Mental Health and Learning Disability Inpatient Inspection Report

21- 22 August 2018

Cloughmore Ward

Bluestone Unit
Craigavon Area Hospital
Southern Health and Social Care Trust

Tel No: 028 3836 6750

Inspectors: Audrey McLellan and Dr Brian Fleming
Lay Assessor: Alan Craig

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

Cloughmore is an 18 bedded ward in the Bluestone Unit on the Craigavon Area Hospital site. The purpose of the ward is to provide acute assessment and treatment for patients with a psychiatric illness who require care in an inpatient environment.

The multidisciplinary team (MDT) consists of nursing staff and health care assistants, two consultant psychiatrists, two ward doctors, a pharmacist, a social worker, a clinical psychologist and an occupational therapist. There were 16 patients on the ward on the days of the inspection. One patient was in the general hospital and staff from the ward were supporting this patient with enhanced observations. One patient was on home leave. Eight patients had been detained under the Mental Health (NI) Order 1986. There were no patient's on the ward who were delayed in their discharge from hospital.

3.0 Service Details

Responsible person: Mr Shane Devlin
Ward manager: Rebecca Fearson
Person in charge at the time of inspection: Rebecca Fearson

4.0 Inspection Summary

An unannounced inspection took place over two days on 21 and 22 August 2018.

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 Cloughmore ward was delivering, safe, effective and compassionate care and if the service was well led.

During the inspection inspectors met with 13 members of the MDT. This included the occupational therapist, the ward manager, two ward doctors, nurses, health care assistants, the ward social worker and the pharmacist.

The inspectors also met with the independent advocate for the ward.

There were no carers/relatives available to speak with the inspectors on the days of the inspection. However inspectors left questionnaires on the ward for relatives/carers to complete and forward to RQIA. None of these questionnaires were returned to RQIA.

A lay assessor Alan Craig was present during the inspection and he met with three patients and their comments are included within this report.

Evidence of good practice was found in relation to:

- The completion of patients' risk assessments.
- Patients' attendance at their MDT meeting each week and their involvement in their care and treatment.
- The compassionate care displayed by staff.

However it was concerning to note that staffing levels on the ward were not adequate. This was due to staff leaving their posts and the Trust having great difficulty recruiting new staff. An area for improvement was made in relation to this.

New areas requiring improvement were also identified in relation to the completion of actions within health and safety assessments and reviewing the wards restricted items. An area for improvement was also made regarding the measures in place to prevent patients from leaving the

ward when they do not have approved leave or are detatined under the Mental Health (NI) Order 1986.

Further areas for improvement were also identified in relation to the lack of evidence based therapeutic interventions, the updating of Trust policies and procedures, deficits in nursing staff mandatory training and the lack of regular patient forum meetings.

Additional areas discussed and agreed by the ward manager included:

- Displaying information on the notice board regarding all members of the MDT, the day of the ward round and the doctor on duty.
- Displaying information about the wards performance.

The inspectors observed staff working practices and interactions with patients using a Quality of Interaction Schedule Tool (QUIS). All interactions observed between staff and patients were noted to be positive. Staff were observed using de-escalation techniques when there was an altercation between two patients. During all interactions patients were treated with dignity and respect by staff.

Patients Experience:

The lay assessor spoke to three patients on the ward. All three patients made very positive comments about the ward. They advised the lay assessor that they felt safe on the ward, that the care was effective and that all staff are compassionate towards them. They also stated that they felt the ward was well led. One patient said that they felt there were times the ward was understaffed and one patient said they do not always know who is in charge of the ward. Patients stated they were updated on their care and treatment as they attended their MDT meetings each week and staff also updated them throughout the week.

Patients Stated:

"I couldn't say enough good things about the nurses here they are superlative. I believe this ward would benefit from more resources and rotation of staff….you get your 20 minutes each day with the nurses…staff are 100% compassionate".

"They're like a well-oiled machine….i could not fault this place in any way whatsoever…..i feel safe and protected from everything….the doctors and nurse are exceptional. They listen to you....they know when you are feeling down…they are tuned in at all times".

Relatives Views:

There were no relatives on the ward available to speak with the inspectors or the lay assessor. The inspectors left questionnaires on the ward for relatives to complete and return to the office. There were no questionnaires returned following the inspection.

Staff Experience:

Inspectors met with 13 members of the MDT. Staff advised they enjoyed working on the ward and they all felt the MDT worked well together. However they stated that due to poor staffing levels on the ward they are rushed, not able to complete their mandatory training or to attend extra training that they are interested in. Staff reported they do not always have the opportunity to spend

quality time with patients. Staff advised they carry out 1:1 therapeutic time with patients but on occasions this is just a quick chat and not very therapeutic. Staff stated they have other essential tasks that need completed on the ward and when they are short staffed patients do not get the time they deserve and require. They advised they are unable to carry out group activities or 1:1 low level psychological therapies. One staff member advised there was an incident on the ward recently which involved two patients who were very aggressive and staff had to contact the PSNI for assistance. This incident upset the staff and patients, however there has been no debrief/reflective practice session with staff since this incident happened. An area for improvement has been made in relation to this.

Staff Stated:

"Low staff is my only concern in this ward….I really like working on this ward…more groups would be more effective …the low staff is a problem…the MDT works well ….everyone gets to give their opinion in planning care for patients…there is no breathing space to look at what we are doing….we are firefighting this could be improved with more staff"

"staffing levels are poor…there should be seven staff however today there are only five staff….I also get my 1:1 done with patients at its important…staff are all very compassionate towards the patients….we are not able to complete low level psychology intervention as there is not enough staff and we are not all trained in this… a lot of new staff like myself"

"On a daily basis the ward is low in staff… there was an incident on the ward and it took 10 minutes for staff to respond…when we are short of staff the training has to be cancelled and there is no opportunity to continue with your professional development ….I have no concerns about the care on this ward as all staff are very good".

"The staffing levels are not safe…there was an incident and staff needed extra staff as only two available and this didn't happen as staff on the ward had responded to an incident on another ward…. Staff are working on a goodwill basis….in 2016 I remember the ward had daily groups for patients it was great but now this doesn't happen and patients who have ground leave don't get it due to poor staffing levels.....staff want to do group activities but can't…we all help each other out…there is good relationships on the ward and good team working…… we are all supportive to each other"

"The ward is busy, we have complex patients and there are raised incidents on the ward…low staff... nurses are great but will get burnt out…nurses are compassionate and caring …more staff would mean the ward would be much effective…..there are good relationships within the MDT"

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

4.1 Inspection Outcome

Total number of areas for improvement	13

Findings of the inspection were discussed with the patient and bed flow manager and the ward manager as part of the inspection process and can be found in the main body of the report.

Escalation action resulted from the findings of 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/

A serious concerns teleconference was held on 28 August 2018 to discuss the concerns raised regarding staffing levels on the ward. The Southern Health and Social Care Trust Acting Director of Mental Health and Disability Services and the Acting Assistant Director of Mental Health and Disability Services participated in this teleconference. An action plan was agreed from this meeting. It was also agreed the Trust would forward RQIA a breakdown of the staffing levels in the Bluestone unit by 31 August 2018. However, given the concerns raised regarding staffing levels RQIA undertook another unannounced inspection of the Bluestone unit on 31 August 2018. This inspection focussed on staffing levels across the unit.

A further serious concerns teleconference was subsequently held on 20 September 2018 due to the continued concerns regarding staffing levels across all of the wards within the Bluestone unit. At this meeting the Trust updated RQIA on the measures they were implementing to deal with the staffing crisis. The Trust also advised that there will be 18 new staff members recruited to the Bluestone Unit in October 2018. However, the Trust stated they continue to have problems retaining current staff and recruiting new staff. RQIA have raised these concerns with the Health and Social Care Board (HSCB) and the Department of Health (DOH). A further serious concerns meeting was held on 12 October 2018 with senior Trust representatives and the chief executive of the Trust. Plans the Trust have put in place to address concerns raised regarding staffing were discussed and an action plan was agreed.

5.0 How we Inspect

The inspection was underpinned by:

- The Mental Health (Northern Ireland) Order 1986.
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.
- The Human Rights Act 1998.
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

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

- The Operational Policy.
- 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.
- Policies and procedures.

The following records were examined during the inspection:

- Care documentation in relation to four patients
- Ward timetable
- Policies and procedures relating to the ward
- Minutes of senior management meetings
- Nursing staff duty rota

- Mandatory training records
- Minutes of ward manager meetings
- Medicine kardexes
- Patient forum meetings

Areas for improvements made at the previous inspections were reviewed and an assessment of compliance was recorded as met.

The preliminary findings of the inspection were discussed at feedback to the service at the conclusion of the inspection.

6.0 The Inspection

6.1 Review of Areas for Improvement from the Most Recent Inspection dated 8-9 August 2017

The most recent inspection of Cloughmore was an unannounced inspection. The quality improvement plan (QIP) was returned and approved by the responsible inspector. This QIP was validated by the responsible inspector during this inspection.

Areas for Improvement	Validation of Compliance	
Recommendation 1 **Ref**: Standard 5.3 1(i) **Stated:** Second Time	The medical section of the ward round template had not been completed each week for patients.	**Met**
	Action taken as confirmed during the inspection: There was evidence that the medical team were completing detailed reports of the outcome of the MDT meetings in the progress section in the PARIS records. The ward manager advised that the Bluestone Unit were piloting a new template that will be completed by all members of the MDT. It is being piloted on Silverwood Ward in the first instance. The associate medical director is leading on the implementation of this new template. When this is finalised it will be completed on PARIS at the ward round and the nurses section, within the PARIS system, will be populated before the MDT meeting. This area for improvement has been assessed as met however a new area for improvement will be made in relation to ensuring the new template is completed by all members of the MDT.	

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 is intended to help them.

Areas of Good Practice

There was evidence that patients were involved in completing their risk assessments. Risk assessments and management plans were in place and were reviewed and updated each week at the MDT meeting. There was evidence that risk assessments informed the patients' care plans and there was also evidence in the patients' progress notes that risks were discussed with patients regarding their home leave and discharge plans.

Staff who spoke to the inspectors evidenced a good understanding of the actions they would take if they had concerns regarding the care and treatment of patients.

Staff confirmed they can raise concerns at team meetings and in individual supervision sessions.

There was evidence that the MDT reviewed patients' detention under the Mental Health (NI) Order 1986 each week at the MDT meetings to ensure patients were experiencing the least restrictive option of care and treatment.

The ward was clean and tidy and in a good state of repair.

Information was available to patients in relation to their rights.

Patients who spoke to the lay assessor said they knew how to make a complaint.

Patient's regular medications were being prescribed within Bristish National Formulary (BNF) guidelines.

Areas for Improvement

The health and safety risk assessment was not completed in full. The risk level had not been completed and there was no action plan in place with a timescale for the completion of the outstanding work.

The fire risk assessment was completed on 16 November 2017 which stated there were three recommendations outstanding. The inspectors were concerned to note that two of these recommendations were assessed as priority 'B' which indicates that they should be completed 'in the short-term'. As this assessment was completed in November 2017 the inspectors were concerned that these recommendations were still outstanding.

A ligature risk assessment was completed on 28 June 2018. The inspectors were concerned to note that the TV units were not boxed in. Previous recommendations had been made in a number of Bluestone wards in relation to this and it is concerning to note that this is an area that is still outstanding.

Inspectors reviewed the incidents on the ward over a 12 month period (1 April 2017 – 31 March 2018) and was concerned to note the number of incidents involving patients using ligatures and other items to self-harm. The ward staff stated that each patient is individually assessed regarding levels of risks. However in light of the incidents recorded on the DATIX the Trust should review the ward's restricted items.

The security and safety of patients should be managed though the provision of adequate staffing levels and good supervision. However, the inspectors were concerned to note the high number of patients who were absent without leave (AWOL) from the ward. In light of the number of AWOL's from the ward the Trust should review the fenced area in the garden and the ward access doors as patients are able to push/kick these doors open.

Staff stated that at times they felt the low levels of nursing staff available on the ward made the ward unsafe for patients and staff. The Trust is relying heavily on bank staff and has asked permanent staff to work extra duties. The inspectors asked for a breakdown of the staffing levels on the ward over the past month (August). This record confirmed that staffing levels were low on a number of days during August. On occasions the ward was down four members of staff which made it difficult to carry out all ward duties and to provide continued enhanced observations to patients admitted to the ward.

The inspectors reviewed four sets of medicine kardexes. Two of these records were not completed correctly by medical staff. In two records three PRN medications had no clinical indications documented.

Number of areas for improvement	7

7.2 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 in patients' care records that assessments were completed and care plans were devised from these assessments

There was evidence that patients' needs were assessed on an ongoing basis, daily by the nursing staff and weekly at the MDT meeting.

Patients were provided with 1:1 therapeutic time each day and there was evidence that their care and treatment was discussed at these sessions.

There was evidence in the care records reviewed that patients were involved in planning their care and treatment.

There was evidence of family involvement in patients' care and treatment.

There was evidence that referrals were made to other professionals when this was identified as a need.

Deprivation of liberty (DOLs) care plans were in place which explained the rationale in relation to the locked door on the ward.

The ward environment appeared relaxed and welcoming, patients were observed sitting in the day room and coming and going from the garden area.

There was evidence that discharge planning had commenced early and appropriate community supports had been discussed with patients and their relatives.

Areas for Improvement

In the four care records reviewed there was evidence of psychological formulations completed in patients' recovery care plans and suitable groups/ interventions were identified which could assist in patients' recovery. However there was no evidence of staff implementing low level psychological therapeutic interventions on the ward. When this was discussed with the staff on the ward they advised that this was due to staff shortages.

Number of areas for improvement	1

7.3 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

The inspectors observed staff responding promptly to patients on the ward during the inspection. Staff were observed using de-escalating techniques with two patients and after this incident staff were observed offering both patients reassurance.

Patients who met with the Lay Assessor stated they felt included and involved in their care and treatment.

There was evidence in the care records reviewed that patients attended their MDT meetings and care and treatment options were discussed at these meetings.

There was evidence in the care records reviewed that any restrictions in place had been discussed with patients. Patients who spoke to the lay assessor expressed no concerns regarding restrictions on the ward.

Deprivation of liberty (DOLS) care plans were in place which explained the rationale in relation to the locked door and any other restricted items.

The three patients who spoke to the lay assessor during the inspection made positive comments regarding their care and treatment they were receiving on the ward.

The inspector spoke to the independent advocate who confirmed they attend the ward three times a week. They meet with all patients on the ward and attend the fortnightly patient forum meetings.

Patients stated staff listened to their views and wishes.

Areas for Improvement

The patient forum meetings were not held on the ward on a consistent fortnightly basis.

Number of areas for improvement	1

7.4 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 MDT is appropriate to the needs of the patient population.

Team meetings were held on the ward and there was evidence that learning from incidents was discussed at these meeting.

Staff who spoke to the inspectors were aware of their role and responsibility in relation to actions they should take if they have any concerns regarding the care and treatment of patients.

Staff who spoke to the inspectors advised that they had up to date appraisals in place and received supervision in accordance with their professional guidance.

Areas for Improvement

The inspectors reviewed the nursing staff mandatory training records and identified a number of deficits within this training record as follows:

- Infection control eLearning 2 staff (no date booked)
- Infection control 4 staff (booked for September)
- Manual handling 1 staff member
- MAPA (12 booked for updated train in Sept/Nov)
- Information governance 4 staff members
- Waste management 7 staff members
- COSHH 7 staff members
- Sharps Awareness 11 staff members
- Equality and good relations 18 staff members
- CPR 4 staff members
- ILS 2 staff members

Staff who spoke to the inspectors raised concerns regarding nursing staffing levels within the ward. They advised that they have discussed this with the ward manager and senior staff within the Trust. They are aware the Trust are in the process of recruiting new staff to the ward however they feel staffing levels on the ward are a concern and that this is affecting the level of care provided to patients. Staff stated they are only able to provide patients with essential levels of care.

There were a number of Trust policies and procedures which had not been reviewed and updated:

- Health and Safety at Work – December 2014
- Procedure for Observation of Service Users during their admission to the Acute Mental Health Inpatient Facility- March 2015
- Management of Violence & Aggression (MOVA) Policy – December 2014
- Whistleblowing Policy – March 2015
- Safeguarding Vulnerable Adults Operational Procedure Guidance – November 2011

Staff advised that there was an incident on the ward recently which involved two patients who were very aggressive on the ward and staff had to contact the PSNI for assistance. This incident upset the staff and patients, however there has been no debrief/reflective practice session with staff since this incident happened.

Number of areas for improvement	4

8.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan. Details of the quality improvement 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 quality improvement plan are addressed within the specified timescales.

8.1 Actions to be taken by the Service

The quality improvement 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 quality improvement plan by 14 November 2018.

Quality Improvement Plan Ward 1	
Priority 1	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** Standard 4.3 (i) **Stated:** First Time **To be completed by**: 19 September 2018	The health and safety risk assessment was not completed in full. The risk level had not been completed and there was no action plan in place with a timescale for the completion of the outstanding work.
	Response by responsible person detailing the actions taken: Ward Managers have met and discussed the health and safety risk assessment with the health and safety officer of the Trust and this is being reviewed and updated accordingly. This has been transferred to the new assessment document, with the risk level and action plan completed in full.
Area for Improvement No. 2 **Ref:** Standard 4.3 (i) **Stated:** First Time **To be completed by:** 19 September 2018	The fire risk assessment was completed on 16 November 2017 which stated there were three recommendations outstanding. The inspectors were concerned to note that two of these recommendations were assessed as priority 'B' which indicates that they should be completed 'in the short-term'. As this assessment was completed in November 2017 the inspectors were concerned that these recommendations were still outstanding.
	Response by responsible person detailing the actions taken: This outstanding work has been compeleted by the Estates department and will be removed from the fire risk assessment during its review scheduled for this Month (November 2018).
Area for Improvement No. 3 **Ref:** Standard 4.3 (i) **Stated:** First Time **To be completed by:** 19 September 2018	A ligature risk assessment was completed on 28 June 2018. The inspectors were concerned to note that the TV units were not boxed in. There were previous recommendations made in a number of Bluestone wards in relation to this and it is concerning to note that this is an area that is still outstanding.
	Response by responsible person detailing the actions taken: The initial trial of the new TV units on silverwood ward has been successful and will now be implemented across the unit, Cloughmore is awaiting a date for this to be completed.

Area for Improvement No. 4 **Ref:** Standard 4.3 (J) **Stated:** First Time **To be completed by:** 19 September 2018	Staff who spoke to the inspectors raised concerns regarding nursing staffing levels within the ward. They advised that they have discussed this with the ward manager and senior staff within the Trust. They are aware the Trust are in the process of recruiting new staff to the ward however they feel staffing levels on the ward are a concern and that this is affecting the level of care provided to patients as they are only able to provide patients with essential levels of care. The inspectors asked for a breakdown of the staffing levels on the ward over the past month (August). This record confirmed that staffing levels were low on a number of days in the month of August. On occasions the ward was down four members of staff which made it difficult to carry out all ward duties and provide patients with enhanced observations on the ward.
	Response by responsible person detailing the actions taken: Staffing concerns have been acknowlerdged by the Trust and raised in an Early Alert to the DOH in August 2018. The Trust continue to have an open recruitment drive within the Trust. Staff from community teams have in the interim been re-deployed to the ward which has been very beneficial however is not sustainable. Staffing pressures are compounded by a lack of supply in the nursing workforce regionally. We have escalated this to SMT and this is one of the main risks for the Trust. A daily patient flow meeting occurs within bluestone where staffing levels are looked at across the unit and immediate action taken to alleviete potential staff crisis points. A number of other initiatives are also being utilised to address the staffing issues including overtime and use of agency staff. We have had discussions with the Deputy CNO about our current pressures and this has prompted meetings with Mental Health Nurse leads from all Trusts. We have proposals in place to increase the number of Senior Nurses available across the 24/7 period by uplifting Band 5 -Band 6 posts. We are due to meet with the Borad and PHA early December 18 to discuss pressures and scope for investment to assist in moving towards staffing recommended in Delivering Care Phase 5a.
Area for Improvement No. 5 **Ref:** Standard 8.3 (a) **Stated:** First time **To be completed by:** 19 September 2018	The patient forum meetings were not held on the ward on a consistent fortnightly basis.
	Response by responsible person detailing the actions taken: Our patients are invited to meet with staff and our patient advocate every two weeks however due to annual leave arrangements for our advocate over the summer period the meetings were held with staff only on occassions. The patient meetings continue to be scheduled two weekly and patients are invited to take part.
Area for Improvement No. 6	In the four care records reviewed there was evidence of psychological formulations completed in patients' recovery care plans and suitable groups interventions were identified which could assist in patients' recovery. However there was no evidence of the staff implementing low

Ref: Standard 5.3.3 (f) **Stated:** First time **To be completed by:** 19 September 2018	level psychological therapeutic interventions on the ward. When this was discussed with the staff on the ward they advised that this was due to staff shortages.
	Response by responsible person detailing the actions taken: Cloughmore identify suitable psychological groups for our patients, these groups are not always held on a regular basis due to staffing levels, however there is a current plan in place with MDT members to re-commence groups on a regular basis, staff have been identified to complete this. The patients are also now linked into the groups that are delivered in the Ferns Resource Centre.

Area for Improvement No. 7 **Ref:** Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 19 September 2018	The inspectors reviewed four sets of medicine kardexes. Two of these records were not completed correctly by medical staff. In two records three PRN medications had no clinical indications documented.
	Response by responsible person detailing the actions taken: Medical staff have been reminded of the importance of completing fully the medication kardexs including clinical indications
Area for Improvement No. 8 **Ref:** Standard **Stated:** First time **To be completed by:** 19 September 2018	Staff advised that there was an incident on the ward recently which involved two patients who were very aggressive on the ward and staff had to contact the PSNI for assistant. This incident upset the staff and patients, however there has been no debrief/reflective practice session with staff since this incident.
	Response by responsible person detailing the actions taken: This incident was reported to senior manangement and was escalated to the PSNI. Staff aware they can seek support from their manager and/or attend reflective practice sessions with our clinical psychologist. An informal debrief took place locally with the Ward Manager. Staff were offered a formal reflective session with the clinical psycologist however staff did not feel they needed this at this time. This was followed up between the Head of Service and the PSNI link Senior Officer.
Priority 2	
Area for Improvement No. 9 **Ref:** Standard 4.3 (i) **Stated:** First Time **To be completed by:** 19 November 2018	The inspector reviewed the incidents on the ward over a 12 month period (1 April 2017 – 31 March 2018) and was concerned to note the number of incidents involving patients using ligatures and other items to self-harm. The ward staff stated that each patient is individually assessed regarding levels of risks. However in light of the incidents recorded on the DATIX the Trust should review the ward's restricted items.
	Response by responsible person detailing the actions taken: Every patient is individually risk assessed at the point of admission regarding level of risk, this is documented in our patient's risk assessment and care plans accordingly and is reviewed by MDT daily this will include items in their possession that has the potential to be used as a ligature or for self-harming . The Trust will also be implementing "tub bins" and paper bags on all wards, following a Safety and Quality Learning letter recommendation from the Western Trust. This is to be completed by January 2019. The Trust continue to review the situation based on information gleaned from DATIX.

Area for Improvement No. 10 **Ref:** Standard 4.3 (i) **Stated:** First Time **To be completed by:** 19 November 2018	The security and safety of patients should be managed though the provision of adequate staffing levels and good supervision. However, the inspectors were concerned to note the high number high of patients who were absent without leave (AWOL) from the ward. In light of the number of AWOLs from the ward the Trust should review the fenced area in the garden and the access doors as patients are able to push/kick these doors open.
	Response by responsible person detailing the actions taken: This has been raised with estates who are currently reviewing the fencing and door mechanisms in bluestone. AWOL is reviewed as individual incidents and as part of general incident review.
Area for Improvement No. 11 **Ref:** Standard 5.3.1 (f) **Stated:** First Time **To be completed by:** 19 November 2018	The new revised versions of the MDT template should be completed by all members of the MDT team.
	Response by responsible person detailing the actions taken: Latest group meeting of Patient Flow and Complex Discharge Team took place on 23/10/18 whereby the new template was further reviewed and refined, next step will be uploading onto PARIS, this will be discussed at next meeting in November 2018. Once in place all disciplines will complete their respective section.
Area for Improvement No. 12 **Ref:** Standard 4.3 (m) **Stated:** First Time **To be completed by:** 19 November 2018	The inspectors reviewed the nursing staffs' mandatory training records and identified a number of deficits within this training record: • Infection control eLearning 2 staff (no date booked) • Infection control 4 staff (booked for September) • Manual handling 1 staff member • MAPA (12 booked for updated train in Sept/Nov) • Information governance 4 staff members • Waste management 7 staff members • COSHH 7 staff members • Sharps Awareness 11 staff members • Equality and good relations 18 staff members • CPR 4 staff members • ILS 2 staff members
	Response by responsible person detailing the actions taken: Staff are being released to attend their mandatory training. This has also been added to our risk register that on occassions due to low staffing levels mandatory training has had to be cancelled and rearranged.The Trust will continue to prioritise use of available resource on a daily basis

Priority 3	
Area for Improvement No. 13 **Ref:** Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 19 February 2019	There were a number of policies and procedures which had not been reviewed and updated: • Health and Safety at Work – December 2014 • Procedure for Observation of Service Users during their admission to the Acute Mental Health Inpatient Facility- March 2015 • Management of Violence & Aggression (MOVA) Policy – December 2014 • Whistleblowing Policy – March 2015 • Safeguarding Vulnerable Adults Operational Procedure Guidance – November 2011
	Response by responsible person detailing the actions taken: Policy for the Observation of Patients has been reviewed and signed off by the Acute Governence Group. The other Policies and Procedures are Trust wide and Senior management are aware of the relevant policies which are due to be reviewed and updated, this will be discussed at the next Governance Meeting on 28/11/18

Name of person(s) completing the quality improvement plan	Rebecca Fearon		
Signature of person(s) completing the quality improvement plan		**Date completed**	13/11/18
Name of responsible person approving the quality improvement plan	Adrian Corrigan		
Signature of responsible person approving the quality improvement plan		**Date approved**	29/11/18
Name of RQIA inspector assessing response	Audrey McLellan		
Signature of RQIA inspector assessing response		**Date approved**	4/12/18

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

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

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