The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Downe Dementia Unit,

Downe Hospital

South Eastern Health and Social Care Trust

12 March 2014

national preventive mechanism

informing and improving health and social care

www.rqia.org.uk

Table of Contents

1.0 Introduction……...3

1.1 Purpose of the inspection……..3

1.2 Methods/process……3

2.0 RQIA Compliance Scale Guidance…… 4

3.0 Ward Profile……...5

4.0 Inspection Summary……6

5.0 Follow-up on Previous Issues ……..8

6.0 Stakeholder Engagement…… 15

7.0 Additional Concerns Noted by Inspectors…..……..... 16

1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Northern Ireland's health and social care services. RQIA was established under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to drive improvements for everyone using health and social care services. Additionally, RQIA is designated as one of the four Northern Ireland bodies that form part of the UK's National Preventive Mechanism (NPM). RQIA undertake a programme of regular visits to places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment, upholding the organisation's commitment to the United Nations Optional Protocol to the Convention Against Torture (OPCAT).

1.1 Purpose of the Inspection

The purpose of this inspection was to ensure that the service is compliant with relevant legislation and good practice indicators and to consider whether the service provided to patients was in accordance with their assessed needs and preferences.

The aims of the inspection were to examine the policies, procedures, practices and monitoring arrangements for the provision of care and treatment, and to determine the provider's compliance with the following:

- The Mental Health (Northern Ireland) Order 1986;
- The Human Rights Act 1998;
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003;
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

Other published standards which guide best practice may also be referenced during the inspection process.

1.2 Methods/Process

Specific methods/processes used in this inspection include the following:

- discussion with patients and/or representatives;
- discussion with multi-disciplinary staff and managers;
- examination of records;
- consultation with stakeholders;
- file audit; and
- evaluation and feedback.

Any other information received by RQIA about this service and the service delivery has also been considered by the inspector in preparing for this inspection.

2.0 RQIA Compliance Scale Guidance

The inspector has rated the ward's Compliance Level against each recommendation made following the previous inspection.

The table below sets out the definitions that RQIA has used to categorise the ward's performance:

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable	Compliance with this criterion does not apply to this ward.	A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant	Compliance will not be demonstrated by the date of the inspection.	A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the inspection year.	In most situations this will result in a recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a recommendation, being made within the Inspection Report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and being made within the inspection report.

3.0 Ward Profile

Trust	South Eastern Health and Social Care Trust
Name of hospital/facility	Downe Dementia Unit
Address	Downe Hospital 3 Struell Wells Road Downpatrick BT30 6RL
Telephone number	028 44613311
Person-in-charge on day of inspection	Sr Paula Thompson
Email address	Mental Health Older People
Nature of service - MH/LD	Dementia Care
Name of ward/s	Downe Dementia
Date of last inspection	21 February 2012
Name of Inspector	Alan Guthrie

The Downe Dementia Unit is a twenty bedded mixed gender ward. The ward provides care and treatment to patients suffering from dementia. The main entrance doors to the ward are locked and access is gained by use of a key fob or by ringing the doorbell.

Due to the dependency of the patients the ward is a secure unit. Patients are admitted for a period of assessment, usually 8 – 12 weeks. On the day of inspection there were 16 patients admitted to the ward.

4.0 Inspection Summary

An unannounced inspection of Downe Dementia Unit was undertaken on 12 March 2014

An unannounced inspection of the Downe Dementia unit was undertaken on 12 March 2014. The purpose of this inspection was to evaluate the progress on implementing the recommendations made following the last inspection on 21 February 2012. Of the 22 recommendations made in the Quality Improvement Plan (QIP) inspectors found evidence to confirm that 16 recommendations were fully met, one recommendation was assessed as being partially met and five recommendations had not been met. Two of the recommendations not met will be restated for a third time.

The ward had complied with recommendations relating to the development of advocacy services and the provision of information, in a format appropriate for patients suffering from dementia, detailing the ward's comments and complaints process. The ward environment had undergone significant change including redecorating, the redesign of the nursing station and the instalment of patterned glass to eliminate patient reflections at night. Inspectors also noted the availability of appropriate signage throughout the ward.

Nursing staff who met with inspectors reported no concerns or difficulties regarding their ability to access supervision and training. Inspectors noted that recommendations made in relation to staff receiving dementia training, protecting adults from abuse training and skills development in the management of challenging behaviours had been met. However, despite retaining appropriate records of training completed by nursing staff the ward manager did not have an overview of the training records for each member of the nursing staff team. Subsequently, the completion of training audits and the continued monitoring of mandatory training requirements was not possible. Inspectors were informed that the ward management team had taken steps to address this and it had been agreed that the ward's administrative officer would collate Trust training records for each member of nursing staff and provide up to date information regarding staff training. The recommendation regarding training audits has been restated.

Appropriate steps had been taken to ensure the ward's vulnerable adult processes were clearly defined. Staff who met inspectors relayed appropriate knowledge and understanding regarding the management of vulnerable adult concerns. Information regarding the vulnerable procedure was also available on notice boards in the main office, the staff room and on the relatives' notice board. Inspectors reviewed the ward's vulnerable adult referrals and incident reports and found these to have been completed appropriately. Inspectors were informed that information from the designated officer (vulnerable adult referrals) and the governance department (incident reports) was available and helpful. However, acknowledgements of receipt of referrals (VA2 form) from the designated officer were not provided consistently and the governance

department did not provide a regular summary/overview of incidents that had occurred within the ward. Recommendations have been made.

Despite the progress made inspectors were concerned that a number of previously stated recommendations had not been implemented. These included two recommendations made as a result of the inspection on the 17 January 2011 which will be stated for a third time. There are also four of the recommendations made as a result of the inspection completed on the 21 February 2012 which will be stated for a second time.

Inspectors also noted a number of further concerns. These included deficiencies in the ward's assistive technology, the absence of support from a physiotherapist, a lack of storage in patient bathrooms, difficulties regarding patient access to the dining and garden areas (fire doors remaining closed although not locked) and repair required to the kitchen serving hatch shutter. Recommendations have been made.

The recommendations to be stated for a third time are discussed below. Recommendations to be stated for a second time are detailed in the Quality Improvement Plan (QIP) and discussed in section 5.0. Further recommendations made as a result of findings from the inspection on the 12 March 2014 are stated on the last two pages of the QIP.

Recommendations stated for a third time:

1. Review of the ward's policies and procedures demonstrated that a number of the Trust's policies were out of date and required review. The inspectors noted the manual handling policy required review in January 2013 and the policy for ensuring appropriate receipting and lodging procedures across all Trust facilities should have been reviewed in December 2012.

2. Inspectors reviewed the ward's internal fire doors and found that four fire doors were wedged opened. Inspectors noted that three doors were wedged open in the main entrance corridor. This corridor links the ward's front entrance to the main body of the ward. The doors wedged open included the door to the staff room, staff toilet and physiotherapist room.

3. Review of the management of the ward's fire extinguishers revealed that the ward manager had contacted the Trust's Fire Officer and presented an overview of the procedures used on the ward. However, contrary to the stated recommendation inspectors noted that a risk assessment for the storage of fire extinguishers was not available.

Inspectors would like to thank the patients, staff, relatives and visiting professionals for their cooperation throughout the inspection process.

5.0 FOLLOW-UP ON PREVIOUS ISSUES

1.0 RECOMMENDATIONS RESTATED FROM THE INSPECTION COMPLETED 17 JANUARY 2011

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1.	It is recommended that staff and patients have an awareness of the role of the advocate and the availability of advocacy services at the point of admission and that this is documented in the patient's notes.	Information regarding the advocacy service including the name and contact details of the ward's advocate were available in the patient information booklet and displayed on the ward's notice boards. The advocate visited the ward on a regular basis and could be contacted by patients, or their representatives, as required.	Fully met
2.	It is recommended that information on the comments and complaints process is more accessible in a suitable format for patients who have dementia.	The comments and complaint process was detailed in the patient information pack and displayed on two of the ward's notice boards in a format suitable for patients who have dementia. The ward also provided an anonymous feedback board where patients, relatives and carers could post comments regarding their experiences.	Fully met
3.	It is recommended that patients are provided with information on a daily basis regarding ward routines in a format suitable for patients who have dementia. The terminology used on the activities board should be reviewed to ensure it is user friendly.	The activities board was available, centrally located and up to date. The information regarding the ward routine was clear, well presented and detailed in a format suitable for patients who have dementia.	Fully met
4.	It is recommended that a review is carried out of the wards' policies to ensure that	Inspectors reviewed a number of the ward's policies. Inspectors noted that the Trust's manual handling policy	Not met

	they are up to date and easily accessible for staff to view. Policies and procedures should be subject to a defined systematic and timely review, at a minimum of at least once every three years.	had been published in January 2010 and was due for review in January 2013. The policy had not been reviewed and was out of date. The Trust's policy regarding the appropriate receipting and lodging of patient money and property was also out of date. This recommendation will be restated for a third time.	
5.	It is recommended that the Ward manager takes precautions against the risk of fire by ensuring the following: • Fire doors are not propped or wedged open at any time • A risk assessment is completed for storage of fire extinguishers in the event that they need to be removed from their allocated point on the ward.	Inspectors reviewed the ward's internal fire doors and found that four fire doors were wedged opened. Inspectors noted that three doors were wedged open in the main entrance corridor. This corridor links the ward's front entrance to the main body of the ward. The doors wedged open included the door to the staff room, staff toilet and physiotherapist room. Inspectors found that the door from the corridor in the ward's six bedded annex to the patient dining room was wedged open using a chair. The dining room was integrated within the ward's kitchen area and inspectors noted that the shutter used to close the serving area between the kitchen and the dining room was also broken. Subsequently, should a fire start in the kitchen it could spread quickly to the dining area and the rest of the ward. A risk assessment for the storage of fire extinguishers was not available. This recommendation will be restated for a third time.	Not met
6.	It is recommended that the ward environment is improved in line with best practice for patients who have dementia (Section 7.1 report completed 17 January 2011 and section 5 additional concerns in	Inspectors reviewed the ward environment and noted that changes had been implemented. These included the reorganisation of the nursing station, redecorating, improvements to the garden and the introduction of non- reflective window coverings. The ward had also	Fully met

	the report completed 21 February 2012)	introduced signage and clocks which were more appropriate for patients suffering from dementia.	
7.	A copy of the proposed timeline for implementation of the agreed environment improvements should be forwarded to RQIA.	A copy of the proposed timeline had been received by RQIA and the environmental improvements had been made.	Fully met
8.	It is recommended that all staff have the opportunity to attend training in dementia care to include Person Centred Care.	Training records retained by the ward manager detailed that all ward nursing staff had completed training in dementia care including person centred care. Staff who met with the inspectors reported no issues or concerns regarding their ability to access training.	Fully met

2.0 RECOMMENDATIONS RESTATED FROM THE INSPECTION COMPLETED 21 FEBRUARY 2012

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
9.	It is recommended that updated training in protection from abuse appropriate to the job role is provided as a matter of urgency for those staff who have not attended update training within the last three years.	Inspectors reviewed the ward's training records. Records detailed that nursing staff had completed mandatory training in relation to the protection of vulnerable adults. Staff who met with the inspectors demonstrated appropriate awareness and understanding of the management of vulnerable adult (VA) concerns.	Fully met
10.	It is recommended the Ward Manger audits training records to identify gaps in knowledge and skills and ensure attendance at required training.	Records of training completed by nursing staff were retained by the ward manager. However, training records had not been centralised to one system to facilitate the ward manager having complete oversight of nursing staff training. Subsequently, staff mandatory training requirements including the need for refresher training were not clearly stated. Inspectors were informed that the ward's management team were in the process of reviewing the Trust's e-rostering and the TAS software systems to ensure that individual nursing staff training records were available.	Not met
11.	It is recommended that deficits in staff training in relation to behaviours that challenge are addressed as a matter of urgency.	Deficits in staff training in relation to behaviours that challenge had been addressed. The ward manager informed inspectors that staff training needs continued to be monitored and reviewed through staff supervision and ward meetings.	Fully met
12.	It is recommended that the policy and procedure for protection of vulnerable adults is amended to provide detail for staff in relation to a definition, types, and	Information regarding the Trust's policies and procedures for the protection of vulnerable adults were available on the notice board in the ward's main office and in the staff room. Paper copies of procedures were	Fully met

	indicators of abuse, and steps to be taken including reporting processes and recording responsibilities.	also available in the main office. Inspectors reviewed the ward's vulnerable adult referrals and found that these had been completed appropriately. Staff who met with the inspectors relayed no concerns regarding their ability to access vulnerable adult training. Staff also demonstrated appropriate understanding of vulnerable adult procedures.	
13.	It is recommended that the ward manager develops a policy and procedure in relation to the use of restraint and physical interventions as a matter of urgency.	A copy of the Trust's restraint policy was available in the ward's main office. The policy had been reviewed and updated in 2012. Inspectors reviewed the ward's procedures in relation to the management of restraint interventions. The procedures were appropriate and in accordance with Trust policy.	Fully met
14.	It is recommended that the Ward manager reviews, and keeps under review, ward staffing levels to ensure that appropriate levels of staffing are available to safely meet the needs of all patients on the ward. Any concerns in relation to deficits in staffing levels should be discussed with line management as appropriate.	Inspectors reviewed the ward's staffing policy and discussed staffing levels with a number of nursing staff. Staff relayed that they felt staffing resources were generally appropriate although the numbers of staff required and the use of bank and agency nursing staff was determined by patient nursing needs (i.e. use of continuous observations with a number of patients). The ward manager detailed that staffing levels were reviewed daily and in accordance with the Trust's workforce planning and inpatient dementia care strategy. The strategy was detailed and specific to the needs of patients within the Trust.	Fully met
15.	It is recommended that the Ward manager continues to develop the ethos of positive risk taking, and the rights of patients to take risks in relation to their care.	Evidence that the ward promoted a positive risk taking ethos was demonstrated through: the provision of daily ward based activities; the movement of patients within the ward; the use of assistive technology; the	Fully met

		monitoring of falls and the implementation of individualised and personalised care plans.	
16.	It is recommended that information on making complaints is displayed inside the main ward in a format suitable to the needs of patients. Complaint documentation should include dates and times of receipt of complaints, actions taken in response to complaints, and date of resolution of complaints.	Information detailing the ward's complaints procedure and "how to make a complaint" was displayed on the ward's main notice board in a format appropriate for people suffering from dementia. Information regarding the Trust's formal complaints procedure was available in the patient information booklet and the relatives/carers information booklet. Patients could also access the ward's advocate who visited on a regular basis and as required. The ward utilised a localised complaints book. Inspectors reviewed complaints made during the previous year and noted that complaints were recorded appropriately and detailed the actions taken and resolutions reached.	Fully met
17.	It is recommended that access to independent advocacy services are formalised and implemented.	The ward's advocacy service had been formalised and implemented. Details regarding the advocate were available in the patient's information booklet and on the ward's main notice board situated at the entrance to the patient's dining room. The advocate visited the ward on a regular basis and could be contacted as required.	Fully met
18.	It is recommended that the ward manager ensures that information in relation to access to information is communicated to relatives.	Inspectors were informed that the Trust had produced an information leaflet for patients and relatives detailing their rights to access information. Inspectors were unable to access copies of this or associated information during the inspection.	Not met
19.	It is recommended that the ward manager reviews and updates the policy and	The Trust's policy for ensuring the appropriate receipting and lodging procedures across all Trust	Not met

	procedure in relation to the handling of patients' monies.	facilities was out of date. The policy had been due for review in December 2012.	
20.	It is recommended that the ward manager reviews the accessibility to the mobile shop for patients in the ward, and manages the decision accordingly.	The ward manager had reviewed and implemented the provision of the hospital's mobile shop to patients within the ward. Inspectors were informed that the shop had since been closed within the hospital and the mobile shop was no longer available.	Fully met
21.	It is recommended that the systems in relation to the identification and laundering of clothing are reviewed to ensure patients clothing is kept safe and there are no unnecessary delays when clothing leaves the ward to be individually marked, or laundered.	The ward management team had taken steps to minimise the delays and to reduce the misplacing of patient clothing within the Trust's laundry services. However, patient clothing continued to be misplaced and delays in laundry returning to the ward were also noted. Inspectors were informed that the ward management team continued to liaise with the laundry manager and the Trust's infection control team in an attempt to address concerns. The challenge for the ward was the fact that it required the use of two laundry sites one situated locally and one situated approximately 25 miles away. The ward's washing machine and dryer were not appropriate to meet the needs of patients.	Partially met
22.	It is recommended that the ward manager develops a policy and procedure in relation to children visiting the ward.	A policy and procedure detailing the arrangements for children visiting the ward was available. The procedure detailed that visits should be pre-arranged, would be facilitated in a room outside the main ward and that children should be supervised by a parent/guardian at all times. Copies of the procedure were available in the patient and relatives information booklets and posted on the ward's notice boards.	Fully met

6.0 Stakeholder Engagement

The following information is a summary of feedback received from those who met with an inspector during the inspection.

Patients: Inspectors met with a number of patients during the inspection. Patients' comments included:

"The staff look after me";

"It's nice hear";

A number of patients were unable to vocalise their experiences due to their illness. Inspections observed staff/patient interactions throughout the day. This included spending time with patients during breakfast and lunch and observing the work of staff providing patients with one to one support and interventions. Inspectors noted that the ward was positive and that patients presented as relaxed.

Carers/ Relatives: Inspectors met with three relatives. Relatives were complimentary about their relative's previous admission (approximately one year ago). They relayed that this was their relative's second admission and they had felt that their relative's hygiene needs were not as well attended to. They reported concerns regarding the ward's laundry provision and the fact that items of their relatives clothing had gone missing. They had been concerned that their relative had previously worn temporary clinical type overalls whilst awaiting clothing to be returned from the laundry.

Visiting professionals: No visiting professionals were available to meet with inspectors.

Staff: Inspectors met with seven members of the staff team. Staff comments included:"

"This is a good place to work";

"Good staff team";

"I feel well supported and receive appropriate supervision and training";

"It can be a challenging place to work";

"We work with patients with a very challenging illness";

"Staffing can be an issue at times and we do rely on bank and agency staff";

"Brilliant place to work";

Advocates: The advocate was not available to meet with inspectors.

7.0 Additional Concerns Noted by Inspectors (if applicable)

Inspectors noted no additional concerns.

Quality Improvement Plan

Unannounced Inspection

Downe Dementia ward, Downe Hospital

12 March 2014

The issue(s) identified during this inspection are detailed in the inspection report and the Quality Improvement Plan.

The details of the Quality Improvement Plan were discussed with the ward manager, the charge nurse, the operations manager, the patients' experience manager and patients' experience assistant manager and the senior social work practitioner either during or after the inspection visit. Please refer to Appendix 1 for specific reference documents. The timescales for completion commence from the date of the inspection.

1. Recommendations restated from the inspection completed on the 17 January 2011

No.	Recommendation	Number of times stated	Details of action to be taken by ward/trust	Timescale
1.	It is recommended that a review is carried out of the wards' policies to ensure that they are up to date and easily accessible for staff to view. Policies and procedures should be subject to a defined systematic and timely review, at a minimum of at least once every three years.	3	The Ward Manager has raised awareness with Staff that policies are accessed via the Trust iconnect system. The Manual handling policy has been updated, staff made aware of same, policy is available for ward staff, next review due April 2017. Ward staff have been made aware of the most recent Trust policy SET/Fin(08)2010 Handling of Patients Cash & Valuables which was due for review in April 2013. The Trust Finance Audit Committee had agreed that finance policies will not be reviewed until the new finance systems have been implemented. Therefore existing	Immediate and On-going monitoring Completed 14/04/2014 14/04/2014

No.	Recommendation	Number of times stated	Details of action to be taken by ward/trust	Timescale
			policies remain, however this policy will now be reviewed & reissued without undue delay. See **Appendix 1** An All User email is circulated on a monthly basis to inform staff of reviewed / new Trust Wide policies issued for that period.	31st May 2014
2.	It is recommended that the Ward manager takes precautions against the risk of fire by ensuring the following: • Fire doors are not propped or wedged open at any time • A risk assessment is completed for storage of fire extinguishers in the event that they need to be removed from their allocated point on the ward.	3	Risk assessment and action plan completed March 2014. All work requests made to Estates on 14th March 2014 & are in progress. See **Appendix 2** Fire Risk Assessment See **Appendix 3** – All User Email regarding the cessation with immediate effect of	Risk Assessment completed 24/03/2014 October 2014

No.	Recommendation	Number of times stated	Details of action to be taken by ward/trust	Timescale
			wedging open fire doors.	

2. Recommendations restated from the inspection completed on the 21 February 2012

No.	Recommendation	Number of times stated	Details of action to be taken by ward/trust	Timescale
3.	It is recommended the Ward Manger audits training records to identify gaps in knowledge and skills and ensure attendance at required training.	2	Staff training records & requirements are currently being added to the erostering system which will provide immediate access and assist with auditing purposes. The audit will be carried out by 28th April 2014	31 May 2014
4.	It is recommended that the ward manager ensures that information in relation to access to information is communicated to relatives.	2	Leaflets re. accessing information made accessible on leaflet stand on ward and also available in welcome pack in each patients room.	Immediate and ongoing
5.	It is recommended that the ward manager reviews and updates the policy and procedure in relation to the handling of patients' monies.	2	The most recent policy SET/Fin(08)2010 Policy Handling of Patients Cash & Valuables was due for review in April 2013. The Trust Finance Audit Committee agreed to defer review of this policy until Shared	

No.	Recommendation	Number of times stated	Details of action to be taken by ward/trust	Timescale
			Services systems are fully implemented as processes may change at that time. The aforementioned policy has been circulated in the interim period to inform staff regarding the safe & appropriate management of patients' monies. Policy to be reviewed & reissued as per point 1 above Refer to QIP Monitoring of in Mental Health, January 2014	October 2014 14/04/14 31/05/2014
6.	It is recommended that the systems in relation to the identification and laundering of clothing are reviewed to ensure patients clothing is kept safe and there are no unnecessary delays when clothing leaves the ward to be individually marked, or laundered.	2	Meeting held with laundry manager and infection control re. laundry process 4th April 2014. Process mapping and action plan agreed .Laundry care-pathway will be	Immediate and ongoing

No.	Recommendation	Number of times stated	Details of action to be taken by ward/trust	Timescale
			operational by 28th April and information regarding laundry management & process will be available in welcome pack for patients, relatives and all staff. Process will be audited June 2014	

3. Recommendations made following the inspection on the 12 March 2014

No.	Recommendations	Number of times stated	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
7.	It is recommended that the ward manager ensures that all assessment and care documentation is completed in accordance with Trust and clinical standards.	1	1	Section 2, number 15.24, page 8.	Nursing documentation will be audited on a monthly basis. 10 records will be audited per month by Ward manager & registered nurses for peer shared learning reflected through supervision and team meetings.	Immediate and ongoing
8.	It is recommended that the ward's designated officer ensures that vulnerable adult referrals generated by the ward are managed in accordance with regional and Trust policy.	1	19	Part 2, number 11.1, page 23.	To improve communication, the investigating officer will provide a weekly update to staff and managers from the designated officer. Accumulative report identifying trends will also be provided by the investigating officer. Quarterly reports are provided centrally	
9.	It is recommended that the Trust's governance department provides quarterly returns to the ward detailing frequency and type of incidents	1	1	Section 1, number 1.3, page 1.	Ward managers will be included in quarterly reports from the risk department & safe and effective	31 July 2014

No.	Recommendations	Number of times stated	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	occurring.				care team and will be discussed at team meetings. Trends and activity are reported through primary care governance group and directorate governance meetings.	
10.	It is recommended that the ward manager ensures that patient and ward bathrooms are fitted with appropriate storage and towel rails.	1	1	Section 4, number 37.22, page 18.	Storage appropriate for use with dementia patients to be sourced & will be ordered for each bedroom. Initial discussion re same commenced April 2014	30 Sept 14
11.	It is recommended that the ward's assistive technology devices are reviewed and any deficits or shortfalls are addressed.	1	1	Section 4, number 39.10, page16.	Patient alarm mats reviewed and wireless falls alert mats to be piloted week commencing 14th April 2014. Will be evaluated post pilot with view to order if deemed appropriate	Immediate and ongoing
12.	It is recommended that the ward manager ensures that fire doors to patient dining areas, the ward gardens and group rooms are reviewed and	1	1	Section 4, number 31.1 and 31.6, page	Estates notified 14th March, Currently out for quotations April 2014 by Estates Dept	31 July 2014

No.	Recommendations	Number of times stated	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	where appropriate fitted with magnetic catches to ensure continued patient access and fire safety.			16.		
13.	It is recommended that the ward manager ensures that the shutter between the kitchen area and the dining room in the ward's six bedded annex is repaired	1	1	Section 3, number 23.2, page 13.	Estates department contacted 13th March 2014 and repair of shutter out for quotations	Pending
14.	It is recommended that the Trust ensures that patients in the ward have ward based access to a physiotherapist.	1	9	Section 9, number 9.5,	Physiotherapy services are currently available via acute services as clinical need demands Workforce report presented to director of Nursing which highlights need for ward based physiotherapist., however there is no funding resource allocated at this time	30 June 2014
15.	It is recommended that the ward manager ensures that access to the ward's IT system is secure.	1	1	Section 3, number 23.3, page 13.	Password is now secure.	Immediate and ongoing
16.	It is recommended that the ward's gardens are cleaned and appropriately maintained.	1	1	Section 5, number 43.1, page	Immediately actioned on the 13th March 2014 with regular	Immediate,

No.	Recommendations	Number of times stated	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
				21.	maintenance and provision of receptacles for safe disposal of cigarettes.	Monitoring ongoing

NAME OF WARD MANAGER COMPLETING QIP	Sr Paula Thompson Downe Dementia Unit
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Brenda Arthurs Acting Assistant Director Primary Care & Nursing

Inspector assessment of returned QIP				Inspector	Date
		Yes	No		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Alan Guthrie	23 June 2014
B.	Further information requested from provider				

Appendix 1 – MHLD Reference Documents

MHLD Document Number	Legislation Title
1	AIMS -Older People(2009)
2	AIMS-Working Age Adults(2009)
3	AIMS-Learning Disabilities(2010)
4	Circular HSS(F)57/2009 – Residents' Monies
5	Complaints in HSC: Resolution & Learning (2009)
6	DHSSPS Interim Guidance - Deprivation of Liberty(2010)
7	DHSSPS Guidance - Restraint and Seclusion(2005)
8	Human Rights Act(1998)
9	Improving Dementia Services Reg Strategy(2011)
10	Learning Disability Service Framework(2012)
11	Mental Health(NI)Order(1986)
12	NICE Quality Standard 14-User experience(2011)
13	NICE Clinical Guideline 136 -User experience(2011)
14	OPCAT(2002)
15	Procedure for Reporting & Follow Up of SAIs(2010)
16	Promoting Quality Care(2009)
17	Quality Standards for HSC(2006)
18	Safeguarding VAs-Shared Responsibility(2010)
19	Safeguarding VAs-Protection Policy & Guidance(2006)
20	Service Framework for Mental Health & Well Being (2011)
21	UN Convention-Person with Disabilities(2006)
22	UN Convention-Rights of the Child(1989)
23	UTEC Guidance(2007)