The Regulation and Quality Improvement Authority

Mental Health and Learning Disability Inpatient Inspection Report
14-16 March 2017

Mental Health Inpatient Unit
Downe Hospital
2 Struell Well
Downpatrick
BT30 6RL

Tel No: 028 44 613311

Inspectors: Audrey McLellan and 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

Mental Health Inpatient Care Unit (MHIPU) is a 25 bedded mental health acute admission ward situated within the Downe Hospital. The ward is a mixed adult ward and can accommodate patients from the age of 18 years. On the day of the inspection there were 24 patients on the ward. Seven patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986.

The multidisciplinary team consists of nursing staff, two occupational therapists (OT's) and an occupational therapy assistant, two social workers, three medical staff and three consultant psychiatrists. There are two advocacy services available weekly for patients and their families. The person in charge of the ward on the day of the inspection was the ward manager.

3.0 Service Details

Responsible person: Hugh McCaughey
Ward manager: Neil Morgan
Person in charge at the time of inspection: Neil Morgan

4.0 Inspection Summary

An unannounced inspection took place over three days on 14-16 March 2017.

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

Evidence of good practice was found in relation to the positive relationships within the multidisciplinary team, the development of a training plan for nurses to ensure that low intensity interventions will be implemented as part of patients' care and treatment, patients' access to the multidisciplinary team and the variety of activities offered by the occupational therapy department.

Areas requiring improvement were identified in relation to patients' care records as they were stored in two different locations, the electronic recording systems MAXIMS and a paper file. Concerns were also raised in relation to the duplication of records by the nursing staff which results in less time spent providing direct care to patients, the absence of risk management plans and the absence of fully completed multidisciplinary records. There was also no pharmacy support on the ward and there were areas within the environment which required attention.

Eight patients met with the inspectors to complete a questionnaire. Patients confirmed that they attend their ward meetings each week and were fully involved in their care and treatment. They advised staff meet with them every day and they stated this was a very beneficial part of their care and treatment. Patients stated how the staff on the ward are always available to them and they made positive comments about the way staff treat them. They advised that they attend activities on the ward within the OT department and they reflected on the benefits of attending these sessions.

One patient stated they were unhappy with a number of issues regarding their care and treatment and they advised they were going to make a formal complaint with the assistance of the advocate on the ward.

Patients said:

“This place is great, nurses and doctors are class…..I have my own named nurse everyday…..I’ve made loads of friends with other patients….staff respond very quickly to me if I need them….food is great…..so much food…I find the staff caring…they listen to you and nothing seems to be a bother there is always someone there to talk to….I feel on top of the world now”

“This is a lovely ward, I’m well supported… it’s a lovely place they are all very good at their job, kind and caring. The doctor is a gentleman, really nice and caring….staff talk to me every day it’s really helpful…. Staff encouraged me to join the groups when I arrived (OT sessions). The staff are great and always available to me when I need emotional support…the food is great…plenty of it”

“I feel safe on this ward…the consultant listens to your views….staff explain your care and treatment to you ….I have good 1:1 discussions with my named nurse….I felt completely relaxed when I was admitted into this ward…..it’s a proactive ward not reactive….. staff engage with patients and when incidents happen on the ward the staff are very professional and check with patients afterwards to ensure they are all ok……the food is very good…..variety and choice is good…..weekends can be long…I would score this ward high because all the staff are great….they are helpful and engaging.. I mean all the staff from the domestic staff to the consultant”

“Staff are always there for me and give me the opportunity to talk…I know my named nurse we talk 2-3 times a week……this ward saved my life and changed my outlook on life”

“This is a good place to be and a place I need to be in to get better”

“Staff are good”

The inspectors met with nine members of the multidisciplinary (MDT). Staff spoke very positive about the ward and stated they were well supported by all members of the MDT. They advised they had received up to date appraisals and supervision in accordance with professional / governance guidance and had received up to date mandatory training. Staff demonstrated a good understanding of evidence based practices to support patients on the ward and the staff nurses advised they were looking forward to implementing low intensity interventions on the ward once they have received their training.

Staff said:

“We are well supported and our opinions are listened to”

“This is a good, supportive team”

“Overall I enjoy working here”

“There’s a good working relationship in the whole team”

“This is a great team to work in the consultant is very good”

There were no relatives available to speak to inspectors on the days of the inspection.

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	10

Findings of the inspection were discussed with senior trust representatives as part of the inspection process and can be found in the main body of the report.

Escalation action did not result from the findings of this inspection.

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

- The 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.
- Policies and procedures.

During the inspection the inspector met with eight service users and eight members of staff.

The following records were examined during the inspection:

- Care documentation in relation to six patients
- Multidisciplinary team records
- Policies and Procedures
- Staff duty rota
- Staff supervision templates
- Clinical room records
- Environmental risk assessment
- Fire safety risk assessments
- Mandatory training records
- Minutes of patient forum meetings
- Minutes of ward manager meetings
- Minutes of a number of different governance meetings and senior staff meetings
- Ward information booklets

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

We reviewed the recommendations made at the last inspection. An assessment of compliance was recorded as not 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 / Recommendations from the Most Recent Inspection dated

The most recent inspection of Downe ward was an unannounced type inspection. The completed provider compliance plan / QIP was returned and approved by the responsible inspector. This provider compliance plan / QIP was then validated by the responsible inspector during this inspection.

6.2 Review of Areas for Improvement / Recommendations from Last Inspection dated 2 June 2015

Areas for Improvement		Validation of Compliance
Number/Area 1 **Ref**: Standard 6.3.2 (f) **Stated:** First time	It is recommended that the Trust puts a mechanism is in place to ensure that patient information is shared appropriately and timely with relevant professionals. Ensuring that all aspects of agreed care and treatment plans are comprehensively implemented.	**Not Met**
	Action taken as confirmed during the inspection: Patients care records were stored in two different locations, the electronic recording systems MAXIMS and a paper file. All members of the MDT were recording on the MAXIMS system apart from the medical staff. Therefore the approach to record keeping was not consistent.	
Recommendations regarding SAI SET101.15		
Number 1	Role of Psychological Wellbeing Practioner to include skilling register nurses on low intensity interventions that will guide 1:1 time.	**Met**
	Action taken as confirmed during the inspection: The trust have recruited a Psychological Wellbeing Practioner (PWP) who is currently in the process of arranging training for nurses in the ward so that low intensity interventions will be implemented by nurses.	
Number 2	Ward Management Team to promote person centred care planning during supervision. (Ward Management Team MHIPU – 31st July 2016)	
	Action taken as confirmed during the inspection: There was evidence in the care records that care planning was holistic and person centred.	**Met**

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

In the six sets of care records reviewed there was evidence that patients had risk assessments completed which were regularly reviewed and updated.

Risk assessments were individualised, were used to inform care plans and there was evidence of patient and / or relative involvement.

A ligature risk assessment had been completed in February 2017 this detailed 'existing control measures' in place to minimise ligature incidents on the ward.

A fire safety assessment was completed on 16 November 2016 with a number of actions. During the inspection the estates department confirmed that all actions had been completed.

The ward manager had completed a health and safety risk assessment which was reviewed every six months. This detailed how risks were managed on the ward regarding a number of 'work activities'.

All staff who spoke to inspectors confirmed they had no concerns regarding the care of patients on the ward. Staff stated that the MDT worked well together and patients are treated with dignity and respect.

Staff confirmed they do not work beyond their role, experience and training.

Patient's detention was in accordance with the Mental Health (Northern Ireland) Order 1986. Patients who were detained had a care plan in place and patient's detention was reviewed every week at the weekly team assessment meeting (TAM).

Patients who were detained in accordance with the Mental Health (Northern Ireland) Order 1986 had been informed of their rights.

Staff were observed gaining consent from patients prior to supporting them with their care and treatment.

Patients stated they knew how to make a complaint and information regarding the complaints procedure was displayed throughout the ward.

There was evidence of staff working toward the least restrictive practice.

Areas for Improvement

In the six risk assessments reviewed there was no management plan or contingency plan in place. In the 'update/change in risk and alteration to risk management plan' section of the risk assessment updates were completed in relation to incidents on the ward. However, this section should detail changes in the risk management plan so staff are aware of how to manage risks for each patient.

A comprehensive health and safety assessment had not been completed. There was a quarterly health and safety proforma which detailed all areas in relation to health and safety on the ward. However, there was no evidence that this checklist/audit had been completed to confirmed that appropriate measures were in place.

Number of areas for improvement	2

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 that patients' needs were assessed on admission by nursing and medical staff and interventions were based on each patient's individual assessed need.

There was evidence that care plans were updated when patients' needs had been reviewed to reflect the change to their care and treatment.

Patients who spoke with the inspectors advised they attended their team assessment meeting (TAM) and were fully involved in their care and treatment.

Care plans were holistic person centred and were reviewed on a regular basis. There was also evidence that care plans had been discussed with patients.

There was evidence of OT assessments completed and personalised OT recovery care plans were developed from these assessments with set goals for each patient to work towards. This included individualised work and group sessions which were reviewed regularly throughout the patients' admission.

There was an OT activity timetable in place which included two sessions every day Monday to Friday.

Patients who spoke to the inspectors stated the OT service on the ward was very beneficial to their recovery and they make positive comments regarding the staff within the OT department. They stated staff were kind, encouraging, caring and had a genuine interest in each patient's needs and let each patient work at their own pace.

It was good to note all members of the MDT attend the TAM's which were held Monday – Thursday each week.

The ward also held 'huddle' meetings every morning where each patient on the ward was discussed to ensure all staff members were up to date with patients' care and treatment.

Patients stated they seen their consultant psychiatrist each week at the TAM.

There was evidence that patients were offered 1:1 time on a daily basis. Records of these meetings were very comprehensive.
There appeared to be a lack of psychological formulation underpinning care plans and directing a models of intervention/treatment. However, there was evidence that nursing staff are being trained/skilled up to provide low level psychological therapies.

The trust had employed a psychological wellbeing practitioner who had completed a pilot project aimed at increasing patients' access to psychological interventions. The outcome of this project has been the development of a training programme for staff. The programme agreed is called 'Structured Psychosocial InteRventions in Teams' (SPIRIT) which will provide patients with Low Intensity Cognitive Behaviour Therapy (CBT). This training includes;

- Behavioural activation
- Problem solving
- Recognising triggers
- What's worked in the past
- Motivational work
- Concentrating on current issues
- Exposure therapies
- Safety behaviour

The first group of staff have completed this training and the second group will be commencing training in April 2017.

Staff are also training in the following programmes:

- Staff nurses have completed skills-based training on risk management (STORM)
- Health care assistants have completed Applied Suicide Intervention Skills Training (ASIST)
- 99% of staff are trained in Wellness Recovery Action Plan (WRAP)

Patients also have access to Dialectic Behaviour Therapy (DBT) from the DBT team.

There was evidence that appropriate referrals were made to other professionals when discussed and agreed at the TAM.

There was evidence in the care records that interventions were reviewed and changes were made when necessary.

Community keyworkers were represented at the TAM when preparations were being made for discharge.

There were two social workers based on the ward who liaised with the community teams to ensure a smooth discharge for patients.
There was evidence of social work staff liaising with patients' family members to complete social history reports and carers assessments.

The ward environment was bright, open and spacious. Patients had their own bedrooms with an ensuite. There were a number of rooms available for patients to sit in and relax.

There was a family room off from the main ward. This room had some toys to occupy children visiting patients on the ward.

There was evidence that the MDT reviewed patients detention regularly to ensure patients were experiencing the least restrictive option.

There was evidence in the care records reviewed that the need for the use of restrictive practices was based on individualised assessment of need.

Areas for Improvement

In the care plans reviewed the goals set were overall goals and not specific to each care plan.

The inspectors observed that the suite of furniture in both the male and female TV rooms needed replaced and the ward needed to be repainted.

The inspectors observed that there were not enough seats in the dining room to accommodate all 25 patients.

Patients could not access the large garden area independently due to risks in this environment.

Patients care records were stored in two different locations, the electronic recording systems MAXIMS and a paper file. All members of the MDT were recording on the MAXIMS system apart from the medical staff therefore the approach to record keeping was not consistent. The MAXIMS system did not appear to be fit for purpose as staff were not able to complete all assessments onto this system and had to also use a paper file.

Nursing staff were completing the same records in a number of different sections in the MAXIMS system creating more work for them, extra time spent in the office and less time on the ward with patients.

- When medical staff record their review of a patient in the paper file the nurses then copy this same information into the MAXIMS system
- Incidents involving patients were recorded in each patient's risk assessment and this same information was also copied into the contact sheets.
- Information was recorded on the MDT template (paper copy) and the nurses also recorded an account of who attended the meeting and the outcome of the meeting on the MAXIMS system.

MDT records were not completed fully.

- Each care record detailed decisions agreed but did not include the responsible person agreed to implement the actions.
- It was not clear if the patient had attended the MDT meeting or not as there was no record on the MDT template.
- There were a number of entries on the signature section of the MDT template which had been recorded with only the persons initials therefore it was unclear who the professional was who attended the meeting.

Number of areas for improvement	7

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

All observations/interactions between staff and patients were observed as positive.

Patients confirmed that staff always have time to support them when they were feeling stressed or emotional.

There was evidence in the patients' care records and by speaking to patients' that they were given the opportunity to be involved in their care and treatment.

Patients stated they met with a member of the nursing staff each day and reflected how this interaction was very beneficial to their recovery.

Patients confirmed they were happy with the care and treatment provided. They made positive comments about the staff on the ward stating they were caring, kind, engaging, therapeutic, reassuring and thoughtful.

Patients confirmed that they are always treated with dignity and respect.

Two advocates visit the ward. On Wednesday a peer advocate from the South Eastern Trust visits the ward and on Thursday an advocate from Mindwise visits the ward. Patients stated that they had received support from both of these organisations and stated the support was very beneficial.

Areas for Improvement

No areas for improvement were identified during the inspection.

Number of areas for improvement	0

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

Staff who spoke to the inspectors demonstrated a good understanding of their role and responsibility if they had concerns regarding care on the ward.

All staff who met with the inspectors stated that the MDT worked well together.

Inspectors reviewed the ward's clinical room and clinical practices. Governance arrangements for the management of medication were appropriate.

Inspectors reviewed the medicine kardexes and no concerns were noted regarding the administration of medication.

Policies and procedures relating to the ward were up to date.

Inspectors examined incidents that had taken place on the ward from April 2015 to March 2016. Inspectors evidenced that the management of incidents was appropriate and completed in accordance to the required standards.

There was evidence that staff were analysing information so that services could be improved.

Staff who met with inspectors reported that relationships within the MDT were positive and supportive.

The ward manager held monthly staff meetings. There was evidence that information from the governance meetings relating to the ward was cascaded down to the staff team.

Inspectors reviewed the ward's complaints and compliments records and there was evidence that complaints had been managed in accordance with Trust policy and procedure.

Patient forum meetings were held on a fortnightly basis. Meetings were facilitated by the ward's peer advocate and the occupational therapist.

Information regarding the ward's organisational and management structure was available. Staff who met with the inspectors stated that they understood their role and responsibilities within the ward.

Nursing staff mandatory training was up to date. The ward manager had good oversight of nursing staff training requirements and training had also commenced for trained staff to complete SPIRIT training.

There was evidence that nursing staff including health care assistants had received supervision and appraisals.

Medical ward staff who met with inspectors stated they had no concerns regarding the support they receive and their ability to access training, appraisal and supervision.

The inspectors reviewed the ward's duty rota and there was evidence that staff shortages were managed through use of bank staff. The ward manager and nursing staff who met with inspectors stated that bank staff were appropriately trained and familiar with the ward and the needs of the patient group.

Areas for Improvement

There was no pharmacy support on the ward to assist in reviewing prescribed medication and to complete medication reconciliation.

Number of areas for improvement	1

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 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 by 9 May 2017.

Provider Compliance Plan **Downe Ward**	
Priority 2	
Previous recommendation No. 1 **Ref**: Standard 6.3.2 (f) **Stated:** Second time **To be completed by:** 16 June 2017	It is recommended that the Trust puts a mechanism in place to ensure that patient information is shared appropriately and timely with relevant professionals. Ensuring that all aspects of agreed care and treatment plans are comprehensively implemented.
	Response by responsible person detailing the actions taken: The Trust recognises the difficulties associated with the number of systems currently in use and is making progress with our IT provider to achieve an increasingly paperless service, with documents held in a secure system and accessible to clinical staff both in and out of hours. Further training to develop this has been rolled out to Trust (including medical) staff and this is ongoing. The Trust anticipates delivery of a Version 2 MAXIMS in January 2018 – a significant upgrade to the current operating system which will provide greater flexibility, accessibility and usefulness
Area for Improvement No. 2 **Ref: 5.3.1 (a)** **Stated:** First time **To be completed by:** 16 June 2017	In the six risk assessments reviewed there was no management plan or contingency plan in place. In the 'update/change in risk and alteration to risk management plan' section of the risk assessment updates were completed in relation to incidents on the ward. However, this section should detail changes in the risk management plan so staff are aware of how to manage risks for each patient.
	Response by responsible person detailing the actions taken: This recommendation has been cascased to all relevant staff through the ward managers' meeting, ward staff meetings and junior medical staff induction. The Mental Health Service has identified the Review of the Assessment and Management of Risk as a key audit priority for 2017/2018. This will result in a robust review of clinical practice associated with risk assessment and management planning with the aim of developing standards for practise that will underpin a programme of learning for all clinical staff.
Area for Improvement No. 3 **Ref: 4.3 (i)** **Stated:** First time	A comprehensive health and safety assessment had not been completed. There was a quarterly health and safety proforma which detailed all areas in relation to health and safety on the ward. However, there was no evidence that this checklist/audit had been completed to confirmed that appropriate measures were in place.
	Response by responsible person detailing the actions taken:

To be completed by: 16 June 2017	The Health & Safety checklist has been shared with the ward managers and has now been completed in MHIPU.
Area for Improvement No. 4 **Ref: 5.3.1 (a)** **Stated:** First time **To be completed by** 16 June 2017	In the care plans reviewed the goals set were overall goals and not specific to each care plan.
	Response by responsible person detailing the actions taken: A number of measures have been undertaken to enhance the recording of person care care planning. This includes the delivery of SPIRIT Training, (includes a specific module on goal setting), the ward has been identified to participate in the regional audit of therapeutic interventions, audit of record keeping and the Ward Management Team are promoting person centred care planning using reflection during supervision.
Area for Improvement No. 5 **Ref: 6.3.2 (a)** **Stated:** First time **To be completed by:** 16 June 2017	The inspectors observed that the suite of furniture in both the male and female TV rooms needed replaced and the ward needed repainted
	Response by responsible person detailing the actions taken: New furniture for these rooms has been ordered. The painting of the ward has been added to the Capital Works Priorties List for 2017/2018. However, the completion of work is dependent on the availability of funding.
Area for Improvement No. 6 **Ref: 6.3.2 (a)** **Stated:** First time **To be completed by:** 16 June 2017	The inspectors observed that there were not enough seats in the dining room to accommodate all 25 patients.
	Response by responsible person detailing the actions taken: New chairs have been supplied with 25 chairs now available in the dinning room.
Area for Improvement No. 7 **Ref: 4.3 (i)** **Stated:** First time **To be completed by:** 16 June 2017	Patients could not access the large garden area independently due to risks in this environment.
	Response by responsible person detailing the actions taken: The identified risks in the enviornement were treated and patients can now access the large garden independently.
Area for Improvement No. 8 **Ref: 6.3.2 (f)**	Patients care records were stored in two different locations, the electronic recording systems MAXIMS and a paper file. All members of the MDT were recording on the MAXIMS system apart from the medical staff therefore the approach to record keeping was not consistent.

<table>
<tr><td>Stated: First time

To be completed by:
16 June 2017</td><td>The MAXIMS system did not appear to be fit for purpose as staff were not able to complete all assessments onto this system and had to also use a paper file.

Response by responsible person detailing the actions taken:
The Trust recognises the difficulties associated with the number of systems currently in use and is making progress with our IT provider to achieve an increasingly paperless service, with documents held in a secure system and accessible to clinical staff both in and out of hours. Further training to develop this has been rolled out to Trust (including medical) staff and this is ongoing. The Trust anticipates delivery of a Version 2 MAXIMS in January 2018 – a significant upgrade to the current operating system which will provide greater flexibility, accessibility and usefulness.</td></tr>
<tr><td>Area for Improvement No. 9

Ref: 6.3.2 (f)

Stated: First time

To be completed by:
16 June 2017</td><td>Nursing staff were completing the same records in a number of different sections in the MAXIMS system creating more work for them, extra time spent in the office and less time on the ward with patients.

• When medical staff record their review of a patient in the paper file the nurses then copy this same information into the MAXIMS system
• Incidents involving patients were recorded in each patient's risk assessment and this same information was also copied into the contact sheets.
• Information was recorded on the MDT template (paper copy) and the nurses also recorded an account of who attended the meeting and the outcome of the meeting on the MAXIMS system.

Response by responsible person detailing the actions taken:
The recording of such information in the nursing records is not intended to represent a copy of what is recorded by medical staff but illustrates nursing staff communicating clinical decisions regarding patient care and identifying responsibility for the implementation of the patient's treatement plan.
Staff are encouraged to review the level of risk and update the respective clinical risk assessment and clinical records to reflect relevant incidents and appropriate management/contingency plans.
Staff are encouraged to identify who is responsible for the implementation of patients' treatment plans and also to evidence having discussed the outcome of the Team Assessment Meeting (TAM) with the patients who choose not to attend the TAM.
All of these matters will be clarified with staff at the Ward Managers' Meeting and Ward Team Meetings.</td></tr>
<tr><td>Area for Improvement No. 10

Ref: 5.3.1 (a)</td><td>MDT records were not completed fully

• Each care record detailed decisions agreed but did not include the responsible person agreed to implement the actions.
• It was not clear if the patient had attended the MDT meeting or</td></tr>
</table>

<table>
<tr><td rowspan="2">Stated: First time

To be completed by:
16 June 2017</td><td colspan="4">not as there was no record on the MDT template.
• There were a number of entries on the signature section of the MDT template which had been recorded with only the persons initials therefore it was unclear who the professional was who attended the meeting</td></tr>
<tr><td colspan="4">Response by responsible person detailing the actions taken:
The medical staff of the ward have agreed to review the consistency and completeness of the recording on the Team assessment sheet to reflect the need to identify the responsible individual agreed to implement the actions, whether the patient attended the TAM or not and to ensure that the signatures of all individuals practitioners who attend the TAM</td></tr>
<tr><td colspan="2">Signature of person(s) completing the provider compliance plan</td><td>Neil Morgan</td><td>Date completed</td><td>3/5/2017</td></tr>
<tr><td colspan="2">Name of responsible person approving the provider compliance plan</td><td colspan="3">Bria Mongon</td></tr>
<tr><td colspan="2">Signature of responsible person approving the provider compliance plan</td><td>Bria Mongon</td><td>Date approved</td><td>10/5/2017</td></tr>
<tr><td colspan="2">Name of RQIA inspector assessing response</td><td colspan="3">Audrey McLellan</td></tr>
<tr><td colspan="2">Signature of RQIA inspector assessing response</td><td></td><td>Date approved</td><td>11/5/17</td></tr>
</table>

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

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care