Mental Health and Learning Disability Inpatient Inspection Report
11-13 October 2016

Ross Thomson Unit

Acute Psychiatric Inpatient
Causeway Hospital
4 Newbridge Road
Coleraine
Tel No: 028 70346114

Inspectors: Cairn Magill, Dr Brian Fleming

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we Look For

2.0 Profile of Service

Ross Thomson Unit is 20 bedded acute psychiatric inpatient mixed gender ward situated in the grounds of Causeway Hospital, Coleraine and is affiliated to Holywell Psychiatric Hospital, Antrim. On the days of inspection there were 18 patients on the ward, five of whom were detained appropriately in accordance with the Mental Health (Northern Ireland) Order 1986.

3.0 Service Details

Responsible person:	Dr. Tony Stevens, Chief Executive
Acting Ward manager:	Roisin Quinn
Person in charge at the time of inspection:	Roisin Quinn, Acting Ward Manager

4.0 Inspection Summary

An unannounced inspection took place between 11 and 13 October 2016.

This inspection focused on the theme of Person Centred Care. This means that patients are treated as individuals, and the care and treatment provided to them is based around their specific needs and choices.

We assessed if the Ross Thomson Unit was delivering, safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to compassionate care, staff responding to patient needs appropriately in a sensitive manner, respecting patient's dignity and privacy, seeking consent from patients before providing interventions, including patients in their care and treatment, access to advocacy services, multi-disciplinary working, consideration of patient's human rights, and onward referrals to appropriate specialists as and when required.

Areas requiring improvement were identified. The oversight of mobile phone usage by patients requires to be urgently reviewed.

RQIA observed patients waiting to be assessed by the crisis response team had direct access onto the ward. RQIA were concerned that this compromised patient's privacy and had the potential to increase the risk on the ward.

These two areas of concerns were discussed at feedback.

Other areas of improvement included the high use of bank staff to cover shifts. Inspectors were informed that there was a significant loss of experienced staff in recent months. Ross Thomson Unit had a significant number of changes in the management and staff on the ward. Ensuring adequate cover of shifts required the use of a high number of bank staff and agency staff. Patients reported that the re-allocation of rooms in the unit resulted in the loss of a quiet room for patients who remain unhappy about this.

Patients stated;

"Staff are very in tune with patient's needs".

“The prospects for me, for my illness and recovery are all going to plan thanks to the staff at Ross Thomson”.

“It’s brilliant. If you are in difficulties there are always staff there to help me”.

“It’s the right people doing the right job for the right reasons”.

“The staff level is quite low and could be increased”.

“The unit could do with more staff. It feels like if they run it down it will give them an excuse to close it”.

“Weekends are long”.

Relatives

No relatives were available to meet with the inspector.

The findings of this report will provide the service with the necessary information to enhance practice and service user experience.

4.1 Inspection Outcome

Total Number of Areas for Improvement	11

The findings of the inspection were discussed with the acting ward manager, members of the multi-disciplinary team and senior management of the trust as part of the inspection process and can be found in the main body of the report.

A letter of concern was issued to the Trust following this inspection.

The escalation policies and procedures are available on the RQIA website.

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

5.0 How we Inspect

Prior to inspection we review a range of information relevant to the service. This included the following records:

- the operational policy or statement of purpose for the ward;
- incidents and accidents;
- safeguarding vulnerable adults;
- complaints;
- health and safety assessments and associated action plans;

- information in relation to governance, meetings, organisational management, structure and lines of accountability;
- details of supervision and appraisal records; and
- policies and procedures.

During the inspection the inspector met with four patients, a further three patients completed the patient questionnaire; six ward staff and one visiting professional. No patients' relative or carers were available to meet with inspectors.

The following records were examined during the inspection:

- care documentation in relation to three patients;
- staff rota;
- training records;
- minutes of the most recent three staff team meetings;
- patient menus;
- nursing activity records;
- minutes of the patient forum meetings; and
- a number of patient's prescribed medication i.e. patient specific Kardex.

During the inspection the inspector observed staff working practices and interactions with patients using a Quality of Interaction Schedule Tool (QUIS).

RQIA reviewed the recommendations made at the last inspection. An assessment of compliance was recorded as met/ partially met/ not met.

The preliminary findings of the inspection were discussed at feedback to ward staff and senior managers at the conclusion of the inspection.

6.0 The Inspection

The most recent inspection of the Ross Thomson Unit was an unannounced inspection. The completed Quality Improvement Plan (QIP) was returned and approved by the responsible inspector. This QIP was validated by the inspector during this inspection.

6.1 Review of recommendations from the most recent unannounced inspections dated 02 March 2016 and 23 July 2015

Recommendation		Validation of compliance
Number 1 **Ref**: Standard 5.3.1 (a) **Stated:** Second Time	It is recommended that the ward manager ensures that risk assessments completed for each patient, admitted to the ward considers the ligature risks. This should include an associated risk management plan where a patient has been assessed as being at risk from using a ligature point.	**Met**
	Action taken as confirmed during the inspection: Inspector confirmed that in three patient records reviewed there was a ligature risk assessment completed for each patient admitted to the ward.	
Number 2 **Ref**: Standard 5.3.1 (f) **Stated:** Second Time	It is recommended that the ward manager ensures that the resuscitation trolley is checked in accordance with Trust's policy and procedure.	**Not Met** **This item is now on daily briefing agenda and in the ward diary to be ticked when completed each day.**
	Action taken as confirmed during the inspection: Inspector reviewed the daily check list of the monitoring of the resuscitation trolley and noted that it was not checked on a consistent basis in accordance with the Trust's policy and procedure. This was restated at feedback.	
Number 3 **Ref**: Standard 4.3 (i) **Stated:** First Time	It is recommended that the ward manager ensures that the activity room is cleared of unnecessary items including cardboard boxes, unused pieces of equipment and trolleys	**Met**
	Action taken as confirmed during the inspection: The inspectors viewed the activity room and was satisfied that the room was cleared of all unnecessary items and unused pieces of equipment. Part of the activity room now had fully functioning gym equipment for patients to use under supervision.	

Number 4 **Ref**: Standard 5.3.1 (f) **Stated:** First Time	It is recommended that the trust ensures that the garden area is cleaned to improve the therapeutic environment for patients.	**Met**
	Action taken as confirmed during the inspection: Inspectors viewed the garden during this inspection and noted it to be clean and tidy with flower boxes and appropriate seating.	
Number 5 **Ref**: Standard 5.3.3 (b) **Stated:** First Time	It is recommended that patients are afforded the choice and opportunity to attend their multi-disciplinary meetings.	**Met**
	Action taken as confirmed during the inspection: Inspectors met with patients and members of the multi-disciplinary team and reviewed patient care documentation. The Ross Thomson unit operate zoning meetings where some patients are discussed at the multi-disciplinary meeting which is held every morning. Every patient will be discussed a minimum of once a week those whose needs are more complex are discussed daily. Following the meeting the patient's consultant or named/ associate nurse speaks with the patient and discusses the proposed plan of care and treatment with the patient. Patients are given the opportunity to make decisions on their care and treatment at this time. A number of patients stated that this was preferable rather than go into a meeting with a larger group of professionals. Patients are invited to attend the formulation meeting and discharge planning meetings. Patients can also speak to individual members of the multi-disciplinary team at any point they are on the ward. The inspector is satisfied that patients are afforded the choice and opportunity to contribute to their care and treatment.	

Number 6 **Ref**: Standard 5.3.1 (a) **Stated:** First Time	It is recommended that the Trust completes an up to date ligature risk assessment of the ward's environment	**Met**
	Action taken as confirmed during the inspection: The ward had a ligature risk assessment completed on 3 September 2015. The trust shared with RQIA the business case application for small expenditure to fund works to address the ligature risks.	
Number 7 **Ref**: Standard 5.3.1 (a) **Stated:** First Time	It is recommended that the ward manager ensures that risk assessments completed for each patient, admitted to the ward, considers the ligature risks. This should include an associated risk management plan where a patient has been assessed as at risk from using a ligature point.	**Met**
	Action taken as confirmed during the inspection: Each patient had a ligature risk assessment completed. One patient who was using a profiling bed did not have any reference to the use of a profiling bed on their ligature risk assessment. However the patient did not have sufficient mobility to place themselves at risk.	
Number 8 **Ref**: standard 6.3 **Stated:** First Time	It is recommended that the Trust ensures that access to the appropriate level of clinical psychology service, in terms of seniority and available sessions. Advice regarding this should be accessed via the head of psychological services and/or professional body.	**Met**
	Action taken as confirmed during the inspection: A consultant clinical psychologist was appointed in mid-July 2016 on a one day a week basis to Ross Thomson Unit. During discussion with the inspector the consultant clinical psychologist advised that the Ross Thomson unit would benefit from additional allocation of hours and psychology staff.	
Number 9 **Ref**: Standard 6.3 **Stated:** Second Time	It is recommended that the trust ensures that Clinical Psychology services are involved within the MDT, not only to provide specialist psychotherapy, but also to assist in the training and supervision of low and high intensity interventions.	**Met**
	Action taken as confirmed during the inspection: The inspector met with the clinical psychologist who outlined their input to the ward and the multi-disciplinary team. As well as providing one to one high intensity work with specific patients, the	

	consultant clinical psychologist is working towards developing a training programme for nursing, occupational therapists and social worker staff to deliver low intensity psychological interventions to patients.	
Number 10 **Ref**: Standard 5.3.3 (a) **Stated:** First Time	It is recommended that the ward's multi-disciplinary team (MDT) ensures that information regarding all members of the ward's MDT is available on the patient information board.	**Met**
	Action taken as confirmed during the inspection: The inspector observed all names of the multi-disciplinary team were displayed on the patient information board. Patients also informed the inspector they knew were the information board was and what information it contained. Staff reported to inspectors that they observed patients referring to the information on the board.	

7.0 Review of findings

7.1 Is Care Safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that are intended to help them.

Areas of Good Practice

Patients are encouraged to be actively involved in signing and managing their own personal safety and risk management plans.

Each patient had a risk assessment and a ligature risk assessment completed.
The ward had a ligature risk assessment completed on 3 September 2015.

Staff who met with inspectors stated they knew how and who to escalate any concerns or risks to in relation to patient or environmental safety

Inspectors found evidence in care records that patients were informed of their rights under the Mental Health (NI) Order 1986.

The patient information leaflet given to patients upon admission explained the zoning meetings and complaints procedure

Throughout care records there was evidence of staff recording instances where they sought patient consent.

Two patients who met with inspectors and three patients who completed the questionnaire reported that staff always seeks permission and consent before completing any care tasks

There was evidence that the ward manager had escalated risks on the Trust Datix system in relation to staff shortages and the associated risk to delivering patient care.

Areas for Improvement

<u>Access to the Ward.</u>

Patients waiting to be seen by crisis response team have direct access to Ross Thomson Unit. This compromises patient's privacy and has the potential to increase risks for patients.

<u>Risk Documentation and Recording</u>

Generic risk assessment forms do not have the facility to record additional detail around specific risks for any patient presenting with more complex needs arising from the risk identified.

The forms used to record the review of the risks did not provide sufficient space for accurate recording.

The documentation following zoning meetings reflect an update and reviews of risks. However these only focused on the mental health status of the individual. Other risks identified on the risk screening tool are generally not recorded on this proforma although they are recorded in nursing progress notes. Two of the patients whose risk assessment and documentation were reviewed by the inspector had significant changes in risks from the original assessments were completed. Whilst appropriate action was taken, the risk assessment and review documentation did not reflect the up-to-date management plan of the risks. Staff were able to demonstrate knowledge and progress notes reflected these changes but the risk assessment document did not reflect the new emerging risks or management of the risks. Therefore they were not immediately accessible for new staff or bank or agency staff to read and become familiar with the risks.

Multi-Disciplinary Recording at Zoning Meetings.

The record of discussion of the multi-disciplinary zoning meetings is completed by nursing and medical staff. Other disciplines do not complete their involvement in the discussion record although their presence is recorded and they do get an opportunity to sign the resulting action plan.

Fire Safety Policy and Evacuation Procedures

Ross Thomson Unit did not have a “major incident emergency grab box” in the event of a fire as per the Trust’s policy.

Causeway Hospital RTU Fire Safety Policy and Evacuation Procedure which was dated April 2013 was provided to RQIA on 24 February 2016 however this was not available on the ward during the inspection. An older version of the Northern Trust Fire Safety & Arson Policy dated September 2012 was provided to the inspector pre-inspection. The RTU Fire Safety policy and evacuation procedure had a number of inaccuracies that did not reflect the current status of the ward. Issues that are to be considered for review include the number of beds allocated to RTU and the allocations of rooms to other services.

Patient’s individual evacuation plans required more detail to ensure all staff are aware of each patient’s specific need.

Number of areas for improvement	Four

7.3 Is Care Effective?

The right care, at the right time in the right place with the best outcome

Areas of Good Practice

There was evidence that patient's needs were comprehensively assessed with an appropriate care/ treatment plan for each assessed need.

The daily zoning meetings are very effective and provide an opportunity for the MDT team to respond to changing needs promptly and as required.

Care documentation evidenced discussion and planning to address assessed needs.

The inspector noted in care records that patients were continually offered the opportunity to comment on their care plans. The inspector observed patient's signature on care plans. Patients who were not well enough to sign their care plans staff recorded "directed care".

Patients who met with inspectors stated that staff listened to their views in the co-production of care plans.

There were evidence based care and treatment plans appropriate to the assessed needs of each patient.

Minutes of the zoning meeting detailing action points and person responsible were located in the patient file.

Appropriate referrals were made for specialised assessments and interventions according to patient's assessed needs.

It was evident in care documentation reviewed that the need for the use of restrictive practices was based on individualised assessment of need. Each patient had a deprivation of liberty assessment and corresponding care plan if required.

Areas for Improvement

Carer Participation in Co-Producing Care Plans

There are no other formal means of the patient's carer or representative being involved in the co-production of a care plan apart from the initial formulation meeting and discharge planning meetings.

Patients do not have Access to a Quiet Room

Patients can only access the gym and day activity room when staff are available to provide supervision.

Number of areas for improvement	Two

7.4 Is Care Compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Areas of Good Practice

All patients who met with the inspectors and who completed the patient questionnaire stated that staff treat them with dignity and respect and respond compassionately to their physical needs and emotional distress.

The range of care and treatment options are discussed with patients and appropriate information is given to help them make an informed decision.

Care documentation reviewed, evidenced that the need for the use of any restrictive practice was explained to patients. Four patients who completed questionnaires stated that staff did explain the reasons for restrictive practice as well as their rights.

Five patients who completed the questionnaire stated they were satisfied with the care and treatment provided and about the way staff treat them from admission to discharge. One patient could not remember their experience at admission

Independent advocacy service is available. Posters are displayed in the ward informing patients of NIAMH advocacy service and dates of when the advocate is next visiting the ward.

Areas for improvement

<u>Recording of Cancelled Activities</u>

The inspector noted some instances were recorded by nursing staff as to why activities were cancelled or unable to be provided – mainly during the evenings or weekends however there was no consistency in recording these and entries were ad-hoc.

Number of Areas For Improvement	One

7.5 Is the Service Well Led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

Areas of Good Practice

The RQIA medical inspector reviewed a selection of medication and kardexes and no issues were identified.

The minutes of the previous three Mental Health and Disability Directorate Governance Team meetings were provided. Upon review of the minutes there was evidence that there was shared learning disseminated from SAI's, accidents and incidents recorded on the Datix system, policies and procedures, safeguarding referrals and service users feedback.

There was a local log kept of informal compliments and complaints kept on the ward. There were no complaints in the file.

All staff who met with the inspector stated there were good working relationships between members of the multidisciplinary team.

There are systems in place to collect patient compliments and complaints.

There was evidence that staff received mandatory training.

Despite previous gaps in supervision all staff have had recent supervision which is in line with Trust policy.

Areas for Improvement

Mobile Phones

There was a lack of direction and management in relation to patient's using their own mobile phones. There were two reports from patients of instances where their privacy was compromised by other patients. There were two examples where mobile phones were inappropriately used to update social media platforms and taking photographs of another patient without their consent.

Patient Forum Meetings

Patient forum meetings are facilitated however this does not happen on a consistent basis. Minutes of the patient forums meetings are recorded and not all actions are followed up

Staffing Issues

Ross Thomson unit has had a number of experienced skilled staff who left either for career progression, sickness or retirement. The unit is under a lot of pressure currently to ensure and maintain skill mix and adequate staffing levels. Given the high usage of bank and agency staff, staff reported that it is a challenge to properly induct new staff on the ward especially if there are a high number of patients on the ward on special observations.

The ward lost a Band 5 OT and now has one Band 6 OT and two part-time OT technicians. Implications of the loss of the Band 5 OT means when the Band 6 OT is off on leave no new patients admitted to the ward can access OT activities until they have an OT assessment. This can only be completed by a qualified OT. Therefore there can be a significant delay in patients accessing OT activities.

The Band 6 OT is unable to deliver one to one recovery based therapeutic work such as assisting patients through the work books entitled, “Dealing with Depression” and “Dealing with Anxiety” as most of their work is focused on group based activities.

There is a consultant clinical psychologist assigned to the ward one day a week. The psychologist’s role is to train, deliver and oversee low level psychological intervention strategies for nursing and OT staff in addition to providing one to one more high intensity interventions with specific patients. The consultant psychologist stated the number of hours per week is not sufficient to meet the needs of the ward/ patient population or training needs of the staff.

The loss of experienced staff, the number of vacant positions currently unfilled and temporary acting up positions as well as with the high use of bank staff and agency use has resulted in staff expressing concern around staffing levels and confidence in management.

Accessing up-to-date Trust policies

Trust policies were not easily accessible by staff on the intranet/ Trust electronic hub. The pre-inspection request for policies and procedures was returned blank.

Number of areas for improvement	Four

8.0 Provider Compliance Plan

Areas for improvement identified during this inspection are detailed in the provider compliance plan. Details of the provider compliance plan were discussed at feedback, as part of the inspection process. The timescales commence from the date of inspection.
The responsible person should note that failure to comply with the findings of this inspection may lead to further /escalation action being taken. It is the responsibility of the responsible person to ensure that all areas identified for improvement within the provider compliance plan are addressed within the specified timescales.

8.1 Areas for Improvement

This section outlines recommended actions, to address the areas for improvement identified, based quality care standards, MHO and relevant evidenced based practice.

8.2 Actions to be Taken by the Service

The provider compliance plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed provider compliance plan for assessment by the inspector.

Provider Compliance Plan Ross Thomson Unit	
Priority 1	
Area for Improvement No. 1 **Ref**: Standard 5.3.1 (a) **Stated:** First Time **To be completed by:** 13 November 2016	The responsible person must ensure the following area for improvement is addressed. <u>Access to the ward</u>
	Response by responsible person detailing the actions taken: THE TRUST IS CONTINUING TO SEEK ALTERNATIVE ACCOMODATION OPTIONS FOR CRHTT TEAM.INTERIM MEASURES HAVE BEEN DEPLOYED TO ENSURE ALL PATIENTS WHO ATTEND CRHTT ARE ACCOMPANIED FOR THE DURATION OF TIME THAT THEY ARE PRESENT IN THE WARD.
Area for Improvement No. 2 **Ref**: Standard 5.3.1 (c) & 6.3.2 (a) **Stated:** First Time **To be completed by:** 13 November 2016	The responsible person must ensure the following area for improvement is addressed. <u>Mobile Phones</u>
	Response by responsible person detailing the actions taken: IN THE ADMISSION PACK, PATIENTS HAVE BEEN GIVEN THE MOBILE PHONE POLICY (ONE SHEET CONDENSED) TO BE AWARE OF SAME PRE ADMISSION. THIS IS CURRENT PRACTICE
Priority 2	
Area for Improvement No. 3 **Ref**: Standard 5.3.1 (f) **Stated:** First Time **To be completed by:** 13 January 2017	The responsible person must ensure the following areas for improvement are addressed. <u>Fire Safety Policy and Evacuation Procedures</u>
	Response by responsible person detailing the actions taken: RED GRAB BOX IS NOW INSITU. FIRE POLICY WILL BE REVIEW AT THE MDT POLICIES WORKING GROUP ARRANGED FOR 20/01/17. STAFF HAVE ALL ATTENDED THEIR FIRE TRAINING
Area for Improvement No. 4 **Ref**: Standard 6.3.1 (a) **Stated:** First Time	The responsible person must ensure the following areas for improvement are addressed. <u>Staffing Issues</u>
	Response by responsible person detailing the actions taken: THERE ARE CURRENTLY NO VACANT POSTS WITHIN THE UNIT.

To be completed by: 17 January 2017	THE BAND 7 PERMANENT POST HAS BEEN APPOINTED AND THE PERMANENT BAND 6 HAS BEEN ADVERTISED WITH CLOSING DATE 7TH DEC AND 10TH JANUARY HELD FOR INTERVIEW. WE CURRENTLY HAVE 3 STAFF NURSES ON SECONDMENT TO COMMUNITY POSTS. WE HAVE IDENTIFIED EXPERIENCED BAND 5 STAFF FROM HOLYWELL WHO WILL BE REDEPLOYED TO SUPPORT THE DEVELOPMENT OF THE WARD TEAM.
Area for Improvement No. 5 **Ref**: Standard 5.3.1 (f) **Stated:** First Time **To be completed by:** 13 January 2017	The responsible person must ensure the following area for improvement is addressed. <u>Risk Documentation and Recording</u> **Response by responsible person detailing the actions taken:** NURSING SERVICES AND ACUTE CARE MANAGER HAVE STATED THAT THE RISK ASSESSMENT IS UNDER REVIEW REGIONALLY. IN THE CURRENT ICP WE HAVE DIVIDED THE SAFEGUARDING SECTION INTO CHILDREN/ADULTS. ALL STAFF ARE HAVING ONGOING RISK ASSESSMENT AND SAFEGUARDING TRAINING.
Area for Improvement No. 6 **Ref**: Standard5.3.1 (f) **Stated:** First Time **To be completed by:** 13 January 2017	The responsible person must ensure the following area for improvement is addressed. <u>Multi-Disciplinary Recording at Zoning Meetings</u> **Response by responsible person detailing the actions taken:** ALL MULTI DICIPLINARY TEAMS AT ZONING ARE NOW COMPLETING ALL SECTIONS OF ZONING SHEET AS FROM 29TH OCTOBER 2016
Area for Improvement No. 7 **Ref**: Standard 5.3.3 (f) **Stated:** First Time **To be completed by:** 13 January 2017	The responsible person must ensure the following area for improvement is addressed. <u>Patients do not have Access to a Quiet Room</u> **Response by responsible person detailing the actions taken:** QUIET ROOM HAS BEEN RE-OPENED ON 1/11/16 AND PATIENTS ARE AWARE OF SAME THROUGH PATIENT STAFF MEETINGS AND ONE TO ONE CONTACT WITH THEIR NAMED NURSE.
Area for Improvement No. 8 **Ref**: Standard 6.3.1 (b) **Stated:** First Time **To be completed by:** 13 January 2017	The responsible person must ensure the following area for improvement is addressed. <u>Patient Forum Meetings</u> **Response by responsible person detailing the actions taken:** STAFF WERE INFORMED IN THEIR DAILY BRIEFING/OPERATIONAL SUPERVISION THE IMPORTANCE OF FEEDBACK TO PATIENTS FROM PREVIOUS MEETING AND

	AGREED ACTION PLANS, THIS IS NOW THE TOP OF THE AGENDA AT THE BEGINNING OF ALL PATIENT FORUMS. NEW TEMPLATE INSITU DATE COMMENCED 15TH OCTOBER
Area for Improvement No. 9 **Ref**: standard 5.3.1 (f) **Stated:** First time **To be completed by:** 13 January 2017	The responsible person must ensure the following areas for improvement are addressed. <u>Accessing up-to-date Trust Policies</u>
	Response by responsible person detailing the actions taken: ALL STAFF HAVE BEEN INFORMED THROUGH DAILY BRIEFING AND OPERATIONAL SUPERVISION HOW TO GAIN ACCESS TO ALL POLICIES. THE POLICY REVIEW GROUP TABLED 20/01/17 ARE IN PROCESS OF UPDATING POLICIES DUE FOR RENEWAL INCLUDING FIRE POLICY.
Priority 3	
Area for Improvement No. 10 **Ref**: Standard 6.3.2 (b) **Stated:** First Time **To be completed by:** 13 April 2017	The responsible person must ensure the following areas for improvement are addressed. <u>Carer Participation in Co-Producing Care Plans</u>
	Response by responsible individual detailing the actions taken: ALL PATIENTS ARE GIVEN THE OPPORTUNITY FOR THEIR NOK TO BE INVOLVED WITH THEIR CARE, STAFF ARE AWARE OF THE IMPORTANCE OF DOCUMENATION IN THE NURSING PROGRESS NOTES VIA DAILY BRIEFING, SUPERVISIONS AND STAFF MEETINGS. INDIVIDUAL TRAINING NEEDS THAT ARE IDENTIFIED ARE FACILITATED.
Area for Improvement No. 11 **Ref**: Standard 6.3.2 **Stated:** First Time **To be completed by:** 13 April 2017	The responsible person must ensure the following areas for improvement are addressed. <u>Recording of Cancelled Activities</u>
	Response by responsible individual detailing the actions taken: EVENING AND WARD ACTIVITIES WILL BE PRIORITISED AS PART OF THE PATIENTS TREATMENT PLAN, ACIVITIES ARE ONLY CANCELLED IN EXCEPTIONAL CIRCUMSTANCES. .STAFF ARE REMINDED AT DAILY BRIEFING/ OPERATIONAL SUPERVISION FOR THE NEED TO DOCUMENT WHEN UNABLE TO CARRY OUT WEEKEND AND EVENING ACTIVITES AND REASON FOR SAME.

Name of person completing the provider compliance plan	ROISIN QUINN		
Signature of person completing the provider compliance plan	obo Mrs Roisin Quinn	**Date completed**	16/12/16
Name of responsible person approving the provider compliance plan	Mr Oscar Donnelly		
Signature of responsible person approving the provider compliance plan		**Date approved**	16/12/16
Name of RQIA inspector assessing response	Cairn Magill		
Signature of RQIA inspector assessing response		**Date approved**	7 April 2017

The Regulation and Quality Improvement Authority

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