Mental Health and Learning Disability Inpatient Inspection Report
4 – 6 October 2016

Downe Dementia

Downe Hospital
2, Struell Wells,
Downpatrick
BT30 6RL
Tel No: 02844 838254

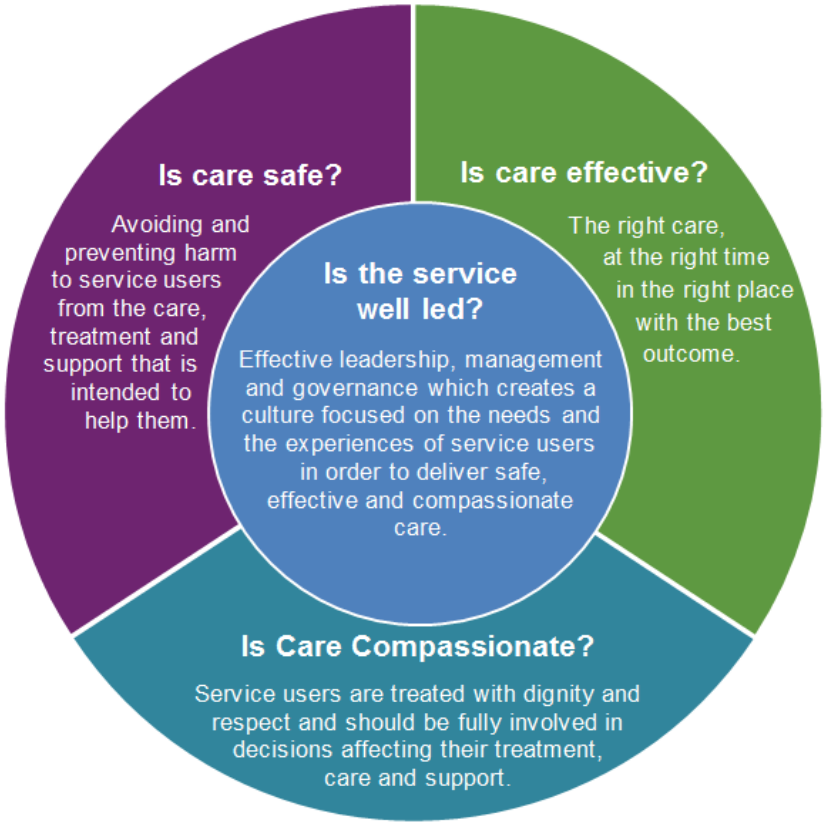
Inspectors: Wendy McGregor, Dr Shelagh Mary Rea

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

The Downe Dementia assessment and treatment unit is a twenty bedded mixed gender ward. The ward provides assessment, care and treatment to patients with dementia who may present with behaviours that are distressing.

There were 12 patients on the ward during the inspection. Five patients were detained appropriately in accordance with the Mental Health (NI) Order 1986.

Patients have access to a multi-disciplinary team consisting of psychiatry, medical, nursing, occupational therapy and social work. Access to psychology, physiotherapy, speech and language therapy and dietetics was by referral.

3.0 Service Details

Responsible person: Mr Hugh McCaughey	**Position:** Chief Executive
Ward manager:	Paula Thompson
Person in charge at the time of inspection: Paula Thompson	

4.0 Inspection Summary

An unannounced inspection took place on 4 – 6 October 2016.

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

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

Evidence of good practice was found in relation to flexible and open visiting. The ward has committed to the John's Campaign "Stay with me" which welcomes visitors 24/7, offers tea and coffee making facilities and overnight stay if required. The team were also shortlisted for an Alzheimer's Association Dementia Friendly Award. There was a good range of recreational and occupational therapy led activities on the ward and these were appropriate to the needs of the patients. Ward staff have worked with acute hospital staff and introduced the "Butterfly" scheme which is a five step approach to communicating effectively with patients who have a cognitive impairment. To promote good staff morale, staff were nominated by relatives, visitors and other staff as "employee of the month" with the incentive of getting a half day leave. The staff had received recognition from a palliative care consultant about their care and treatment.

Areas requiring improvement were identified. The ward did not have a health and safety risk assessment or audit completed and the fire risk assessment was not up to date. Recommendations made following the last fire risk assessment completed in June 2015 had not been met. RQIA informed senior management and a member of staff from estates during feedback and received confirmation on 17 October 2016 that both these areas had been addressed. Other areas for improvement were identified in relation to incident reporting which were addressed with the ward manager during the inspection and a mechanism was put in place before the conclusion of the inspection to address these concerns. Other areas identified for improvement included the recording of information in care documentation, the ward environment and the sharing of governance information with all staff working on the ward.

Patients and relatives said that care was safe and effective. Relatives confirmed that they were involved with decisions and kept up to date with any changes relating to their family members' care and treatment and were also informed about any accidents or incidents. Patients and relatives said that they knew how to make a complaint and stated that staff were approachable and friendly. Relatives stated their family member was treated with dignity and respect. Overall patients and relatives were satisfied with the care and treatment on the ward.

Relatives stated:

"I cannot speak highly enough about the care which my mum has received here at Downe Hospital. I am kept informed of any changes in mum's condition and the staff across the board, treat mum with respect and kindness (and humour) which all aids in her recovery."

"Happy with everything."

"Staff are very good, the place is spotless, I have no concerns and I am very happy with the care my wife receives."

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	16

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

There were three areas for improvement that required attention by 17 October 2016. These were in relation to the timely reporting of incidents using the IR1 mechanism, the fire risk assessment and the completion of a health and safety environment audit. The inspector noted that a mechanism was put in place on the days of the inspection to ensure that IR1's were sent to the appropriate people in accordance with trust policy and procedure. The inspector received confirmation that 21 out 22 recommendations made following the fire risk assessment

completed in June 2015 were met. A plan is now in place to address the one outstanding recommendation which is in relation to fire drill practice and this is scheduled to be completed on 9 November 2016. The inspector received an up to date health and safety audit for the ward on 17 October 2016.

5.0 How we Inspect

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

- The operational policy or statement of purpose for the ward.
- Incidents and accidents.
- Safeguarding vulnerable adults.
- Complaints.
- Health and safety assessments, fire risk assessments, cleaning audit and associated action plans.
- Governance arrangements, structure and lines of accountability.
- Details of supervision and appraisal records.
- Policies and procedures.
- Staffing levels, supervision and appraisals, vacancies, bank and agency usage.
- Use of mental health legislation.
- Monitoring of admission and discharge.

During the inspection the inspector met with five patients, eleven ward staff, and four relatives.

A lay assessor was present during the inspection and their comments are included within this report.

The following records were examined during the inspection:

- Care documentation in relation to four patients.
- Care documentation audits.
- Staff rota.
- Training records.
- Staff meetings.
- Governance reports.
- Minutes from governance meetings.
- Compliments.
- Key Performance Indicators.

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

The inspector reviewed the recommendations made at the last inspection. An assessment of compliance was recorded as met, partially met, or 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 from the most recent inspection dated 22 June 2016

The most recent inspection of the Downe Dementia was an unannounced inspection. The Quality Improvement plan (QIP) was returned and approved by the responsible inspector and the QIP was validated by the responsible inspector during this inspection.

6.2 Review of areas for improvement from last inspection dated 22 June 2016

Areas for improvement		**Validation of compliance**
Number/Area 1 **Ref**: 5.3.1 (a) **Stated:** Second time	It is recommended that all restrictive practices on the ward and blanket restrictions in response to individual risk are reviewed to insure that risk management strategies are based on individual assessment.	**Met**
	Action taken as confirmed during the inspection: Inspector reviewed care documentation in relation to four patients. Each patient had a care plan in place to address any restrictive practices and blanket restrictions. Care plans detailed the risk and the rationale for the restriction. The four care plans reviewed evidenced that the restriction was necessary and proportionate to the risk. The care plans were reviewed every week.	
Number/Area 2 **Ref**: 5.3.1 (a) **Stated:** First	It is recommended that the ward manager ensures that each patient has an individualised ligature risk assessment completed for use of the profiling beds. This should include a subsequent risk management plan to address any identified risks, in accordance with the Northern Ireland Adverse Incident Centre (NIAIC) – EFA/2010/006 safety alert self-harm associated with profiling beds.	**Met**

	Action taken as confirmed during the inspection: The inspector was informed by the ward manager that there were no patients on the ward during the inspection assessed at risk of self harm. All beds on the ward were profiling beds as these were required to meet the physical health needs of patients. The inspector reviewed care documentation in relation to the four patients. Each patient had risk assessment completed. This was in the form of a flow chart. None of the patients reviewed were assessed at risk of using the profiling bed, therefore there was no care plan required. However, none of the risk assessments had been reviewed since each patient had been admitted to the ward, and therefore a new finding for improvement has been recorded.	

6.3 Review of findings

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

The management of patient risks were individualised and incorporated into each patient's care plan.

There was evidence of patient and relative involvement in the management of risks.

Relatives confirmed they were kept up to date with changes in risks, accidents and incidents.

Risk management and care plans were discussed by the multi-disciplinary team and reviewed every week at the Team Assessment Meeting (TAM) meeting.

Risk management and care plans detailed that de-escalation and distraction techniques should be implemented as a first line strategy to support patients who were presenting with behaviours that challenge. This support was also observed on the ward by the inspector.

The frequency of the use of Care and Responsibility (physical intervention to support patients) was low (10) between 1 April 2015 and 31 March 2016. This demonstrated that staff were

using de-escalation and diversionary methods to avoid the use of physical intervention. It also evidenced that this restriction was used as a last resort.

Each patient had a risk assessment in place for the use of the profiling bed.

The ward social worker shared information in relation to patient safety with community staff.

All staff knew what to do if they were concerned about safety on the ward.

All staff interviewed stated they did not work beyond their role, experience or training.

Staff were familiar with the needs and the care plans for each patient.

All patients interviewed stated they felt safe on the ward.

The medical room was organised and the emergency equipment had been checked according to trust policy and procedure and a record was maintained.

There were two handovers every day, in the morning and after lunch, and risks were highlighted and recorded on the daily handover sheet.

The risk of falls is assessed, documented and reviewed every week. Measures are put in place to highlight patients who are at a high risk of falling, and a discreet sign placed on the patient's bedroom door. Patients who have a high risk of falling have a care plan in place, which highlighted the extra precautions to be taken i.e. 15 min checks.

Falls were recorded as an incident and reviewed by senior management at the quarterly governance meeting.

A C4C cleaning audit score was completed July 2016. The ward scored an overall functional score = 90.98%.

An up to date ligature risk assessment was in place.

All staff had received up to date health and safety training.

Patients and relatives knew how to make a complaint and staff knew how to manage complaints.

There were 2 complaints made April 2015 – March 2016. These were managed in accordance with trust policy and procedure.

Staff interviewed all confirmed the process for Safeguarding Vulnerable Adults.

All staff knew how to access the on call out of hours rota service for contact with senior management and the duty social worker.

Detention rights were explained to patients and their relatives. There was evidence of review and regrading of patients who were detained in accordance with the Mental Health (Northern Ireland) Order 1986.

Staff were observed seeking consent prior to care delivery. Staff demonstrated their understanding of capacity to consent and best interests decision making.

Key Performance Indicators were completed every month. The most recent scores were 100% for skin care, 92.88% for hand hygiene, 77% for National Early Warning Score (NEWS) and 100% for nutrition.

The Infection Control team visited the ward every month and completed an audit.

There was a call alert system for patients and staff.

All medication dosages were written within British National Formulary (BNF) guidelines.

Areas for Improvement

Risk assessment and risk management

Two out of four patients reviewed had a dementia risk screening tool completed. It was acknowledged that this is a pilot and was commenced four weeks prior to the inspection. To date 25 risk screening booklets have been completed.

Each patient's risk assessment in relation to the use of profiling beds had not been reviewed since admission.

Incident reporting

There were a number of IR1 forms completed but not forwarded to the health and safety team and senior management since 24 September 2016. Four IR1 forms reviewed were not completed in accordance with trust policy.

Environmental safety

Recommendations made following the fire safety survey and risk assessment completed June 2015 had not been met. The fire risk survey and risk assessment was not up to date.

A health and safety environmental audit had not been completed.

There was no action plan in place to address deficits in the C4C cleaning audit scores.

Medication

The risk management and care plans did not detail when Pro Re Nata (PRN) medication should be administered. It was noted that two patients were prescribed three PRN medications for tranquilisation. This was not reflected in either of the patient's care plan to guide staff when and what PRN medication should be administered.

The following was noted on review of the medication kardexes:

- The front page and medicine management section was not always completed in full with the name of the consultant, date of admission, height, and weight.
- The indication for the use of PRN medication was not always recorded.
- The maximum dosage in 24 hours was not always recorded.
- The frequency of medication was not always clear, for example intervals between doses was noted as TDS or QID instead of 4 hourly or 6 hourly.
- Two patients were prescribed three PRN medications for tranquilisation with no clear indications recorded.

Number of areas for improvement	4

6.4 Is Care Effective?

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

Areas of Good Practice

Relatives stated that being in hospital was helping their family member.

Patients and their relatives were involved in assessments and care plans.

The ward was piloting a Dementia Inpatient Discharge summary.

Each patient reviewed had a falls assessment, skin care assessment and moving and handling assessment and these were reviewed every week.

There was a range of care and treatment options available in line with best practice guidance.

Nursing care plans were reviewed every day.

Patients had access to a full time occupational therapy (OT) service.

Each patient had an appropriate OT assessment completed.

Patients were appropriately referred to Speech and Language Therapy for a swallowing assessment and recommendations were included in patient's care plans

There was good community outreach, however this requires to be formalised. Community outreach appears to have reduced the number of readmissions to the ward.

Nursing staff monitor each patient's nutrition and hydration needs every day.

The ward scored 100% in their Key Performance Indicator (KPI) for nutrition.

There was a multi-disciplinary team assessment meeting (TAM) every week.

The layout, design, and ambience provided a therapeutic environment. There was good natural light on the ward. Patients had open access to fresh air in a safe garden space. Patients had their own bedrooms and en suite facilities. The ward looked and felt welcoming. There were spaces for activities and a well-equipped activity room. There was space for patients to walk around independently.

There was a good range of appropriate activities such as art and craft, cooking, current affairs, reminiscence therapy, games, quizzes. There was a weekly display of available activities.

There was adequate staffing and skill mix to meet the individual needs of patients.

Staff discussed any restrictive practices with patients and their relatives. Information in relation to Deprivation of Liberty was discussed and displayed on the ward and also included in the ward welcome folder.

Each patient had a care plan in place in relation to Deprivation of Liberty. The care plan detailed the rationale for the restriction.

The use of PRN medication was noted to be minimal.

The trust has recruited a clinical psychologist.

Areas for Improvement

Multi-disciplinary care documentation / assessments and care / intervention plans

None of the patients reviewed had an individualised, goal orientated, occupational therapy activity schedule / intervention plan completed.

Social work records were not included in the patients' multi-disciplinary care file.

Team Assessment Meetings (TAM) template was not always completed in full.

Nursing care plans were not goal orientated as goals were recorded as interventions.

The falls care plan was a generic core care plan and stated that if a patient's score indicates that they are at risk of falling they should be referred to the OT for assessment of environment, as well as physiotherapy for assessment and training of strength, balance, gait, and coping mechanisms and Social Worker for assessment of social circumstances. This was "ticked" in the care plans reviewed but there was no evidence that these referrals or interventions had occurred.

The following was noted in the four sets of care documentation reviewed:

- One patient who was a diabetic did not have a care plan completed to address their physical health needs of the patient.
- One patient who was admitted on 30 August 2016 did not have a nursing assessment in their care documentation.

- One patient was assessed at risk of a pressure sore on 26 September 2016 but did not have a prevention management plan or care plan completed.
- One patient did not have a nutritional assessment completed.
- One patient did not have an up to date assessment reflect their risk of aspiration, although a care plan was in place.

Behavioural and psychology support

Patients who presented with non-cognitive behavioural and psychological symptoms of dementia or behaviours that challenge did not have a behavioural and functional analysis completed or an individually tailored care plan developed to address these specific needs.

There was no input from clinical psychology to support patients, relatives or guide staff with the care of patients who presented with behaviours that challenge.

Effective Environment

There was limited use of colour coding on the ward to support patients with orientation. Not all of the sanitary fittings (toilet seats etc.) were coloured to contrast with the bathroom walls and floors.

Number of areas for improvement	3

6.5 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

Staff were available in the communal areas at all times.

Relatives had independent access to tea and coffee making facilities.

The trust has recruited a volunteer (a relative of a previous patient) to visit the ward and complete a walk about of the environment to suggest improvements.

Relatives and patients confirmed that they were treated with dignity and respect.

Patients were participating in activities both on and off the ward. There was good use of the activity room.

Relatives were complimentary of all the staff and the care their family member received.

Patients said they were treated with dignity and respect.

The staff had received recognition from palliative care consultant about the care they delivered.

The inspector observed staff treating patients with respect, were courteous and offered choice.

The inspector observed staff responding compassionately to patients who were distressed, confused and disorientated. Staff were observed to be skilled at using de-escalation and diversionary measures. Staff were also attentive with patients who were physically unwell. Staff were patient and caring and were observed taking time to talk to patients and their relatives.

Relatives and patients were given information to assist with making informed choices.

There was a ward welcome folder for patients and relatives.

Patients have access to an advocate who attends the ward every Monday. Contact details for the advocacy service were displayed on the ward.

There was motivational art work and poems displayed on the ward.

Information in relation to each patient's primary nurse was displayed in their bedrooms.

Areas for Improvement

Compassionate Environment

A small number of patients (six) had to eat their meals in a corridor.

Patient information

Staff photographs were out of date and did not include all staff working on the ward including medical staff.

Number of areas for Improvement	2

6.6 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

A quarterly governance report was completed and included details in relation to incidents, vulnerable adults, compliments, complaints, patients experience, service improvement initiatives, staff sickness and the use of bank and agency staff. The report was discussed at the quarterly Primary Care and Mental Health Services for Older people governance meetings.

Staff interviewed were aware of role and responsibility in relation to safeguarding vulnerable adults, child protection, and whistleblowing.

Staff knew how to access trust policies and procedures.
The ward social worker monitors delayed discharges. All delayed discharges were reported to the Health and Social Care Board.

Staff reported good working relationships between the multi-disciplinary team and good team work. The multi-disciplinary team said they were well supported by their peers and senior staff.

Staff supervision and appraisals were all up to date.

There were mechanisms in place to gather patient experience by a relative satisfaction survey.

The ward manager completed an audit of the care records every month. Staff were notified of the outcome and an action plan completed.

The trust has developed a Primary Care and Older People Management Plan for Safety Quality Experience (SQE) service improvements which included corporate and directorate objectives and an action plan for completion by March 2017.

Areas for Improvement

Governance reporting overview and monitoring

Length of stay and delays in discharge were are not included in the quarterly governance report or discussed at quarterly Primary Care and Mental Health Services for Older people governance meetings.

Patient experience

There was no information displayed in relation to comments received from patients and relatives.

Medication governance

There was no evidence that an audit of the kardexes had been completed.

There was no pharmacy support for overview of the prescription and administration of medication.

Policies and procedures

Eight policies and procedures were out of date:

- Good practice guidance on assessment and management of risk (July 2016)
- Fire safety policy (June 2015)
- Code of practice on protecting the confidentiality of service user information (Feb 2016)
- Policy on the prevention of inpatient and residential facilities falls and essential care after falls (May 2014)
- Policy of guardianship (Nov 2015)
- Preparation for enhanced care planning meeting (Dec 2014)
- Discharge of patients from South Eastern Trust hospitals (July 2016)
- Policy of the management of violence and aggression and the use of restraint (September 2015)

Sharing of governance information

Members of the multi-disciplinary team interviewed by inspectors were not always informed of the outcomes of incidents.

The quarterly governance report was not shared with ward staff or members of the multi-disciplinary team.

Staff were not aware of the number of times Care and Responsibility (physical intervention) had been used on the ward and this information was not displayed for staff.

Multi-disciplinary team working

The staff meeting did not include all of the multi-disciplinary team and minutes reviewed evidenced that the meetings were only attended by nursing staff.

Staff training

Out of 27 nursing staff the following staff had not received up to date training:

- Manual handling – 6
- Fire Safety – 2
- Patient handling – 4
- Infection prevention – 3
- Care and Responsibility – 2

Number of areas for Improvement	7

7.0 Provider Compliance Plan

Areas for improvement identified during this inspection are detailed in the provider compliance plan. Details of the provider compliance plan was 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.

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 to Team.MentalHealth@rqia.org.uk for assessment by the inspector.

Provider Compliance Plan Downe Dementia Ward	
Area for Improvement No. 1 **Ref:** Standard 5.3.1(f) **Stated:** **First** time **To be completed by:** 17 October 2016	The responsible person must ensure the following area for improvement is addressed. <u>Environmental safety</u>
	Response by responsible person detailing the actions taken: All recommendations from the fire safety survey undertaken in June 2015 have been actioned and the Unit fire safety file updated accordingly. A health and safety environmental audit and a fire safety survey for 2016 have been completed and reports forwarded to RQIA in October 2016. Identified requirements have been undertaken from the C4C cleaning audit and an action plan is available on file in the Unit.
Area for Improvement No. 2 **Ref:** Standard 5.3.2 **Stated:** First time **To be completed by:** 6 October 2016	The responsible person must ensure the following area for improvement is addressed. <u>Incident reporting</u>
	Response by responsible person detailing the actions taken: All IR1 forms were reviewed and completed as per Trust policy on 6th October 2016. Ward Manager & Deputy Managers have ensured all staff are aware of the process and expected standard of IR1completion. IR1 completion will be regularly monitored to ensure compliance.
Area for Improvement No. 3 **Ref:** Standard 5.3.1 (a) **Stated:** First time **To be completed by:** 6 January 2017	The responsible person must ensure the following area for improvement is addressed. <u>Risk assessments / risk management</u>
	Response by responsible person detailing the actions taken: All new patients have a dementia risk screening tool completed on admission. A full review of the dementia pathway and discharge booklet pilot is scheduled for 14th December 2016 which will include the review of the dementia risk screening tool. Risk assessments for profiling beds are completed for all patients on admission and reviewed weekly. A review of the admission / discharge pilot (which includes the profiling bed risk assessment) has been scheduled for 14th December 2016. The ward manager has added the use of the profiling bed risk assessment to the monthly audit to monitor and ensure compliance.

Area for Improvement No. 4 **Ref**: Standard 5.3.1(f) **Stated:** First time **To be completed by:** 6 January 2017	The responsible person must ensure the following area for improvement is addressed. <u>Medication</u> **Response by responsible person detailing the actions taken:** All medication kardexes have been reviewed and all sections of the front pages are completed. The indication for PRN medications and maximum dose in 24 hours is clearly recorded in all kardexes. Clear recording regarding frequency is recorded without abbreviations. Arrangements have been made for these standards to be highlighted to junior staff at the beginning of rotations and added to supervision for ward doctors. An audit schedule is being developed to ensure compliance is maintained.
Area for Improvement No. 5 **Ref**: Standard 5.3.1(a) **Stated:** First time **To be completed by:** 6 April 2017	The responsible person must ensure the following area for improvement is addressed. <u>Multi-disciplinary care documentation / assessments and care / intervention plans.</u> **Response by responsible person detailing the actions taken:** Occupational therapy documentation has been reviewed and now includes a section for goals, activities, treatment plans and ongoing review. Social work records are being incorporated into the multi-disciplinary documentation. Staff have been reminded to fully complete the team assessment meeting template, this has been added to the monthly audit to ensure compliance. All nursing care plans have been reviewed to be goal orientated; this has been added to the monthly audit to ensure compliance. Staff will be identified through this process re: requiring additional care planning training as appropriate. A full review of the dementia pathway and discharge booklet is arranged for 14th December 2016 and the falls care plan will be reviewed to clearly evidence the referral to and completion of assessments and reviews by AHPs and SW if required. All areas noted in the documentation review were fully addressed by the team and learning shared via the formal handover sheets and staff meetings. Ward managers have reviewed the monthly documentation audit tool to monitor areas identified and maintain good standards of documentation.
Area for Improvement No. 6	The responsible person must ensure the following area for improvement is addressed.

Ref: Standard 5.3.1(a) **Stated:** First time **To be completed by:** 6 January 2017	Behavioural / psychology support
	Response by responsible person detailing the actions taken: The dementia pathway used for every patient is based on behavioural and functional analysis and collates this information from the time of admission. The Unit is also using behavioural monitoring charts for patients displaying behavioural and psychological symptoms (BPSD) of dementia. This provides important information from which individual care plans are developed to meet identified needs. The Mental Health Services for Older People have employed a Nurse Consultant who has expertise in BPSD and who will support future developments of the model of care within the Unit. Referrals are made for psychology input as required.
Area for Improvement No. 7 **Ref**: Standard **Stated:** First time **To be completed by:** 6 April 2017	The responsible person must ensure the following area for improvement is addressed. Effective Environment
	Response by responsible person detailing the actions taken: A Stirling University Dementia Environmental Audit is scheduled for the Unit to maximise the existing dementia design features and to identify additional recommendations to make the environment more enabling for people with dementia. An estates request has been made to replace some existing bathroom fittings to maximise contrast and visibility.
Area for Improvement No. 8 **Ref**: Standard 5.3.3 **Stated:** First time **To be completed by:** 6 April 2017	The responsible person must ensure that the following area for improvement is addressed Compassionate Environment
	Response by responsible person detailing the actions taken: As part of the scheduled dementia environmental audit, alternative dining room space and design will be explored. This is in conjunction with estates and occupational therapy teams.
Area for Improvement No. 9 **Ref**: Standard 6.3.2 **Stated:** First time	The responsible person must ensure that the following area for improvement is addressed Patient information
To be completed by:	**Response by responsible person detailing the actions taken:** Staff photos have been updated and photography equipment

6 January 2017	purchased so changes to the team can be made at ward level and in a timely manner in future.

Area for Improvement No. 10 **Ref**: Standard 4.3(b) **Stated:** First time **To be completed by:** 6 January 2017	The responsible person must ensure that the following area for improvement is addressed Governance reporting / overview/ monitoring
	Response by responsible person detailing the actions taken: Length of stay and delays in discharge have been added to the governance template and will be monitored and discussed quarterly at the primary Care and Mental Health Services for Older People.
Area for Improvement No. 11 **Ref**: Standard 6.3.2(g) **Stated:** First time **To be completed by:** 6 January 2017	The responsible person must ensure that the following area for improvement is addressed Patient experience
	Response by responsible person detailing the actions taken: A notice board is now in place to display cards and letters from patients and relatives.
Area for Improvement No. 12 **Ref**: Standard 5.3.1(f) **Stated:** First time **To be completed by:** 6 January 2017	The responsible person must ensure that the following area for improvement is addressed Medication governance
	Response by responsible person detailing the actions taken: An audit of medication kardexes and audit schedule is being formalised. A request for pharmacy input to undertake medication rationalisation for all inpatients has been made.
Area for Improvement No. 13 **Ref**: Standard 5.3.1 **Stated:** First time **To be completed by:** 6 April 2017	The responsible person must ensure that the following area for improvement is addressed Policies and procedures
	Response by responsible person detailing the actions taken: All Trust policies identified as out of date have been highlighted to the governance department. All outstanding policies are currently under the Trust policy review procedure and will be disseminated and added to policy library on completion.
Area for Improvement No. 14	The responsible person must ensure that the following area for improvement is addressed

Ref: Standard 8.3 (d) **Stated:** First time **To be completed by:** 6 January 2017	Sharing of governance information **Response by responsible person detailing the actions taken:** Safety alerts, incidents (including falls and use of care and responsibility) and outcome of incidents have been added as a rolling agenda item at the multi-disciplinary staff meetings. The quarterly governance report is available for all staff via staff meetings and copy on staff notice board.
Area for Improvement No. 15 **Ref:** Standard 4.3 **Stated:** First time **To be completed by:** 6 January 2017	The responsible person must ensure that the following area for improvement is addressed Multi-disciplinary team working **Response by responsible person detailing the actions taken:** The ward manager holds regular staff meetings for all disciplines and has extended an additional invitation to welcome all members of the team to attend. The multi-disciplinary management team meets monthly and is well represented by all disciplines.
Area for Improvement No. 16 **Ref:** Standard 4.3 **Stated:** First time **To be completed by:** 6 April 2017	The responsible person must ensure that the following area for improvement is addressed Staff training **Response by responsible person detailing the actions taken:** Dates have been identified for outstanding mandatory training for staff. Training requirements are reviewed monthly at staff meetings and a visual aid training board in in place in the Unit staff room so staff can apply for courses as required. Training is audited monthly by ward manager to ensure attendance and identify any issues or training course needs.

Name of person(s) completing the provider compliance plan	Paula Thompson		
Signature of person(s) completing the provider compliance plan	Paula Thompson	**Date completed**	22/11/16
Name of responsible person approving the provider compliance plan	Brenda Arthurs		
Signature of responsible person approving the provider compliance plan	BA	**Date approved**	24/11/16
Name of RQIA inspector assessing	WENDY McGREGOR		

response			
Signature of RQIA inspector assessing response	Wendy M'Gregor	Date approved	1 Dec 2016