The Regulation and Quality Improvement Authority

Carrick 4

Holywell Hospital

Northern Health and Social Care Trust

Unannounced Inspection Report

19 – 23 October 2015

npm national preventive mechanism

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Our Vision, Purpose and Values

Vision

To be a driving force for improvement in the quality of health and social care in Northern Ireland

Purpose

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

Values

RQIA has a shared set of values that define our culture, and capture what we do when we are at our best:

- **Independence** - upholding our independence as a regulator
- **Inclusiveness** - promoting public involvement and building effective partnerships - internally and externally
- **Integrity** - being honest, open, fair and transparent in all our dealings with our stakeholders
- **Accountability** - being accountable and taking responsibility for our actions
- **Professionalism** - providing professional, effective and efficient services in all aspects of our work - internally and externally
- **Effectiveness** - being an effective and progressive regulator - forward-facing, outward-looking and constantly seeking to develop and improve our services

This comes together in RQIA's Culture Charter, which sets out the behaviours that are expected when employees are living our values in their everyday work.

Contents

1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

RQIA's programmes of inspection, review and monitoring of mental health legislation focus on three specific and important questions:

Is Care Safe?

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

Is Care Effective?

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

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

2.0 Inspection Outcomes

This inspection focussed on the theme of

Person Centred Care

This means that patients are treated as individuals, with the care and treatment provided to them based around their specific needs and choices.

On this occasion Carrick 4 has achieved the following levels of compliance:

Is Care Safe?	**Partially met**
Is Care Effective?	**Met**
Is Care Compassionate?	**Met**

3.0 What happens on Inspection

What did the inspector do:

- reviewed information sent to RQIA before the inspection
- talked to patients, carers and staff
- observed staff practice on the days of the inspection
- reviewed other documentation on the days of the inspection
- checked on what the ward had done to improve since the last inspection

At the end of the inspection the inspector:

- discussed the inspection findings with staff
- agreed any improvements that are required

After the inspection the ward staff will:

- send an improvement plan to RQIA to describe the actions they will take to make the necessary improvements
- send regular update reports to RQIA for the inspector to review

4.0 About the Ward

Carrick 4 is a locked 16 bedded ward situated on the ground floor, off the central corridor, in the main Holywell Hospital building. The ward provides a psychiatric inpatient service to both female and male patients. The main purpose and function of the ward is recovery and rehabilitation.

On the day of the inspection there were 16 patients on the ward; eleven patients were detained in accordance with Mental Health (Northern Ireland) Order 1986.

The multi-disciplinary team incorporates nursing, medical, psychiatry, occupational therapy, social work and clinical psychology.

The ward manager was in charge of the ward during the days of the inspection.

5.0 Summary

5.1 What patients, carers and staff told inspectors

During the inspection patient representatives were asked to complete questionnaires. One patient's relative returned a completed questionnaire.

The patient's relative said that staff were accessible, available and they felt staff listened to them. They knew who was involved in their family member's care and treatment and they were also involved in any decision making. The patient's relative stated they had been informed of their family member's diagnosis and had also been informed how to help their relative regarding their illness. The relative stated they did not feel their family member was getting better and that privacy and dignity were respected.

Inspectors met with:

6 patients (4 patients completed the patient experience questionnaire)
0 carers
8 staff
1 advocate

Patients told inspectors that:

The majority of patients indicated that care was safe. Patients had been informed of their rights. Patients also indicated that when they did not feel safe they could talk to a staff member and felt reassured that concerns about their safety were addressed adequately.
In relation, to effective care, two patients confirmed that they were fully involved in their care and two patients indicated they were involved in some parts of their care. All patients stated that they had to ask for the results of assessments and

investigations as staff did not actively inform them of the results. Three of the four patients interviewed stated that staff regularly informed them on how they were progressing and one patient stated staff sometimes discussed progress with them. All patients stated they were offered the opportunity to attend activities every day and felt these activities were helpful. Two patients felt that staff had all the knowledge and skills to help them recover. One patient stated they were unsure if being on the ward was helping them recover while one patient stated they did not feel that being on the ward was helping them recover. The overall response indicated that care delivered on the ward was compassionate. All patients stated staff were helpful and supportive, always listened and always sought consent before care delivery. Three patients stated staff were warm, empathetic and respectful, and treated them with dignity and their privacy was respected. One patient responded that staff were not always as sensitive as they could be, however their privacy was always respected.

Two patients who spoke informally to inspectors stated they had no concerns or complaints and overall they were satisfied with their care.
When asked if patients felt that anything could be improved; none of the patients had any suggestions.
All patients particularly valued having their own bedroom and en-suite facility.
The above findings in relation patient experience were discussed with the ward manager and any improvements are noted in the trust improvement plan accompanying this report.

Patient quotes;

"*The ward is more homely than other wards."*
"Staff are good."
"You can talk to staff at any time if you have any worries."
"There is always someone there if you need someone to talk to."
"You have your own bedroom and privacy."
"Staff treat you well and have respect for you."
"The OT is good."
"Being on this ward has helped me recover, if it wasn't for the staff I would not be ready to leave to my new home in the community."

Staff told inspectors that:

Inspectors met with eight members of the ward team, including nursing, medical, housekeeping, occupational therapy and social work. Each member of the ward team clearly identified their role and their responsible duties. The multi-disciplinary team demonstrated good knowledge of patient's needs, and informed inspectors of each patient's rehabilitation and recovery plan. Staff demonstrated how they clearly and actively prepared patients for discharge. The multi-disciplinary team had knowledge of safeguarding vulnerable adult processes and incident reporting and recording. Staff spoke compassionately about patients and were respectful when discussing patients with inspectors. Staff spoke positively about patient's plans for the future. Staff indicated that morale was good and communication between the ward team was effective. All staff

commented that they felt valued. Staff commented on the positive changes on the ward and stated the opening of the internal doors was *"great, and better for patients".*

Inspectors were informed of two areas of good practice; housekeeping staff were kept up to date and fully informed of any risks on the ward. The ward social worker had developed methodology called Patient Ongoing Review Template (PORT). The methodology was to ensure the timely review and update of all patient care plans and risk assessments.

Medical staff informed inspectors that there is a locum speciality doctor based on the ward on a full time basis Monday to Friday for all the patients. Medical staff stated the locum provides good continuity of medical and psychiatric care to patients who suffer from serious mental illness and who are extremely complex. Medical staff are particularly keen for this post to become a substantive post due to the complex needs of the patients. The trust will continue to review medical cover on the ward.

Inspectors spoke to the patient advocate. The advocate attends the ward two times a week. The advocate stated that staff on the ward were very good at referring patients to advocacy services and used the service appropriately. The advocate stated that the ward had improved, as it was more open and less restrictive and patients were offered more activities. The advocate told a story of how the staff supported a patient whose mother was terminally ill. The advocate described the staff as considerate and compassionate when supporting the patient and stated the staff also *"went beyond the call of duty."*

See attached Appendix 2

5.2 What inspectors saw during the inspection

The ward environment was clean and tidy. Bedrooms were single with ensuite facilities. The ward was spacious and there were several sitting rooms. Patients could retreat to their own bedrooms for privacy. The outside space was clean and well maintained. Facilities were available for patients to meet with their visitors and to make a phone call in private.

The function of the ward, complaints processes and advocacy services was displayed on the ward. Information on activities offered was also displayed. The activity schedule was noted to be comprehensive and activities appropriately met the needs of the patients on the ward.

On the days of the inspection there was enough staff on duty to meet the needs of the patients. Inspectors observed positive interactions between patients and all staff. Staff were attentive and promptly responded when patients sought reassurance. Staff had a relaxed and friendly nature. Patients appeared relaxed and comfortable.

Further detail is contained in the ward physical environment observational tool / checklist and the Quality of Interaction Schedule (QUIS).
See attached Appendices 3 and 4

5.3 Key outcomes

5.3.1 Is Care Safe?

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

Compliance Level	**Partially met**

See attached Appendix 5

What the ward did well

- ✓Risk assessment and management plans were individualised, comprehensive up to date and reviewed at the weekly ward round
- ✓Risk assessments were completed by the multi-disciplinary team.
- ✓Risk management plans were individualised, and addressed the risk assessed.
- ✓Risk management plans focused on personal strengths.
- ✓The ward environment was clean, tidy, organised.
- ✓The ward is a large spacious environment, with accessible facilities; staff were present in the communal areas at all times during the course of the inspection.
- ✓There were private spaces available for patients to meet with their visitors and to make a phone call.
- ✓ Staff had attended regular supervision meetings with their line manager in the last year. Staff had received up to date appraisals.
- ✓There was good MDT medical, nursing, OT, social work and clinical, psychology input. All staff were currently available as part of the team. Appropriate referrals are made to other disciplines i.e community occupational therapy, forensic services, dietetics, and speech and language therapy.
- ✓ Patients interviewed knew their rights. There was evidence in the care documentation that rights had been explained to each patient in relation to their detention and staff had ensured each patient understood.

✓There was evidence that patients had been facilitated to make application to the Mental Health Review Tribunal.

✓ Housekeeping staff were kept up to date on any incidents, risks and anything they need to know to ensure their safety.

✓There were enough staff available during the inspection to meet the needs of the patients on the ward.

Areas for improvement

Risk assessments

- Risk assessment and risk management plans had not been signed by the multi-disciplinary team, the patient or their carer (where appropriate). *Quality Standard* 5.3.1 (a)

Medication

- Indications and the maximum dose for Pro Re Nata (PRN) medication was not always recorded. *Quality Standard 5.3.1 (f)*

Environmental safety

- A ligature risk assessment completed in June 2014 identified 208 ligature risks. A further ligature risk assessment was completed October 2015 with the most of the same risks identified (18 months later). The action plan in June 2014 stated remove / replace for some of the ligature points. There was no responsible person identified to complete the action and no timescale. The ligature risk assessment completed in October 2015 did not identify the responsible person for completing the action plan or timescale. There was no plan in place to inform staff how to manage the risks locally. The ward manager was not involved in this process nor was fully aware of the scoring matrix*Quality Standard 5.3.1 (f)*

- There was one profiling bed in use on the ward. The risk assessment and care plan did not clearly identify the rationale or clinical need for the use of this bed. There was no management plan in place. (This recommendation will be restated for a second time in the trust improvement plan accompanying this report). *Quality Standard 4.3 (i)*

- Environmental checks were completed for, infection control, repairs, and cleanliness etc. However there was no action plan in place and no date to evidence that this had been completed. *Quality Standard 5.3.1 (f)*

- Vulnerable adult referrals were not recorded as incidents. *Quality Standards 5.3.2 (a)*

Staffing

- × Not all staff had received up to date mandatory training in the following areas – Cardio Pulmonary Resuscitation (C.P.R), Infection Control, Fire Training, COSHH, manual handling, safeguarding Vulnerable Adults and child protection. *Quality Standard 4.3 (m)*

Governance

- × Seven out of ten trust policies sent to RQIA prior to inspection were out of date. *Quality Standard 5.3.1 (f)*

- × Information in relation to the governance mechanisms / arrangements in relation to the review of incidents and accidents was not available. Incidents and accidents were not reviewed and discussed at the monthly business meetings and staff meetings. Appropriate information from Directorate Governance meetings was not shared with the ward team, in order to promote learning and inform care and practice. *Quality Standard 4.3 (b)*

- × Staff meetings did not occur regularly. *Quality Standard 8.3 (d)*

- × The Operational policy for Carrick 4 was in draft form. *Quality Standard 5.3.1 (f)*

5.3.2 Is Care Effective?

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

Compliance Level	**Met**

See attached Appendix 6

What the ward did well

- ✓ Patients were involved in their assessments and care plans.

- ✓ Integrated Care Pathways (ICP) were holistic and individualised and patient's goals were clearly identified.

- ✓ Care and treatment pathways were in place.

- ✓ Patients said staff told them how they were actively progressing.

- ✓ Patients were offered the opportunity to attend their weekly ward round.
- ✓ The consultants met with their patients every week.
- ✓ There was a good range of activities and patients spoke positively about activities**.**
- ✓ Patients were involved in planning for their discharge.
- ✓ The ward environment was enabling in design. Improvements had been made and the ward environment was more open and less restrictive.
- ✓ Individualised care plans had been completed in relation to any restrictive practices, these evidenced that restrictions were proportionate and necessary to the risk idientified. There was evidence that the mulit-disciplinary team; considered the least restrictive options, reviewed the restricions every week and actively worked on ways to reduce the restriction.
- ✓ Human rights were embedded in the ethos of the ward. Staff had clearly considered the impact of any care and treatment on the patient's human rights. This was documented in the patients care recordsand reviewed every week at the ward round.
- ✓ Patients stated they felt that being on the ward has helped them get better and prepare for discharge.
- ✓ Following eachweekly ward round the ward team meet and are debriefed on the outcomes.
- ✓ Medical notes were well organised and tidy. There were regular medical progress notes and medical problems were well addressed. Patient's had six monthly physical checks which included; blood tests, ECGs, where appropriate.

Areas for improvement

- **Personal well-being plans**

  - ✗ Patients had not signed their occupational therapy assessments and plans. *Quality Standard 5.3.3 (b)*
  - ✗ Patient and nurse one to one time was not consistently recorded as being offered. Nursing progress notes detailed a description of the patient's day, nursing care provided, how the patient appeared, however nursing staff did not always record if they had spoken to the each patient and measured their progress on a daily basis. *Quality Standard 5.3.3 (b)*

✘ Multi-disciplinary team ward round template was not always fully completed. *Quality Standard 5.3.1(f)*

5.3.3 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

Compliance Level	**Met**

See attached Appendix 7

What the ward did well

✓ The patient handbook was comprehensive.

✓ Staff sought consent before every care intervention.

✓ Capacity to consent had been assessed in relation to finances and restrictive practices.

✓ Good advocacy involvement. Staff had knowledge of the role of the advocate and made appropriate referrals. Staff informed patients and their families about the advocacy service.

✓ Staff were observed engaging positively with the patients. Staff were compassionate and treated patients with dignity and respect.

✓ Exit from the ward was controlled by staff. However information in relation to this was clearly displayed on the ward. Each patient had an individualised care plan completed in relation to the locked exit. The rationale for the locked door was clearly recorded.

✓ Patients were involved in various activities both in the ward and the community, and were well supported by staff.

✓ Staff actively encouraged patients to keep in touch with their families

✓ There was evidence that spiritual and cultural needs were respected. Patients spiritual and cultural needs was recorded in the in the care documentation

- ✓ Patients interviewed were satisfied with their care and treatment.
- ✓ Feedback from patients and/or their representatives, and stakeholders was positive about the way staff treat people.

Areas for improvement

There were no areas for improvement in relation to compassionate care.

6.0 Follow up on Previous Inspection Recommendations

Eleven recommendations were made following the last inspection on 8 & 15 may 2015. The inspector was pleased to note that ten out of the eleven recommendations had been implemented in full. One recommendation in relation to ligature risks associated with the use of the profiling bed had not been implemented. The recommendation will be restated for a second time.

See appendix 1 for details.

7.0 Next steps

Areas for improvement are summarised below. The Trust, in conjunction with ward staff, should provide an improvement plan to RQIA detailing the actions to be taken to address the areas identified.

Area for Improvement		Timescale for implementation in full
Priority 1 recommendations		
1	A ligature risk management plan / schedule of works was not available for this ward.	23/10/2015
2	Governance mechanisms / arrangements for the review of incidents and accidents were not available for this ward.	23/10/2015
Priority 2 recommendations		
3	Risk assessments and risk management plans had not been signed by the multi-disciplinary team, patient, or their carer (where appropriate).	23/01/2016
4	Indications and the maximum dose for Pro Re Nata (PRN) medication was not always recorded.	23/01/2016
5	There was no action plan in place or date for completion for the environmental / hygiene assessment.	23/01/2016

6	Vulnerable adult referrals were not recorded as incidents.	23/01/2016
7	Staff meetings did not occur regularly.	23/01/2016
8	Patients had not signed their occupational therapy assessments and plans.	23/01/2016
9	It was not consistently recorded that patients were offered one to one time. Staff did not always record if they had spoken to the each patient and measured their progress on a daily basis.	23/01/2016
10	Multi-disciplinary team ward round template was not always fully completed.	23/01/2016
Priority 3 recommendations		
11	Not all staff had received up to date mandatory training in the following areas – Cardio Pulmonary Resuscitation (C.P.R), Infection Control, Fire Training, COSHH, manual handling, safeguarding Vulnerable Adults, and child protection.	23/04/2016
12	Seven out of ten trust policies sent to RQIA prior to inspection were out of date and the Operational policy for Carrick 4 was available in draft form.	23/04/2016

Definitions for priority recommendations

PRIORTY	TIMESCALE FOR IMPLEMENTATION IN FULL
1	This can be anywhere from **24 hours to 4 weeks from the date of the inspection** – the specific date for implementation in full will be specified
2	Up to **3 months** from the date of the inspection
3	Up to **6 months** from the date of the inspection

Appendix 1 – Previous Recommendations

Appendix 2 – PEI Questionnaires

This document can be made available on request.

Appendix 3 – Ward Environmental Observation Tool

This document can be made available on request.

Appendix 4 – Quality of Interaction Schedule

This document can be made available on request.

Appendix 5 – Is Care Safe?

This document can be made available on request.

Appendix 6 - Is Care Effective?

This document can be made available on request.

Appendix 7 - Is Care Compassionate

This document can be made available on request.

Appendix 1

Follow-up on recommendations made following the unannounced inspection on 8 & 15 May 2015

No.	Reference.	Recommendations	No of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	5.3.1 (c)	It is recommended that the ward manager conducts audits of safeguarding activity.	3	Inspectors noted that the safeguarding nurse specialist had completed an audit on safeguarding activity during February to April 2015. Following this the ward manager had completed an audit of safeguarding activity every three months. Inspectors noted that safeguarding activity is also discussed at monthly business meetings and with staff at duty handover every morning.	Met
2	4.3.(m)	It is recommended that the ward manager ensure that all staff attend up to date training in the management of patients' monies and valuables.	3	Inspectors reviewed the training records and noted that all staff had attended up to date training on the management of patient's monies and valuables.	Met
3	4.3 (b)	It is recommended that the ward manager ensures that individual patient statements are received from the cash offices in order to verify that transactions are correct.	3	Inspectors reviewed documentation in relation to patient's monies and noted that a copy of each patient's statement was received from the cash offices every month and retained in each patient's financial file. Inspectors also noted that the ward manager completes and documents a weekly safe audit and verifies that transactions were correct.	Met
4	5.3.1 (f)	It is recommended that the ward manager ensures that regular weekly checks of patients' money held against the cash ledger are undertaken and appropriately recorded.	3	Inspectors reviewed documentation in relation to the patient's monies. An audit was completed every week of the amount of money held for each patient in the safe against the cash ledger.	Met

5	4.3 (i)	It is recommended that the ward manager ensures that all patients who use a profiling bed have a clear rationale in their care records supported by a risk assessment and care plan.	1	There was one profiling bed in use on the ward. Inspectors reviewed the care documentation in relation to the patient using the profiling bed. A risk assessment was complete which indicated that there were risks associated with using the profiling bed and the patient should be provided with an alternative bed (ligature free bed). Inspectors were informed that the patient had chosen the profiling bed and due to their clinical need this was agreed. However this was not clearly documented in the patients care plan. This recommendation will be restated for a second time and included in the improvement plan accompanying the report.	Not met
6	5.3.1 (a)	It is recommended that the ward manager ensures that care plans and risk assessments are completed for all new admissions to the ward within a reasonable timeframe. In the interim a multi-disciplinary interim care plan should be devised.	1	Inspectors reviewed care documentation in relation to five patients including the most recent admission. Inspectors noted that each patient had an up to date integrated care pathway and an up to date risk assessment completed.	Met
7	5.3.1 (f)	It is recommended that the ward manager ensures there is a copy of the physical intervention form available in the patient's notes.	3	Inspectors reviewed care documentation in relation to five patients and noted that a copy of the physical intervention form was available in the patients file.	Met

8	5.3.1 (f)	It is recommended that the trust expedite the replacement or repair of the bath on the ward.	1	Inspectors completed an environmental check list and noted that the bath on the ward had been repaired.	Met
9	5.3.1 (a)	It is recommended that the ward manager ensures that care plans no longer applicable to patient care are reviewed and subsequently discontinued.	1	Inspectors reviewed care plans in relation to five patients and noted that all care plans had been reviewed, were up to date and applicable to the needs of the patient.	Met
10	5.3.1 (a)	It is recommended that the ward manager ensures that the integrated care pathway is completed and in place for all patients on the ward.	1	Inspectors reviewed documentation in relation to five patients and noted that each patient had an up to date integrated care pathway completed.	Met
11	5.3.3.(a)	It is recommended that the ward manager ensures that information in relation to the detention process and the mental health review tribunal is included in the patient's individual handbook.	2	Inspectors reviewed the patient's individual handbook and noted that information in relation to the detention process and the mental health review tribunal was included in the patient's handbook. Inspectors observed copies of the handbook were available on the ward and in patient's bedrooms.	Met

HSC Trust Improvement Plan

WARD NAME	**Carrick 4**	**WARD MANAGER**	**John Quinn**	**DATE OF INSPECTION**	**19 – 23 October 2015**
NAME(S) OF PERSON(S) COMPLETING THE IMPROVEMENT PLAN	John Quinn	**NAME(S) OF PERSON(S) AUTHORISING THE IMPROVEMENT PLAN**		Dr Tony Stevens	

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

The areas where improvement is required, as identified during this inspection visit, are detailed in the inspection report and improvement plan.

The completed improvement plan should be completed and returned to team.mentalhealth@rqia.org.uk from the HSC Trust approved e-mail address, by 10 December 2015.

Please password protect or redact information where required.

PRIORTY	TIMESCALE FOR IMPLEMENTATION IN FULL
1	This can be anywhere from **24 hours to 4 weeks from the date of the inspection** – the specific date for implementation in full will be specified
2	Up to **3 months** from the date of the inspection
3	Up to **6 months** from the date of the inspection

Part A

Priority 1: Please provide details of the actions taken by the Ward/Trust in the timeframe **immediately** after the inspection to address the areas identified as **Priority 1**.

Area identified for Improvement	Timescale for full implementation	Actions taken by Ward/Trust	Attached Supporting Evidence	Date completed
Key Outcome Area – Is Care Safe? A ligature risk management plan / schedule of works was not available for this ward on the day of inspection **Minimum Standard 5.3.1 (f)** This area has been identified for improvement for the **first** time.	23 October 2015	Anti ligature audit completed on 19/10/15 sent to Trust estates manager for pricing. Following a meeting on 3/12/15 to discuss work required two minor capital work requests submitted 1 minor works to include ensuites, soap dispensers, towel rails, toilet roll holders .1 x minor works for door handles. Remaining work will require to be raised as a major project and will require a business case being submitted	Anti ligature audit with initial costing minor works forms 1 &2	Minor works End March 2016 Business case financial year with completion of all works March 17
Corporate, strategic and local governance mechanisms / arrangements for the review of incidents and accidents were not available for this ward. **Minimum Standard 4.3 (b)** This area has been identified for improvement for the **first** time.	23 October 2015	A record of all incidents and accidents will be kept by ward manager and nursing admin and will be a standing item on both the business and staff meetings for discussion and review. These meeting are held monthly	Templates for staff and business meeting	23/10/15
Key Outcome Area – Is Care Effective?				

There are no priority one improvements required in relation to effective care.				
Key Outcome Area – Is Care Compassionate? There are no priority one improvements required made in relation to compassionate care.				

Part B

Priority 2: Please provide details of the actions proposed by the Ward/Trust to address the areas identified for improvement. The timescale within which the improvement must be made has been set by RQIA.

Area identified for improvement	Timescale for improvement	Actions to be taken by Ward	Responsibility for implementation
Key Outcome Area – Is Care Safe? Risk assessment and risk management plans had not been signed by the multi-disciplinary team, the patient, or their carer (where appropriate). **Minimum Standard 5.3.1 (a)** This area has been identified for improvement for the **first** time.	23 January 2016	The MDT will review all risk assessment and risk management plans at the team meeting and ensure these are signed by both the team and patients/carers where appropriate. Assessments that are identified with signature missing it will be documented in the MDT record sheet the professional responsible for obtaining the appropriate signatures.	M.D.T
Indications and the maximum dose for Pro Re Nata (PRN) medication was not always recorded. **Minimum Standard 5.3.1 (f)** This area has been identified for improvement for the **first** time.	23 January 2016	Consultants have reviewed the medication Kardexs with the medical team and have updated and corrected indications and the maximum dose for Pro Re Nata (P.R.N) medication is recorded	Consultants Dr Anderson Dr Frances-Naylor
There was no action plan in place or date for completion of findings from the environmental / hygiene check. **Minimum Standard 5.3.1 (f)** This area has been identified for improvement for the **first** time.	23 January 2016	Action plan attached as evidence and date for completion of findings indicated	John Quinn

Vulnerable adult referrals were not recorded as incidents. **Minimum Standard 5.3.2 (a)** This area has been identified for improvement for the **first** time.	23 January 2016	Incident forms will be completed on all vulnerable adult referrals and filed in patient notes	John Quinn
Staff meetings did not occur every month. **Minimum Standard 8.3 (d)** This area has been identified for improvement for the **first** time.	23 January 2016	Dates have been forward planned for the next twelve months Meetings will be on the first Thursday of each month Dates included	John Quinn
Key Outcome Area – Is Care Effective? Patients had not signed their occupational therapy assessments and plans. **Minimum Standard 5.3.3 (b)** This area has been identified for improvement for the **first** time.	23 January 2016	Discussed with occupational Therapist and agreed on completion of assessment and plan these will be signed	Clare Hudson O/T John Quinn
It was not consistently recorded that patients were offered one to one time. Staff did not always record if they had spoken to the each patient and measured their progress on a daily basis. **Minimum Standard 5.3.3 (b)** This area has been identified for improvement for the **first** time.	23 January 2016	This has been highlighted to all staff and is emphasised at daily supervision the importance of documenting one to one time spent with patients. Ward manager conducts audits on patients files to ensure this practice is adhered to.	John Quinn
Multi-disciplinary team ward round template was not always fully completed.	23 January 2016	Discussed at M.D.T ward round and the professional completing the document will ensure all fields are fully	Medical staff

Minimum Standard 5.3.1 (f) This area has been identified for improvement for the **first** time.		completed	
Key Outcome Area – Is Care Compassionate? There are no priority two improvements required made in relation to compassionate care.			

Part C

Priority 3: Please provide details of the actions proposed by the Ward/Trust to address the areas identified for improvement. The timescale within which the improvement must be made has been set by RQIA.

Area identified for improvement	Timescale for improvement	Actions to be taken by Ward	Responsibility for implementation
Key Outcome Area – Is Care Safe? Not all staff had received up to date mandatory training in the following areas – Cardio Pulmonary Resuscitation (CPR), Infection Control, Fire Training, COSHH, manual handling, safeguarding Vulnerable adults, and child protection. **Minimum Standard 4.3 (m)** This area has been identified for improvement for the **first** time	23 April 2016	Those staff requiring updates have been booked to attend relevant training	John Quinn
Seven out of ten trust policies sent to RQIA prior to inspection were out of date and the Operational Policy for Carrick 4 was available in draft form. **Minimum Standard 5.3.1 (f)** This area has been identified for improvement for the **first** time	23 April 2016	The Trust policies are under review with staff identified to take the lead in the review process The operational policy for Carrick 4 is currently under review and will be sent for approval January 2016	Suzanne Meenagh
Key Outcome Area – Is Care Effective? There are no priority three improvements required made in relation to effective care.			
Key Outcome Area – Is Care Compassionate?			

There are no priority three improvements required made in relation to compassionate care.			

Part D

Outstanding Recommendations: Please provide details of the actions proposed by the Ward/Trust to address outstanding recommendations, identified at previous inspections. The timescale within which the improvement must be made has been set by RQIA.

Recommendation	Timescale for improvement	Actions to be taken by Ward	Responsibility for implementation
Key Outcome Area – Is Care Safe? A clear rationale supported by a risk assessment and care plan was not available for one patient who was using a profiling bed. **Minimum Standard 4.3 (i)** This area has been identified for improvement for the **second** time		A risk assessment and care plan were drawn up and are now in the patients file	John Quinn
Key Outcome Area – Is Care Effective? Not outstanding recommendations			
Key Outcome Area – Is Care Compassionate? Not outstanding recommendations			

TO BE COMPLETED BY RQIA

Inspector comment (delete as appropriate)	**Inspector Name**	**Date**
I have reviewed additional information from the Trust and I am satisfied with the proposed actions	Wendy McGregor	6 January 2016