credibility at the outset. Just over a third of the files highlight the implications of the allegations for staff, that is, they are most typically removed from the ward/working with the patient who made the allegation. As one file noted, "Has history of making allegations which is why two staff are always present." However, a relative has also

[19] The Review Team is cautious in providing specific numbers since the files do not permit specificity
[20] Required in the Referral/Screening information: Regional Adult Protection Procedures

countered, “makes allegations in frustration.” Is it not possible that some patients have memories of previous events at unknown times which are resistant to forgetting and about which, no one took them seriously?

62. Layer onto the patients’ allegations considerations of the mental capacity status of the patients and inconsistencies begin to emerge. **Around a half of the files referred to patients’ mental capacity, however, it is not consistently clear how decisions concerning capacity have been facilitated or what they relate to** - as the following quotations reveal:

    Mental capacity regarding…? *has capacity//did not have capacity// deemed incapable…would have limited capacity// does not have capacity// patient not capable…does not take responsibility for actions nor does patient have capacity to consent// lacks capacity// has capacity in relation to some issues.*

63. Mental capacity is decision-specific and concerns the ability to decide about a matter at the time that the decision needs to be made. To adopt an “all or nothing” approach to mental capacity is unwise. It is unacceptable to assume dominion over another person without the facility for this to be questioned.

    Mental capacity re referral/interview/adult safeguarding: *not fit for interview// does not have capacity to engage in interview// does not have the capacity to be interviewed in respect of this matter// lacked capacity when interviewed// does not have capacity to consent to safeguarding process// deemed not to have consent at [resent to engage in the adult safeguarding process// would not have the capacity to make a complaint under the vulnerable adult process// does not have sufficient capacity re adult safeguarding processes…does not have capacity to consent to safeguarding processes// lacks capacity/ understanding to engage in vulnerable adult process// mental state poor – interview won’t be appropriate at this time…advice sought re X’s capacity to engage in safeguarding process…was deemed to have capacity but did not fully understand the process, including the court process// would lack the capacity to understand the purpose of the measures in place and the safeguarding process// does not have capacity to manage money…does not have sufficient capacity to make Achieving Best Evidence statement.*

64. Do patients routinely receive independent help and support with understanding issues and putting forward their views, feelings and ideas? There are no documented occasions when patients have been offered enough information to make specific decisions. In fact, **there is an example of a patient being denied the opportunity to attend “Keeping Yourself Safe” training. Since this is arguably one means of assisting patients to understand abuse and the ways it may be prevented, it appears unreasonable**.

    Contingent on clinicians’ decision-making: *will be given the opportunity to engage in adult safeguarding if deemed by the psychiatrist to do so// unable to engage in vulnerable adult process due to deterioration in mental state…capacity and understanding is dependent on patient’s mental state// with patient’s limited understanding it is very unlikely that Dr will think patient has capacity to engage in the investigation process//*

due to the extreme detrimental effect this would have…does not have the capacity to be interviewed.

65. **Even though the Mental Capacity (Northern Ireland) Act (2016) remains to be fully implemented, it appears extraordinary that clinicians are determining whether there should be a safeguarding investigation**.
66. **A great deal is expected of patients making allegations, most particularly if they anchor an event to a time or date, for example, it was noted of one patient that he was "an unreliable historian." Their specificity is taken at face value, for example, one file noted that an event could not have occurred because the member of staff was "not on duty on the night in question." Is it not possible that some patients with learning disabilities have a limited understanding of dates, days of the week and the passage of time?**
67. There is an example of a patient stating that a peer's allegation was untrue because they were together, and the alleged event did not happen. Similarly, staff members who witness or a party to an event that becomes the focus of an allegation are instrumental in either escalating what has been witnessed to a senior manager and/or contributing to the determination of whether a patient was harmed by providing an account of events. There are trauma-specific memories which carry influence over time. Although the corroboration of others is consistently helpful, there must be some consideration of the possibility that *something* has happened, perhaps in a context like that of the allegation.
68. Delays in investigating an allegation may result from the Hospital's protocol, that is, "As per the Hospital protocol, where safeguarding concerns are raised regarding a staff member and the patient is not a Belfast Trust patient, these are referred out to the relevant community team."
69. **Patients' families appear to have a critical role in converting an allegation into a safeguarding investigation** as the following quotations reveal:

    Father happy with the management plan of allegations…satisfied that no assault occurred// mother does not wish to take further action// mother does not wish to take it any further…does not wish to make a complaint to PSNI on X's behalf// parents have not been informed due to …unacceptance of "allegations"// mother does not wish to make a complaint// family do not feel there are grounds to progress a police investigation// mother did not feel it was a big issue// relative wants it investigated// NOK aware of circumstances and not raising concern// family *do not wish police involvement//* relative *rang PSNI very anxious and influenced by recent media attention…was reassured about X's care…does not wish to have the matter investigated by the police// relative stated "this is X's usual avoidance behaviour"//* family *was satisfied that no abuse occurred.*
70. It appears that **although families are likely to be informed of their relative's allegations or the harm experienced by their relatives**. However, **such communication is vulnerable to being construed as seeking permission to undertake a safeguarding investigation**.
71. Three files refer to thresholds, that is, *did not meet the threshold of a safeguarding investigation given sufficient evidence that this did not occur// referral does not meet the*

threshold of an adult in need of protection and can be screened out// This does not meet the threshold of serious harm under new policy.

72. **The terms "screened out" and "rejected," are stark and yet commonplace in the files**. It is not clear that they were succeeded by risk assessments of individuals and/or specific wards. For example, one patient made 18 allegations when he was on Erne.
73. **Three files refer to whether an allegation is "RQIA notifiable" and it is not possible to discern from these files what would constitute a notifiable incident**.
74. The Police did challenge the requirement of an earlier safeguarding protocol which was stringently applied. *It stated that unwanted physical contact or unwanted touch amounted to an assault. Belfast Trust refused to amend it, even though it resulted in the Hospital's postcode becoming the most violent place in Northern Ireland*. Good professional relationships were developed between the Hospital and the PSNI with the latter becoming familiar with the "the regulars" during Tuesday and Thursday clinics. With notable exceptions, a lot of the work was "a paper exercise." **Over a third of the files referred to the Police**:
75. With reference to Hospital practices, *incidents of weighted blanket and lack of observations in seclusion are not being progressed by the police// unmonitored* [in seclusion] *but door not locked so police do not believe this matter falls within any criminal remit// this incident meets the criterion for not reporting to PSNI// not a reasonable suspicion that a crime has been committed// incident does not meet the threshold for police intervention// even if X doesn't have capacity they will still take a statement// allegation has changed a number of times.*
76. The patients appeared to have been offered the option of police involvement, that is, *doesn't want police// has not requested the need for police involvement or any further investigation.*
77. On more familiar police territory, *police to interview staff…does not meet the threshold for PSNI involvement// police investigated an allegation* [of rape] *…she retracted*[21] *the allegation during the interview.* **Although there is some documented evidence of seeking to evaluate a patient's ability to testify and encourage truth-telling the extent to which the practice is routine cannot be ascertained from the files**.
78. **Some patients' families were instrumental in determining police involvement**, *patient's mother does not wish to make a complaint to PSNI on her behalf…not a reportable offence// family do not feel there are grounds to progress a police investigation.*
79. **The PSNI regarded the evidence of new staff and/or staff who were shadowing Hospital staff prior to patients' moving out as particularly compelling. They were new to a ward's custom and practice and spoke up**. **However, without exception they were ostracised and *had no support from management in the process*.** The absence of support is a signature of the isolation that is part of the territory of making allegations against colleagues. The personal costs are known to have been great even though the allegations may prevent the unchallenged continuity of previously unknown behaviour; give others strength to challenge; and it may yield self-respect and peace of mind.

[21] The circumstances resulting in either retractions and/or apologies are not documented in the files

80. Overall, **the files do not reveal how the Hospital dovetailed adult safeguarding procedures, inspections, professional regulation, police investigations, complaints, clinical governance and internal disciplinary processes**.

(c) Adult safeguarding protection plans

> *Staff informed inspectors that X had capacity to make the decision to inform his mother while his mother believed he did not…family excluded from protection planning process* (Six Mile 2012);
>
> *no clear protection plans were evident…staff unaware of where individual protection plans are stored* (Ennis 2013).

81. The Review Team was advised that MDTs "review the clinical aspects" of safeguarding events, contribute to the protection plans and provide managerial oversight.
82. There was no single document across all files which was labelled a Protection Plan. Discussions confirmed that increased staffing levels, "2:1" and variations on "enhanced monitoring" were the typical responses to safeguarding allegations.
83. It was stated in one file that *this is not a Protection Plan…but a decision of the ward manager for the protection of staff.* (Appendix 4 reflects on the workforce implications of this).

(d) Advocacy arrangements

> His *advocacy is provided by Mindwise who are resistive to coming on the ward…not in their contractual arrangements* (Six Mile 2012);
>
> *Inspectors concluded not sufficient practice presence of advocacy on ward* (Ennis 2012); *attendance at patient forums sporadic and advocate not present…inequity of access to advocacy for patients from Western Trust* (Cranfield 2012);
>
> *clear evidence that psychiatry and MDT had been advocating for discharge of a patient* (Cranfield 2013);
>
> *Advocates occasionally attend meetings on the ward but do not routinely visit or spend time with children being assessed and treated* (Iveagh 2012);[22]
>
> *physical environment not conducive to people's needs, particularly concerning noise levels* (Killead 2014);
>
> *advocates only available to see those subject to a care order* (Iveagh 2017);
>
> *Patient Forum meetings had begun* (Cranfield 2015).

84. The Review Team was advised that *Funding issues impact on the availability of advocacy. There is a carers' advocate to support families. However, advocacy is not well developed and*

[22] Although the children and young people's service is not within the remit of the Terms of reference its inspection reports are pertinent to this review since they reference identical themes to those of the Hospital: its purpose; advocacy; pressures re admission; staff numbers and skill mix; repeated RQIA recommendations; preventing admissions; the necessity of senior management oversight; the reduction of incidents; and young people's under-occupation

there aren't many hours available. It was inspiring to meet a member of the *Tell It Like It Is* [TILII] group state:

> *I tell people that it's not ok to be hurt…it's not ok if people say things. You've got to keep yourself safe – it's really important for when you go back to the community. I make sure to tell people that it's not ok to be hurt.*

85. It was noteworthy that **advocacy is typically absent from considerations of safeguarding**. Given the significance of this agenda and the fact that the Hospital is a high-risk setting, the Review team envisaged a much more proactive role for advocacy. For example, contact with people's families confirmed their anxiety about patients who do not have relatives advocating on their behalf. The RQIA reports, which comment on advocacy, would suggest that the practice of advocating on behalf of patients has been compromised by not meeting/spending time with patients.
86. Scrutiny of complaints made to the Hospital (see footnote 14) indicates that families have a lead role in advocating for their relatives. Complaints are less likely to originate from self-advocates and even less likely to originate from "advocates," Members of the Legislative Assembly, solicitors or the Northern Ireland Law Centre.
87. The Team was advised that the current advocacy input from Mencap and Bryson Care amounts to 25 and 30 hours a week respectively. Their reflections on the circumstances of Hospital patients are apposite:

> *People are caught here – it's not meant to be their home. It's what the staff can do. Patients come in at a low period – it grieves their families – and then they get stuck. It's sad because then they spend years of their lives in here. There aren't the places in the community and the Hospital is left now with the more challenging people…Staffing levels…there's a lack of 1:1 to go out and do activities. The patients are bored a lot of time on the wards… We're involved with MDT meetings right from the start. There are concerns about staffing levels. It's the more able patients who can reflect on restrictive practices… It's difficult when they don't go out on trips and the staff get demoralised. When patients are in and out* (e.g. in Cranfield) *its unsettling for the long-term patients – some have been asked to give up their beds; some have been wrongly placed in the forensic unit and staff are not able to address this. I went to the top about the patient who had to give up a bed and spend the day on a different ward.*
>
> *Attrition levels in the community are sky high. Staff are paid minimum wages and they realise it's not worth the money. Patients return and it's generally due to untrained staff. Beds are kept for three months after discharge; they have to be readmitted for MH because staff in the community can't manage their behaviours, the situations escalate, and the police are called.*
>
> *The Hospital needs more staff and more 1:1 interventions for quality time; the patients need things to do, something worthwhile. We've been dealing with the smoking ban, raising this on behalf of the patients… The changes at the Hospital have been phenomenal in terms of how patients and advocacy is treated. We have access to the consultants.*

[Managers] *suggested that we went round the wards with them to see if we could see things that they are not seeing. Also, we've been asked to comment on two Hospital policies.*

88. It is axiomatic that public services should put centre-stage the experience of people who use them. An expanded version of advocacy is one that presents a fundamental challenge to services, that is, it brings to the foreground people's aspirations and it acknowledges the legitimacy of attempts by self-advocates and their families to positively influence the opportunities and services available. **The best advocacy is uncomfortably powerful because it engages with the immediate and pressing circumstances of an individual, most particularly an individual whose interests might otherwise be inadequately recognised and supported**. Such advocacy must connect outwards and upwards to arrangements for the provision of local services and outward and upwards again to the collective advocacy of the Trust.
89. **It is possible that the long association that advocacy services have had with the Hospital and the impact of protracted delayed discharges has blunted its core purpose**. The Review Team can see no alternative to advocacy activities which first and foremost promote and safeguard patients' Human Rights.

(e) Governance and Quality Assurance in learning disability services

Family *did not feel informed about his care…no documented record of the views in the meeting* (Six Mile 2012);

no specific explanation of monitoring role documented…the appropriate complement of staff for the ward remains unclear…will continue to monitor staffing levels closely, the recording of incidents, actions taken and adherence to clear governance protocols (Ennis 2012);

food quality poor…difficulties in accessing extra contractual referrals for specialist treatment (Cranfield 2012);

patient expressed frustration with the length of time it takes to be discharged (Cranfield 2013); *some relatives concerned about future care* (Greenan 2012);

*Little progress concerning privacy measures…people's experience could be perceived as degrading…disappointing…that patients were not experiencing care which would enhance their quality of life (*Moylena 2012);

one child's accommodation hinged on the leave arrangements of others (Iveagh 2012);

it should be a leading centre of excellence…was operating without the full range and availability of multi-disciplinary staff (Iveagh 2013);

care records were not formally audited (Erne 2014).

There's a journey to go to make sure that patients' voices are heard. "Your voice counts" has been crucial in listening to and learning from patients and their families – hearing first hand is better than any governance system. No system would have alerted us to what happened.

90. **The absence of *modern community-based services,* including home treatment, supported living and provider expertise, is unequivocally associated with crisis admissions and the sense of failure (i) for the patients, their relatives and staff and (ii) leadership in learning disability services – as one person noted, *we need more than politician's assertions*.**
91. One family described their bleak experience:

    When our brother was moved last year, it was on a "day trip" and a member of the Hospital staff went with him. She stayed overnight and the next day. He seemed happy and we emphasised that they could get in touch with us at any time – same with the hospital. But we slowly discovered that the staff were incapable of coping – they didn't listen to us about how they shouldn't put their heads down in front of him and yet they did – when we were there! He was there for five weeks and they never rang anyone for help. They had promised day care and swimming, but nothing was done. They gave him board games on the dining room table. Being at the table to him means having food. He attacked a member of staff and we were told on a Monday that a decision would be made by Wednesday. They must have decided that afternoon that he was going back to the Hospital because he went on the same day. With all the movement of staff at the Hospital he was with new staff he didn't know, and he became so bad we didn't think it could get better. At the placement he was stir crazy because they didn't know how to work with him and nothing was in place for him. He lay on the sofa for five weeks. It was a bungalow for six people, but one person stayed in his room for the whole of the time. He had been assessed by the people from the bungalow but the one time we visited we were told "he's wrecking our house!" Why are they not answerable? Why are they still registered to care for people with learning disability, challenging behaviour and autism?

    [The service] *talked about Person Centred Plans for everyone. We asked if they would cope if he developed dementia and they agreed that they would. Yet they couldn't be bothered to work with us as a family. Northern Trust had sent an extra member of staff to help. One day I arrived and there was no chat – the place was in chaos. The nurse was on the phone to the doctor and residents were locked in their rooms for safety. She was panicking…We want him to go out again but this time – with some honest engagement.*
92. Research[23] has identified **five components of effective governance**:
    i. **clarity of goals**, scope of activity and purposes, including shared principles, multi-agency commitment and strategic leadership
    ii. **structures**, including clear divisions of responsibility and mechanisms for communication, and explicit linking between functions or activity
    iii. **membership**, including a clear rationale for inclusion of agencies, understanding of roles, responsibilities and commitments, evidence of engagement and protocols for chairing, quoracy, resource contributions and business management

[23] Braye, S., Orr, D. and Preston-Shoot, M. (2012) The governance of adult safeguarding: the findings from research *The Journal of Adult Protection* 14 (2), 55-72

iv. **functions**, including strategic planning and operational oversight, appreciation of the difference between governance and executive management, and a strong developmental and improvement agenda which embraces audit, performance management and quality assurance

v. **accountability**, including standards for and assessment of committee performance, clarity about decision-making authority and reporting channels and explicit links to other partnerships.

93. **Thus, governance requires more than place hunting to move people out of the Hospital**. It is about recognising the aspirations of so many families for ordinary lives with individualised support; stimulating and shaping the contributions of all agencies to set out a vision of the opportunities and support which should be available to people with learning disabilities and their families over the life course. Irrespective of Bamford and the very considerable efforts to reduce the Hospital's population, **it appears likely that most families have seen little change.**

94. This Review confirms the significance of:
    - focusing on people's lives and those of their families and embracing a partnership model in which all are active participants
    - designing supports which enhance people's sense of achievement, belonging, continuity, purpose, security and significance
    - having clarity of purpose with clear criteria for Hospital admission, that is, no re-admissions arising from "breakdowns" for example; commissioner led "care and treatment reviews" concerning potential admissions
    - training for service development for all staff to facilitate the transition from segregated provision to mainstream opportunities. At the Hospital this will involve Continuing Professional Development, clinical supervision, and support for ward staff for example. In the community, this will involve "out of hours" support, enhanced roles for community teams, risk registers identifying people whose support is becoming fragile
    - redefining agency responsibilities and moving away from "specialist" to mainstream services, that is, commissioning for in-patient *and* community services.

(f) The implementation of recommendations arising from safeguarding investigations and RQIA inspections[24]

Recommendations during inspection of 2010 were assessed, some were restated (Greenan 2012);

Concerns highlighted in previous inspection had not been fully addressed (Moylena 2012);

several recommendations remained outstanding from the previous inspection (Iveagh 2012);

there were a total of 34 recommendations made following the last inspection (Cranfield 2015).

[24] See Appendix 6

95. The Review Team understands that the RQIA has an inspection process for individual wards. There was no evidence of an overarching view of the Hospital. **A hospital is more than the sum of its wards. Patients have left, wards have closed, and the Hospital has demonstrated its resilience. The Hospital's interconnections are less visible, for example, the criteria for admission and discharge, the budgets, the gossip and the functions and purpose**. The 61 RQIA inspection reports concerning Hospital wards were found to contain a lot of recommendations – the initial five which were skimmed contained 18, 26, 23, 6 and 44 recommendations. The Review Team noted that two reports stated: *concerns highlighted in previous inspection had not been fully addressed…several recommendations remained outstanding from the previous inspection.* Three other reports noted the *marked absence of an agreed, consistent, proactive behavioural management strategy…physical environment not conducive to the patients' needs, particularly concerning noise levels…*the importance of *developing and implementing a system of governance to ensure that incidents that result in the use of physical intervention, seclusion or PRN administration are comprehensively reviewed.* Such observations have consequences for the ways in which inspectors organise their work, manage their discretion and report on performance. The principal topics on which the Review Team focused were:
    - patient experience
    - safeguarding practice and
    - recording at the Hospital.
96. These topics are evidenced in the RQIA reports, to which were added the additional themes of:
    - institutional practices
    - the workforce
    - multi-disciplinary working
    - the purpose of the Hospital
    - restrictive practices.
97. A Briefing Paper (see Appendix 5) outlining these themes was circulated to the commissioning managers (Appendix 6 is the response of the RQIA to the Review Team's paper). The documented observations of inspectors are reflected in the Review Team's findings.
98. An RQIA overview report of February 2013 noted,

    …the identification of safeguarding issues includes the concerns and complaints received from patients, relatives and staff. Information of this nature can highlight issues or cases of abuse never previously identified or reported. When patients, relatives or staff have a concern or complaint they should have access to the organisation's complaints procedure (p.19).[25]
99. **The interface between complaints and safeguarding is unclear**.

[25] RQIA (2014) *Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland – Overview Report*

(g) Leadership

Seeking alternative solutions to admission…more robust home treatment or crisis response solutions…to prevent children…being admitted on a crisis and emergency basis (Iveagh 2012);

unclear about the role of the unit (Oldstone, 2013);

urged to give urgent priority to establishing a more robust, tiered model of intervention in the community to ensure Iveagh beds are used appropriately…need to consider a step up/ down unit to enable young people to receive alternative supports…some misunderstanding/ differences concerning the purpose of the centre was evident (RQIA, Iveagh 2013);

police attended and used leg restraints and handcuffs (Iveagh 2014);

staff…highlighted that continued support and oversight…from senior management team

would be key to continued improvement within the service (Iveagh 2014);

lack of managerial and clinical input (Donegore 2016);

re allegation of *unsafe staffing level…substantiated, however, levels had improved due to a reduction in staff absence and re-deployment* (Cranfield 2017).

100. The Review Team accepts that leadership is distributed across individuals, including those who have experience of safeguarding and their relatives. The Team was advised that the Hospital has recently endorsed *collective leadership* and that although, *the psychiatrists are supposed to provide clinical leadership…historically it's not happened.*
101. **The circumstances of patients with learning disabilities require a network of leaders inside and outside the Hospital. Managers who are working independently of each other, seeking to address problems that interact with the problems of other managers, need more than the promise of the full implementation of the Bamford Review** – now 14 years old.
102. **Any coalition for progress must begin with individual experiences**. These must exercise tangible influence over decisions about setting priorities, sharing leadership, exploring new planning and delivery arrangements, using resources, working with and through other agencies, learning from cycles of diagnosis, development and review, and demonstrating that the impact of all decisions on people with learning disabilities is intrinsic to identifying the skills, people, organisation and systems changes required.

(h) Good practice

103. The Hospital has made real progress in relocating hundreds of patients since the 1980s and 1990s. The Hospital and community services have demonstrated that they are well placed to contribute to the next larger scale cycle of change.
104. There is a strong sense of the importance of being proactive. *Strategically we need to work with these families* [when the children are at] *pre-school – not the point at which their families are burned out e.g. 24 LD nurses have trained as health visitors and the feedback from families*

is really positive. This observation is as compelling as the evidence which supports it. **Families with infants with learning disabilities and other developmental challenges vary as much as all families. However, over time some families experience difficulties and restrictions in activities and relationships, most particularly where high levels of behaviour challenges emerge. The most valued services meet children's and families' needs and are positive about the immediate future. They involve parents and they liaise with all other services. No families with relatives at the Hospital described such attentive early intervention**.

105. One staff team has provided necessary support to a patient who alleged being harmed during a visit home and who becomes distressed at the prospect of subsequent visits.
106. Killead explicitly recognises the importance of engaging in interesting and enjoyable activities. This women's admission ward draws attention to the pleasures of being able to choose what to do. They are assisted by staff who understand the importance of providing the kinds of opportunities and routines which are valued by all of us.
107. The initiative of a ward manager to document an approach characterised by conflict resolution merits particular attention. It could have invoked a safeguarding investigation, yet the approach adopted acknowledged and documented the felt and expressed harm. The relations of power at the Hospital are complex and subtle. The ward manager sought to explore a solution which changed the relationships of the two men concerned. The Review Team commends this approach because the resolution of conflict hinges on the art of facilitating an appropriate process for those in dispute to problem-solve together and, through the process, to reconstruct their relationship.

(i) Other relevant matters

108. With reference to patients' **health status**:

> *patients had been unsettled…many with UTI…had condition which caused regular bleeding* (Ennis 2012);
>
> *screening patients for physical healthcare needs was an issue* (Cranfield, 2014);
> *an overarching clinical summary of each patient's psychological and medical condition was not available* (Erne 2014);
> re *people's access to physical healthcare screening…no progress* (Cranfield 2016).
>
> Inquest of Hospital patient, November 2014: *death due to choking on food.*
>
> Inquest of Hospital patient, October 2017 who died in 2015: *due to a history of swallowing difficulties X was considered to be at risk of aspiration…a member of staff was in arm's reach when X was in the dining room…a post mortem examination…revealed the presence of a metal teaspoon in the small intestines.*
>
> *We have rubbish data – nothing useful to enable projections or effective decisions.*

109. The Review was advised of a lack of general medical services at the Hospital *We need GPs alongside the MDT.* **People with learning disabilities are disadvantaged in terms of their**

health status compared with the general population - they have greater mortality, more significant health conditions, and they experience poor standards of health care. It is this inequality which justifies a focus on research evidence concerning what is known about the special care and attention owed to infants and children who have extensive medical and health support needs and for whom the quality of their lives is an immediate and urgent challenge (see Appendix 7). It is critically important that all services demonstrate their readiness to plan for the treatment and care of these emergent generations and monitor on a continuing basis how they and their families are faring.

110. **Opportunities to engage in interesting and enjoyable activities**:

> *weekends long with few activities* (Cranfield 2012;
>
> *some patients only getting up at 11.30…outings off ward limited* (Greenan 2012);
>
> *evidence of some people experiencing restrictions due to the needs of their peers…patients spending majority of time in group rooms…no choice…no evidence of the provision of activities* (Moylena 2012);
>
> *no ward-based schedule for therapeutic activities* (Cranfield 2013);
>
> *would like more activities to take part in, especially in the evenings* (Iveagh 2016);
>
> *there are not a lot of activities at nights* (Cranfield 2017);
>
> *people who do not attend day care complain of boredom* (Cranfield 2015).

116. The Review Team was informed that inactivity within the Hospital remains to be addressed because *Patients are bored! There is a lack of stimulation and that's part of the picture. There's a lot of sitting about with no staff interaction; there is a lack of line managers on* the *wards.* Patients' inactivity has safeguarding implications: *there was seven-day a week day service – the majority of safeguarding incidents happen at w/ends/ Out of Hours when there are more patients about* with nothing to do.

117. **CCTV** – a patient noted that, *With the issue in the hospital we don't know about it. We were happy we were safe so now it's a good thing that they have cameras that they're being watched so the patients can know it is safe. The cameras are good.* However, some staff suggested that, *there's a fear among staff and they leave. They're rushed and they're fearful that they might lose their PIN. Yes, we wanted the CCTV, but we're worried about how we can be perceived. Staff are fearful – it's palpable. The job is changing because of the CCTV and the investigations.*

CONCLUSIONS

I say to patients, "You will get better – but not in this environment!" The single most effective therapeutic act of an Assessment and Treatment service is to discharge patients. It results in a majority of behaviours disappearing. The tasks of Assessment and Treatment do not require repeating and should occupy no more than six months, after which I explain, "This is it. This is as good as X is going to be. If X is not discharged she will deteriorate" Dr Ashok Roy.

"Being here has helped me a lot but I'm fed up waiting on a place in the community" (Cranfield 2017).

We need a change of culture from a residential campus to a hospital ethos.

On women's admission we have a lot of readmissions. The women feel safe and secure here and a lot of the readmissions would be social e.g. the breakdown of a relationship. They maybe short – a day or two. Then there are those who don't feel they can go back to the community.

118. **The Hospital's compromised progress in resettling long stay patients and in addressing the acute need arising from mental health delayed discharges impact on safeguarding and are compromising the capacity of the Hospital to provide Assessment and Treatment. Safeguarding must be seen in this context and against this backdrop**.
119. **The Hospital should only be used for rapid and short-term admissions since such admissions result in better outcomes. An Assessment and Treatment service is not a respite service. Historical reliance on the Hospital by some Trusts means that it is the self-perpetuating default placement for ex-Hospital placements, irrespective of their prior Assessment and Treatment**. The Hospital, its commissioners and community services have learned that when former patients are not offered support to sustain important relationships, to have better physical and mental health, and fuller, richer lives, their behaviour deteriorates, and they become homeless.
120. The families of current and former patients are alarmed at (i) the failure to honour the promise of *betterment* for former Hospital patients, most particularly in relation to those without families to advocate on their behalf, and (ii) the power of current community services to exclude former Hospital patients, abdicate responsibility for the impacts of their decision and return them to the Hospital.
121. **It is possible that repeated exposure to chronic and low-level allegations, to outbursts of distressed behaviour, and to violence directed at peers and staff are perceived as "normal" at the Hospital. It is possible also that a superseded policy requiring the involvement of the PSNI has skewed understanding of what proportionate responses to allegations arising from the Hospital should look like. However, since the copious paperwork associated with investigations and inspections did not uncover the abuses captured on CCTV, development beyond the procedural rigidity of the safeguarding and inspection processes is warranted**.
122. **New Hospital staff and visiting staff who were unfettered by loyalty to the Hospital employees had high expectations of their colleagues' behaviours and were perceived by the**

police to be valuable witnesses. Although their allegations had the potential to begin to shape a different kind of work culture, it could neither stop individuals against whom allegations were made from taking long term sick leave and/or resigning nor could these newly vulnerable staff insist on the support of senior management. The safeguarding and PSNI task were most challenging when there was no evidence other than the testimony of a patient and the denial of the accused.

123. The test of policies and practice is the improvement they bring to people's lives. The Review Team takes the view that since there is no evidence that seclusion works, it is best avoided. Although the behaviour which triggers use of the seclusion room will stop, this is more likely to be due to a patient's physical exhaustion than evidence of a promising therapeutic benefit. The practice is experienced by some patients as punishment. Such routinised practice represents "containment within containment." It has not required high level authorisation. The CCTV coverage does not suggest that seclusion is the response of last resort at the Hospital.
124. Appendix 3 highlights the variation in responses to allegations in which the typical "constant" or "Protection Plan" is to increase staffing levels. This is remote from the underpinning principles of safeguarding. The methods of reconciliation explored by a single ward manager set out a basis of firm progress for the settlement of particular disputes, that is, between formal safeguarding procedures and pragmatic diplomacy, where there are untried possibilities. This is an opportunity for learning across the Trusts. The Review Team believes that a more judicious use of the safeguarding procedure is required.
125. **Just as the Hospital's decline was associated with becoming rundown, understaffed, overpopulated and obsolete as a model of service provision during the 1980s and 1990s, in 2018, it is based on an acute care model that does not work for people with life-long support needs**. There is proven mileage designing pathways of care with families whose relatives are at different stages of the life course, including those with life-limiting conditions. This may include Assessment and Treatment services but not necessarily in an in-patient setting. It should not be serially available to the same patients. It is a specialised supplementary service which should be provided only to the extent that it is required. It should not exercise control over all or most aspects of a person's life.
126. How staff work with the people they serve is critical to efforts to create individualised services. Commissioners, clinicians, social care staff, community teams, Personal Assistants and families will want to see examples of valued outcomes arising from securing tenancies for people for whom the Hospital may once have been regarded as the only option.
127. Real gains will be made when the Department of Health and all Trusts draw and disseminate lessons from people who are experienced in planning and securing supports around individuals:
    - The goals of coalitions of parent groups throughout the life course, including those with experience of accessing Direct Payments
    - General practitioners, Practice Nurses and paediatricians and geriatricians responsible for coordinating the health care of their patients with learning disabilities

- Community Teams attuned to the families which are known to require a great deal of assistance and/or may be considering sharing or relinquishing care
- Mainstream schools, colleges, supported employment and leisure centres
- Faith communities with experience of involving people with learning disabilities as full members
- Adult fostering and shared care
- Ordinary housing schemes for people with learning disabilities
- Imaginative transition planning in which people's IQs are of no consequence.[26]

[26] The Review Team was advised that people's IQ determines their eligibility for adult services

LEARNING IDENTIFIED
Accessing a safeguarding response should not require negotiating obstacle strewn territory. Considerations of whether a patient (i) "has a history of making allegations" (ii) has mental capacity (iii) has the permission of their family and/or (iv) meets thresholds, may preclude support to the patient to understand processes associated with safeguarding and/or a police investigation for example. Whether or not safeguarding processes are invoked cannot be determined solely by people's relatives or psychiatrists. It is not feasible for psychiatrists to establish whether all citizens with learning disabilities and autism in Northern Ireland have capacity to benefit from, *inter alia,* the scrutiny of adult safeguarding activities or even participation in safeguarding training.
The responses of staff to allegations of harm and/or to witnessing harm are situational. It is stressful witnessing violence when (i) personal safety may be threatened and (ii) some kind of help is required. The support of senior management must be explicit in the reporting process, that is, the consequences of reporting, the rights and protections which may be expected should be set out. The best reporting procedures are voluntary, non-punitive and protected.
There's a journey to go to make sure that patients' voices are heard…hearing first hand is better than any governance system. Meeting with the families of Hospital patients whose communication is limited and who were observed to have been harmed is more illuminating than the patients' records and accounts of investigations.
Muckamore Abbey Hospital must be mean, lean and purposeful. Get the overall vision right and make changes. It mustn't be seen as offering all sorts – it should provide short term A&T. That's the vision of the new co-director. This is a horrendous environment to live in – that knowledge has to pervade the whole system. A&T has to be slick – a place where people are happy and safe - and less than half the current size. Diversion from the courts doesn't mean that people are here permanently so that families get used to it. People don't have to live here – in the middle of the country – to go out for a walk. The Hospital is nested within the Belfast Trust, within the sum of Trusts, within the Department of Health, and within the Legislative Assembly. It follows that changing one element of these has the least effect on the whole system. The whole system will carry on being itself, changing only slowly if at all. A system's elements, interconnections and purposes are all critical – and the case for major change is incontrovertible.
The *life course* perspective of families of people with learning disabilities is relevant to the aspirations of families and to safeguarding practice. Patients' biographies involve their families and communities, continuities and discontinuities across different environments – including settings where there is a premium on privacy and trust. Such perspective shifts the focus to understanding the life stage of the patient, what is known about their history – including the experience of abuse or harm earlier in their lives - as well as the Hospital and ward context. What outcomes for patients can the Hospital report? It does not appear that the Hospital keeps track of the lives of former patients unless they return. This compromises the Hospital's credibility in setting out its achievements with and on behalf of patients. It is highly *unlikely* that the families of infants with learning disabilities and complex neuro developmental disabilities envisage Muckamore Abbey Hospital as part of their waiting future.

RECOMMENDATIONS

The Review Team recommends that there must be:

1. Evidence of a renewed commitment (i) to enabling people with learning disabilities to have full lives in their families and communities and (ii) to services which understand that ordinary lives require extraordinary supports – which will change over the life course.

2. An updated strategic framework for Northern Ireland's citizens with learning disability and neuro developmental challenges which is co-produced with self-advocates with different kinds of support needs and their families. The transition to community-based services requires the contraction and closure of the Hospital and must be accompanied by the development of local services. The Review Team suggests that elements of the latter include purposefully addressing the obstacle cited by so many, that is, "there are no community services." A life course vision of "age independent pathways," participative planning, and training for service development, for example, remains to be described. Elements of the contraction and closure include individual patient relocation, staff consultation and participation, and maintaining quality and morale.

   Long term partnerships with visionary housing associations, including those with experience of developing shared ownership, for example, is crucial to closing and locking the "revolving door" which enables existing community services to refuse continued support to former patients in group living, residential care or nursing home settings. If a young person or adult has their own home or settled tenancy, there is no question about where their destination will be if they have required Assessment and Treatment.

POSTSCRIPT

Points and recommendations proposed at the feedback sessions of 24 & 25 September 2018

Patients' relatives supplemented and underlined the bleak accounts of the experiences set out in the review. For example:

There's a lack of communication…there's no information sharing…we weren't allowed to read his file…why is information not shared?

We couldn't have him at home. We were told if we took him for a night, he would lose his place on the ladder. We waited for a year and after a year we were told he didn't have a place

She used to talk about going to the bungalow for a year. Then there was nothing. She no longer talks about the bungalow

For a long time, I raised issues and I wasn't listened to. I don't feel I was listened to…X was assaulted five or six times. I made complaints of course and nothing happened. When I reported what my relative was saying I was told that X was wrong

There is no need for a seclusion room. My X was put in it. It's not treatment putting someone in a room they can't get out of. They didn't listen when I challenged it

There's a lack of normality for our relatives. Patients are moved around the hospital site. They are distressed, and they hurt each other

This should be a homely place - like it used to be

It's nothing like a home. It's even worse than prison

They leave Iveagh at 18 and then they come here!

They're not getting out enough…it's cabin fever…why not open up a couple of wards?

It's obvious that you can't put distressed people together

I want to see the end of seclusion. Why does it exist? It is anything but therapeutic

The doctors, the managers – they all knew what it was like

What about the staff who are not registered? What about the staff who are responsible for the harm?

I have lots of questions about what happened to X. Will they be answered?

What was the RQIA doing? What was the Trust doing? What's the point of all this form filling if people are getting hurt?

Bad management has a knock-on effect

The staff should be moving around the hospital site

You don't need to apologise – it's the former managers who should be apologising. Those managers were ruthless and closed everything down. They are the ones who should be made accountable

The culture changed a few years ago when there was nowhere for patients to move to. I have to hope that my X is happy here. This hurts me. I want good support for people here – ways to fill their days that don't hurt them

Families recommended that:

- Hospital staff at all levels must invest in repairing and establishing relationships and trust with patients and with their relatives as partners
- Families and advocates should be allowed open access to wards and living areas
- There is an urgent need to (i) invest in valued activities for all patients and (ii) to challenge the custom and practice concerning the improper and excessive use seclusion at the Hospital
- The use of seclusion ceases
- The perception that people with learning disabilities are unreliable witnesses has to change
- People with learning disabilities and their families are acknowledged to have a critical and ongoing role in designing individualised support services for their relatives
- The Hospital's CCTV recordings are retained for at least 12 months
- Families are advised of lawful practices the Hospital may undertake with (i) voluntary patients and (ii) sectioned patients[27]
- Families are given detailed information, perhaps in the form of a booklet, about the process of making a complaint on behalf of their relatives
- Families receive regular progress updates about what happening as a result of the review

The feedback was uncomfortable for **Hospital Staff** to hear:

- *You're talking about harms when they are allegations*
- *What incentives are there for staff to remain here?*
- *Partnerships are very challenging and these need to be more robust most particularly if we are to see appropriate and timely discharges*
- *In Northern Ireland we have to start working with children at an early age – we're very reactive in Northern Ireland. We have to be more focused. Muckamore Abbey is the biggest unit in NI and we should have the skills here. We should be reporting on research. We should be planning forward*
- *We're at a tipping point. The resettlement agenda has been lost*
- *There are some encouraging things – learning disability nurses/health visitors*
- *There are so many small things that would make a positive difference e.g. having a second bus*
- *There are too many walls between the Trusts and the Hospital*
- *We want to intervene early and support people in their decision-making*

[27] A family was advised by a clinician seeking to section their relative that "It doesn't sit easy using seclusion on a voluntary patient"

- *The pressures are constant. I have never seen any abuse in all the time I have been here*
- *The lack of focus affects all our work*
- *The activities have all been stripped away*
- *Families are in crisis for a long time and have no support*
- *Safeguarding processes are slow, and the paperwork is crazy. We have people coming here from England and Wales and they can't believe that we have to report everything and spend hours filling in forms*
- *What about staff safety? I was head-butted in the face yesterday*
- *Staff morale is terrible*

Staff recommended that:

- An enhanced role for specialist nursing staff is set out
- Responses to safeguarding incidents and allegations are proportionate and timely
- Safeguarding documentation is substantially revised

Senior Managers from the Health and Social Care Trusts and the RQIA reported that there was "no dissension" about the urgency of patients' circumstances.

- *There's a lack of robustness of community services…the energy has gone from community development…it affects other care groups too…Supporting People isn't delivering, and the processes aren't doing what they're supposed to be doing…There is underfunding*
- *It'll take time to develop the transformation required…this is for the system*
- *We could begin collectively commissioning*
- *We're all in this together…there is more to do*
- *The CNO is aware – the skills of MAH nurses are transferable*
- *We need to go forward in a tiered way…there is urgency because we can't be confident that MAH is safe…there is vicarious guilt*
- *What if a nurse states "I cannot run this ward safely"?*
- *We should be bringing leadership and values to the Learning Disability population…it's a shared responsibility…begin with small steps - in the community*
- *We know that there are perverse incentives…we have to push back to the Trusts which are seeking to admit patients to MAH…there is pressure to admit people who require behaviour crisis management.*
- *"There are no alternatives// there aren't the community placements"*
- *We could state "We'll receive no admissions after 5.00 on Fridays and at weekends."*
- *We might build up an evidence base of prospective data*
- *There's a DH workshop in November which stems from Bamford. It's setting out a five-year plan*
- *We can get lots done now…It's up to us to deploy leadership and bring energy to the task…Trusts and community services have over-relied on MAH*

- *Our language matters and we should use it carefully…we're placing expertise in the community – staff are key to doing a good job.*
- *there has to be a shared narrative…we can't carry on doing what we've always done*
- *There has to be a new beginning – an acknowledgement that people have suffered harm…there have been totally unacceptable events – there is a collective sense of shame and embarrassment…we have to start working outwards – working with the independent sector*

Senior Managers recommended that:

- A shared narrative is set out
- Commissioners specify what "collective commissioning" means
- The transformation required in learning disability services must be values driven and well led
- The purpose of all our services is clear
- All Trusts should invest in people-skills and be cautious about focusing solely on learning disability nursing
- The default "Friday afternoon and weekend admissions" to Muckamore Abbey Hospital have to stop[28]
- Time limited and timely Assessment and Treatment become the norm
- Trusts and Commissioners must be knowledgeable about the "user experience" and that of their families
- Trusts and Commissioners should set out the steps required in the Department of Health's post Bamford plan: in the short and medium term[29]

[28] At the time of the feedback events, the Hospital was addressing its low threshold for admissions

[29] For example, it may be helpful to distinguish the recommendations and points made in the review which may be addressed in the short term and in the medium term. For example, in the short term:

1. The three main stakeholders – people with learning disabilities, their families and advocates; the Learning Disability service providers in NI and commissioners should work as equal partners so that the service can be transformed - perhaps as an accountable group
2. The flow of admissions - especially readmissions - into the hospital should be restricted to halt the "revolving door" phenomenon. The hospital is being used inappropriately to respond to a wide range of situations which would need to be managed locally if community services are to begin designing services around individuals
3. Existing patients need to spend time in and be visible in the community
4. Families and advocates should be allowed open access to wards and living areas
5. Monitoring and reporting of all restrictive practice - the use prn medication, physical restraint and seclusion must be strengthened

In the medium term:

1. Trusts should begin to build "all age care pathways" which bring together children's and adult services, hospital and community services and health and social care and education services
2. Out of hours services should be enhanced using strengthened community learning disability and mental health teams as well as the hospital team to support families and service providers for all age groups
3. The professional development of all front-line staff must be prioritised using educational approaches based on providing better care rather than on formal course-based approaches
4. New approaches to enhance housing capacity need to be accelerated to deal with ever increasing demand

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Appendix 1

How the *Senses Framework* may stimulate change at Muckamore Abbey Hospital

Background

1. To promote better lives for people with learning disabilities it is recognised that it is important to develop new opportunities as well as change the ways that public authorities go about their work. However, there is a danger that the pressures for change and reform become "ends" in themselves.

The environment

2. The ward environments impact on patients, their families and staff. Experience of the re-provision of services to less segregated settings does not necessarily herald improved lives for people with learning disabilities. If poorly resourced and managed, depersonalising environments and regimented care practices may also be found in smaller settings.
3. The Review Team has highlighted the quantity of assessment tools identified by the RQIA which are used at Muckamore Abbey Hospital. These include, for example, Person-Centred Care Plans, Personal Activity Plan, Care Plans for Each Need Assessed, Positive Behavioural Support Plans, Individualised Incentive Plans, Patient Progress Records, Progress Notes, Assessment of Communicative Needs, Functional Analysis of Care Environments, Risk Assessment and Quality of Life Assessments (see Appendix 5). The Team's contact with patients, staff and relatives underlines the importance of creating and nurturing 'healing' environments. The *Senses Framework* offers a credible means of creating an environment in which the needs of patients, their relatives and staff are acknowledged and addressed.

The *Senses Framework*

4. Nolan, Davies and Grant (2001) sought to link theories, conceptualisations and research evidence. The *Senses Framework* is derived from, and reinforced by, an extensive literature search and 'testing' in acute settings as well as long term environments. By 2012, the 'senses' had been further developed "by, with and for older people, family carers, staff and students..." (p105).
5. There are six 'senses' each of which is pertinent to all of us:

Sense of achievement

For people with learning disabilities:[1] opportunities to meet meaningful and valued goals; to feel satisfied with your efforts; to make a recognised and valued contribution; to make progress towards therapeutic goals as appropriate

[1] In M. Nolan and S. Allan (2012) the table references *older people*

For family carers: to feel that you have provided the best possible care, to know you have 'done your best;' to meet challenges successfully; to develop new skills and abilities

For staff: to be able to provide good care; to feel satisfied with your efforts; to contribute towards valued therapeutic goals; to use your skills and abilities to the full

Sense of belonging

For people with learning disabilities: opportunities to maintain and/or form meaningful and reciprocal relationships, to feel part of a community or group as desired

For family carers: to be able to maintain/improve valued relationships, to be able to confide in people you trust; and to feel that you are not in this alone

For staff: to feel part of a team with a recognised and valuable contribution to make, to belong to a peer group, a community of practitioners

Sense of continuity

For people with learning disabilities: recognition and value of personal biography; skilful use of knowledge of the past to help understand the present and future; seamless and consistent care delivered within an established relationship by known people

For family carers: to maintain shared pleasures/pursuits with the person; to be confident that the person receives high standards of care whether delivered by self or others; to ensure that personal standards of care are maintained by others; to maintain involvement in care across care environments as desired/ appropriate

For staff: positive experiences of work with service users from early career, exposure to good role models and environments of care, standards of care communicated consistently and clearly

Sense of purpose

For people with learning disabilities: opportunities to engage in interesting and enjoyable activities; to be able to identify and pursue personally valued goals and challenges; to exercise choice

For family carers: to maintain the dignity and integrity, well-being and 'personhood' of the person…without ignoring other valued goals

For staff: to have a sense of therapeutic direction, a clear set of goals to aspire to

Sense of security

For people with learning disabilities: attention to essential physiological and psychological needs, to feel safe and free from harm, threat, pain and discomfort; to receive competent and sensitive care

For family carers: to feel confident in their knowledge and ability to provide good care without detriment of personal wellbeing; to have adequate support networks and timely help when required; to be able to give up caring when appropriate

Paid caregivers: to feel free from physical threat, rebuke or censure; to have secure conditions of employment; to have the emotional demands of work recognised and to work within a supportive but challenging culture

Sense of significance

For people with learning disabilities: to feel recognised and valued as a person of worth, that your actions and existence are of importance, and that you 'matter'

For family carers: to feel that your caring efforts are valued and appreciated and to have an enhanced sense of self

For staff: to feel that your practice is valued and appreciated, that your work and efforts 'matter'

6. A human rights perspective is the central theme grounding adult safeguarding in Northern Ireland. It is especially pertinent to the men and women at the Hospital since they are dependent on health, social care and accommodation where practices such as partnership working, and assessment are critical. The Senses Framework draws attention to the day to day experience of people's lives as well as the reciprocity involved in all aspects of care.

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Appendix 2

A Historical Context to the Review

Background

Ian Montgomery and Joe Armstrong (2009) wrote, *From Specialist Care to Specialist Treatment: A History of Muckamore Abbey,* which was published in Belfast by the Ulster Historical Foundation. It sets out the principal milestones and themes in the hospital's history. In addition, the Northern Ireland Assembly's Research and Information blog[1] is referenced. This details relevant reviews, policies and reports.

The Timeline

During **1946**, the Gordon Report on mental deficiency in Northern Ireland was published.

During **1948**, the Mental Health Act (Northern Ireland) made the Northern Ireland Hospitals Authority responsible for '*persons requiring special care*.'

During **1949**, the Muckamore Abbey estate was purchased for a new hospital. Initially, the house had accommodated four "*high grade*" girls.

During **1951**, the Special Care Service Management Committee was established.

During **1952**, an extension was built at Muckamore Abbey, increasing accommodation capacity to 68 beds. It had 51 patients. It was noted that it was "*not easy to separate older girls from younger groups who have not yet developed anti-social tendencies.*" Also, efforts were made "*to avoid chaotic conditions arising from…the indigestible mixture of patients of all grades.*" There were 743 patients accommodated in six mental hospitals in Northern Ireland, 120 of whom were children. The opening of Muckamore Abbey Hospital meant that all young people and adults over 16 years were finally removed from mental hospitals.

The purpose of provision for children, young people and adults with learning disabilities over the course of the hospital's history included: helping with socialisation; training; occupation and recreation; to return to the community; supervised employment (for a minority); accommodation for those with *poor moral sense/*whose families were unable to cope/unable to fend for themselves; to make a worthwhile contribution to the costs of administration – including growing vegetables and assisting with cleaning, mending clothes and maintenance work, for example. Also, farming was perceived as a therapeutic activity. Additional purposes for Muckamore Abbey included being a halfway house and a centre for medical research. Latterly, the mission of the hospital is confirmed as an Assessment and Treatment centre with no patients living there long term. However, due to problems in discharging treated patients, "*serious overcrowding*" has resulted.

[1] http://www.assemblyresearchmatters.org/2017/03/08/mental-health-illness-northern-ireland-1-overview-related-strategy-reports/ (accessed on 17 March 2018)

Also, during 1952, the Association of Parents of Handicapped Children was established. *Later when Muckamore Abbey Hospital opened, the Association became known as the "Society of Parents and Friends of Muckamore Abbey Hospital".*[2]

During **1953**, a £2m special care colony was inaugurated. Also, a company of girl guides was formed at the hospital.

During **1955**, nurse training began at Muckamore Abbey Hospital. It was noted that "*this type of nursing, which is more of an instructional or training nature, often appeals to the girl who is not attracted to the routine of nursing in general hospitals.*"

The numbers of people diagnosed as requiring hospital care grew.

By **1958**, it was noted that at Muckamore Abbey, "*TV viewing has become a very popular evening pastime*."

During **1960**, the school opened and "*in some cases pupils learned to read and write.*" There were nine villas on the site. These were designed to accommodate ambulant patients and were unsuitable for those with additional physical support needs.

During **1961**, a school was opened at Muckamore Abbey.

During **1966**, Muckamore Abbey had 880 patients.

During **1967**, the swimming pool opened.[3]

During the **1960s**, hospital staff were less willing to live on site. One villa accommodated 40 men, some of whom were doubly incontinent/removed clothing/pulled down curtains/broke windows and self-harmed, for example.

During **1963**, a teacher's college opened at Muckamore Abbey for special needs teacher training.

During **1964**, Muckamore Abbey had its own cinema and radio.

During **1965**, most of the hospital's land was transferred. Farming ceased as a therapeutic activity since the hospital no longer had large numbers of physically fit patients.

During **1968**, 200 rugs were made by patients; the hospital laundry dealt with between 55k-65k items each week; and the stationery used by the ESCS was printed at Muckamore Abbey.

[2] From the Society's leaflet, *Caring in Partnership*

[3] The Society of Parents and Friends of Muckamore Abbey Hospital *raised hundreds of thousands of pounds to improve patient facilities including major contributions to the hospital swimming pool…Community Centre building funds…also donated numerous items of equipment e.g. the bicycle scheme* [Caring in Partnership]

During **1969**, the Inquiry at Ely Hospital, Cardiff identified, *inter alia,* the combination of poor buildings, inadequate funding and a shortage of trained staff. This was subsequently referenced by managers and clinicians seeking additional funding for Muckamore Abbey.

By the late **1960s** and early **1970s** there was a growing sense that treatment and training should take place in the community. Overcrowding at the hospital was becoming a problem.

By **1970**, 344 of the hospital's 814 patients were assisting with the hospital's routines.

During **1971**, the sports pavilion opened at the hospital.

During **1973**, because of Health Service reorganisation, the Eastern Health and Social Services Board became responsible for Muckamore Abbey. The latter provided accommodation and the District Social Services teams became responsible for day care.

During **1978** the DHSS published *Policy and Objectives: services for the mentally handicapped in Northern Ireland.*

By **1980**, there were more than 20 villas on the hospital site. The hospitals workshops integrated men and women patients. A survey determined a decrease in the number of patients deemed suitable to transfer to the community.

During **1984**, the number of children and young people resident in hospitals was declining, that is, 81 out of 1,428 (Independent Development Council, 1984). However, Muckamore Abbey was one of the largest hospitals in the UK. Nearly 50% of its patients had no "off ward" activities.

A rehabilitation unit was created during **1986**.

During **1987**, special schools transferred to Education. At Muckamore Abbey, a unit for patients with profound handicaps was created.

Individual care plans were introduced during the late **1980s**.

During **1990**, a snoezelen room was opened at Muckamore Abbey.

During **1992**, nurse training ceased at Muckamore Abbey. *Health and Wellbeing into the new Millennium* determined that each Board and Trust should develop a comprehensive range of support services by 2002; that long-term institutional care should not be provided in traditional specialist hospital environments; and that the number of adults admitted to specialist hospitals should reduce.

By **1993**, the fabric of the hospitals buildings required attention and the hospital received a cash injection. The dispersed colony layout resulted in the underground mains becoming overloaded; there were heating problems; and asbestos was present in the buildings. There

were 596 patients at the hospital. Muckamore Abbey argued for the retention of a specialist Assessment and Treatment function on site, boosted by a petition with 7k signatures.

A forensic unit was established during **1994.**

By the mid-**1990s**, the presence of adolescents on adult wards had become a "significant issue."

During **1998**, Pauline Morris' study of long stay hospitals was published. This criticised the clinical model of care and commended a socio-therapeutic model in which training was as important as nursing and medical functions.

It was acknowledged that in the absence of a community infrastructure in Northern Ireland to support long stay hospital patients, those who had been in hospital for 30-40 years should remain there. The resettlement of patients was primarily driven by the availability of private and voluntary facilities. The average yearly cost of a single patient was £25k. The resettlement of 50 patients would result in a net loss of income of £1.25m.

During **2001**, the closure of seven wards was approved. These were inappropriate living environments.

A survey determined that most admissions to Muckamore Abbey were of people with behaviour which challenged – most of whom have been brought up in family homes and had attended special schools.

During **2002**, the Department of Health, Social Services and Public Safety initiated the Bamford Review of the law, policy and services affecting people with a mental illness or a learning disability.

The Review's key messages included – the promotion of positive mental health; a need for reform of mental health legislation (Mental Capacity Act (NI) 2016); a shift from hospital to community-based services; and the need to develop specialist services, including for children and young people.

There have been two Bamford Action Plans, 2009-11 and 2012-15.

An evaluation of the Action Plan 2009-11 listed the challenges identified in 2009, including:

- *Streamlining access and establishing a stepped care approach;*
- *Enhancing the range of options available to primary care professionals;*
- *Improving access to psychological therapies;*
- *Home-based care and support to be the norm;*
- *A systematic approach to focus on 'recovery' from long term conditions; and*
- *Increasing the range of specialist mental health services.*

The 2012-2015 Action Plan contained 76 actions. The interim monitoring report noted that good progress had been made with 63 actions on target. In 2016, the Department of Health (NI) initiated a full evaluation of the 2012-2015 Action Plan – publication is expected by the summer of 2017. It will assess how Departments have performed, include the views of service users and carers, and identify needs and service gaps.

Initial findings include a continuing need to – promote psychological therapies and the 'recovery' concept; provide more practical support to carers; improve access to mental health crisis services; improve patient experience in acute facilities; increase involvement of the voluntary/community sector; and increase (supported) employment opportunities/social enterprises.

During **2003**, the business case for a new Core Hospital was made. The refurbished swimming pool re-opened.

During **2004**, *Equal Lives* was published. This envisaged no patients living in hospital and people with learning disabilities living in residential services and their own homes with support.

During **2005**, a regional strategy was published, *A Healthier Future: A twenty-year vision for Health and Wellbeing in Northern Ireland 2005-2025.* It anticipated an increase in the population of people with learning disabilities and in the proportion of people with complex support needs.

There were 318 patients at Muckamore Abbey. It was determined that the number would be reduced to 87 by 2011.[4]

During **2006**, a 35-bed admission and treatment unit was opened, and a 23-place forensic unit was close to completion. These cost £8.4m.

Muckamore Abbey Hospital comprised three populations:

- Assessment and Treatment
- Resettlement
- Delayed Discharges.

During **2011**, *Transforming Your Care* was published. This urged the completion of resettlement from long stay hospitals and highlighted the need for a new service framework setting out standards of care for people with learning disabilities.

The Regional Community Integration Project was established to implement the Department of Health's regional strategy/Bamford vision that "no-one should have a hospital as their home." The strategy identified 235 Priority Targeted List of patients (PTL) at Muckamore Abbey who should be offered homes of their own outside of the hospital environment.

[4] In December 2011, there were 225 patients at Muckamore Abbey Hospital

During 2012 – to date, 188 of these patients have been resettled leaving 14 patients from the PTL still to be discharged. As a result, the following wards were closed - Finglass, Greenan, Rathmullan, Oldstone, Ennis, Mallow, and Moylena. Only one resettlement ward remains open – Erne.[5]

During **2014**, the Northern Ireland Assembly's Health Committee reviewed *Transforming Your Care*. This focused on disability discrimination and the promotion of people's physical health care.

During **2016**, the Mental Capacity (Northern Ireland) Act sought to bring mental health and mental capacity law together.

Montgomery and Armstrong assert that the Muckamore Abbey was built at the end of the era of institutional care to an obsolete colony plan. However, after becoming a model to be emulated in the 1960s, it began to decline in the 1970s and 1980s when it became understaffed and overpopulated. During Muckamore Abbey's history it is acknowledged that too much emphasis had been placed on the development of large hospitals with the result that the development of community services was neglected. People with learning disabilities and their families lived with the shortcoming of there being no alternative. The expansion of the hospital ceased at the end of the 1970s when disconnection from community services was mandated and underfunding and overcrowding persisted. It was increasingly an isolated hospital, serving people with a considerable range of support needs. Muckamore Abbey resettled patients during the 1980s and by the 1990s, the fabric of its buildings was deteriorating, and major investment resulted. The authors accepted (in 2009) that specialist community services and progress in resettling patients was unfinished business.

References

Committee of Inquiry (1969) *Report of the Committee of Inquiry into Allegations of Ill Treatment of Patients and other Irregularities at Ely Hospital, Cardiff* London: HM Stationery Office

Independent Development Council for People with Mental Handicap (1984) *Next Steps: An independent review of progress, problems and priorities in the development of services for people with mental handicap* London: IDC

Morris, P (1998) *Put Away: A sociological study of institutions for the mentally handicapped* London: Routledge

[5] Update provided by RO14

Appendix 3
The Hospital's safeguarding files

The following seven Tables[1] set out the principal allegations of patients or concerning patients and the outcomes arising from the allegations. If "History of Making Allegations" is cited in a patient's file, this is reflected in the column HMA.

Table 1 The allegations and outcomes (a)

Year	Ward	Allegation	HMA	Outcomes
2013	Erne	Staff pulled hair; staff tore up cigarettes	*	2 staff always present; case closed
2015 2017	Erne Killead	Unnecessary chastisement from staff; angry at being woken - alleged staff hit patient; having hit staff member stated that would inform relative that staff hit patient	*	Patient said it wouldn't recur and wanted this to be known to family; "screened out x 2;" 2 staff to be present when argumentative
2016	6 Mile	Staff assault; alleged staff kneed in groin		Patient does not wish any action; staff not to work with patient, case closed
	Ennis	Patient alleged staff hit peer		Peer stated allegation untrue
2014	Cranfield	(historical?) abuse		Patient had received financial compensation; "no evidence or substance"
2014	Killead Cranfield	Staff burned patient in bath; alleged staff pushed patient to floor; staff put hands around patient's neck	*	Staff not to be alone with patient; patient stated had been "telling tales" - allegation unsubstantiated
2016	6 Mile	Staff held patient around neck during a scuffle		Staff member not to work with patient and should have carried an alarm
2015	Cranfield	Staff witnessed colleague rough handling/ shaking and pushing a patient		Staff member referred to PSNI
2016	Cranfield	Sexual assault and physical assault by relative and relative's partner		Relative advised to visit alone; visits supervised; 2:1 staffing
2014	Killead	Name calling by staff	*	Staff denied allegation. 2:1 staffing and staff implicated will not work with patient

Potential explanations surrounding the allegations are given coverage in some files e.g. "X's health is poor…may be one factor…unsettling issue may be his proposed move to nursing home// …has a difficult relationship with staff member and has made comments in past…doesn't want staff member to work with [patient]// …very agitated and requested PRN//…eventually decided. did not want police involved, *I don't know what to do for the best. What should I do?...I'll drop it, I'm tired…I don't want to do anything. I just want to leave it. Will it not happen again? //* Relative gave three accounts of what happened// relative says that [allegations] X's *normal avoidance behavior."*

[1] For ease of reading these have been grouped in blocks of 10 per table

Table 2: Allegations and outcomes (b)

Year	Ward	Allegation	HMA	Outcomes
2017	Cranfield	Angry at being woken, refused meds		Do not touch X when waking X
2014	Killead	Pushed by staff – retracted allegation		?
2014	Erne	Staff observed staff push patient who hit head on floor		First aid to patient, staff suspended and PSNI informed
2013	Cranfield	Patient told relative, had been pushed by staff		Patient stated that *it's just guys trying to have fun…don't worry about it*
2012 2013	Oldstone	Staff called patient "lying bitch;" staff pushed patient resulting in fall	*	Screened out; unsubstantiated allegation – staff not to work alone with patient
2013	Donegore	Staff pulled patient's hair		*No substance to allegation*
2016	Cranfield	Staff pushed patient		Didn't meet criteria. Staff member not to work with patient…to be followed up by community colleagues
2016	Cranfield	Overheard telling relative that staff had pushed her head into glass window		?
2012	Oldstone	Patient had been uncooperative and disruptive - Staff had punched chest saying "Go away;"		Patient wanted PSNI involved; asked to say yes/no it happened/ did not happen – patient "scared that staff will get in trouble if says yes"
2016	Moylena	Punched and sworn at during physical intervention	*	Staff x4 present – allegation unfounded

Potential explanations included, "…has long forensic history…anxious about community placement// agitation and distress have increased// unsettled."

Table 3: Allegations and outcomes (c)

Year	Ward	Allegation	HMA	Outcomes
2014	Donegore	Staff bullying patient		Relative contacted the PSNI; was reassured by Hospital of the context
2015	Donegore	Staff bullying patient	*	No concern
2013	6 Mile	Thrown against wall by staff		? Illegible handwriting
2017	Cranfield	Relative states patient has bruised wrist		Rejected; 2:1 staffing in bedroom
2014	Greenan	Staff verbally and physically aggressive to 2 patients		PSNI contacted, Protection Plan in place
2013	Oldstone	Patient hit by staff	*	Patient apologised. Staff moved as part of Protection Plan
2013	Ennis	Staff nipped patient during physical intervention		?
2016	Erne	Staff name calling		Rejected
2013	6 Mile	Staff swearing at patient		Screened out – *happy with outcome*
2013	Cranfield	Staff hit and abused patient		? Illegible handwriting

Explanations included, "Staff gave another patient a hug, didn't give the patient one// *the doctors and nurses push me around…the staff annoy me//* very unwell at present."

Table 4: Allegations and outcomes (d)

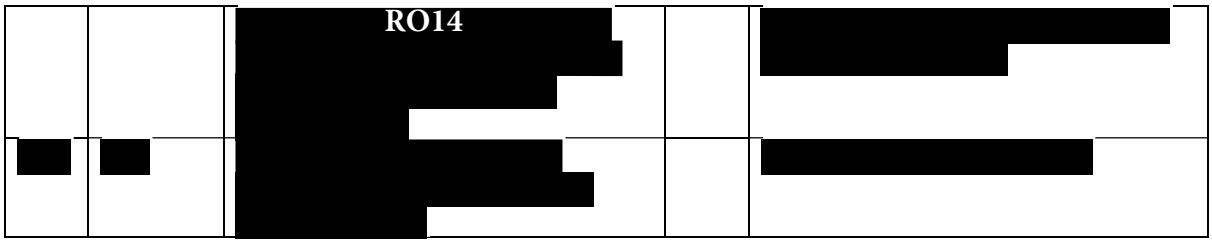
Year	Ward	Allegation	HMA	Outcomes
2013	Ennis	Staff hit patient	*	?
2017	Killead	Staff hit and kneed patient		Increase of supervision, 2:1…threshold of adult in need of protection has not been met…screen out…meets the criteria for not referring to PSNI
2013 2014	Donegore	Staff called patient names; staff had tapped hand; was refused a hot drink and told to "F off"	*	Retracted allegation; staff confirmed patient was not tapped – not to be alone with patient in bedroom; Care plan in place
2014	Moylena	Staff dragged and pushed patient to toilet - given dry shave *in inappropriate manner*, opened bowels in shower		PSNI recommended prosecution re assault/ ill treatment - staff member plus witness resigned. Adult safeguarding process…NFA re adult safeguarding. Time lapse in reporting incident
2013 2015	Cranfield	Complained (?) about being hurt during physical intervention. Had been destructive and aggressive, *high level hold;* patient subject to physical intervention during which bruising occurred. Had been threatening to self-harm and attack staff		PSNI – *insufficient evidence;* ?
2017	Cranfield	Staff member observed to tip patient out of chair to *prompt* patient to have dinner		PSNI advised *no crime…does not meet threshold of serious harm under new policy*
2012	6 Mile	Shoulder scratched by finger nail by staff *prompting* patient to get up		Staff member moved…*has not requested the need for PSNI involvement or further investigation*
2016	Cranfield	Bruising sustained from staff…*not making a complaint*		Rejected, *does not meet eligibility criteria and staff witness…state the incident did not happen*
2012	6 Mile	Required physical intervention having assaulted staff. Apologised and claimed staff member *started fight*		Rejected…screened out
2013	Ennis	Relative reported patient allegation that staff hit patient	*	Staff no longer in employment

Explanations included, "Being treated for psychotic illness// Relative does not wish police involvement// patient's perceptions of situations can be confused// distressed that children were freed for adoption// unsettled."

The references to complaints suggest that an allegation may be directed to a process other than safeguarding.

Table 5: Allegations and outcomes (e)

Year	Ward	Allegation	HMA	Outcomes
[redacted]	[redacted]	RO14 [redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]



Explanations included, "Staff can be offered training/ support// concerns raised about *staff attitude and physical interaction//* patient's *agitation and imminence of move to the community// very influenced by what patient sees on TV//… no positive behaviours were being shown by this staff member…empathised with the service users as to how they might feel being the victims of it// patient had been unsettled// behavior deteriorated recently…may be worried re future accommodation."*

A ward sister expressed concern about *this standard of unsafe and ineffective care, not to mention lack of compassionate care…culture and attitudes.* The importance of communicating with and debriefing relatives was noted, particularly *if they witness any distressing incidents.*

Table 6: Allegations and outcomes (f)

Year	Ward	Allegation	HMA	Outcomes
		RO14		

		patient on chest; staff hit patient; staff hit patient…*sorry for telling lies*; staff nipped patient; staff hit patient; pushed patient		hours; relative remained to assist in settling patient; screened out; false allegation as 3 staff present; ring relative if patient unsettled; a lot of these incidents can be dealt with quickly; referral to PSNI; allegation unsubstantiated; relative complained; screened out of safeguarding; accompanying staff confirmed untrue; relative does not wish to make 3rd party complaint – screened out…satisfied with protection measures; no injuries consistent with being pushed
2014	Moylena	Staff hit patient	*	Staff moved…2 members of staff have been removed…very upset; family group discussion; liaison with PSNI – agreed NFA; risk of false allegations managed with 2:1
2012 2013	Ennis Donegore	Staff used *inappropriate language* and feigned hitting patient; staff *assaulted* patient; staff sits on patient x2; staff hurt patient's *boobs*		Staff suspended – not to work bank shifts; relative does not wish to make 3rd person complaint; PSNI informed, Protection Plan in place…activity schedule to commence; relative does not wish to make 3rd person complaint; skin irritation under breasts/ prone to rashes; 2:1 during personal care
2013	Cranfield	Patient held up against a wall by staff – 16 years ago		Relative *does not wish to make a complaint*

Explanations include, "fluctuating mental health can limit patient's understanding// does not take responsibility for actions// patient has learned that if they make allegations then staff are *swapped out//* patient's new ward means *he is closed in completely//unfamiliar staff…day staff covering night shifts…staff shortages…other patients discharged."*

Table 7: Allegations and outcomes (g)

Year	Ward	Allegation	HMA	Outcomes
2014 2015 2017	Donegore	Historical abuse claims; staff told patient to "F off, go away"	*	2:1 for intimate care, staff have *heightened awareness.* Relatives believe patient was historically abused…no evidence/ investigated by PSNI – family have long standing concerns re effects of meds – suggested that staff should be told *to be better people and stop doing sneaky things to wind up patient;* relatives do not wish to take allegation further – screen out
2017	Cranfield Killead	Staff raped patient – retracted; staff hit patient – latter wants to *run away and kill self*; staff hit and dragged patient – retracted; staff raped, hit and declined to give patient food; staff hit patient - retracted	*	No staff alone with patient; on 2:1 to protect patient and staff; refers to historical incidents…screened out of safeguarding; leading questions should not be asked…walking away when patient distressed feels like rejection; referral does not meet threshold of an adult in need of protection…screened out
2012 2013	Greenan	Staff hit patient's head – retracted; staff twisted patient's arm	*	This would not be RQIA notifiable; relative does not wish to take further action..2:1 when attending to patient's hygiene

Explanations include, “patient wants the police to get patient out of the Hospital// mental health has deteriorated in the last few months// patient wanted a befriender// has been requesting PRN.”

Appendix 4

Workforce Issues at Muckamore Hospital

1. During discussions with various staff groups the Review Team heard repeated reports, particularly from Ward Managers and Team Managers, of their concerns around staffing levels and the ability to recruit and retain the required number of qualified staff to provide the care necessary to meet the needs of a hospital inpatient population. That is, a population which presents with ever increasing health and behavioural challenges and complexities. To gain a greater understanding of this concern the Review Team decided to explore this issue a little further and were kindly assisted in this task by senior hospital staff and representatives from Human Resources who provided the additional information requested.
2. Nurse staffing throughout Muckamore is viewed by many staff as a persistent challenge with a perception that ward staffing complements are insufficient to meet need. It should be noted at this point that little evidence was provided that shortfalls in care resulted and Nurse Managers have provided the Review Team with ample evidence of the ongoing attempts to recruit trained staff. The Review Team was told that nurse staffing shortages at Muckamore were identified as a risk and featured in the Trust's corporate risk register.
3. The Trust continues to use several strategies to recruit both Registered Nurses, learning disability (RNLDs) and Health Care Assistants (HCAs) to Muckamore, including open recruitment and recruitment fairs, advertised through social media with some success. Data provided by Human Resources suggests that the hospital consistently carries several funded vacant posts. The Review team accepts that, as yet, there is no agreed regional normative staffing model for learning disability nursing, however, there was no evidence of any systematically applied objective assessment methodology of staffing need at Muckamore that could draw some accepted conclusion on the staffing shortfall.
4. Successive RQIA inspection reports have raised the issue of staff shortages, although the Review Team did not see any evidence that this matter was raised with the Trust beyond the parameters of the individual ward inspection.
5. Variables to be considered when reviewing staff recruitment and retention issues include (among others):
    - Regional demand and supply of appropriately qualified RNLD
    - Time taken to recruit to vacant positions
    - Age profile of the existing workforce and the impact of potential retirement in the next 3-5 years
    - Ability to retain staff through attractive career development opportunities and progression
    - The impact of sickness and absence on current staff profiles
    - Reliance on the use of Bank and Agency Nurses to fill vacant positions

6. While recognising that all these issues are inextricably linked and consequently collectively impact on staff complements in Muckamore, the Review sought to tease out some of the challenges in each area.

Regional Demand/Supply of RNLDs

7. The Trust does not wait until posts are vacant to commence a recruitment process for RNLD posts. An open recruitment process is in operation so that RNLDs can apply at any time. The Trust combines this with Job Fair recruitment days advertised through social media targeting RNLDs for Band 5 posts and Health Care Assistant posts at Band 3. While this process has been successful in attracting staff it is notable that the Trust has not been able to recruit beyond the established number of funded posts. This approach is adopted by several Trusts in Northern Ireland, who experience similar problems recruiting RNLDs, which is indicative that the region is not training enough RNLDs to meet service demand. Additional training places have been commissioned (10 extra RNLD places for 2018-19).
8. ***The Review understands that this increase is only for one year and is not yet intended to be recurring. This small and one-off increase, while welcome, will be quickly absorbed across all Trusts in Northern Ireland and will do little to relieve RNLD vacancies at Muckamore.***

Time taken to Recruit to Vacant Posts

9. Like other Trusts, the operation of recruitment to vacant positions at Muckamore is undertaken by a shared service provided by the Business Services Organisation (BSO). The Review heard how this process has led to a delay in recruiting to posts, prolonging the period posts remain unfilled, with a sense of the Trust's lacking control over this issue and little indication of improvement. The view expressed to the Review Team was that it is unlikely that responsibility for recruitment would return to the Trust however, there is a real sense that unless significant improvements are made to BSO recruitment processes the likelihood is that delays in filling vacant posts will get even longer.

Age Profile of existing Nursing Staff

10. The Review understands that the age profile of the existing nursing workforce at Muckamore indicates that there is potential for many skilled and experienced staff to retire in the next few years. This is not unusual, although when combined with a sense that younger staff don't stay at Muckamore more than a few years, it leads to real concern that the nursing workforce at Muckamore will be the youngest and most inexperienced group of staff to provide nursing care for an inpatient population with increasing health and behavioural complexity.
11. ***Given the Review Team's conclusion that the role and function of Muckamore needs to be reconsidered and refocused with the objective of hospital admission only for assessment and treatment, combined with an understanding that the future population requiring hospital based care will be even more complex and challenging, there is a greater urgency to ensuring that the staff at Muckamore are equipped with the necessary skills/experience and appropriately supported to manage these challenges***.

Ability to retain staff through attractive career development opportunities and progression

12. Muckamore is no different in many respects to all other Learning Disability Hospitals in Northern Ireland in the context of the success of the 'resettlement programme' for people that were living long term in hospital. Wards have closed, and many staff moved to community services.
13. The historical nursing career infrastructure that was inherent in the older institutions has dissipated with the changing service profile. Consequently the opportunities for career progression at Muckamore are fewer and less frequently available. Following registration, younger staff take up positions at Muckamore to gain experience and generally after 2-3 years move to community services where career opportunities appear more attractive and accessible.
14. Whether staff shortages and the perceived lack of development opportunities at Muckamore influence this migration out of hospital would need to be tested further. Nonetheless the Review Team was told that staff shortages frequently mean that prearranged training and development programmes have been cancelled at the last minute to maintain safe care on the wards.
15. ***Provided an agreed future service purpose for acute inpatient care for adults with a learning disability can be agreed, then plans need to be in place with immediate effect to retain nursing staff which includes providing them with a sustainable programme of continued professional development directly linked to the needs of the service user group requiring a period of hospital care. To retain staff, consideration needs to be given to developing promotion opportunities for hospital staff, including more specialist roles embedded in ward teams rather than separate. Such roles must have a clear evidential base in terms of the benefit to service users and be linked directly to Continuing Professional Development (CPD) opportunities.***
16. There is evidence that the Trust has invested in staff to undertake further education programmes to acquire a recordable specialist nursing qualification. ***However, these staff have returned to the substantive positions that they held prior to acquiring these new skills, and consequently are not always working in a dedicated role that allows them to use their specialist skill to benefit service users and lead on nursing practice development.***

The impact of sickness and absence on current staff profiles

17. Sickness and absence rates for nursing staff at Muckamore consistently run at 7% or over and exceeds that of any other professional group. This is particularly high and, combined with the number of vacant funded posts, clearly adds to the pressure of maintaining adequate staffing levels on wards and increases the need to replace absent staff through bank and agency nursing. This issue is not unique to Muckamore and the Review team was informed that the Trust's Management of Absence Policy and Procedures were followed.
18. ***Nonetheless given the challenges in maintaining staffing levels at Muckamore, the Review Team suggests that the Trust and senior hospital managers, in partnership with staff side representatives, may wish to consider how absence management could be strengthened***

and more robustly managed and monitored to reduce the impact and cost of lost nursing hours on service provision.

Ratio of RNLDs (Registered) to HCAs (Non-registered) Nursing Staff

19. Nursing staff ratios of registered nurses to non-registered nursing staff is recognised as one of many indicators of the quality of care. If all funded nursing posts in Muckamore were filled the ratio of registered to non-registered staff would 49%/50%. The Review team acknowledges that registered to non-registered nursing staff ratios are very fluid and can vary from day to day and clearly is affected by the difficulty in recruiting staff to fill vacant funded posts. As a result of these challenges the ratio of registered to non-registered nursing staff across the nursing workforce in the hospital has dropped to 38% registered to 62% non-registered staff. This is an average figure taken at a point in time (31 June 2018); therefore it is reasonable to conclude that daily this ratio can change considerably in individual wards across the hospital. This figure is concerning given that the inpatient population of Muckamore, at any one point in time, is considered as the most challenging and most complex, including those whose discharge from hospital is delayed because suitable supported community accommodation to meet their needs cannot be identified or secured. Although there are no empirical studies addressing safe staffing levels, there are factors which are known to impact on the delivery of safe and compassionate care, that is: people's support needs; staff attributes; staff perceptions of challenging behaviour; working as a team; job satisfaction; work overload; organisational support; and working in the community for example.[1]
20. It is not clear that Muckamore has an agreed preferred registered to non-registered nursing staff ratio, although a preferred ratio of 70% registered to 30% unregistered is not unreasonable for the complexity of need presented by those admitted to Muckamore. Although this ratio is perhaps unrealistic or unachievable, a 48%:52% ratio should raise questions about (i) the ability of registered RNLD staff to adequately lead and supervise the work of non-registered staff who are delivering most of the direct patient care interventions and (ii) the capacity of this workforce to champion people's health improvement, enhance their well-being and enable them to leave the hospital and enjoy full lives after discharge.[2]
21. ***It is unlikely that the registered to non-registered nursing ratio at Muckamore will change significantly in the next five years and therefore there is an immediate need to invest in education and training of the Band 3 Health Care Support workforce which will continue to provide much of the direct patient care. This should be combined with a serious effort to reduce the administration burden placed on registered staff to afford them more time to plan and supervise care, to ensure the appropriate availability of knowledge and skills to***

[1] National Quality Board (2018) *Safe, Sustainable and Productive Staffing - An Improvement Resource for Learning Disability Services: Appendices*

[2] Department of Health, Department of Health, Social Services and Public Safety, Welsh Government and The Scottish Government (2012) *Strengthening the Commitment: The Report of the UK Modernising Learning Disabilities Nursing Review* Edinburgh: The Scottish Government

meet the increasing health and behavioural complexity of need of the projected future population who may require inpatient care.

Note: The Review Team recognises that while registered to non-registered staff ratio is one of many indicators of the quality of care, a low ratio of registered staff was not a factor in the PICU where the initial patient safeguarding incidents arose.

Use of 1:1 or 2:1 Observations

22. During this Review the Team read all the safeguarding files for the time period of 2012-2017. It became apparent that the customary response to allegations of abuse made against staff by patient(s) resulted in the implementation of 2:1 observations; to provide witness to any further allegations made by the individual about a member of staff. On the face of it this appears to be a defensive and expensive response to the issue that serves more to protect staff than the service user. The number of occasions this was evidenced in the files suggests that this has become the accepted response, yet it creates an unfeasible demand for additional staff.
23. ***The use of observations was never intended as a safeguarding/protection strategy and there is little evidence of multi-disciplinary review of allegations to determine potentially more proportionate means of responding to allegations against staff, that seek to provide more positive interventions other than 1:1 or 2:1 observations. For example, being attentive to patient grouping and patients having full diaries of purposeful and negotiated activities – including physical activities.***
24. ***Apart from the creation of a significant demand for nursing staff the continued use of observations in this way becomes in a very short period, of little therapeutic value, intrusive and oppressive. Consideration should be given to developing and implementing more therapeutic and supportive interventions in such cases with a clear focus on multi-disciplinary review and accountability. Patients spend too much time doing nothing. With a few exceptions, people's boredom is tangible.***

Dependence on Bank and Agency nursing hours

25. Because of some of the issues highlighted above, Muckamore relies heavily on replacing unfilled nursing posts and shifts by commissioning additional bank and agency staff at considerable cost. The Review acknowledges that in many cases it is existing hospital staff (or retired staff) who volunteer to undertake additional hours on top of their existing contracted hours to fill vacant shifts. There is no doubt that without the commitment of these staff it would be virtually impossible to operate all the wards and maintain a service. However, this reliance on Bank hours has become the norm at Muckamore, like many other hospitals and Trusts in Northern Ireland. This phenomenon remains an unstable and unsatisfactory way to build and maintain consistent wards nursing teams that can collectively engage in and provide sustainable quality improvements.
26. An unintended consequence of the reliance on bank and agency staff is that current systems do not afford timely management and intervention when staff are scheduled to work hours

that take them beyond accepted legal requirements for adequate rest and recuperation, even for staff who have opted out of the European Working Time Directive. Ward Teams appear to struggle just to provide a safe service and have little opportunity to develop nursing practice. It is questionable whether staff who consistently work excessive hours become tired and unable to maintain the drive and enthusiasm required to work with service users in an optimally therapeutic way. To maintain a safe service the wards experience constant changes of personnel. This is disruptive to patients, it does not lend itself to the creative environments required for a stable nursing team to develop their nursing practice or to meet future complex behavioural complexity in the future.

27. The cost to the Trust of agency and bank hours had recurrently equated to a weekly average of 50 Whole Time Equivalents (WTE)

Average bank hours per week converted to WTEs	
2014 – 2015	59
2015 – 2016	53
2016 – 2017	56
2017 – 2018	43

28. Over the last four financial years the Trust has been spending at least to the equivalent of 50 WTE nurse per week on bank hours and therefore should by default consider this level of investment as unavoidable to maintain services at Muckamore. Arguably, the Trust should seek to recruit to this level in permanent posts to significantly reduce the reliance on Bank hours and create more stable and sustainable ward teams.
29. However, given the existing difficulties in securing staff it is unlikely that the numbers required will be available in Northern Ireland in the next five years. ***Reluctantly the Review Team recognises that this position for the Trust represents high cost and significant risk to quality of services as they are currently configured at the hospital. This position hastens the need to quickly decide whether Muckamore has a future. Identifying its future role and purpose within the context of assessment and treatment services is a matter of urgency.***

Appendix 5

Themes arising from Regulation and Quality Improvement Authority (RQIA) Reports 2012-2017 at Muckamore Abbey Hospital

Background

1. The Terms of Reference for the Level 3 Investigation state that the Review Team should review the effectiveness of "the implementation of previous recommendations following Serious Adverse Incidents, Adult Safeguarding investigations and RQIA reports…from 2012 – 2017."
2. A preliminary scrutiny of RQIA reports, including the associated recommendations and actions, suggested that the demands of tracking hundreds of recommendations and actions was substantial. An alternative approach was negotiated. In brief, the Team sought to identify the principal themes which Inspectors have addressed within a five-year time frame.
3. The twin tasks of inspection and quality improvement are perceived by most of us as straightforward. Belfast Health and Social Care Trust describes Muckamore Abbey Hospital as a provider of:

   > *"…inpatient, assessment and treatment facilities for people with severe learning disabilities and mental health needs, forensic needs or challenging behaviour…* [a] *full range of services are available including, psychiatry, nursing, social work, psychology, day services, behaviour support as well as Allied Health Professionals as required"*[1]
4. So, a hospital for adults with learning disabilities employs competent and experienced nurses and staff and, if it does not, the regulator will step in to help or protect the patients. This consideration of themes points to a different reality – inspectors requiring the hospital to act on the multiple recommendations associated with each inspection irrespective of the persistence of certain themes in RQIA reports.
5. The RQIA identify their responsibilities concerning "Mental Health and Learning Disability" as:

   > *…promoting good practice; preventing ill treatment; remedying any deficiency in care or treatment; terminating improper detention in a hospital or guardianship; and preventing or redressing loss or damage to a patient's property. We talk directly to patients and ask them about their experiences.*[2]

What we did

6. On 30-31 January 2018, two reviewers determined some rules of thumb to make sense of 61 RQIA reports of announced and unannounced inspections concerning ten Muckamore Abbey Hospital wards, some of which have since closed:
   - After a preliminary reading of a small sample of reports, identify some strong clues which may or may not be themes
   - Amend, develop or set aside the potential clues/themes based on the attention which the RQIA pays to them

[1] http://www.belfasttrust.hscni.net/LearningDisabilityService-MuckamoreAbbeyHospital.htm (accessed on 9 April 2018)
[2] https://rqia.org.uk/what-we-do/mental-health-learning-disability/ (accessed on 2 February 2018)

- Identify the "outlier" reports – the ones which stray from the more typical generic inspections
- One reviewer to read all the reports, a second reviewer to read over a quarter of the reports and two reviewers to read three, randomly selected reports to ensure the credibility of the emergent themes.

7. The reviewer who read all the reports invited the second reviewer to identify the potential themes. These were set aside until the first reviewer had finished reading all the reports and had identified evidence to confirm and strengthen each theme.

What we found

8. The inspection reports were complemented with 12 "Patient Experience Interviews" with patients and/or their representatives from all but two wards (Ennis and Iveagh) using a RQIA questionnaire. Most of these interviews took place during 2014. One was published even though no patients were interviewed. One stated that the questionnaire was *not completed due to patients' inability to verbally communicate and participate,* and another noted *no specific issues raised.*
9. The reviewers' scanning of the Patient Experience Interviews highlighted the following topics:
   (i) knowledge of advocacy/access to advocacy/involvement of advocacy (e.g. Greenan, Cranfield and Donegore)
   (ii) experience of restraint/rationale for restraint/hurt by restraint and relative not informed (e.g. Greenan, Cranfield, Killead and Iveagh[3])
   (iii) experience of seclusion/rationale for seclusion (e.g. Donegore, Cranflied and Six Mile)
   (iv) anxiety about leaving the hospital/delayed discharges (e.g. Oldstone)[4]
   (v) desire for activities/structured programmes/getting out and about (e.g. Cranfield and Six Mile)
   (vi) feeling safe/noise (e.g. Killead and Six Mile)
   (vii) change/no change resulting from expressed concern (e.g. Erne)
   (viii) not enough staff/too many staff (e.g. Six Mile)
   (ix) therapeutic wages (e.g. Six Mile)
   (x) food (e.g. Six Mile) and
   (xi) the removal of possessions such as mobile phones, razors and lighters (e.g. Six Mile).
10. It would be inaccurate to identify (i)-(xi) as themes since they derive from an RQIA questionnaire. Although inspectors undertook to ask hospital staff about some of the matters identified by patients, it is not known what changes, if any, the Patient Experience Interviews brought about.

[3] Iveagh is a Tier 4 children's service on a different site providing specialist in-patient, assessment and treatment services

[4] *There are a number of people living in hospital who do not need to be there. They are waiting for community living arrangements to be funded so that they can leave hospital* http://www.belfasttrust.hscni.net/LearningDisabilityService-MuckamoreAbbeyHospital.htm (accessed 9 April 2018)

Table 1: The number of inspection reports for ten wards

Wards	2012	2013	2014	2015	2016	2017
Ennis*	2	2				
Cranfield	1	2	1	4	1	4
Greenan*	1					
Moylena	1		1	2	1	
Iveagh	3	3	4	1	1	1
Oldstone*		2				
Donegore		1	1	1	1	1
Killead			2	1	1	2
Erne			2	1	1	2
Six Mile	1	1		2	1	1

*These wards have closed

11. The following Table considers the backdrop to RQIA inspections and the different types of inspections. They typically indicate the reason for inspection as follows: A = an announced inspection; Un = an unannounced inspection; C = a complaint investigation; WB = triggered by whistle-blowing; SC = triggered by incidents and/or "serious concerns"; * = inspection status not specified

Table 2: The origins and types of RQIA activity and inspections

Ward	2012	2013	2014	2015	2016	2017
Ennis	Un SC	Un x 2				
Cranfield	A	Ax2	Un	Un x 4	Un	Un WB SC x 2
Greenan	WB					
Moylena	A		Un	Un x 2	WB	
Iveagh	? x 2 A	Un WB A	Un x 3 SC	Un	Un	Un
Oldstone		A x 2				
Donegore		A	Un	Un	*	Un
Killead			A Un	Un	SC	Un SC
Erne			Un x 2	Un	Un	Un x 2
Six Mile	C	A		Un x 2	Un	Un

12. The 2012 **complaint** concerned the alleged bullying of a male patient. The complainant was a relative who had "been advised by a staff member." The patient reported to their relative that they were told "Your [relative] can't help you while you are in here." He reported feeling unsafe, being subject to sexual advances and witnessing patients' engaging in sex. His mental capacity was questioned. The staff did not believe the patient to be "under threat" and it was concluded that there was "no evidence to confirm [the] allegation that he was treated badly." The man's relative was not assured by the investigation. "There was no sense that advocates were proactively involved." The relative was excluded from the patient's protection planning process, the records were insufficiently detailed, and a family visit was curtailed by the ward. The relative noted that staff were "unwilling to record incidents that happened to [the patient] but they are very quick to record anything he does." The RQIA undertook "to monitor the safety, quality and care of patients at Six Mile and follow up the treatment and care provided to" the complainant's relative.
13. The "**serious concerns**" of **2012** hinged on the "alleged abuse" of patients on Ennis ward. The inspectors noted "the major potential for behaviour problems," the "history of low staffing levels…the appropriate complement of staff for the ward remains unclear…[the] significant number of vulnerable adult referrals" and the challenges in securing post-hospital placements for patients. The RQIA concluded that the "practice presence of advocacy" was required.
14. The "serious concerns" of **2014** concerned the involvement of the Police Service of Northern Ireland in the use of handcuff and leg restraints on a young person who was subsequently taken to a seclusion room. Meeting minutes concerning this event were unavailable. It was unclear whether (i) de-escalation methods had been employed prior to the restraint or (ii) formal debriefing had resulted. The RQIA noted the limited knowledge of staff concerning the management of behaviours which challenge and sought the improved governance of physical interventions, the use of seclusion and PRN medication. Among the RQIA's 35 recommendations was the drafting of a protocol "to define the circumstances in which the police should be required to assist staff to manage challenging behaviour."
15. The "serious concerns" highlighted during **2016** concerned patients' deteriorating physical health, overcrowding, staff shortages, noise levels, increasing incidents and the absence of activities for patients. The RQIA inspectors found "no evidence" of compromised health, overcrowding, staff shortages, noise levels or under-occupied patients. They acknowledged the increase in the frequency of incidents yet determined that these were "not disproportionate."
16. There were three "serious concerns" identified during **2017**: the first hinged on "unsafe staffing levels" which the RQIA deemed substantiated, "however, levels had improved due to a reduction in staff absence and redeployment." The second concerned "staff shortages" which the RQIA acknowledged "on some occasions." It found that noise levels were substantiated. There was no evidence of an increase in incidents. The third concerned patients unable to access Allied Health Professionals; unmonitored care and treatment and temperature control. No evidence was found to substantiate these concerns.

17. **Whistle-blowing** led to two RQIA inspections. One during **2013**, alleged that a young person was sleeping on a temporary bed in [Iveagh's] day room and that young people were using the beds of patients on home leave. The RQIA "urged…urgent priority to establishing a robust, tiered model of intervention in the community to ensure that Iveagh beds are used appropriately…need to consider a step-up/down unit to enable young people to receive alternative support."
18. The whistle-blowing of **2016** alleged that Moylena was "dangerously understaffed" and that standards of hygiene were wanting. The RQIA noted the changes in ward management arrangements, "including the unplanned absence of the ward manager…the resignation and imminent departure of the deputy ward manager" has resulted in "confusion/uncertainty."

The Emergent Themes

19. Incrementally, the RQIA's reports over five years point to consistent themes – two in particular comprise the backdrop: (i) "Visiting professionals expressed concern about the prolonged [delayed] discharge of many patients…felt they were exhausting all possibilities within their own remits but there was a greater issue outside the hospital" [Killead] and (ii) "Concern regarding people's access to physical health care screening" [Cranfield].
    (i) **Institutional practices** embrace the management of groups of patients who are perceived to have similar support needs or experience identical circumstances, e.g. "major potential for behaviour problems…difficulty in getting appropriate placements for patients…" [Ennis); "TV in protective storage…weekends long with few activities…Patient Forums sporadic and advocate not present" [Cranfield]; "dormitory areas…some [patients] have been on site for more than 50 years…outings off ward are limited…patients woken to get dressed at 6.00am to assist day staff…previously inspectors had been told it was patients' choice to get up early" [Greenan]; "routines…modified to ensure individual access to bathroom areas…open dormitory…little progress regarding privacy measures…patients' experience could be perceived as degrading …personal property contained in locked wardrobes (which patients could) look at in the mornings …patients spending majority of time in group rooms…absence of personal items…staff ambivalent about belongings/having pictures in bed space area…subject to the routines of the ward…partitions (in the dormitory) would make it difficult for patients to be observed by staff"[Moylena]; re the transfer of a young person to an adult ward, it was anticipated that a change in environment may be therapeutically beneficial… unclean patient equipment… patients to wear only their own clothing" [Iveagh]; "blanket restrictive practices…not appropriate" [Six Mile]; "noise levels can be disturbing…environment in need of upgrading...over-reliance on agency/bank staff" [Ennis]; young people being admitted "over agreed bed capacity" [Iveagh]; "they stopped the gardening programme without telling us" [Six Mile]; "physical environment not conducive to the patients' needs, particularly noise levels" [Killead].

(ii) The **workforce** embraces: **the staffing establishment** e.g. "staffing stretched…sick leave 5-5.5% average for the hospital" [Greenan]; "staffing appropriate" [Six Mile]; "reduced staffing levels…staffing deficits" [Oldstone]; "over-reliance on agency/ bank staff…insufficient staffing levels…current staffing ratio does not facilitate therapeutic interventions…increased staffing provided" [Ennis] "staff sickness/ turnover has led to extensive use of bank and agency staff" [Iveagh]; "staffing allocation had been supported by staff from another facility…night staffing levels vary" [Moylena] "sometimes there's a lack of staff" [Cranfield] "not enough staff…because of the observation levels" [Six Mile]; "staffing levels did not reflect the needs of the patients. Health Care Assistants are frequently left to supervise patients without the oversight of qualified staff" [Erne]; "staffing pressures…unsafe staffing levels…low staffing impacting on incidents…staffing levels appeared adequate to support the assessed needs of the patients" [Cranfield]; **staff preparation, training and supervision** e.g. "arriving without clear instructions about their placement" [Ennis]; "most staff trained in safeguarding…[Greenan]; "staff not supervised for five months" [Cranfield]; "all staff had received up to date supervision…not all mandatory training up to date" [Killead]; "Inspectors noted a lack of knowledge and understanding amongst staff team about how to address behaviours that challenge staff other than the use of restrictive practices…nursing staff can only attend mandatory training" [Iveagh]; **staff perceptions and experience** e.g. "We work in a demanding and stressful environment, but we have an excellent team of staff who provide a high-quality service to each child…number and nature of injuries to staff is unacceptably high" [Iveagh].

(iii) **Multi-disciplinary working** embraces: its **availability** e.g. "inequity of access to advocacy…no dedicated social worker for the unit…operating without the full range and availability of multi-disciplinary staff…a number of clinical specialists were not available…psychotherapeutic services not evident" [Iveagh] "no clinical psychologist attached to the ward…no OT input" [Cranfield]; "no pharmacy support on ward" [Iveagh] "insufficient managerial and clinical input to the ward" [Donegore]; "no evidence of input from Behavioural Support Services…in assessing behaviour and devising/overseeing management plans" [Ennis]; "medical staff not always available" [Cranfield]; **purpose**, e.g. "MDT were continuing to develop patient care pathways to improve patient experience and enhance therapeutic effectiveness" [Six Mile]; "MDT meetings…more focused on resettlement since 2012" [Ennis]; "clear evidence that psychiatrist and MDT had been advocating for the discharge of a patient" [Cranfield]; "Interdisciplinary Care Reviews had been reintroduced" [Iveagh].

(iv) **Purpose** at micro and macro levels: e.g. ward has a "resettlement focus" [Ennis]; "many patients have been receiving inpatient care for more than 50 years…no evidence of provision of activities or meaningful engagement with staff" [Moylena]; "continued admission was detrimental to individuals no longer receiving inpatient treatment…not in keeping with the philosophy, function and purpose of the ward"

[Six Mile]; "most patients are delayed discharges…managing frustrations" [Oldstone]; "the rationale or therapeutic aim…was not clearly documented" [Cranfield]; "difficult to carry out a monitoring role and be involved in nursing duties at the same time" [Ennis]; "some misunderstanding/differences about the purpose of [Iveagh] was evident;" "marked absence of an agreed, consistent, proactive behavioural management strategy…need to revisit the educational input to clarify the role of the visiting teacher" [Iveagh]; "I don't think the Team had a set plan" [Oldstone]; rationale/therapeutic aim not consistently recorded re restrictions [Killead]; transition back…not thought through" [Erne]; "difficulties in accessing extra contractual referrals for specialist treatment…range of patient profile and needs (impacts on) creating an appropriate therapeutic environment/recovery model…the introduction of a "sensory modulation room which patients could use to relax and listen to music…fibre optic lighting and massage chair…seclusion room being redesigned to include a low sensory area with the aim of reducing the number of patients requiring seclusion…difficult to track patients' progress" [Cranfield]; "goals should be recorded in care plans…there are smaller areas for patients to sit and form friendships" [Cranfield]; "in circumstances where people required enhanced observations, nursing care and team duties were prioritised over activities…some patients choose not to access therapeutic interventions" [Six Mile]; "patients had several sets of care files"[5] [Moylena].

(v) **Restrictive practices** embrace physical interventions, including restraint, secluding patients and administering PRN medication, e.g. "no evidence of restricted access or removal of patient's mobile" [Six Mile]; "hospital has been commended in the training and audit of physical restraint by BILD. Seclusion records were examined and reflected Trust policy…many of the restrictive practices in use were not documented…and were not under regular review" [Cranfield]; "evidence of some patients experiencing restrictions due to the needs of their peers…physical intervention audited…use of [planned] restraint for patient who required support to provide a blood sample…four staff involved yet care plan did not support this. No best interests discussion, no independent advocate" [Moylena]; "blanket restrictive practices…not appropriate [i.e.] locked doors, phone access, time off ward, personal

[5] The RQIA reports include references to over 25 types of assessment and planning tools: Comprehensive Risk Assessments, Risk Management Plans, Care Plans, Person-Centred Care Plans, Personal Activity Plan, Care Plans for Each Need Assessed, Positive Behavioural Support Plans, Individualised Incentive Plans, Patient Progress Records, Progress Notes, Assessment of Communicative Needs, Restrictive Practices Assessment, Individual Assessments for Therapeutic and Recreational Activities, Individualised Restrictive Practice and Deprivation of Liberty Care Plan, Discharge Care Plan, Care and Treatment Plan, Holistic Needs Assessment, Capacity Assessment, Best Interests Checklist and Decision-Making, Financial Capacity Assessment, Occupational Therapy Assessment, Swallowing Assessment and Hospital Passport. In addition staff use a Betterment Audit Tool, undertake Significant Events Audits, Braden Scale Assessments, Malnutrition and Universal Screening Tool, Risk Screening Tools, Promoting Quality Care Screening, Interdisciplinary Care Reviews, Management of Actual and Potential Aggression, Belfast Risk Audit and Assessment Tool, Functional Analysis of Care Environments Risk Assessment and Quality of Life Assessments

searches…Patients had signed their Restrictive Practices Assessment indicating that they had agreed to Restrictive Practices being used " [Six Mile]; "practices…that could be viewed as restrictive" [Cranfield]; "Explanation about the use of restrictive practices…detailed in Easy Read in the ward's Welcome Pack" [Donegore]; "patients did not have access to their bedrooms and personal belongings during the day…all patients are subject to the same level of restriction…locked doors and covert medication" [Ennis]; "Inspectors noted a number of referrals that could be viewed as restrictive but rationale/therapeutic aim not documented…new pro forma to record episodes of seclusion…no evidence that capacity to consent to care and treatment was being considered…no explanation why episodes of seclusion had significantly reduced over past months" [Cranfield]; "observation levels, alarms on bedroom doors – restrictive?" [Killead]; "the practice of locking patients' wardrobes and chest of drawers had been stopped and all locks removed" [Erne]; "not all staff had received training in restrictive practices" [Moylena]; "incident re use of restraint and seclusion (re police involvement using leg restraints and handcuffs)…patient was transferred to a seclusion room using a bed sheet…Inspectors noted a lack of knowledge and understanding amongst staff team about how to address behaviours that challenge staff other than through the use of restrictive practices…informal discussion (followed these) incidents…no evidence of any learning [Six Mile]; "There were 120 incidents of seclusion in January 2014, 29 in June; 65 PRN in June…7 in July; 65 physical interventions in June, 19 in July …a significant reduction in interventions…staff confident in use of proactive strategies and motivated by…success…one patient stated they had been hurt" (during restraint)[Iveagh]; "bi-monthly restrictive practices meetings to discuss episodes of seclusion, PRN and other restrictive practices" [Cranfield]; "Rules are unfair. I'm not allowed out…reduction of seclusion use, physical interventions and PRN…staff actively problem-solving and implementing positive behaviour support plans" [Iveagh].

(vi) **Records and their maintenance** e.g. "comprehensive risk assessment does not have contemporaneous information… notes did not evidence consideration or discussion about vulnerable adult referral or recording in incident records" [Six Mile]; "seclusion rooms were examined and reflected Trust policy" [Cranfield]; "no specific explanation of monitoring role documented…unable to clarify how incidents reported" [Ennis]; "some information in care documentation lacked detail…documents about one patient noted a number of different behaviour support plans…documents about a patients noted that behavioural supports were not used (staff explained that the patient was) so autistic" [Cranfield]; "no protocol concerning in-hospital transfers [Iveagh]; "no ward based schedule for therapeutic activities" [Cranfield]; "no clear protection plans were evident…staff unaware where (these plans) are stored" [Ennis]; "Safeguarding officers are automatically alerted if more than three alerts are received for the same patient, however, does not alert safeguarding officers to multiple referrals due to same alleged perpetrator…care

plans and risk assessments not signed by patient or relative…rationale for some interventions not included in the documentation reviewed… care plans not person-centred" [Cranfield]; "care records were not formally audited…an overarching summary of each patients' psychiatric and medical condition was not available" [Erne]; "malnutrition assessments not being reviewed on a monthly basis… patient satisfaction survey bi-monthly" [Cranfield]; "Patient records were not stored securely…care plans not always up to date" [Erne]; "reviews did not always reflect if the restrictions had reduced" [Cranfield]; "care plans about actual or perceived Deprivation of Liberty did not evidence that the multi-disciplinary team had considered proactive strategies to reduce the use of restrictions" [Killead]; "although a safeguarding vulnerable adults protocol had been developed, staff were not correctly completing the documentation…patients had several sets of care files" [Moylena].

(vii) **Engagement with patients' families and advocates** e.g. "staff believed he had (mental) capacity…his mother believed he did not…did not feel informed about his care…family excluded from the protection planning process…unintentional that (a) visit impinged on family time" [Six Mile]; "a recommendation made to consistently inform relatives about incidents and vulnerable adult referrals to ascertain and record their views" [Cranfield]; "relatives to have more access to living areas…representatives said that they had never been informed or had any indication from staff that their relative had been hurt during a physical intervention (or that a seclusion ward was used)…advocates only available to see those subject to a Care Order" [Iveagh]; "informing relatives of the purpose of meetings in advance" [Erne]; "relative highlighted level of assistance given to relative and the consistency of care delivery across the staff team" [Cranfield]; "advocates occasionally attend meetings on the ward but do not routinely visit or spend time with children being assessed… [Iveagh]; "there's significant demand (for advocacy) but availability is limited due to funding" [Cranfield].

20. The endurance of these themes has not yielded to effective remedies thus far.

Response to Briefing Paper – Themes arising from Regulation and Quality Improvement Authority (RQIA) Report 2012-2017 at Muckamore Abbey Hospital

General Overall Comments

- RQIA would have welcomed sight of this paper being made available prior to the meeting with the review team so that we may have given informed comments at the meeting. (Report dated 9 April 2018: meeting convened 14 May 2018).

- We note that the Terms of Reference have not addressed all of the findings and recommendations, following inspections (para 1). Ww would welcome the opportunity to provide further information and context to the review team.

- There is no reference to RQIA inspection methodology, processes or procedures. There is no reference to the Mental Health Order (Northern Ireland) 1986 and MHLD's statutory functions. This seems incomplete as it does not set the context for RQIA legal and regulatory function with respect to services delivered in Muckamore Abbey Hospital (MAH).

- We would welcome some discussion/descriptor of RQIA's inspection methodology. The term 'typical generic inspection' is not familiar as our methodology takes into account additional indicators.

- RQIA would welcome the review team's clarification of the use of the term 'serious concerns'. This is an RQIA internal process that falls under our Enforcement Policy; subsequently the review team's use of this terminology is unclear to us.

- It is not clear as to what methodology the review team used to rate, catalogue and determine the themes.

- Patient Experience Interviews (PEI) are carried out in accordance with our legislative functions. We meet with patients in private and subsequently they are not a form of inspection, rather they are a core element of the overall inspection process.

- Whilst RQIA understand the review team is assessing safeguarding processes, this report fails to reference the positive experiences that the patients shared with inspectors during inspections and PEIs.

Section Comments

Page 1-Para **3.**	• RQIA undertake MHLD inspection in accordance with legislation and minimum standards for care and treatment. Any subsequent recommendations are followed up in accordance with RQIA's Inspection Policy.
Page 1-Para 3.	*"The twin tasks of inspection and quality improvement are perceived by most of us as straightforward."* • It is not clear what is meant by 'straightforward'.
Page 1-Para 5.	• RQIA would like clarification of this statement as staffing issues are largely related to commissioning and as such are the responsibility of DOH/HSCB. RQIA's inspection role is to identify and remedy any potential deficiencies in care and treatment. We would comment on the general theme of staffing and ask for attention and/or remedy. The role of protecting patients falls within the responsibility of a number of agencies. RQIA do not undertake safeguarding reviews although we do review safeguarding processes.
Page 1-Para 5.	• The report makes no reference to RQIA's Escalation and Serious Concerns Procedures, which have been invoked on 21 separate occasions. The section of the report is inaccurate given that RQIA have commissioned thematic reviews.
Page1-Para 7 (and supporting bullet points)	• Requires clarification regarding the reasoning behind the statement 'make sense of 61 RQIA reports'. RQIA's reports are public facing, written in clear and concise english, and are available in easy read versions. Furthermore, RQIA does not understand the term 'outlier reports' within the context of the report. We would welcome further clarification.
Page 2- Para 3:	• This paragraph suggests that we did not speak with patients. Please note, sometimes it is not possible when patients are very unwell, or, as in this situation, not capable of answering the questions. We have alternative approaches, usually involving observation and advocates.

Page 3-Table 2	• RQIA does not investigate complaints, but we do act in response to intelligence received and invoke our serious concerns processes.
Page 4-Para 2	• We would welcome clarification as to whether this relates to the Iveagh centre; it reads as if it was Ennis Ward? If it is Iveagh, RQIA undertook to work closely with this ward to improve standards and care practices. We would ask that our work is included/ reflected appropriately here. In July 2014 five Improvement Notices were issued, it is important to note however that was the only time RQIA's MHLD Team have taken this action following an inspection. • Regarding the improved use of seclusion and PRN medication, this statement can be interpreted in two ways, positively or negatively.
Page 5-Para 1.	• There has been no mention of any progress made following recommendations made, post inspection.
Page 5-Para 2	• RQIA note the report has not qualified the two major themes. These have not been developed fully. We are not clear, as it goes on to talk about different themes e.g. institutional practices. There is no reference to the successful implementation of previous recommendations, e.g. increased OT and Psychology levels on the wards following RQIA recommendations.
Page 6-Para 1	• The report does not provide the context in relation to staffing issues. There is no reference to variation across the hospital site, contingency planning, escalation, training improvements, supervision and environmental improvements. Again lots of reference to Iveagh which is a different facility providing a different level of care from the MAH.
Page 6-Para 3	• RQIA have addressed all these themes on a consistent basis during inspections (and follow up inspection) since 2012.
Page 7-Para 1	• There is no measure of the implementation of the recommendation despite this being the main purpose of the review.

Page 7-Para 2	• Restrictive Practice Sixmile Ward – we note there is no reference made to patients refusing to leave this regional low secure ward. We understand that patients are willing to stay voluntarily and the Trust supports this.
Page 9, final sentence - *The endurance of these themes has not yielded to effective remedies thus far*	• RQIA would not concur with this statement and contests that the findings presented in the report do not support this outcome. We would welcome evidence supporting this outcome determination.

Appendix 7

Health Needs

Changing demographics and population across the lifespan

The population of neonates, children and young people living into adulthood with a range of multiple and complex neurodevelopmental disabilities and learning disabilities is increasing.[1] There is an increase in the number of premature neonates surviving into adulthood who have a wide range of interrelated complex physical and mental health conditions and challenging behaviours.[2] [3] Many require invasive health procedures to sustain life and are more technologically dependent due to their co-existing physical health conditions.[4] This population are also presenting with neurodevelopmental disorders, including Foetal Alcohol Spectrum Disorder, Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder.[5] [6] [7] [8] [9] [10] [11]

Physical health conditions

Physical health conditions are common in people with learning disabilities and many remain unidentified and untreated with significant implications for the individual, their family and carers and care services.[11] Many people with learning disabilities present with a range of multiple co-morbid physical health conditions that if untreated leads to avoidable, premature deaths.[12] [13] The common physical health conditions experienced by many people with learning disabilities include, respiratory disease, cardiovascular disorders, endocrine disorders, neurological disorders, haematological disorders, infectious diseases, dermatological disorders, sensory impairments, sleep disorders and metabolic disorders.

Respiratory Disease

Respiratory disorders are the leading cause of death in the learning-disabled population, notably by way of chest infections, secondary to dysphagia, contributing to premature and avoidable death.[14] [15] Swallowing disorders are common and contribute to gastric aspiration and pneumonia and contribute to avoidable death.[16] Asthma is common, notable in those who smoke and are obese. Respiratory cancers associated with smoking are less common when compared to the general population.[17] [18] However some people with learning disabilities do smoke and access is required to programmes and support to quit smoking.[19]

Cardiovascular Disease

Cardiovascular disease is the second commonest cause of premature death.[20] Cardiovascular disease occurs at a younger age in adults with learning disabilities and a prevalence of 14% has been identified.[21] Cardiac and circulatory conditions effect 21% of adults with learning disabilities and contributes to premature death.[22] People with learning disabilities experience higher prevalence of hypertension, obesity and are physically inactive.[23] Coronary artery disease contributes to the premature death of older adults with Down syndrome.[24] Metabolic syndrome is now being experienced by people with learning disabilities, presenting with an increased risk of coronary heart disease and type-2 diabetes, with risk factors found to be

higher in young adults with learning disabilities.[25] [26] In older adults with learning disabilities the prevalence rate was double that found in the general population.[27]

Epilepsy

Epilepsy is the most common co-morbid neurological condition experienced by people with learning disabilities. In a systematic review of the research evidence, an overall prevalence of 22% was identified. A prevalence of 12% was found in people with Down syndrome, which increased with age and in those with Alzheimer's dementia.[28] The prevalence of epilepsy increases with the severity of the learning disability. It is most prevalent in people with severe learning disability.[29] Epilepsy contributes to accidents and injuries and premature death in people with learning disabilities.[30] Access to assessment, diagnosis, treatment and management of epilepsy can be more complex in the learning disabled population due to other health co-morbidities, communication disorders and the range of complex seizures types that present.[31] There is evidence of an association between epilepsy and neuropsychiatric conditions, notably negative mood symptoms and are more common in those with severe forms of epilepsy.[32] Partnership working with primary care, paediatric and acute hospital services is necessary to enable investigations and diagnosis and at the point of transition between services.[33] Epilepsy management needs to be included in planning for discharge from assessment and treatment units to ensure that accommodation is appropriate, and the right levels of staffing support are in place.[34] As the number of children and young people with learning disabilities with complex health needs increases, there will be greater demand for assessment, treatment, psychoeducation and epilepsy management, including medication compliance.[35] Therefore, effective epilepsy management is needed and there are key roles for practitioners in specialist learning disability in-patient assessment and treatment units and community learning disability teams.

Gastrointestinal Disorders

Gastrointestinal disorders are common in people with learning disabilities and increase with the severity of the impairment, notably those with cerebral palsy and is associated with gastric-oesophageal reflux disorder (GORD), rumination, vomiting and hematemasis and anaemia.[37] [38] Links have been identified between GORD, agitation, self-injury and rumination in people with more severe learning disabilities.[39]

Mental Health Conditions

Mental illness is common in people with learning disabilities, notably depression and anxiety and psychotic disorders, including schizophrenia.[40] [41] Mental illness is also associated with developmental disabilities, including, ADHD and Autism.[42] [43] People with learning disabilities are at greater risk of developing a mental illness due to a range of factors including, adverse life events, poverty and abuse.[44] [45] Mental illness is also common in older adults with learning disabilities, with a high prevalence of dementia, which is particularly the case in people with Down syndrome.[46] [47] Diagnosis requires access to specialists with knowledge and expertise regarding the different clinical presentation of mental illness in people with learning

disabilities and address needs related to communication disorders, co-morbid physical health conditions and diagnostic overshadowing.[48] [49] Despite the high prevalence of mental illness there remains a lack of access to appropriate psychological therapies for people with learning disabilities and this is an area that requires attention and investment.[50]

Offending Behaviours

Some people with learning disabilities commit offences and come into contact with the criminal justice system, with the prison populations comprising some 7-10% of people with mild learning disabilities.[51] Some people with learning disabilities are diverted from the prison system and receive treatment and interventions in secure health service settings.[52] Health co-morbidities are common in people with learning disabilities who offend and include, physical health conditions such as obesity, diabetes, sensory impairments and mental illness by way of anxiety disorders, depression, substance use and suicidality.[53] Other commonly occurring conditions include ADHD and Conduct Disorders.[54] In relation to women with learning disabilities who offend, long standing mental illness is common, including a major depressive illness, psychosis and schizophrenia, with polypharmacy being evident and need for access to psychological therapies.[55] There is a need to improve access to psychological therapies for people with learning disabilities who offend and are receiving treatment in health services secure settings.[56] Life events and trauma is also common in adults with learning disabilities which can result in PTSD and the need for access to assessment and treatment.[57]

Behaviours that challenge

Challenging behaviours are common in people with learning disabilities, with prevalence rates being between 10-15%.[58] Challenging behaviours include aggression, self-injury, agitation, destructive behaviours, arson and sexual misconduct.[59] Comprehensive assessment and treatment is required for challenging behaviour to identify and exclude untreated medical conditions and it is recommended that annual health checks are undertaken with people with learning disabilities[59] [60] Challenging behaviours have been identified in children and young people with rare chromosomal abnormalities.[61] A range of treatment options are required to support people with learning disabilities and challenging behaviours.[62] [63] There is limited evidence for the use of and effectiveness of psychotropic medication to treat challenging behaviour.[64]

Dementia

People with learning disabilities are at great risk of developing dementia, with a prevalence rate of 18% found in those over the age of 65.[65] Dementia is also common in people with Down syndrome, who develop the condition some three decades earlier than in the general population. By the age of 60, 80% of people with Down syndrome will have developed Alzheimer's dementia.[66] Both pharmacological and non-pharmacological treatments are recommended for people with learning disabilities and dementia, with implications for future health and social care services.[67] As the learning-disabled population ages and lives longer,

services will see more older people with dementia and other physical and mental health morbidities. Specialist services will be required to provide assessment, treatment and management of larger numbers of people with learning disabilities and dementia.[68]

Health checks and health improvement activities

Despite the research evidence of health needs and multiple health morbidities, people with learning disabilities need to access health checks and preventative care.[69] There is poorer uptake of proactive health screening, less uptake of national health screening programmes and prevention and health promotion activities when compared to the general population.[70] There are benefits to having a health check, including uptake of immunisations, cancer screening, the detection of treatable disorders such as thyroid conditions and the identification and management of dental and oral health conditions, dermatology conditions, gastrointestinal disorders.[71] Undertaking a systematic health check results in the detection of unmet, unrecognised and management of treatable health conditions.[72] Health checks lead to targeted interventions that improves the health and quality of life of the individual and their family and carers and reduces the burden on health and social care services.[73] Therefore, ensuring the comprehensive health check systems are in place in specialist in-patient assessment and treatment units and Community Learning Disability Teams is essential, particularly given the evidence of the increasing complexity of health needs and multiple health morbidities.

Supporting access to initiatives and activities directed at improving health and well-being is vital for people with learning disabilities and must be an integral part of specialist health service models and day-to-day practice.[74] People with learning disabilities need support to access national programmes available to the whole population, such as cancer screening. Health promotion programmes available for the general population need to be made accessible for people with learning disabilities, such as for the prevention of diabetes.[75] Activities focused on healthy eating, physical activity and weight management are required as an integral part of the care and support provided by universal and specialist learning disability health and social care services.[76] Where possible people with learning disabilities should be supported to access health screening and health improvement activities available to the whole population and where this is not possible due to the needs of the individual, person-centred and individualised adjustments need to be made.[77]

Multiple Health Morbidities

It is clear from the international research evidence that the health profile of children, adults and older people with learning disabilities is changing and the population increasing and ageing.[78] Many more young people are living into adulthood with multiple, complex health morbidities.[79] Collectively there is therefore a 'new generation' of children and young people living into adulthood with significant neurocognitive impairments and deficits and associated physical, mental health and challenging behaviours.[80] Older adults with learning disabilities are ageing with multiple, complex health morbidities.[81] [82]

The impact on services in the future

There are changes in the demographic profile of people with learning disabilities. The changes include increased longevity and changing patterns of morbidity and mortality. The last decade has seen a rise in life expectancy as in the general population, except for people with Down syndrome, epilepsy or multiple disabilities.[83] [84] Older adults are proportionally the largest and fastest growing group in the learning disabled population.[85] Life expectancy for an older person with a learning disability is now 70 years, with a projected 164% increase in the number aged 80 and over using care services by 2030.[86] The global increase in life expectancy is due to a number of factors including improved neonatal care and improved access to health and social care services.[87] Despite these improvements, many people with learning disabilities do not receive equal access to services and treatable health conditions remain undetected.[88] However, overall, life expectancy for people with learning disabilities remains 13 years lower for men and 20 years lower for women when compared to the general population.[89]

All education, health and social care services now and in the future will see more people with significant care and support needs of a different and more complex profile. Due to the interrelated complex physical, mental health and challenging behaviours, there will also be a growing and increasing demand for access to specialist care services, with assessment, treatment, interventions, care and support provided by highly knowledgeable skilled practitioners.[87] [88] [89] This growing learning disability population with multiple, complex health needs brings about new challenges for all health and social care professionals and care services. The planning and provision of quality healthcare is crucial to improving the health and quality of life. A long-term, strategic approach is required to build knowledge, skills and capacity within all health and social care services to meet future demands. The changes in the learning disability population will impact on all future service provision, including primary and acute care, emergency and unscheduled care, services for children and young people with complex physical health conditions, child and adolescent mental health services, specialist in-patient assessment and treatment services and Community Learning Disability Teams. There will also be a growing demand on specialist in-patient assessment and treatment services as the complexity of patients admitted changes and increases. It is therefore essential that there are a range of service and workforce responses in place to respond.

Due to their different pattern of health conditions from the general population, people with learning disabilities admitted to in-patient assessment and treatment services will require access to specialists with knowledge, skills and expertise to assess and treat a range of interrelated physical, mental health and challenging behaviours. As health and social care services are being redesigned and transformed to meet the changing needs of the wider population, so too must specialist in-patient assessment and treatment services and Community Learning Disability Teams. Investment in workforce, education, training and new service models is required.

From a specialist community learning disability team perspective, there will be increasing demands for assessment and treatment, interventions, education and supports for people

with learning disabilities, their families and carers. Arising from this is the increasing need for access to the knowledge and skills of psychiatrists, clinical psychologists, social workers, speech and language therapists, occupational therapists, physiotherapists, dieticians and learning disability nurses. It is therefore necessary to ensure that there are accurate long-term workforce development plans in place to ensure that there are professionals in place. Flowing from this is the need to ensure that there is the right level of commissioning of undergraduate and postgraduate students is in place, necessary to meet workforce needs in the future. Failure to recognise and respond will increase the health inequalities gap experienced by many of this vulnerable population and result in on-going system and service failures that contribute to poor outcomes and avoidable premature deaths.

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Belfast Health and Social Care Trust

caring supporting improving together

Chief Executive
Mr Martin Dillon

Chairman
Mr Peter McNaney, CBE

22 December 2017

Mr Sean Holland/Prof Charlotte McArdle
Chief Social Work Officer/Chief Nursing Officer
Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

Dear Charlotte/Sean

I am writing in response to your letter of the 30 November 2017 to provide the further written assurance requested therein.

Like the Department, I expect and have requested the highest level of independence for the Level 3 SAI Panel and this review.

Trust Briefing Paper

With regard to the written update provided to the Trust's Assurance Committee, the Chairman had specifically requested that Board members be updated on the total number of patients currently residing in Muckamore, a profile of the various wards and an update on resettlement to include an update on the number of delayed discharge patients. Hence the inclusion of the context setting section.

The Trust did not seek to imply or infer – nor would it ever do such a thing – that the challenges of managing patients with complex needs and very challenging behaviours was or is in any way a contributory factor to or a mitigating factor for staff behaviours which were utterly unacceptable. Muckamore Hospital as a regulated facility is required to deliver safe and person-centred care with all staff acting with the highest degree of professionalism. This is what we expect and what we overwhelmingly find, the small number of recent serious incidents notwithstanding.

I can provide assurance that the DoH correspondence of 20 October was shared with the Chairman and Trust Board. The Assurance Committee were also fully informed of the initial chronology and management of events.

The data related to *'abuse by staff to patients'* on Muckamore Abbey Hospital between April 2016 and October 2017 is part of the collation of the regular key data used for trend analysis and monitoring.

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Again, the purpose of the paper to the Trust's Assurance Committee where this data appears was not to provide detailed information on each of the incidents. I can provide assurance to the Department that all of these incidents have been investigated by Adult Safeguarding and any appropriate actions followed up.

Proposed Turnaround Teams

The Trust did initially consider the concept of an independent '*turnaround*' team however on reflection concluded that this was not feasible or likely to produce the outcome needed. They key reasons include the difficulties related to identifying and securing the appropriate expertise in a timely way. Furthermore the level of complexity involved in undertaking the necessary comprehensive investigation and analysis requires a multi-layered and sequenced approach.

Currently the Trust has put in place a number of additional supports which provide assurance that the current practice of staff and managers is of the highest standards.

These are detailed below.

a) Directors Oversight Group - A number of Directors *(Medical Director/Deputy Chief Executive, Director of Adult Social and Primary Care, Director of Nursing, Director of Social Work and Director of Human Resources)* have been meeting the Muckamore Abbey Hospital Multi-Disciplinary senior team on a weekly basis. This meeting is used to hold to account and monitor the implementation of the action plan which has been developed to provide the Trust with the assurance it requires in relation to patient safety. This Director' Group provides an open door invitation to all staff to directly engage in relation to any issues or concerns they wish to raise.

b) Enhanced Monitoring of Practice – This remains in place across all the wards at Muckamore Abbey Hospital.

c) Patient Protection Co-ordination Group - A group of senior managers with operational responsibilities meet on a weekly basis to monitor and review practice supervision arrangements for all wards. This group to date have had responsibility for viewing and reporting on the CCTV images. This group is responsible for implementing actions identified for the protection of patient's action plans and reporting progress to the Directors Oversight Group on a weekly basis.

d) Strategic Multi Agency Group - The second meeting of the multi-agency group is scheduled to meet on the 8 January 2018. This meeting ensures that all involved organisations are informed and actions co-ordinated.

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This group includes:

- Northern HSC Trust
- RQIA
- HSCB
- PSNI
- DOH
- Belfast HSC Trust

e) External Support Team - The Trust has appointed an independent support team consisting of:

Yvonne McKnight – Senior Adult Safeguarding Specialist
Professor Owen Barr – University of Ulster
Frances Canon – NIPEC

This group has two key roles:

1. To review all actions taken to date by the Trust and provide feedback and advice
2. To support the Adult Safeguarding Investigations in respect of specialist nursing expertise

The Terms of Reference for this group are being developed and will be shared with DOH when agreed.

Adult Safeguarding Investigations

The Joint Agency Investigation remains ongoing in relation to the incidents of the 12 August and 1 October. The PSNI have indicated that they hope to complete their interviews with staff prior to Christmas.

The Trust's Adult Safeguarding is also ongoing and action plan is in place with HR and Adult Safeguarding processes closely aligned.

The two staff referred to in terms of their alleged failure to report have been returned to PICU ward on restricted practice and enhanced supervision. Their actions will be subject to a disciplinary investigation once PSNI have completed their interviews.

I can clarify that the Adult Safeguarding Investigation is not complete. Progress reports and action plans are developed and updated regularly. To date Adult Safeguarding investigation processes have focused on the individual incidents. The next step in this will be the screening interviews with staff, patients and relatives and this will require the additional support of the Trusts Adult Gateway Safeguarding Team. The Trust would wish to highlight that a further two staff have been suspended following a report of a historical allegation and the management of this matter. This is being investigated under Adult Safeguarding procedures.

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Other Issues

I can confirm that in the interest of regaining public and other stakeholders' confidence the Trust intends to review all of the CCTV footage and is currently identifying additional independent support to complete this.

Independent Level 3 SAI

A fully independent panel is being appointed and is due to commence its work in late January 2018. The Terms of Reference are currently under consideration by the HSCB Designated Review Officer (DRO) and once agreed will be forwarded to you.

The panel members who have been appointed are as follows:

Name	Role	Expertise
Margaret Flynn	Chairperson	Significant experience in leading serious case reviews in Learning Disability including Winterbourne.
Professor Michael Brown	Policy Queens University	
Dr Ashok Roy	Consultant Psychiatrist, Coventry & Warwickshire Partnership Trust/Chair, Faculty of Intellectual Disability Psychiatry/Royal College of Psychiatrists	

The remaining members of the panel are being considered in consultation with the HSCB DRO to ensure full independence and will be confirmed in the coming weeks.

I can confirm that the Trust has included the need for a review of all allegations of abuse by staff over the last 5 years and the actions taken in response thereto in the Terms of Reference. I can also confirm that the Terms of Reference include an examination of the recent communication failures.

Social Media Comments

The Trust has examined the posts on social media, which mention a small number of previous patients (3). All of these patients have been cared for in Muckamore in the past, over 20 years ago. None have been recent In-patients. With regard to staff posts, there are no current staff posting, the individuals who posted are retired.

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Further Reporting

I wish to assure Department colleagues that the Trust is actively aware of the seriousness of the concerns and are deeply committed to conducting this investigation to the highest standards of independence and competence.

The Trust will provide fortnightly updates from the date of this letter. In addition the Trust would like to suggest and extend an invitation to both of you to meet with the Directors Oversight Group at Muckamore Abbey Hospital to provide ongoing assurance.

Yours sincerely

Martin Dillon
Chief Executive

Copy Mr Peter McNaney, Chairman

Trust Oversight Group:
Dr Cathy Jack
Mrs Marie Heaney
Miss Brenda Creaney
Mr John Growcott
Mr Damian McAlister

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