MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT
Statement of Lynn Long
Date: 26 April 2024

I, **Lynn Long**, make the following statement for the purpose of the Muckamore Abbey Hospital ("**MAH**") Inquiry.

The statement is made on behalf of the Regulation and Quality Improvement Authority ("**RQIA**") in response to a request for evidence by the Inquiry Panel.

This is my second statement to the Inquiry.

I will number any exhibited documents, so my first document will be "**Exhibit 1"**.

Qualifications and positions

1. I have included at paragraphs 5 to 12 of my first statement to the Inquiry details of my relevant qualifications and positions.

2. I provide this statement on behalf of RQIA and in my role as RQIA's current Director of Mental Health, Learning Disability, Children's Services and Prison Healthcare.

3. In providing this statement, I have been supported by past and present colleagues at RQIA, including Assistant Director of Mental Health, Learning Disability, Children's Services and Prison Healthcare, Wendy McGregor.

Module

4. I have been asked to provide a statement for the purpose of **M5: RQIA and MHC**; a module devoted to the mechanics and effectiveness of RQIA inspection.

5. My evidence relates to paragraph 13 of the Inquiry's Terms of Reference.

6. I have been asked to address a number of questions/issues for the purpose of my statement. I will address those questions/issues in turn.

Q.1: RQIA inspected individual MAH wards until in or around 2018, when it began to inspect MAH as a whole. Please explain:

i. Why there was a change in approach?

ii. What were the advantages and disadvantages of each approach?

7. A significant change in RQIA's approach to inspection of MAH came in 2019, when RQIA began inspection of MAH as a whole site. Previously, all inspections had been ward-based. The new methodology allowed for multi-disciplinary inspections of management and care provision across the whole site. Multi-disciplinary inspections are those that involved a team of inspectors and others from a range of different professional backgrounds.

8. This new methodology built upon RQIA's successful implementation of the whole-site inspection methodology in acute (non-MHLD) services. The potential benefits of implementing that whole-site approach were reinforced to RQIA by the findings of Dr Margaret Flynn and the 'A Way to Go' report, in which analysis was undertaken of RQIA's inspection findings from a whole-site perspective, allowing themes and trends that indicated wider, systemic concerns with the management and governance of MAH to be identified and explored.

9. The change in approach to inspections has since been supported by a change to the way in which RQIA aligns inspectors to caseloads. Previously, inspectors had been aligned to particular wards. Since 2021, inspectors have been aligned to a particular HSC Trust. The purpose of this is to allow inspectors to develop a more comprehensive understanding of a whole service or HSC Trust governance. Previously, the alignment of inspectors to wards across a number of services and HSC Trusts did not promote broad oversight of a service beyond ward level.

10. There are advantages and disadvantages of both ward-based and whole-site inspections. These are discussed below.

Ward based inspection approach

11. There are several advantages of a ward-based inspection approach. RQIA continues to undertake ward-based inspections where those are considered appropriate in the circumstances and where concerns appear to be isolated to a particular ward. Ward inspections are targeted towards wards about which there is a particular concern. The targeting of wards in this way can be impactful for the patients on that specific ward.

12. For example, RQIA undertook an inspections of MAH's Erne ward on 21 January 2021. This unannounced inspection was undertaken in response to intelligence received by RQIA about Erne ward on 18 January 2021.

13. Ward based inspections can be prepared at short notice in response to intelligence received. These inspections can be planned and undertaken quickly, where necessary, allowing RQIA to be more agile in response to incoming intelligence. These inspections are also less resource intensive because they tend to be undertaken by one or two inspectors as opposed to a larger team of people. Individual RQIA inspectors could conduct more frequent inspections of single wards in MAH; but this did not give an overall picture of the hospital as a whole . Accessing information during a ward based inspection is often simpler and quicker because the information required is generally limited to that which, or should be, readily available on the ward. Ward based inspections result in relatively swift reporting of findings and feedback, allowing providers to commence work on recommendations more quickly.

14. As a result of findings from a ward-based inspection, RQIA may extend the inspection to cover other wards, or to inspect the whole site at another date, using the ward-based inspection findings to make that determination.

15. A significant disadvantage of the ward-based inspection methodology, which RQIA has sought to overcome with the shift to a whole-site approach, is that such inspections focussed on the single ward and the management of it. These inspections were limited to providing RQIA with a snapshot of just one ward at one point in time. This approach is not conducive to identifying trends and

themes across a whole site, which might identify concerns that extend beyond ward management level.

Whole-site inspection approach

16. Having considered the findings of pre and post 2018 inspections, the advantages of the "whole site" approach at MAH are evident. The new methodology allowed RQIA to gain an overarching view of MAH leadership and governance. It was this multi-disciplinary, service-wide, approach to inspection that led to escalation and enforcement action in 2019. It was at this stage that RQIA first used its power to issue Improvement Notices on the Belfast Health and Social Care Trust ("**BHSCT**") in relation to MAH and RQIA recommended to the Department of Health that MAH should be placed into Special Measures. The whole-site inspection approach provided RQIA with strong evidence that improvement was needed across the service.

17. In the past, when the norm was ward-based inspections, RQIA often targeted its recommendations at individual wards. On reflection, the ward managers' ability to effect change in some of these areas may not have been within their gift. Some of the recommendations required systemic changes led by senior management or clinical level personnel in order for the recommendations to be met and compliance with the recommendations to be sustained. The move away from routine ward based inspections shifted the emphasis away from ward managers and onto senior management of MAH and the BHSCT Board.

18. Whole site, multi-disciplinary, inspections do have some disadvantages. These in depth inspections often involve a team of people being at an inspection site for up to one week. The preparation and resource required in advance of, and following, such an inspection is also significant.

19. In RQIA's first and second statements to the Inquiry, Briege Donaghy outlined the role and functions of RQIA under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 ("**the 2003 Order")** and the Mental Health (Northern Ireland) Order 1986 ("**the 1986 Order")**. The whole-site inspection methodology, and its focus on systems, leadership and governance, lends itself to RQIA's role and functions under the

2003 Order. Ward-based inspection methodology allowed for a greater review of the care and treatment of individual patients and their needs. RQIA continues to reflect on its methodology and recognises that by focussing on inspection of *systems*, RQIA's role began to move away from that which is outlined in the 1986 Order[1], being to keep under review the care and treatment of patients.

20. While continuing to develop its methodology, RQIA is seeking to continuously fulfil the requirements of both the 2003 Order and the 1986 Order and to use its resources effectively to inspect the whole site while retaining focus on patients as individuals. In seeking to ensure that there remains a focus on individual patients, RQIA has continued to seek ways to improve patient and relative engagement in inspections, including changing the way that feedback is sought from families. Further information about this is provided at paragraphs 87 to 89, below. Again, with a view to focussing on the care and treatment of individual patients, in July/August 2022, RQIA completed a focussed inspection of MAH to consider a typical day in the lives of 12 patients at MAH. A copy of the inspection report is exhibited at **Exhibit 1.**

Q.2: Before 2015, RQIA used a method of inspection that included self-assessment and pre-inspection analysis, along with ward visits. RQIA then changed this, to *exclude* self-assessment, and to use slightly different criteria (i.e. 'safe', 'effective' and 'compassionate', and later adding 'well-led'). Why were these changes made?

Key indicators of 'safe', 'effective', 'compassionate and 'well-led'

21. RQIA's Corporate Strategy for 2015-2018 proposed to focus on three key outcomes for users of health and social care services in Northern Ireland: safe, effective and compassionate care. This strategy aligned RQIA's work with the strategic vision of the Department of Health, Social Services and Public Safety as set out in 'Quality 2020'[2]. Professor Roy McConkey, in his 2016 report *'Evaluation of the Pilot for a Revised Inspection Methodology for MHLD'* (exhibited at **Exhibit BD2** to the first statement of Briege Donaghy),

[1] Article 86(1) of the 1986 Order

[2] DHSSPS(NI) – Quality 2020 – A 10 Year Strategy to Protect and Improve Quality in Health & Social Care in Northern Ireland

recommended that the new domain of 'well led' should be added. In implementing this change, RQIA was following the CQC's lead. The CQC had added a 'well led' domain in 2014 in light of the Francis Report into the failures of care at Mid Staffordshire NHS Foundation Trust. The addition of a "well-led" domain to RQIA's inspection methodology sought to assess and improve levels of governance and leadership of wards and provide recommendations aimed at ensuring effective leadership, management and governance.

Removal of self-assessment

22. The methodology from 2015 marked a move away from the completion of self-assessment information by the service provider prior to inspection. Self-assessment was intended as a means by which providers could evaluate their service provision against the expected level of service so as to facilitate their self-improvement plan. In reality, service providers often rated the service differently than inspectors and self-assessment often did not present an accurate reflection of a ward's compliance positon.

Q.3: Why did some RQIA inspections involve one or two inspectors, and others involve very large numbers of inspectors?

23. The number of inspectors required at an inspection was, and continues to be, determined by the reason for, and the scope of, the inspection. Inspectors undertook a pre-inspection analysis, which informed the decision of how many inspectors were needed for an inspection and whether any additional areas of expertise were necessary.

24. Pre-planned routine inspections using self-assessment and the 'safe, effective and compassionate' domains were usually undertaken by one or two inspectors and later were routinely undertaken by an inspector alongside a sessional consultant. A sessional consultant is an independent consultant who is engaged by RQIA when their specialist input is required. RQIA had sessional consultant psychiatrist and psychologist input into its work.

25. There were times prior to 2019 when inspections involved a larger team, for example, an intelligence-led inspection of Ennis ward in 2013 involved five

inspectors. Some inspections, particularly intelligence-led inspections, may have required more than one inspector. This was determined by the nature of the intelligence received and the level of support that the lead inspector expected to need. Additional support may have been required due to the amount of documentation or information to be reviewed or assessed. It may also have been determined that the lead inspector required additional expertise from colleagues specialising in areas such as infection prevention and control, estates (environment), pharmacy, finance or medical.

26. The number of inspectors is also now determined by the number of wards to be inspected. There has been an increase in the number of RQIA colleagues being involved in inspections due to the change in methodology to the whole-site, multi-disciplinary approach. In response to escalating concerns at MAH in 2019, there was also involvement of senior RQIA personnel in inspections at that time.

Q.4: How effective were RQIA's system(s) of mental health and learning disability inspection(s) at MAH during the period of the Terms of Reference, that is 02 December 1999 to 14 June 2021, in:

i. Developing key lines of enquiry.

ii. Analysing key themes over time.

iii. Following up on recommendations.

iv. Responding to individual patient concerns identified at inspections.

How effective were RQIA's system(s) of mental health and learning disability inspection(s) at MAH in developing key lines of enquiry?

27. In Briege Donaghy's second statement to the Inquiry, RQIA exhibited the 'record of inspection' template, which is a tool that acts as an *aide memoir* for inspectors to use as a checklist of particular topics and questions that they may wish to explore once they have determined their key lines of enquiry through the preparation process. Inspectors generally refer to key lines of enquiry as 'themes' to be examined at an inspection.

28. The nature of inspections is such that it is not possible to explore in detail every aspect of a service provider's compliance and RQIA's time and resources need to be focussed on key themes. The key themes to be examined are identified prior to the inspection as part of an inspector's preparation. In addition, other key themes may develop reactively during an inspection based upon an inspector's findings while on site.

29. It is not expected that inspectors will consider each item from the record of inspection. They should identify areas of focus and the record of inspection supports them with exploring these. Not every theme detailed in the record of inspection is explored at every inspection.

30. The system for determining which themes will be given greater focus at an inspection was based on the aligned inspectors review of intelligence held against the ward (later the hospital) and review of the previous inspection report and recommendations. While it is difficult for RQIA to reach a conclusion on the effectiveness of its systems for identifying themes throughout the Inquiry's period of reference, it is apparent that the inspector's methods were identifying areas for improvement and leading to recommendations being made.

How effective were RQIA's system(s) of mental health and learning disability inspection(s) at MAH in analysing key themes over time?

31. One of the ways in which RQIA has consistently aimed to identify themes over time is through the tracking of recommendations from one inspection to the next (see paragraphs 38 to 42 below in relation to the tracking of recommendations).

32. While it may be considered that this system limits the potential to track issues over a longer period than beyond the previous inspection, inspections did also consider new themes, including those that had been inspected and reported on previously. It is not the case that once a recommendation was identified and compliance reached that the matter would never resurface. However, the ability to detect recurring themes over a longer period of time is reliant on a manual process and inspector knowledge.

33. The role of inspectors is paramount to analysing key themes *over time.* There are a number of features of RQIA's systems that supports inspectors in this regard, being:

    a. The alignment of inspectors to wards (and latterly, alignment of inspectors to HSC Trusts). The aligned inspector receives and reviews any incoming intelligence relating to their aligned ward/HSC Trust, allowing them to build experience and knowledge of the services and develop a picture of issues and recurring themes over time. Prior to 2019, re-alignment of inspectors occurred regularly, which (while had its benefits) brought challenges in redeveloping that professional knowledge of a service. This was addressed, as far as practicable, through peer support and handovers.

    b. The quality assurance process for inspection reports means that the Senior Inspector and the Head of Programme (which was a title later replaced by Assistant Director) were sighted on inspectors' findings. The Head of Programme role was filled by the same individual for most of the relevant period, facilitating knowledge of themes at a more senior level.

    c. In order to ensure that inspectors have a wider knowledge of issues that may present outside of the ward/HSC Trust that they are aligned to, since 2019, all MHLD inspectors attend a weekly safety brief meeting at which each inspector presents to the group about key concerns and emerging or ongoing themes in their aligned wards/HSC Trust. This equips inspectors with broader knowledge about emerging themes across other settings. This knowledge can be borne in mind when an inspector prepares for inspections in their aligned ward/HSC Trust.

    d. Since 2019, there has been a weekly MHLD directorate safety brief meeting, which is attended by Senior Inspectors, Assistant Directors and myself, as Director of MHLD. Any potential emerging themes in individual services are discussed by the MHLD senior leadership team. Consideration is given to any common or specific issues and agreement reached on the appropriate next steps.

34. Since 2019, if RQIA inspectors identified a theme emerging at their aligned service, they could also seek support from RQIA's Information Team, which can provide bespoke intelligence reports based on information held in the Iconnect system, using defined parameters set by the inspectors. These reports support the inspectors' preparation for upcoming inspections (and guide their areas of focus for the inspection). These reports are bespoke to the service being inspected.

35. RQIA is exploring ways that it can improve its ability to identify and analyse themes over time. The Iconnect system, and the reports produced from it, is a helpful support tool for inspectors in preparing for individual inspections. However, identification of themes and trends relies upon inspectors' knowledge in the first instance. Inspectors will always be a key part of that process and there is no substitute for their knowledge and experience. However, RQIA would welcome an IT system that has the ability to support RQIA with the identification of emerging trends over time, not only on a service-by-service basis but identifying trends across Northern Ireland.

36. This new system should have the ability for inspectors to capture information while out on inspection, likely through mobile technology, rather than the paper-based system used today. Capturing the information electronically, with appropriate coding capabilities in the system, will allow evidence of non-compliance with standards to be captured in a structured and consistent way across services. This will enable the grouping and trending of findings from inspections across sites. It will allow the capture and coding of regulatory actions taken, also enabling an analysis of RQIA responses across sites, to allow RQIA to audit for consistency and proportionality.

37. The Department of Health has been supportive of RQIA in this regard; having recently approved funding for RQIA to employ a full-time Project Manager to develop a business case for a new IT system to support RQIA in its approach to intelligence-enabled regulation. The implementation of new software to support RQIA is likely to be between three and five years away, subject to funding.

How effective were RQIA's system(s) of mental health and learning disability inspection(s) at MAH in following up on recommendations

38. The methodology for inspections is such that an assessment is made as to whether recommendations made at the previous inspection have been fully met. If a recommendation has not been met, the recommendation is stated again and the inspection report highlights that the recommendation has been stated for a second (or third) consecutive time. If a recommendation has been stated for a second (or third) time, the date by which compliance must be achieved is determined by RQIA. The timeframe allowed for improvement will depend upon the progress made, the risks arising and the ability of the HSC Trust to comply within a certain timeframe.

39. If recommendations are escalated to senior personnel at the HSC Trust as 'serious concerns[3]' in accordance with RQIA's Escalation and Enforcement procedures, this elevates the recommendations beyond the normal process for following up on recommendations. These escalated recommendations/concerns are followed up via the escalation/enforcement process, involving senior personnel from both RQIA and the BHSCT, rather than being assessed at the next inspection in the usual way.

40. As highlighted at paragraphs 82 to 89 of Briege Donaghy's second statement to the Inquiry, there were several occasions when RQIA convened a Serious Concerns Meeting with the BHSCT as a method of following up recommendations made during an inspection.

41. By way of example, an unannounced inspection of Erne ward took place between 19 and 21 July 2016 which resulted in escalation. As a result, a Serious Concerns Meeting was held with the BHSCT on 1 August 2016. RQIA's concerns related to ward hygiene, governance of the ward and staffing levels amongst other issues. This resulted in an urgent action plan being provided by the BHSCT to resolve these concerns. Thereafter, at the follow-up inspections of Erne wards 1 and 2 held on 4 and 5 September 2017 and 24 October 2017

[3] An explanation of the 'serious concerns' means of escalation is provided in Briege Donaghy's first statement to the Inquiry, at paragraphs 60 to 62.

respectively, the recommendations were again assessed and all were considered to be 'met'.

42. RQIA's escalation procedures may also be instigated due to a lack of progress by the BHSCT in implementing recommendations. For example, in an unannounced follow up inspection of Killead ward on 24 April 2015, nine of the 14 previous recommendations had been implemented, however, RQIA found a lack of progress against five of the recommendations and some of these recommendations had been stated for a third time. This led to a Serious Concerns Meeting being held between RQIA and the BHSCT on 8 May 2015 to agree an action plan and updated timeline to ensure that these recommendations could be met.

How effective were RQIA's system(s) of mental health and learning disability inspection(s) at responding to individual patient concerns raised at inspection?

43. The means by which inspections gathered patient feedback was dependent on the methodology employed at a particular time. The various means by which patient feedback was sought included carrying out patient experience interviews ("**PEI"**) inviting patients to complete pre-inspection questionnaires, and speaking with patients who were available, able and willing on the day of inspection.

44. In seeking to respond to this question, RQIA reviewed all inspection reports for reference to patients raising concerns at inspection and considered how it responded to those concerns.

45. RQIA has been able to conclude that it responded to the vast majority of concerns voiced by patients. The range of responses included making recommendations, discussion with ward staff, seeking assurance of appropriate safeguarding referrals, review of records, and in some cases involvement of senior BHSCT personnel, the Department of Health and the Health and Social Care Board ("**HSCB**").

46. A concern did not need to be actively stated by a patient for an inspector to respond. Inspectors also responded to concerns about individual patients if apparent to them in the course of the inspection.

47. RQIA's review found that in 2010 and 2011, inspectors usually made recommendations for improvement that directly responded to concerns raised at the inspections. Inspectors also sought to examine specific records relevant to the concern and spoke with staff to gain further understanding of the issues. If there was evidence that the concern was being managed effectively, or additional information provided satisfactory explanation on the issue, then a recommendation may not have been made. There is evidence of inspectors raising patient-specific concerns directly with ward staff in order to facilitate an individual resolution. Inspectors sometimes provided information to the patient where it was apparent to be lacking, for example the rights of detained patients, or details of the HSC complaints process. Inspectors assessed whether the appropriate procedure/policy had been applied to the concern, for example that adult safeguarding (formerly vulnerable adults) procedures and/or referral to PSNI had occurred where it was appropriate. On one occasion, RQIA recommended that a review and investigation be carried out in relation to an individual patient's concern.

48. In 2012, there was one inspection in response to concerns raised with RQIA by the mother of a patient. This inspection assessed the care and treatment of this individual patient and the management of his and his mother's complaint by the BHSCT and the SEHSCT. Three other inspections were in direct response to two whistleblowing concerns received by RQIA. One of these was in relation to Ennis ward, and the inspections assessed the ward's safeguarding arrangements. RQIA's response to these concerns mirror that described in relation to the 2010 and 2011 period. However, in cases where the inspection itself was a response to a concern, RQIA's actions tended to be wider-reaching, involving requests to view information on specific issues outside of the inspection process, and communicating with senior management at the BHSCT and at times the Department of Health about its findings.

49. In 2013, concerns voiced by patients resulted in RQIA requesting that disclosures about restraint be investigated via adult safeguarding referrals. RQIA later requested details on the progress of the investigation and the protection plans being put in place. By 2013, it is evident that in some cases recommendations can carry over from one inspection to the next without resolution. Therefore, while RQIA was effectively responding to the patient's concern by highlighting the issue and outlining improvements needed, this did not always affect a prompt positive outcome. It is also evident that some issues arising at inspection were beyond the scope of the ward/MDT/Clinical management teams to influence improvements. For example, RQIA examined records of a patient who expressed frustration with delayed discharge, and found that the service was already advocating strongly for the patient on this issue.

50. In 2014, RQIA managed these concerns in the same vein as described in previous years. In the case of a patient who made allegations against a staff member, RQIA raised an adult safeguarding referral and provided a witness statement to the PSNI regarding the disclosure. RQIA followed up to check that safeguarding measures had been put in place to protect this patient. In 2014, patients continued to report on the impact of delayed discharge. In the 2013 inspection year, RQIA had made recommendations around delayed discharge, but acknowledged that MAH were exhausting efforts in resolving this issue. RQIA had responded by formally escalating the issue to the HSCB.

51. In 2015, the findings of these inspections were not always mirrored in concerns voiced by patients. For example, the findings from the inspection of Killead ward in April 2015 were escalated to a Serious Concerns Meeting with senior BHSCT representatives in May 2015 yet the seven patients consulted during the inspection reported that they were very satisfied with their care and treatment.

52. During 2016 inspections, RQIA sought patient feedback from a sizable proportion of patients. Patients did not raise any concerns at inspections about their care and treatment on the wards. However, during the inspection of Cranfield Male ward in November 2016, patients did voice frustrations about the

delay in moving out of hospital to placements in the community, when fit to be discharged. Some patients also shared their experience of placement breakdown and readmission. RQIA noted in the Quality Improvement Plan ("**QIP**") that it had found “a lack of involvement of consultant psychiatrists and ward nursing staff in the commissioning, planning and delivery of community placements”, and “a lack of meetings between consultants and senior managers”. RQIA noted elsewhere in the report that in response to this issue, they had written to the HSCB to highlight the impact of delayed discharge on patients at MAH.

53. In 2017, all patient concerns appeared to link directly or indirectly with the fact that individuals continued to reside in wards when they were well enough to leave. RQIA responded by assessing whether the services were proactively working to address the issues of delayed discharge, and RQIA was also checking that the hospital was keeping HSCB informed. RQIA concluded that ward staff and the hospital had taken appropriate action to address concerns and therefore these concerns would not be included in the QIP. RQIA stated in three of the reports that the lack of appropriate community placements continued to be a barrier to discharge. One report stated that RQIA had highlighted the impact of delayed discharge to the HSCB on a number of occasions.

54. In 2018, one inspection responded to intelligence received, and focussed on assessing the safeguarding arrangements in place for a specific patient. The concerns raised by patients appeared in the main to be causally related to delayed discharge and staffing levels. One inspection focussed heavily on assessing staffing levels within the ward, and found that MAH's interim management plan to address short staffing ensured safe coverage whilst a recruitment drive was underway. Another inspection stated that RQIA was aware of the recruitment difficulties, and that the BHSCT had informed RQIA of efforts underway to address the issues. These concerns did not therefore progress to recommendations as RQIA considered that the service had evidenced that robust actions were being taken.

55. There is limited patient feedback captured in the inspections of 2019. However, serious concerns were apparent, and RQIA's focus was on escalating these and taking enforcement action. The themes of concern that patients had reported in 2019 and in preceding years i.e. understaffing and delayed discharge, mirrored those that RQIA were escalating and taking enforcement action on throughout the year.

56. In 2020, inspections adapted in line with guidelines imposed by the Covid-19 pandemic. Patient feedback was sought in the form of questionnaires, and concerns raised about quality of food and communication regarding staff changes, were discussed with MAH senior management team.

57. In 2021, patient comments were positive, with the only concerns raised being from patients who were anxious about resettlement and stated a preference for remaining at MAH.

Q.5: On average, RQIA inspections appear to have been spread over two days. In relation to these inspections:

i. What proportion of time was spent speaking to staff?

ii. What proportion of time was spent checking paper/electronic records?

iii. What proportion of time was spent interviewing patients?

iv. Was sufficient time spent on each of the above?

58. RQIA has been unable to quantify the proportion of time spent on various elements of inspections between 2010 and 2021. The vast number of inspections, the varied nature of the inspections (some being focussed, PEI, or intelligence-led), the changing methodology and the different patient profiles meant that each inspection and the proportion of time spent on the elements identified in the Inquiry's question were not uniform. There is no means by which RQIA can reasonably measure the average proportion of an inspector's time spent on the elements listed. Each inspection is unique. That said, the vast majority of inspections (aside from some focussed inspections) contain each of these elements to some degree, supporting inspectors to triangulate

their findings. The inspection methodology has never been prescriptive about the proportion of time to be spent on various elements of the inspection. This needs to be flexible to accommodate an inspector's professional judgement.

59. In answer to the Inquiry's question about whether sufficient time was spent on each of the components identified, every inspection is time limited and time spent on each component part of the inspection has its boundaries, bearing in mind the need to be proportionate and use resources effectively across all MAH and other MHLD inpatient facilities in Northern Ireland.

60. However, if an inspector requires additional time to ensure that they are satisfied that they have enough information to reach their conclusions then an inspection can be (and has been) extended. It is not the case that at the end of the second day of an inspection, the inspection must conclude.

Q.6: Does RQIA conduct meta-analysis of inspections to identify recurring themes? If so, please provide details.

61. The answer to this question links with the answer to Question 4(ii) (paragraphs 31 to 37 above), in relation to RQIA's analysis of themes over time. RQIA is exploring ways that it can improve its ability to identify themes using technology, not only in relation to recurring themes from inspections but from intelligence gathered from a range of sources and across MHLD inpatient facilities.

Q.7: From in or around 2015, a direct observation schedule was used ('QUIS'). In relation to this schedule:

i. Was it useful?

ii. What, if anything, did it reveal that other methods did not?

62. The Quality of Interaction Schedule ("**QUIS**") was used to enable inspectors to record the interactions observed with patients and to code them as positive social, basic care, neutral or negative. The number of interactions coded in each category could be summated for the ward observations undertaken.

63. The QUIS was designed to be a method of systematically recording interactions, albeit the observations by inspectors were similar to that which

were done prior to introduction of the recording tool. The tool allowed inspectors to apply a 'measure' of these observations. RQIA produced a QUIS Guidance Note for use by inspectors, which is exhibited at **Exhibit 2**.

64. While the QUIS tool had the benefit of producing a structure for recording and measuring interactions, it is no longer used as part of the current inspection methodology for MHLD inpatient settings. It was felt that formally observing and noting observations in close proximity to mentally unwell patients and patients with learning disability, who may already be anxious at the presence of a stranger in the ward environment, could cause distress to patients.

65. Inspectors continue to conduct observations but do so more discreetly rather than completing the QUIS document while observing. Inspectors observe each time that they visit a ward; they spend time speaking with patients and staff, observing activities (sometimes participating in the same) and recording their observations on return to the base room away from the ward. This allows inspectors to better observe the true nature of a ward and the care delivered while 'blending in' to the environment as much as possible. In the period 2015 to 2019, RQIA engaged 'lay assessors' to support with observations, including lay assessors with learning difficulties. The numbers of lay assessors depleted over time but RQIA has begun to reintroduce lay assessors (now referred to as Inspection Support Volunteers) in a pilot of its care home inspections. RQIA intends to extend the use of Inspection Support Volunteers to inspections of other settings, including MHLD inpatient services.

Q8: Some RQIA inspections were announced, and some were unannounced.

i. How was this decided, and who was this decided by?

ii. Were there any differences in outcome? If so, what were they?

66. During 2010 and 2011, when RQIA first began inspecting MAH, all inspections of MAH were announced in accordance with the developing inspection methodology at that time.

67. There was a shift to unannounced inspections in mid-2012 to align MHLD inspections with the methodology being used by RQIA for services which it regulated.

68. There remained some occasions in 2013 and 2014 when inspections were announced. The decision of whether an inspection was announced or unannounced would have been made in consultation and discussion with the Senior Inspector and Head of Programme based on the objectives of the inspection.

69. In preparation for the MAH Inquiry, RQIA's review of inspection reports has not identified any particular differences in outcome between those inspections that were announced and those that were unannounced. There are varied numbers of recommendations made and recommendations met in the inspection reports and there appears to be no correlation between the numbers of recommendations made/met and whether the inspection was announced or unannounced.

70. From 2015 until the present day, RQIA has conducted very few announced inspections of MAH. Announced inspections of MAH since 2015 have either been inspections to assess progress following enforcement action or they have been 'focussed' inspections, whereby RQIA inspectors focus on a specific topic (see paragraphs 106 to 108 for more information about focussed inspections).

71. Examples of such announced inspections include the finance inspection of MAH in July 2019 (for further detail, see paragraph 72, below). RQIA served an Improvement Notice on the BHSCT in relation to financial governance further to this inspection. The decision for this to be an announced inspection was made in conjunction with RQIA's Finance Inspector. The reasoning behind the decision to proceed with an announced inspection was that records needed to be reviewed that might not have been readily available if the inspection was unannounced. It was also important that the relevant BHSCT personnel were available during the inspection.

72. Another example of an announced inspection in recent years is the announced inspection of MAH in 2020. This was a remote inspection due to Covid-19

restrictions. The purpose of the inspection was to assess compliance with the extended Improvement Notice IN000004E, which related to the governance of patients finances, and the Improvement Notice IN000005E, which related to adult safeguarding. RQIA was of the view that the information required to assess compliance could be provided electronically and reviewed remotely in light of Covid-19 restrictions in place at that time. I made the decision that this inspection was to be announced.

73. While all inspections of MAH since 2020 have been unannounced, RQIA considers that there remains a place for announced inspections in appropriate circumstances. In making a decision whether an announced inspection is appropriate, RQIA considers whether an unannounced inspection will support RQIA in gathering the information it requires for an effective inspection. In circumstances where RQIA inspectors need to meet with particular staff members and/or require certain categories of documents to be available in readiness for an inspection then providing advance notice to the HSC Trust can be the optimal route to assessing compliance.

Q.9: Did RQIA inspectors who visited MAH have learning disability training? If so, please provide details.

74. All MHLD inspectors employed by RQIA are from a nursing, social work or allied health professional background, which must include significant experience in either mental health or learning disability. Nurses are either mental health or learning disability qualified nurses. RQIA's MHLD team, both currently and historically, is a group with a combination of both mental health and learning disability experience. RQIA's Assistant Director of Mental Health, Learning Disability and Prison Healthcare, who joined RQIA as an inspector in 2012, is a learning disability nurse. In the main, individuals with learning difficulties were being treated in MAH as a result of their deteriorating mental health needs. It was, therefore, considered important that MAH inspectors had knowledge and understanding of both learning disability and mental health.

75. RQIA provides training on associated topics relevant to learning disability, such as safeguarding of children and vulnerable adults, and training on the Mental Capacity Act (Northern Ireland) 2016 and 1986 Order. Some inspectors have

attended training on positive behaviour support (British Institute of Learning Disability). RQIA consulted with patients and patient representative groups (the 'Telling It Like It Is' Group, Patients Council MAH and Parents and Friends of MAH) in March 2013 when developing 'easy read' information and reports. RQIA's Easy Read report writing and communication guidance and training for inspectors was developed by an inspector together with a learning disability nurse.

Q.10: In respect of wards which were inspected by RQIA:

i. Were there obvious and sustained differences between wards? If so, what were those differences and what does RQIA attribute those differences to?

ii. Were there differences in 'culture' between wards? If so, what were those differences, and how can they be explained?

76. RQIA inspection reports do not always detail findings on 'culture' specifically. Culture is a broad concept that in its widest sense can permeate most criteria considered at inspections. Shortcomings relating to, for example, safeguarding, staff training and incident management can be indicative of poor culture. A comparison of culture of different wards over a period of years, based upon inspection reports, has not been possible to do. There are a number of variables which make such comparison difficult including: the different profiles of wards in terms of their patient population, the changing nature of wards (consolidation of wards and changes to patient profiles on wards in different years) and changes in management personnel.

77. In preparation for providing this statement to the Inquiry, RQIA sought input from current and past inspectors about the differences they observed between the various wards at MAH. Inspectors observed that MAH appeared to be split into two hospitals; the older wards (Moylena, Greenan, Ennis and Erne) and the newer wards (Cranfield 1 and 2, Cranfield PICU, Donegore, Killead and Six Mile), with MAH staff referring to the newer wards as the "new hospital".

78. One of the clearest differences between the older and newer wards was the physical environment. The older wards were housed in old buildings, which

were difficult to maintain. Those wards had more dormitory style sleeping arrangements for patients, leaving them with little privacy.

79. Inspectors reported that the care of patients was generally different depending on which part of the hospital they resided in. Those patients who lived in the older wards were generally those requiring resettlement rather than active treatment. There was less multi-disciplinary team input into the patients' care on those wards and the patients did not appear to have the same access to MDT care as those who resided in the newer wards.

80. The older and newer wards had different management. Assistant Director, Wendy McGregor's, recollection is that governance of the older wards was weaker and there were fewer visits from hospital managers to those wards.

81. Since the closure of Erne ward, the older wards are now all closed and those patients requiring resettlement reside in the newer wards. There are a limited number of ward managers across the site, and the impact on those wards without a ward manager is obvious; ward-based governance and oversight of those wards is observed to be weaker.

iii. How were families selected for consultation during RQIA inspections?

82. When RQIA first began inspecting MAH, the methodology for announced inspections included family questionnaires being sent to the ward prior to the inspection for distribution by staff to visiting relatives. These questionnaires were to be returned to ward staff and given to the inspector during the inspection.

83. During all inspections (both announced and unannounced), families who were visiting their relatives during the time of the inspection were offered the opportunity to meet and share their views with inspectors about the care and treatment that their relative was receiving. Posters were displayed at the entrance to wards informing any visitors that an inspection was underway and inspectors encouraged ward staff to inform visiting families that RQIA was undertaking an inspection.

84. During inspections, families were also contacted by ward staff informing them of the inspection and offering the relatives the opportunity to talk to an inspector on the phone or meet with an inspector on the ward. This resulted in some families coming to the ward to meet with inspectors. RQIA provided leaflets to ward staff and the inspector requested that those were distributed to visiting family members. The leaflets were not intended to replace speaking with patients and relatives directly, which was preferred and encouraged, but they were intended to inform relatives and patients of an alternative route by which they could provide feedback discretely to RQIA.

85. Responses from families were recorded in inspection reports and from a review of inspection reports it can be seen that the number of responses received from relatives was generally low. RQIA found similar low levels of response across all MHLD inpatient settings; this was not unique to MAH. RQIA explored ways to improve family engagement, which included inspectors remaining on wards into the evening to try to speak with relatives who visited at that time of day.

86. For focused inspections, RQIA may not have sought to contact each patient's family. For example, in the recent inspection of MAH, which commenced in July 2023 and concluded in March 2024, RQIA contacted only families of those relatives whose records were selected for review at the inspection.

87. There has been a recent change to the way in which RQIA seeks feedback from families. In 2023, RQIA began requesting contact details of relatives from service providers to allow RQIA to contact relatives directly. If a patient has capacity to consent to RQIA contacting family, then contact with families would be made only with that patient's consent. If an RQIA inspector determines from information known about the patient, and/or from meeting with the patient, that they would not have capacity to consent to relatives being contacted, RQIA determines whether contacting the relative is appropriate.

88. RQIA request that MAH staff contact the family first and seek consent for RQIA to contact them. Not all families wish to be contacted by RQIA.

89. A very small number of patients in MAH do not have active family contact. RQIA would not consider it appropriate to contact the named next of kin of those patients.

Q.11: Some wards and staff have been extensively criticised by families, however, these criticisms do not appear in RQIA inspection reports. How can this be explained?

90. There were occasions when RQIA was alerted to concerns relating to MAH by families of relatives, often outside of inspections, by way of direct contact. RQIA has reviewed the evidence given to the Inquiry by families, concentrating on those families who noted that they had contact with RQIA. Details of some of those criticisms do appear in RQIA's inspection reports.

91. RQIA must be mindful about the information it places into the public domain via its inspection reports. It may not be appropriate to note particular concerns in a published inspection report, particularly where the concerns raised are of a particularly sensitive nature, or where it might be possible to identify patients concerned (which is particularly relevant in smaller wards). In the past, RQIA has received criticism from patient groups for sharing detail of its concerns in published inspection reports and inspectors must exercise caution about the information placed into the public domain. A criticism from a family member that is known to RQIA but which does not feature in an inspection report is likely to have been raised with the BHSCT by other means. The intelligence from family members would also have fed into the preparation for the inspection (and may even have prompted a decision to undertake an inspection – see, for example, paragraph 104), even if that is not stated in the inspection report.

92. One explanation for there being limited mention of family criticism in the inspection reports is that RQIA's consultation with families was limited in the past, meaning that the views of many families were not always known to RQIA and therefore did not translate into inspection reports.

93. A review of RQIA inspection reports shows that references to family feedback in inspection reports is limited; noting a reduction in family input following the

shift to unannounced inspections in 2012. Following the move to unannounced inspections, the return rate of family questionnaires was low.

94. Public Inquiries, both current and in recent years, have stressed the importance of listening to patients and families as key sources of information about service safety and quality; and of taking on board what is said. RQIA understands the importance of communication with families.

95. RQIA has already taken steps to improve the way that feedback is sought from families (further information is provided at paragraphs 87 to 89).

96. RQIA has been following the evidence provided to the Inquiry by families. It has been noted that many families never had contact with RQIA and, regrettably, others did not know of the existence of RQIA or its role at all. RQIA has acknowledged that more needs to be done to ensure that the organisation is known by stakeholders right across the HSC system. Raising RQIA's profile has been an objective of the organisation in recent years. Efforts have continued this year with RQIA holding a series of online engagement sessions, open to members of the public, to explain RQIA's statutory role relating to mental health services.

Q.12: Were inspections ever carried out because of complaints received from families of patients? If so, was an investigation ever initiated following a single complaint, or was more than one complaint on an issue required before an inspection would be carried out?

97. Since 2009, with the publication of the HSC complaints procedure, '*Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning'*, RQIA has not had a formal role in in the handling and consideration of complaints in the HSC sector. When RQIA is contacted with a complaint, RQIA signposts families towards the BHSCT, as provider of the service, to make the complaint and advises families of the role of the Patient Client Council in providing support with doing so.

98. However, while the complaint itself ought to be managed by the BHSCT, as provider of the service (with recourse to the Ombudsman), complaints that are

brought to RQIA's attention are an important source of intelligence for RQIA. Information received in this way is logged onto RQIA's Iconnect system and used to assess whether a regulatory response is required by RQIA under the requirements of the 1986 Order and/or 2003 Order.

99. Information received from families is a form of intelligence to RQIA because such complaints may serve to highlight non-compliance with 1986 Order, the 2003 Order or the associated quality standards. When intelligence is received by RQIA, whether from patients, families or from other sources, RQIA makes a determination on the appropriate regulatory response in the circumstances. RQIA logs the information as intelligence against the relevant service and inspectors respond to the intelligence in one or more of the following ways:

    a. Referring the matter to the HSC Trust's adult safeguarding team;

    b. Seeking information directly from members of staff (e.g. ward managers) to assess the service's response;

    c. Seeking assurances/evidence from the HSC Trust about the care and treatment of patients;

    d. Meeting with relevant HSC Trust personnel;

    e. Using the information to inform the next inspection of the service;

    f. Undertaking an unannounced inspection; and/or

    g. Instigating enforcement action.

100. Making the best use of intelligence is central to tailoring RQIA’s actions to individual services and targeting its resources where it can have the greatest regulatory and quality improvement impact. RQIA's response to intelligence received from family members is determined by a number of factors, including the seriousness of the concerns, triangulation with other intelligence held by RQIA about the service, perceived risk to service users and RQIA's available resources at the time of the receipt of the intelligence.

101. At times, intelligence received from families has indicated a potential serious risk to a service user or had broader implications, and RQIA has sought recourse from the BHSCT senior management in the first instance. The means of response available to RQIA are not mutually exclusive. RQIA's response often included a combination of the actions outlined at paragraph 99, above.

102. In addition to the information received from families being a source of intelligence for RQIA to consider in light of its role under the 1986 Order and 2003 Order, depending upon the nature of the information received, RQIA may consider it necessary to complete an 'inquiry' into care and treatment of patients pursuant to RQIA's role outlined in the 1986 Order[4]. In deciding whether to commence an inquiry, RQIA considers whether or not the patient and/or their nearest relative are engaged in any other process with respect to the patient's care and treatment and considers any potential implications for RQIA's work (such as an active/ongoing complaint/safeguarding investigations). This may not necessarily exclude the commencement of an inquiry, but may help inform the process.

103. There are a number of occasions when information received from families of patients did prompt unannounced inspections of wards at MAH. RQIA occasionally deemed an inspection to be an appropriate response to a single piece of intelligence received from a relative of a patient. However, it should be noted that it would not be RQIA's default or usual position to proceed immediately to an inspection upon receipt of intelligence from a family member. The proportionate response is determined with regard to perceived risk in the circumstances. If RQIA determines that the appropriate response to intelligence is to undertake an inspection, the objective of the inspection is, in the main, not to investigate the complaint itself but to assess the information in the context of the care and treatment being provided to patients, in the

[4] **Article 86** (1) It shall be the duty of RQIA to keep under review the care and treatment of patients, including (without prejudice to the generality of the foregoing) the exercise of the powers and the discharge of the duties conferred or imposed by this Order.
(2) In the exercise of its functions under paragraph (1) it shall be the duty of RQIA—
(a) to make inquiry into any case where it appears to RQIA that there may be ill-treatment, deficiency in care or treatment, or improper detention in hospital or reception into guardianship of any patient, or where the property of any patient may, by reason of his mental disorder, be exposed to loss or damage.

knowledge that the HSC Trust will address the individual complaint if it has been made known to them by the complainant.

104. Listed below are examples of RQIA inspections that were undertaken as a response to information received from families of patients:

a. The unannounced Inspection of Cranfield Female on 17 May 2013 (submitted to the Inquiry RQIA-A-00009);

b. The unannounced Inspection of Cranfield Female Ward on 28 October 2016 (submitted to the Inquiry RQIA-A-000146);

c. The unannounced inspections of Erne ward on 21 December 2016 and 26 January 2017;

d. The unannounced inspection of Killead ward on 14-15 February 2017 (submitted to the Inquiry RQIA-A-000147) (arising from two separate family complaints);

e. The unannounced inspection of Cranfield 1 ward 13 July 2017 (submitted to Inquiry RQIA-A-00024); and

f. The unannounced inspection of Cranfield 1, 2, and ICU wards on 10 July 2018 (Submitted to Inquiry RQIA-A-00026). This followed a number of complaints from a relative.

Q.13: How can the difference between what was seen by inspectors on the MAH wards and what appeared on the CCTV in 2017 be explained?

105. While RQIA inspectors observe behaviours during inspections, it is possible that the presence of an inspector on a ward changes behaviour and acts as a deterrent. RQIA acknowledges this limitation of the inspection process. RQIA seeks to mitigate this by its triangulation of various sources of evidence, including the review of patient records and direct engagement with patients.

Q.14: Occasionally RQIA focused inspections on topics, for example, finance or resettlement. What led to a topic focused inspection being carried out?

106. Most RQIA inspections of MAH have been 'full inspections' or 'follow up' inspections. Occasionally, as a result of intelligence, RQIA focused its inspections on particular topics, for example, finance, pharmacy, or hygiene. The following are several reasons why inspectors considered that a focused inspection was necessary or appropriate:

    a. intelligence received by RQIA indicated an emerging theme or trend;

    b. specific intelligence was received from a patient, relative, staff member or another source that suggested that a targeted inspection was appropriate;

    c. findings from an inspection warranted a more in-depth review of a particular topic; and/or

    d. compliance with improvement notices needed to be assessed.

107. Intelligence and findings from inspections may also feed into RQIA's review programme or other focussed project for RQIA (see paragraphs 112 and 113 of Briege Donaghy's first statement to the Inquiry for details of RQIA's review programme).

108. An example of a focussed inspection of MAH is the 'finance' focussed inspection that took place on 1 July 2019. Previous inspections had identified required improvements in relation to MAH's financial governance arrangements. This subsequent finance-focussed inspection on 1 July 2019 led RQIA to conclude that it was not assured of the implementation of, and compliance with, agreed financial procedures across MAH. RQIA was also not assured of the BHSCT's capacity to provide robust financial governance. On 16 August 2019, RQIA served an Improvement Notice on the BHSCT in relation to financial governance, alongside two other Improvement Notices relating to (a) staffing and (b) safeguarding. The subsequent inspection in April 2020 was also a focussed inspection to assess progress against the improvement notices.

Q15 to Q19: Ennis Safeguarding Report

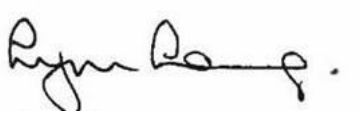
109. The Inquiry's questions numbered 15 to 19 have been answered in my first statement to the Inquiry.

Q.20: Do you wish to draw to the attention of the Panel any other matters that may assist in the Panel's consideration of paragraph 13 of the Terms of Reference?

110. RQIA restates its intention to engage with the Inquiry in an effective, candid and transparent manner and remains committed to cooperating with the Inquiry's work in meeting its core objectives identified within the Terms of Reference. RQIA welcomes any opportunity to assist further with the Inquiry's examination of the matters identified within paragraph 13. To the best of its ability RQIA has nothing further to add at this stage but reiterates its desire to cooperate fully and candidly with the Inquiry.

Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed: 

Date: 26 April 2024

List of Exhibits (Lynn Long)

Exhibit 1: RQIA Inspection Report, 1 - 29 July 2022

Exhibit 2: RQIA's Quality of Interaction Guidance

MUCKAMORE ABBEY HOSPITAL INQUIRY

WITNESS STATEMENT

Statement of Lynn Long

Regulation and Quality Improvement Authority ("RQIA")

Date: 26 April 2024

Exhibit 1

Inspection Report

01 - 29 July 2022

Belfast Health and Social Care Trust

Mental Health & Learning Disability Hospital
Muckamore Abbey Hospital
1 Abbey Road
Antrim
BT41 4SH
Tel no: 028 9446 3333

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

<table>
<tr>
<td>Organisation/Registered Provider:
Belfast Health and Social Care Trust (BHSCT)</td>
<td>Responsible Individual:
Dr. Cathy Jack
Chief Executive, BHSCT</td>
</tr>
<tr>
<td>Person in charge at the time of inspection:
Natalie Magee, Co-Director, LD Services</td>
<td>Number of registered places:
There are five wards operating within Muckamore Abbey Hospital
<table>
<tr><th>Name of ward:</th><th>No of patient's accommodated:</th></tr>
<tr><td>Cranfield 1</td><td>Seven</td></tr>
<tr><td>Cranfield 2</td><td>Eight</td></tr>
<tr><td>Six Mile</td><td>Nine</td></tr>
<tr><td>Killead</td><td>Seven</td></tr>
<tr><td>Donegore</td><td>Six</td></tr>
</table>
</td>
</tr>
<tr>
<td>Categories of care:
Acute Mental Health and Learning Disability</td>
<td>Number of beds occupied in the wards on the day of this inspection:
37</td>
</tr>
<tr>
<td colspan="2">Brief description of the accommodation/how the service operates:
Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability (MHLD) Hospital managed by the Belfast Health and Social Care Trust (the Trust). The hospital provides inpatient care to adult's aged 18 years and over who have a learning disability and require assessment and treatment in an acute psychiatric care setting. MAH is a regional service and as such provides a service to people with a Learning Disability from across Northern Ireland. Patients are admitted either on a voluntary basis or detained in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO). The Psychiatric Intensive Care Unit (PICU) has remained closed since 21 December 2018. Admission to any other ward within the hospital is significantly restricted, any decision to admit new patients is risk assessed on an individual patient basis and alternative options fully explored before an admission is facilitated.</td>
</tr>
</table>

2.0 Inspection summary

An unannounced inspection of MAH commenced on 01 July 2022 at 04:00am and concluded on 29 July 2022, with feedback to the Trust's Senior Leadership Team (SLT). All wards were inspected at least once during this period. The inspection team comprised of care inspectors, a senior inspector, assistant directors and a director.

The decision to undertake this inspection (following so soon after the inspection in March 2022) was based on intelligence detailed in Early Alerts received by RQIA in June 2022.

RQIA has a statutory responsibility under the Mental Health (Northern Ireland) Order 1986 and the Health and Social Care (Reform) Act (Northern Ireland) 2009 to make inquiry into any case of ill-treatment, deficiency in care and treatment, improper detention and/or loss or damage to property.

The inspection identified limited progress towards meeting the areas for improvement (AFI) identified during the inspection in March 2022. Additionally, RQIA found that staffing/workforce and adult safeguarding arrangements were inadequate and had impacted on the care and treatment of patients. RQIA escalated these concerns to the Trust's Chief Executive and SLT at the conclusion of the inspection. The Trust accepted RQIA's findings. RQIA has also escalated these concerns to the Department of Health and with the Strategic Performance and Planning Group. A number of AFI have been made.

MAH continues to experience a number of challenges to maintaining service delivery. The Public Inquiry into the historical abuse of patients in MAH is ongoing, the impact of which is felt by patients, families and staff. There are continued challenges with high levels of staff vacancies, a lack of skilled and experienced learning disability speciality staff, and the ongoing management of adult safeguarding incidents.

Following this inspection, RQIA met with the Trust's Chief Executive and SLT on 4 August 2022 to discuss our intention to issue two Improvement Notices relating to staffing/workforce and adult safeguarding. During this meeting RQIA received assurances as to the actions taken and planned by the Trust to address each of the areas of concern. RQIA will closely monitor the Trust's progress in this regard. Further information is detailed in sections 5.2.1 and 5.2.2 of this report.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect performance at the time of our inspection, highlighting both good practice and any AFI. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

The inspection focused on eight key themes: staffing/workforce; adult safeguarding; governance and leadership; assessment and treatment/resettlement; patient experience; patient engagement; family engagement; and staff engagement.

During the inspection we observed patient care and treatment, and the lived experience of patients in the wards. We conducted unannounced visits at different times of day and night to ensure patient care was observed on every ward across the full 24 hour period. We observed staff practice and reviewed staffing arrangements in all wards, including the profile of staff. We engaged with the multi-disciplinary team (MDT) and Senior Leadership Team and reviewed relevant patient and governance documentation. Experiences and views were gathered from staff, patients and their families.

Evidence was gathered to supplement the intelligence already gained through the contemporaneous scrutiny of all safeguarding notifications involving staff, which RQIA has undertaken since July 2019.

4.0 What people told us about the service

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

We received two completed questionnaires from patients, both which reflected that they thought care was good and staff were kind, however, they stated the ward was not organised, nor did they feel safe. We shared this feedback with staff on duty. We spoke with a small group of patients on one ward and with four patients who requested to speak with inspectors. Some patients expressed concern about staffing while others expressed anxiety about the behaviours of other patients.

Opportunities to speak with relatives during the course of the inspection were limited as a result of the Covid-19 visiting restrictions; consequently, we were supported by ward staff to make direct telephone contact with patients' relatives. Twelve families availed of this opportunity and provided a range of views based on their experiences of visiting the wards and engaging with hospital staff. While some relatives expressed high levels of satisfaction with the standard of care provided, others advised of their concern about staffing levels, communication, safeguarding and availability of activities.

Several staff requested to speak with inspectors in private and other opportunities were taken to speak with staff during visits to each of the wards. Staff spoke openly about the concerns they had. We did not receive any completed staff questionnaires; however, staff did contact us following the inspection to discuss concerns they had in relation to the safety of patients and staff.

5.0 The inspection

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

The previous inspection to MAH was undertaken on 02 – 31 March 2022. We assessed the progress made towards achieving compliance with the six AFI identified at the last inspection and identified that insufficient progress had been made to meet the Quality Standards. Our findings are as follows:

Areas for improvement from the last inspection to Muckamore Abbey Hospital 02 – 31 March 2022		
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 5.1 Criteria: 5.3.3 **Stated**: Second time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should develop a specific training programme for agency staff that will develop knowledge and skills to support them to safely and effectively meet the specific needs of the patients within MAH.	**Not met**
	Action taken as confirmed during the inspection: An agency specific training programme had not been developed. Additional concerns were also identified in relation to the skills and competencies of agency staff. Further detail is provided in Section 5.2.1. This AFI has not been met and has been subsumed into a new AFI.	
Area for improvement 2 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should ensure and support a collaborative approach to nursing care, and promote working well together. Agency staff should be embedded within the staff teams and their skills effectively utilised in the delivery of patient care.	**Not met**
	Action taken as confirmed during the inspection: There was insufficient evidence that efforts had been made to embed agency staff within staff teams and further evidence indicated continued relationship difficulties amongst staff groups. Further detail is provided in Section 5.2.1. This AFI has not been met and has been subsumed into a new AFI	

Area for improvement 3 **Ref:** Standard 5.1 Criteria: 5.3.3 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should develop an effective mechanism to monitor staff compliance with relevant training requirements and take the necessary actions to address any identified deficits.	**Not met**
	Action taken as confirmed during the inspection: Issues were identified in relation to compliance with mandatory and service specific staff training. Effective mechanisms to monitor staffs' compliance with relevant training and take necessary actions to address deficits were not in place. This was concerning given the risks associated with the competence, skills and knowledge of staff. Further detail is provided in Sections 5.2.1 and 5.2.2. This AFI has not been met and has been subsumed into a new AFI.	
Area for improvement 4 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should review the role of the Nurse Development Leads (NDL) and consider the utilisation of this resource to strengthen leadership and management at ward level and support the development of nursing staff within each ward.	**Not met**
	Action taken as confirmed during the inspection: The NDL resource had reduced since the last inspection. As a result it was not possible to determine the impact the NDL role was having. This is discussed further in Section 5.2.8. This AFI has not been met and has been subsumed into a new AFI.	

Area for improvement 5 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust Senior Management Team for MAH should seek opportunities to engage with staff to determine how best to support them. Consideration should be given to: 1. A schedule of leadership walk rounds with a report to evaluate the outcome of the visit. 2. ASM & ST having a visible presence across all wards to support staff and govern practice.	**Partially met**
	Action taken as confirmed during the inspection: The presence of the SLT on wards to support staff during incidents was noted. We identified gaps in provision of consistent and continuous support to staff at ward level from the middle management team which was having a direct impact on the effective delivery of care. This is discussed further in Section 5.2.8. This AFI has been partially met and has been subsumed into a new AFI.	
Area for improvement 6 **Ref:** Standard 5.1 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 30 June 2022	The Belfast Health and Social Care Trust should ensure the Adult Safeguarding Regional Policy is adhered to by staff at all levels, including the SMT. Consideration should be given to: 1. A review of operational adult safeguarding processes and if required steps to address any identified gaps. 2. Prioritising team building sessions between operational and adult safeguarding team to promote a collective approach to patient safety and protection in line with the Adult Safeguarding Regional Policy.	**Not met**
	Action taken as confirmed during the inspection: Issues in relation to implementing effective and suitably protective adult safeguarding arrangements continue. This is discussed further in Section 5.2.2. This AFI has not been met and has been subsumed into a new AFI.	

5.2 Inspection findings

5.2.1 Staffing / Workforce / Staff Profile

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

The safety and well-being of patients in MAH was directly affected by the current staffing arrangements. The staffing concerns were not, in the main, related to the numbers of staff on duty. MAH as a site, was operating continuously with 83% to 85% agency nursing and health care staff in addition to ad hoc shifts being covered by bank staff and staff from other areas, across all of the wards. Continuity and consistency amongst the staff team was limited with a limited number of staff taking responsibility and accountability for the delivery of care.

There were significant gaps in the level of competence, skills and knowledge required to support patients who have a learning disability, who require support with communication, and present with complex and distressing behaviours.

We noted that staffing levels, in line with the Telford model, was often not being achieved and that the rotas did not accurately reflect the actual staff on shift.
Staffing was not based on the assessed needs of the current patient population. Staffing levels had reached a critical point with difficulty in retaining and recruiting appropriately experienced staff, across all grades.

Staffing levels were not adequate to respond to temporary or unplanned variations in the assessed needs of patients and staff were frequently redeployed to provide cover in other wards when incidents occurred. Planned visits and outings with family members had been cancelled at short notice due to staff shortages.

Robust arrangements were not in place to oversee and assure the supply and deployment of agency staff across the site. This directly impacts patients' safety and contributes to poor patient outcomes. There was evidence that agency and other staff were self-selecting shifts and not following the correct procedure for booking shifts leading to inadequate oversight of the staffing arrangements and in one instance significant safeguarding concerns. The Trust took immediate action to address this risk when highlighted.

Agency staff were working excessively long shifts, often consecutively and without any breaks or sufficient rest periods between shifts. We have taken separate actions to address these concerns with the registered providers of the relevant agencies. Such working patterns are known to impact adversely on both the health and wellbeing of the staff, and on the quality and safety of care provided to patients. We found that staff morale was poor and there was evidence of conflict amongst staff groups.

The current staffing arrangements were detrimentally affecting the resilience and wellbeing of staff and their ability to provide safe, effective and compassionate care, often in very challenging circumstances and therefore must be urgently taken into account in organising staffing at MAH.

Staff training records for Trust and agency staff identified deficits in a number of areas including; Adult Safeguarding Training, Positive Behaviour Support (PBS) and Management of Actual or Potential Aggression (MAPA). There was no agency specific training programme to develop agency staff knowledge and skills to support them to safely and effectively meet the specific needs of the patients in MAH. There was limited evidence of an effective mechanism to monitor staff compliance with relevant training requirements or actions taken to address any identified deficits. Individual staff training records were not up to date and an accurate summary of staff training compliance was not available.

There was no evidence of the promotion of a PBS culture in wards. PBS is a person centred approach to supporting people with a learning disability; it is based on assessment of the social and physical environment in which the behaviour happens and includes the views of the individual. A PBS model if used effectively would contribute to a reduction in incidents. Bespoke PBS plans were available and documented in patient care records; however, staff had limited understanding of, and were reluctant to implement the PBS model. Staff were not equipped or skilled to deliver a PBS model resulting in an over-reliance on the use of restrictive practices such as the use of pro re nata (PRN) medication, and MAPA. PRN medication is medication administered as needed, to support patients with regulating their behaviours.

Staff reflected feelings of fear and an inability to safely manage patients when they present with distressed or challenging behaviours.
Staff were focused on managing and predicating the outcome of distressed or challenging behaviours rather than on proactive action to avoid escalation of behaviours

There was evidence, in one ward, of an over-reliance on the use of PRN medication to manage the presentation of some patients and we were concerned to note that some administration times coincided with shifts where there were staffing deficits, and when staff on duty were not familiar with the patients' needs. The Trust committed to undertaking an urgent review of all patients' prescribed medications.

Effective post-incident debrief and support was lacking and as a result opportunities to reflect on and learn from incidents are missed. Some staff reported that their behaviour support staff colleagues did not visit the wards.

Staff providing front-line care displayed resilience and should be commended for their dedicated service to patients and patients' families.

On 8 August 2022 RQIA wrote to the Department of Health (DoH) under Article 4 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (the Order), to inform the DoH of the significant concerns in relation to workforce and staffing arrangements, and submitted our views under Article 35 (1) (d), Article 35 (3) (d) and Article 35 (4).

We invited the Trust's SLT to a meeting on 4 August 2022 in which we discussed our intention to serve an Improvement Notice in relation to the staffing/workforce arrangements. This meeting was attended by the Trust's Chief Executive and members of the SLT.

At this meeting the Trust's Executive Management Team, presented a comprehensive action plan describing their plans to address the staffing/workforce concerns arising from the inspection. They informed us of the recent recruitment of nine new staff, five of which are newly qualified registrants, and gave an overview of further plans to recruit and retain staff at all levels.

Additional workforce resources have been secured from within the Trust including senior and middle management levels, a significant number of who will work within the adult safeguarding team. The Trust provided a clear commitment to enhance the leadership within MAH, assurance arrangements through the Executive Management Team, and up to Trust Board level, and also through the engagement of external expert support. As a result of the assurances provided and the comprehensive action plan, RQIA decided not to take enforcement action at that time and will monitor the delivery of the Action Plan outlined.

5.2.2 Adult Safeguarding

Adult safeguarding is the term used for activities which prevent harm from taking place and which protects adults at risk (where harm has occurred or likely to occur without intervention).

In some instances ward staff demonstrated a poor understanding and knowledge of adult safeguarding processes, including the threshold for making a referral to the adult safeguarding team. There was limited evidence regarding adult safeguarding training delivered to substantive staff members and we could not assess if agency staff had the necessary adult safeguarding training as training records for this group were not readily available.

There was limited assurance that incidents of a safeguarding nature were being responded to in a timely way. Delays in reporting incidents to the adult safeguarding team have resulted in delayed patient protection planning.

Staffing shortages within the adult safeguarding team have led to delays in the adult safeguarding process, with a large volume of adult safeguarding investigations not progressed. A lack of Designated Adult Protection Officers (DAPOs) is leading to ineffective management of new adult safeguarding concerns, ongoing adult safeguarding concerns and any actions as a result of the ongoing historical safeguarding concerns.

Patients involved in adult safeguarding incidents were subject to a protection plan, however; there was no evidence that the protection plans were reviewed or updated regularly. Staff involved in adult safeguarding incidents were also subject to protection plans which we found in some cases to be unrealistic with poor oversight and management. Staff told us they feel at risk due to the level of scrutiny and are fearful for their professional registration.

The PSNI were regularly called to attend the site in response to incidents. There were fewer than expected occasions of debrief and robust incident management oversight resulting in insufficient learning and improvement post incident. There was limited evidence of the effectiveness of audit and analysis of incidents with opportunities to reduce risk and improve patient care missed.

As a result of our significant concerns we wrote to the Department of Health (DoH) under Article 4 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (the Order), to advise the DoH of serious concerns we identified in relation to adult safeguarding, and submitted our views under Article 35 (1) (d), Article 35 (3) (d) and Article 35 (4).

We invited the Trust's SLT to a meeting on 4 August 2022 in which we discussed our intention to serve an Improvement Notice in relation to the adult safeguarding arrangements. This meeting was attended by the Trust's Chief Executive and members of the Trust's SLT. At this meeting the Trust presented a comprehensive action plan describing their plans to address the adult safeguarding concerns arising from the inspection. They advised additional adult safeguarding team resources that have been secured and the additional managerial oversight that has been planned to enable outstanding adult safeguarding work to progress.

The Trust has provided a clear commitment to enhance the leadership within MAH, assurance arrangements through the Executive Management Team, and up to Trust Board level, and also through the engagement of external expert support. As a result of the assurances provided by the Trust, and the comprehensive action plan, RQIA decided not to take enforcement action at that time and will monitor the delivery of the Action Plan outlined.

5.2.3 Assessment and Treatment / Resettlement

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

There were 37 patients in MAH, a small number of whom are receiving active care and treatment. This is a reduction from 39 (-2) since January 2022.

A lack of suitable community placements with appropriately skilled staff are some of the contributing factors that have hindered discharge plans for several patients. Some patients, who were preparing for discharge, had in reach staff.
In reach staff are supplied from a prospective care provider, to support patient care on site to enable patients to have a smoother transition into the community when they are discharged.

Assessments for those patients in receipt of active care and treatment were of poor quality and had not been regularly reviewed; some assessments were incomplete. This has led to ineffective care and treatment planning. Care delivered was based on a medical model and MDT meetings were focused on describing incidents and lacked evidence of meaningful decision making about changes in care planning. This has impacted on the effectiveness of the MDT's input into patient care.

Restrictive practices were not being effectively reviewed and patients were subject to restrictions that impacted on their freedom of movement. Enhanced observations (used when staff have assessed that the risk of self-harm or risk to others is increased) were not being reviewed regularly and there was no evidence that consideration had been given to reduce observation levels in a timely manner.

5.2.4 Patient Experience

Patient experience was assessed by directly observing patients lived experiences on the wards and by speaking with patients, ward staff and patients' relatives. Observations were completed across a range of day and night time periods.

The focus on patients' human rights was limited. Care, at times, lacked dignity and respect, and there was little consideration for patients' right to a private and family life. Communal living alongside other patients with complex needs created difficulties for some patients, for which there were very limited options.

Ward environments were for the most part, noisy with limited quieter spaces available for patients to avail of. Some patients who were trying to rest or sleep were disturbed by others. Noise levels on some wards were noted to be high and persistent. This had the potential to cause other patients to not want to use communal spaces. Other noise impacts include the staff alarm system, the patient mix and environmental factors associated with communal living. This is not a therapeutic environment that supports patients' mental wellbeing and their enjoyment of private and family life.

Two patients stated they were concerned about staff safety, and about the impact of the behaviours of other patients on their own wellbeing.

All of the wards visited are locked wards; and patients rely on staff availability and cooperation to support any off ward activity. While some patients were noted to have regular access to the grounds, day care and outings, not all patients can avail of these. Staffing shortages were noted to impact on a planned outing, a family visit and on individualised work with patients.

Staffing arrangements impacted directly on patient activities as not all patients received the necessary support to structure their day, promote their independence, and develop skills enabling them to manage and self-regulate their emotional wellbeing.
Patient Activity Schedules were, for the most part, not implemented, with patients largely dependent on day care staff for activities. Staff demonstrated limited purposeful engagement with patients and tended to stand in groups with, or talk to other staff.

There was no structure to the patients' day or ward based activities resulting in boredom and an increase in incidents of challenging behaviour.

In line with some patients assessed needs and to support their individual care they have been allocated a pod area within the ward footprint. Pod areas are a suite of rooms allocated specifically for one patient, and closed off to other patients. The configuration of some pod areas creates a heavily reliance on staff availability and cooperation to support the patients to access required areas outside of their pod. Staffing shortages and patient acuity were impacting staff's ability to provide individualised care. This has the potential to impact patient dignity, their physical and mental health and their ability to retain their independence and personal care skills.

We observed meal time experiences for patients. Staff demonstrated limited interaction with patients and did not provide a dignified meal time experience for some. Staff stood beside seated patients whilst assisting them with their meal and spoke to other staff rather than the patient they were assisting.

We observed examples of compassionate care to individual patients. This included supporting patients to participate in activities of their choosing both on site and off site. Staff were also observed responding compassionately to patients who were experiencing distress, offering them comfort and reassurance.

5.2.5 Patient Engagement

We observed patients seeking out and engaging with some staff in a positive way. Some patients called for staff by name, whilst others smiled and looked happy to see staff who were familiar to them. We observed patients responding negatively to staff who were unfamiliar to them.

Four patients requested to meet with inspectors. One patient expressed concerns about the safety and wellbeing of ward staff and reported that staff had been assaulted by other patients. Three patients expressed anxiety relating to the behaviours of other patients and reported feeling bullied by other patients. A small group of patients on one ward expressed concerns about the inconsistency in staffing.

Two patients completed questionnaires; both reflected that care was good and staff were kind, however, they both stated the ward they were in was not organised, nor did they feel safe there.

5.2.6 Family Engagement

We sought contact with all families/carers of patients to establish their opinions about the care their relative received. Twelve families/carers gave their opinions. Common themes are detailed as follows:

Staffing
Families had mixed views on staffing. Several reported wards were short staffed and staff had poor understanding of patient needs, while others praised staff, stated they were doing the best they could under difficult circumstances and felt staff were not recognised enough for the good work they do. Several families praised individual staff and identified them by name.

Communication
Several families raised poor communication with staff at all levels as an issue. They raised concerns about site management and the lack of contact they had with them. Additionally, some families described good communication with ward staff and commended staff.

Adult Safeguarding
Several families spoke of their concerns in relation to adult safeguarding processes. They stated they were not provided with updates about ongoing investigations and had no confidence that they would be informed of any outcome from the investigations. Some families stated that it was positive that issues were being reported to the adult safeguarding team.

Food
A small number of families had concerns about food supplied to the patients. They did not think the food was of a good standard and some felt the need to provide take away food to supplement the meals provided.

Activities
The majority of families stated there were not enough activities for patients and had concerns about how patients spent their day. Some families correlated the lack of activities with incidents of challenging behaviours. Several families stated they would like increased use of the onsite swimming pool for the patients.

Visiting
Families expressed an understanding and appreciation of the restrictions in place during the Covid-19 pandemic; however, they raised issues not impacted by these restrictions. Some had negative experiences when attempting to visit including a pre-planned visit cancelled at short notice due to staffing shortages.

5.2.7 Staff Engagement

We met with a number of staff who spoke openly about the concerns they had.

Some staff stated morale was poor and they did not feel supported. They spoke about the high level of injuries sustained by staff during incidents that occurred during their shifts, the impact this had on them, and the lack of debrief and opportunity to discuss it.

Staff were confused and concerned about the future of the hospital and what this would mean for patients and themselves. They reported feeling traumatised, anxious and on edge in relation to the level of scrutiny the hospital was under and the negative portrayal of the hospital in the media.

Despite the issues described by some staff, the staff continue to work at the site and show commitment and dedication to the patients, many providing additional hours beyond their contracted hours and some working whilst retired.

5.2.8 Governance – Leadership and Management

Governance arrangements were assessed through a review of SLT meeting records, discussions with senior staff and observations of care delivery.

Leadership, management and overall governance arrangements need to be strengthened. We determined that poor patient outcomes in relation to patient safety, quality of life, and experience were attributed to a lack of leadership at a middle management level across the site, and suitable management arrangements on the wards. Some wards did not have a dedicated manager, and the 'nurse in charge' was responsible for overall management of the ward, in addition to fulfilling their duties as a member of the team on shift. Staff described disharmony amongst teams and lack of cohesion between substantive and agency staff. There was limited evidence of the effectiveness of the NDL role to support shortfalls in staff development and ward management.

The Trust's oversight of agency staff supply and deployment across the site was not robust, which resulted in discrepancies between staff on rota to work and the actual staffing on shift. The staffing records provided were not a reliable source of information to determine the activity and location of staff members on any given shift, day or night.

They did not clearly or accurately outline the deployment of staff, as observed and did not provide an overview of staff movement across the site during shifts. We evidenced that the fluidity of staffing across the site has impacted on the delivery of safe and effective care to patients.

Management arrangements overnight are often depleted, with one night coordinator responsible for overseeing the whole site. They are responsible for the allocation of staff across the site, the redeployment of staff as necessary during the shift, and supporting staff. The depletion of the night coordinator role has resulted in new staff, unfamiliar with patients and their needs, working at ward level, with limited support available. This contributes risks in relation to patient and staff safety.

Staff who were involved in, or who had witnessed incidents of challenging behaviour were not routinely in receipt of a post incident de-brief. This reduces the opportunities to learn from incidents, and to provide necessary emotional support to staff, some of whom have sustained significant injuries while at work.

The absence of appropriate oversight of the staffing arrangements has impacted on patient safety and on the quality of care patients received. We observed staffing levels on the wards to be focussed on the numbers of staff; the skills and experience of staff members was a secondary consideration.

The Trust presented a comprehensive action plan describing their plans to address the leadership and management concerns raised with them during the inspection feedback meeting. They gave an overview of plans to recruit and retain staff at all levels, and described additional workforce resources that have been secured from within the Trust, including senior and middle management levels.

The Trust must provide strong operational leadership to bring stability to the service. The wider Health and Social Care system could support the Trust in achieving stabilisation, which RQIA recommend should be driven by a clear and transparently communicated vision for the future of MAH, shared with all stakeholders, with a fixed period of transition to its achievement. A commitment to assisting with workforce needs during that transition should be secured from other HSC providers with access to appropriately skilled and experienced staff.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Mental Health Order (Northern Ireland) 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

	Regulations	Standards
	N/A	9

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

Quality Improvement Plan	
Action required to ensure compliance with The Mental Health Order (Northern Ireland) 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).	
Area for improvement 1 **Ref:** Standard 5.1 Criteria: 5.3.3 **Stated**: Third time **To be completed by:** 31 October 2022	The Belfast Health and Social Care Trust must urgently undertake a review of the induction, training and ongoing development needs of all staff supplied to work in MAH, including those who are supplied at short notice. A training and development plan must be implemented that sets out the range of mandatory and other relevant training to be undertaken by staff. Training plans must be specific and records maintained of when training was provided, by whom and the date of any update or refresher.
	Response by registered person detailing the actions taken:

Area for improvement 2 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 31 October 2022	The Belfast Health and Social Care Trust must urgently review the staffing arrangements to ensure there are at all times sufficient numbers of adequately skilled and experienced staff available to meet the needs of patients. The Trust must implement a staffing model to determine staffing levels which must be consistent with the changing needs of patients and the challenges associated with the use of agency staff.
	Response by registered person detailing the actions taken:
Area for improvement 3 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 31 August 2022	The Belfast Health and Social Care Trust must put in place arrangements for the effective oversight of staff supply and deployment across the site. This will include the establishment and implementation of robust protocols relating to the supply of agency and new staff, their fitness and suitability to practice, and the management and oversight of records relating to staff supplied.
	Response by registered person detailing the actions taken:
Area for improvement 4 **Ref:** Standard 5.3 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 31 November 2022	The Belfast Health and Social Care Trust must urgently review the care and treatment plans of all patients to ensure that their assessed needs are adequately outlined and that a plan is in place to meet their needs. The Trust must ensure that appropriately skilled staff have oversight of each patient's plan, that the patient and their relatives are involved in its development, and that there are arrangements in place for plans to be reviewed regularly by the multi-disciplinary team.
	Response by registered person detailing the actions taken:

Area for improvement 5 **Ref:** Standard 5.3 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 30 November 2022	With the current focus on resettlement of patients from MAH resulting in a reduction in numbers of patients across each of the five wards, the Belfast Health and Social Care Trust must keep under review each patient's living areas to ensure that patients are receiving care and treatment in the most therapeutic environment. The review should take account of matters relating to excessive noise, restrictions in freedom of movement, or incompatibility with other patients and should be developed with the patient and where appropriate, their relatives.
	Response by registered person detailing the actions taken:
Area for improvement 6 **Ref:** Standard 7.1 Criteria: 7.3 **Stated:** First time **To be completed by:** 31 October 2022	The Belfast Health and Social Care Trust must put in place arrangements to promote the wellbeing of all staff. A staff wellbeing plan must be developed which sets out the Trust's arrangements for staff to access and receive support and guidance.
	Response by registered person detailing the actions taken:
Area for improvement 7 **Ref:** Standard 5.3 Criteria: 5.3.1 **Stated:** Second time **To be completed by:** 30 September 2022	The Belfast Health and Social Care Trust must urgently undertake a review of the Adult Safeguarding Operational Procedures in Muckamore Abbey Hospital in line with Regional Policy. An action plan must be developed to address the deficits in the implementation of the regional Policy, the measures to be taken to address these, and the timescales for completion.
	Response by registered person detailing the actions taken:
Area for improvement 8 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 30 September 2022	The Belfast Health and Social Care Trust must put in place suitable arrangements for the effective delivery and oversight of adult safeguarding policy and procedures. These arrangements should include an ongoing evaluation of the effectiveness of the safeguarding arrangements on MAH site and the impact the adult safeguarding process has on patients, relatives and staff.
	Response by registered person detailing the actions taken:

Area for improvement 9 **Ref:** Standard 4.1 Criteria: 4.3 **Stated:** First time **To be completed by:** 31 October 2022	The Belfast Health and Social Care Trust must urgently take steps to strengthen the leadership and governance arrangements in MAH taking account of the clinical leadership and middle management structures. The outcome of this process must be shared with RQIA and must set out clearly any revisions to the management structure, roles and responsibilities and accountability arrangements.
	Response by registered person detailing the actions taken:

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

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

MUCKAMORE ABBEY HOSPITAL INQUIRY

WITNESS STATEMENT

Statement of Lynn Long

Regulation and Quality Improvement Authority ("RQIA")

Date: 26 April 2024

Exhibit 2

Quality of Interaction Schedule (QUIS)

The quality of interaction audit is a tool designed to help evaluate the type and quality of communication that takes place on the ward inspected.

The tool described in this guide has been designed to help inform evaluations of the type and quality of interaction that takes place between staff and patients and their visitors in a mental health hospital setting.

What is a quality of interaction audit (QUIS)?

This is method of systematically observing and recording interactions whilst remaining a non-participant. It is a technique first developed for use in long term residential mental health settings, but the tool has undergone substantial revision and has been adapted for more general use in residential and general hospital settings (Dean, Proudfoot, & Lindesay 1993).

It can be used as both a qualitative and quantitative tool to provide a measure of the quality of interaction between staff, patients and visitors. It is designed to develop the therapeutic and more sensitive communication within a ward or department.

It should be used sensitively and discreetly with full knowledge of senior managers, staff, patients and relatives.

Using observation during inspection

During inspections the views and experiences of people who use services are central to helping the inspection team make a judgement. This is one of a number of different tools which will be used to allow patients and visitors to share their views and experiences.

The main focus of the observation is to review the way that staff respect and interact with patients with a mental health problem and their visitors. If inspectors undertaking observation, observe practice that may put the patient at risk the observation should stop and the observation immediately reported to the person in charge. If any team member sees that a patient is in danger they should immediately call for help from staff.

Inspectors to use their professional judgement on whether the use of the QUIS tool is appropriate on the day(s) of the inspection. Inspectors will not complete the tool if judged that it could be detrimental to the presenting needs of the patients.

Inspectors should choose an appropriate time for the 20 minute observation e.g meal times, patients leaving for day care or during activities.

The limitations of observation

Person centred care is care which demonstrates compassion, dignity, privacy, clear

communication and shared decision making. Not all aspects of person centred care can be observed and not all observations can be interpreted without additional information.

Observation data will therefore be used alongside findings to provide a more complete picture of the care of older people and to put the observation data in context.

Getting started

On arriving at the ward the person in charge will be informed of the observation. Observations will generally be carried out at times of day when speaking with patients or handing out questionnaires would be inappropriate or obtrusive. It is important that you observe in an unobtrusive way that preserves people's dignity and human rights. If anyone becomes distressed by your presence you should immediately stop observing. If anyone is concerned about confidentiality assure them that this will be respected. Do not start any interaction with a patient or visitor during the observation period.

- Let the staff and patients in the bay/or point of observation know what you are doing.
- Always observe in a communal area.
- Select your observation point and find somewhere that is unobtrusive to sit and record for 20 minutes.
- Do not following patients out of the observation area.
- Be happy to explain/ chat – "but after I have finished this, in a few minutes"
- Say goodbye and thank you before leaving.

The number of people you can observe will be determined by the number of patients being cared for in the observation area, the layout of the ward or bay your observation position, and the level of ward activity. Typically not more than six patients will be observed.

Equipment

- Watch with second hand and pen
- Observation sheets
- Highlight pen for events (optional)

What should be observed?
The focus of the observation is interaction:

- All staff – patient interactions that take place within the ward during the period of observation should be recorded.
- Any staff – visitor interactions that take place within the ward during the period of observation should be recorded.

Note: Interactions by the following should not be recorded unless you there is something significant to record. Any equality and diversity issues must be recorded

- Staff – staff,
- Older patient – older patient
- older patient – visitor

Rating the interactions

When rating the quality of the interaction:

- Be consistent
- Use common sense but give a fair picture
- Negative interactions even as part of a 'better' whole must be identified. A sharp instruction or command, belittling, or inappropriate behaviours or endearments stick in the mind of patients and relatives.
- Rate straight away – this is essential

Discuss your thoughts with your colleagues, some activities or events just need extra thought and discussion

You will record a short description of each observed interaction between staff and patients or between staff and visitors during the observation period, including verbal and non-verbal interactions. You will also rate the quality of interaction using one of three categories: positive social interaction, basic care/neutral interaction or negative interaction.

Coding categories
The coding categories for observation on general acute wards are:

Examples include:

Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.	**Basic Care: (BC) –** basic physical care e.g. bathing or use if toilet etc with task carried out adequately but without the elements of social psychological support as above. It is the conversation necessary to get the task done.
• Staff actively engage with people e.g. what sort of night did you have, how do you feel this morning etc (even if the person is unable to respond verbally) • Checking with people to see how they are and if they need anything • Encouragement and comfort during care tasks (moving and handling, walking, bathing etc) that is more than necessary to carry out a task • Offering choice and actively seeking engagement and participation with patients • Explanations and offering information are tailored to the individual, the language used easy to understand ,and non-verbal used were appropriate • Smiling, laughing together, personal touch and empathy • Offering more food/ asking if finished, going the extra mile • Taking an interest in the older patient as a person, rather than just another admission • Staff treat people with respect addressing older patients and visitors respectfully, providing timely assistance and giving an explanation if unable to do something right away	**Examples include:** Brief verbal explanations and encouragement, but only that the necessary to carry out the task No general conversation

Staff respect older people's privacy and dignity by speaking quietly with older people about private matters and by not talking about an individual's care in front of others • Staff use of curtains or screens appropriately and check before entering a screened area and personal care is carried out with discretion	

Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.	**Negative (N) –** communication which is disregarding of the residents' dignity and respect.
Examples include: • Putting plate down without verbal or non-verbal contact • Undirected greeting or comments to the room in general • Makes someone feel ill at ease and uncomfortable • Lacks caring or empathy but not necessarily overtly rude • Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact • Telling someone what is going to happen without offering choice or the opportunity to ask questions. • Not showing interest in what the patient or visitor is saying.	**Examples include:** • Ignoring, undermining, use of childlike language, talking over an older person during conversations. • Being told to wait for attention without explanation or comfort • Told to do something without discussion, explanation or help offered • Being told can't have something without good reason/ explanation • Treating an older person in a childlike or disapproving way • Not allowing an older person to use their abilities or make choices (even if said with 'kindness'). • Seeking choice but then ignoring or over ruling it. • Being angry with or scolding older patients. • Being rude and unfriendly • Bedside hand over not including the patient

Events
Remember you may observe event or as important omissions of care which are critical to quality of patients care but which do not necessarily involve a 'direct interaction'. For example a nurse may complete a wash without talking or engaging with a patient (in silence).

Record and highlight as an event on the observation sheet.

An example of an omission of care may be

- a patient repeatedly calling for attention without response,
- a patient left inadequately clothed,
- a meal removed without attempts made to encourage the patient to finish it,
- a patient clearly distressed and not comforted.

Feedback and presentation of the results
Provide initial feedback to the person in charge and as part of the overall feedback session a written summary on all the 20 minute observations will be provide in the report.

Simple percentages of the quality of interactions will be used for evidence of the quality of verbal and non-verbal communication e.g. 20% of observation were positively social (n=20), 70% were basic care interactions (n=70), 5% were neutral interaction (n=5) and 5% were negative interaction (n=5).
These will be presented visually in the report as a Venn diagram (pie chart)

References
QUIS originally developed by Dean, Proudfoot and Lindesay (1993). The quality of interactions schedule (QUIS): development, reliability and use in the evaluation of two domus units. *International Journal of Geriatric Psychiatry* Vol *pp 819-826.

QUIS tool guidance adapted from Everybody Matters: Sustaining Dignity in Care. London City University.