The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Inver 4

Holywell Hospital

Northern Health & Social Care Trust

21 & 22 January 2015

national preventive mechanism

informing and improving health and social care

www.rqia.org.uk

Contents

1.0 General Information

Ward Name	Inver 4
Trust	Northern Health & Social Care Trust
Hospital Address	Holywell Hospital 60 Steeple Road Antrim BT41 2RJ
Ward Telephone number	028 9441 3359
Ward Manager (acting)	Karen Graham
Email address	Karenp.graham@northerntrust.hscni.net
Person in charge on day of inspection	Karen Graham
Category of Care	Mental Health
Date of last inspection and inspection type	8 September 2014, Patient Experience Interview
Name of inspector	Wendy McGregor

2.0 Ward profile

Inver 4 is a 20 bedded dementia intensive care unit situated in Holywell hospital. The purpose of the ward is to provide assessment, treatment and rehabilitation to male and female patients with dementia who have memory problems and who may display behaviours that challenge.

Patients within Inver 4 receive input from a multidisciplinary team which includes psychiatry, nursing, social work, physiotherapy and occupational therapy. Dietetics, dentistry and speech and language services were also available on the ward by referral.

On the days of the inspection there were twenty patients on the ward of which twelve patients were detained in accordance with The Mental Health (Northern Ireland) Order 1986.

The ward environment was noted to be clean, well maintained and clutter free. Male and female sleeping areas were separate. Patients and their relatives could access a number of communal / living areas. There was a private visitors room. Each patient had a memory box situated outside their bedroom, with photos, and memorabilia from hobbies and interests. There were large photos of landmarks from Northern Ireland, which promoted discussion between staff, patients and their relatives. The ward lay out was spacious, which enabled patients to mobilise freely and there was a red hand rail on the wall to support patients with their mobility.

3.0 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).

3.1 Purpose and Aim of the Inspection

The purpose of the inspection was to ensure that the service was compliant with relevant legislation, minimum standards and good practice indicators and to consider whether the service provided was in accordance with the patients' assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

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

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

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

3.2 Methodology

RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the inspection standards.

Prior to the inspection RQIA forwarded the associated inspection documentation to the Trust, which allowed the ward the opportunity to demonstrate its ability to deliver a service against best practice indicators. This included the assessment of the Trust's performance against an RQIA Compliance Scale, as outlined in Section 6.

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.
Specific methods/processes used in this inspection include the following:

- analysis of pre-inspection information;
- 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.

The recommendations made during previous inspections were also assessed during this inspection to determine the Trust's progress towards compliance. A summary of these findings are included in section 4.0, and full details of these findings are included in Appendix 1.

An overall summary of the ward's performance against the human rights theme of Autonomy is in Section 5.0 and full details of the inspection findings are included in Appendix 2.

The inspector would like to thank the patients, staff and relatives for their cooperation throughout the inspection process.

4.0 Review of action plans/progress

An unannounced inspection of Inver 4, Holywell Hospital was undertaken on 21 and 22 January 2015.

4.1 Review of action plans/progress to address outcomes from the previous unannounced inspection

The recommendations made following the last unannounced inspection on 19 March 2014 were evaluated. The inspector was pleased to note that all recommendations had been fully met.

4.2 Review of action plans/progress to address outcomes from the patient experience interview inspection

There were no recommendations made following the patient experience interview inspection on 8 September 2014 were evaluated.

4.3 Review of action plans/progress to address outcomes from the previous finance inspection

The recommendations made following the finance inspection on 2 January 2015 were evaluated. The inspector was pleased to note that one of four recommendations had been fully met. Two of four recommendations were not relevant, as patients money was held in the hospital accounts and not on the ward. Compliance had been achieved in the following areas:

- there was a system that verified clothes and other items purchased for patients were checked against the receipt and received by the patients..

However, despite assurances for the Trust, one recommendation had not been met.

One recommendation will require to be restated for a second time, in the Quality Improvement Plan (QIP) accompanying this report.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection it was good to note that all the recommendations made following the unannounced inspection on 19 March 2014 had been fully met.

The inspector was pleased to observe the level of therapeutic engagement between the multi-disciplinary team and patients during the inspection. Staff were observed communicating with patients and their relatives in a way that promoted dignity, privacy and respect. Staff were observed to be compassionate, understanding and were cognisant of patients' needs in

relation to their dementia. Staff were also observed engaging with patients' relatives and were considerate of their needs and concerns. It was positive to note that the ward operated an open visiting policy with several communal visiting areas as well as a private room. It was also good to note that staff had reviewed the attendance at the carer forum meetings and introduced a new way of encouraging carers to attend a less formal forum by hosting tea party.

The following is a summary of the inspection findings in relation to the Human Rights indicator of Autonomy and represents the position on the ward on the days of the inspection.

Information in relation to capacity and consent was available for patients, relatives and staff on the days of the inspection. This information was available in an easy to read version. Staff had attended training on capacity and consent as part of a two day work shop when the dementia intensive care unit opened. Patients' capacity to consent was assessed on admission, and recorded with relative involvement. Capacity was assessed daily and at least weekly at the multidisciplinary team meetings. A family meeting was convened ten day post admission to discuss relative care and treatment plans. Relatives were encouraged to complete a "life story book" which detailed their family members' values and preferences, likes and dislikes. This information was used to make reasonable adjustments in order to gain to consent. Staff had recorded when the patient did not consent however staff had not recorded how or if they had sought consent before care delivery. Staff demonstrated their knowledge of capacity and consent and their ability to obtain consent, and the action they followed if the patient was not consenting. Staff were mindful that patients' capacity to consent could fluctuate at different times in the day and therefore knew when the best time was to support patients with their care and treatment. The consultant psychiatrist had assessed patients' capacity in relation to their ability to consent to discharge plans and future placements with relative involvement. Relatives indicated they did not have any concerns about their family members' ability to consent. Patients' needs were assessed comprehensively by the multidisciplinary team and assessments were individualised and holistic. There was evidence of patient and or representative involvement in the assessments. A Montessori assessment of abilities and strengths had been completed for each patient. Following assessment appropriate referrals were made to occupational therapy. Assessments were reviewed at patients' multi-disciplinary meetings and changes accordingly made to patients care plans. Patients who had additional needs in relation to their physical health, were referred to a relevant service e.g continence service, tissue viability, speech and language and dietetics.

Care plans were completed for each identified need, however, care plans were generic and therefore not individualised or person centred. Promoting Quality Care risk screening tools were completed and were risks were identified a comprehensive risk assessment had been completed. Risk screening tools and or comprehensive risk assessments were reviewed weekly or earlier if required. Relative and or patients' involvement in the risk assessments was inconsistent. Patients' communication needs were

assessed and reviewed by the multi-disciplinary team with relative involvement. Assessments identified if patients required support with their communication and included reading and hearing checks.

Staff demonstrated how they knew how to actively engage and support patients with their communication. Relatives stated they were always welcomed on the ward and all the members of the multi-disciplinary team were available to speak to them. The inspector also observed this during the inspection**.**

Staff stated they encourage and facilitate family visits on the ward. The ward had open visiting.

Multi-disciplinary assessments involving the patients relatives were completed in relation to therapeutic and recreational activities. Montessori assessments which included coordination, matching skills, and reading were completed. Each patient had a life story book completed by their family which detailed patients, likes, dislikes, preferences, usual routines, and their values. The ward had a designated full time occupational therapist with the support from two occupational technical instructors. Patients were offered a choice of individual and group based, therapeutic activities such as an occupational therapy cognitive activity group, sensory based interventions, reminiscence work, chair based movement and movement to music. Individual activities focused on the previous roles and routines patients' had and still enjoyed e.g. housework tasks, meal preparation, and previous occupations. Relatives were actively encouraged to participate in activities with their family member. Patient participation in activities was recorded by the multi-disciplinary team. Recreational activities were offered to patients on the ward such as a hairdresser visited the ward once weekly, and there was live music once a week for dancing and a sing along. Access to the garden was restricted due to safety issues. The ward sister stated a works request has been submitted to estates. Staff indicated the importance and value they place in facilitating family involvement and promoted ways to encourage family participation in the patients' daily activities. Staff also indicated the value they place on the use of therapeutic and recreational activities and the importance of meaningful patient engagement.

Patients who were detained in accordance with The Mental Health (Northern Ireland) Order 1986 and their next of kin had been informed of their rights. Patients were supported to apply to the Mental Health Review Tribunal. Information in relation to how to make a complaint, and independent advocacy services was displayed in the ward communal areas. Information on how to make a complaint was also detailed in the ward information booklet. The independent advocate visited the ward twice weekly and met with individual patients. The advocate stated that staff make appropriate referrals e.g. discharge planning. The advocate also stated that any concerns raised by relatives have been minor in nature and addressed promptly by the relevant staff.

Complaints, comments and compliments were shared and discussed at the daily debriefing and ward weekly meetings. Relatives stated that staff were always approachable and any concerns were dealt with satisfactorily and promptly.

Five out of 22 staff working on the ward had not received up to date training in the use of physical intervention.

The following restrictions were recorded and observed; exit from the ward was restricted; restricted environments, enhanced observations; and the potential use for physical interventions. Risk assessments were completed in relation to each restriction, with relative involvement. A rationale was recorded for each restriction and restrictions were noted to be proportionate to the risk identified. Proactive strategies and reactive strategies had been recorded. Restrictions were reviewed at the weekly ward meeting or earlier if required. Deprivation of liberty care plans had been completed, however these were noted to be generic and not person centred. A behavioural science approach is used to manage behaviours that challenge. This approach involved the completion of formulations for patients which took into account the patient's life story, personality, hobbies, likes, physical health, mental health, medication environment and neurology. This information was used to develop proactive strategies to reduce the likelihood of behaviours that challenge. Relatives were aware of restrictions on the ward. Staff interviewed demonstrated their knowledge of restrictive practices and Deprivation of Liberty Safeguards (DOLS) - interim guidance (2010).

There were two patients on the ward who had been referred to the resettlement team and there was one patient whose discharge was delayed.

Patients discharge plans were discussed at the first multi-disciplinary meeting and reviewed weekly. Discharge plans along with potential future placements were discussed ten day post admission at the family meeting.

From admission a multi-disciplinary discharge assessment summary was commenced. This assisted with planning for discharge so the patients' needs will be met when discharged from the ward. A formulation on how to best support patients was also completed and shared with staff from identified future placements. Patients whose discharge was delayed discussed at the weekly multi-disciplinary meetings. The independent advocate attended the hospital resettlement meetings.

The nursing services manager informed the inspector they do not report delayed discharges to the Health and Social Care Board.

Consideration to patients' Human Rights Article 3 the right to be free from torture, inhuman or degrading treatment or punishment, Article 5 the right to liberty and security of person, Article 8 the right to respect for private and family life and Article 14 the right to be free from discrimination was documented. Staff demonstrated their knowledge and how they consider patients Human Rights.

Details of the above findings are included in Appendix 2.

On this occasion Inver 4 has achieved an overall compliance level of **substantially compliant** in relation to the Human Rights inspection theme of “Autonomy”.

6.0 Consultation processes

During the course of the inspection, the inspector was able to meet with:

Patients	**Five**
Ward Staff	**Three**
Relatives	**Two**
Other Ward Professionals	**One**
Advocates	**One**

Patients

The inspector met with five patients during the patients indicated they were satisfied with their care and treatment.

Relatives/Carers

The inspector met with two relatives during the inspection. Relatives were positive with their responses, were complimentary about the staff and stated they were happy with the care and treatment their family member received. Relatives stated they felt welcome on the ward and all staff were approachable. Relatives stated that staff were mindful and understanding of their needs and supported them with their roles as carers. Relatives stated they had been invited to multi-disciplinary meetings and were consulted about their family members care and treatment plans. Relatives stated *"the medical care is good and you wouldn't get care like it anywhere else"* and *"staff couldn't be better".*

Ward Staff

The inspector met with three ward staff. Staff indicated they enjoyed working on Inver 4. Staff stated they felt well supported by their peers, the ward sister and the team work was good. Staff stated they were encouraged and supported with professional development. Staff stated the loss of the Montessori nurse made it difficult to provide patients with activities.

Other Ward Professionals

The inspector spoke with the ward occupational therapist. The occupational therapist described her role on the ward. The occupational therapist stated that team work on the ward was good.

Advocates

The inspector met with the independent advocate. Feedback from the advocate was positive in relation to patient care and team work. The advocate stated *"staff were pro-active in looking at new ways of working."* The advocate stated any concerns raised by patients or their relatives were minor in nature and were dealt with promptly and appropriately.

The inspector was disappointed that the additional resource of the Montessori nurse was no longer available. This was addressed with the ward sister and nursing services manager who stated the Montessori nurse continues to work on the ward as a staff nurse and has been absorbed into the staffing numbers. There were no plans to replace this resource.

Questionnaires were issued to staff, relatives/carers and other ward professionals in advance of the inspection. The responses from the questionnaires were used to inform the inspection process, and are included in inspection findings.

Questionnaires issued to	Number issued	Number returned
Ward Staff	25	4
Other Ward Professionals	8	2
Relatives/carers	17	3

Ward Staff

Three out four questionnaires returned stated staff had received training in capacity and consent, human rights and were aware of Deprivation of Liberty Safeguards (DOLS) - interim guidance (2010). Four staff were aware of restrictive practices on the ward. Three out of four staff stated they had not received training in restrictive practices. Two out of four staff stated they had received training on meeting the needs of patients who need support with communication. Three out of four staff stated patients communication needs were recorded in their assessment and care plan. Four staff stated they were aware of alternative methods of communication, these were used in the care setting and the ward had processes in place to meet patient's individual communication needs. Four staff stated the ward had information in a format to meet individual needs in relation to; patient's rights in relation to the Mental Health Order, detention processes, making a complaint and accessing advocacy services. Four staff stated that patients on the ward accessed therapeutic and recreational activities and three out of four staff stated that the therapeutic and recreational activity programmes met patients individual needs.

One staff quoted *"excellent facilities completed with relation to the Montessori ways of working especially in terms of the challenging behaviours displayed".*

Other Ward Professionals

One questionnaire was returned from another ward professional. They stated they had not received training on capacity to consent, human rights or Deprivation of Liberty Safeguards (DOLS) - interim guidance (2010) but a date had been planned. The staff stated they were aware of restrictive practices on the ward and had received training in relation to this The staff stated they had received training on meeting the needs of patients who need support with communication and individual communication needs were recorded in their assessment and care plans. The staff stated they were aware of alternative means and "when appropriate" used in the care setting. The staff stated the ward had processes in place to meet patients' individual communication needs. The staff stated they were aware that information was available in relation to; The Mental Health Order, detention processes, making a complaint and accessing advocacy service but was unsure how many formats these were available in.

Staff quoted; *"All staff members adjust their communication to meet the needs of the patients as far as possible on the ward. There is limited SALT* (Speech and Language Therapy) *input into the ward and it is highly likely that individual communication needs would be better understood and met by all staff with increased input from a specialist clinician in the area of communication such as SALT".*

Relatives/carers

Three questionnaires were returned by patients' relatives. The three relatives stated they felt the treatment their family member had received was excellent. The three relatives stated they had no concerns about their family members' ability to agree / consent. Two out of three relatives stated their family member had been offered the opportunity to be involved in decisions about their care and treatment. All three relatives stated they had been involved in their family members care and treatment. Two out of the three relatives stated their family member did not have an individualised assessment completed in relation to their therapeutic and recreational activity. All three relatives stated their family member took part in therapeutic and recreational activities. Two out of the three relatives stated their family member did not require an assessment of their communication needs. One relative stated their family member did and they did not know if this had happened or if alternative means of communication had not been provided for their family member. Two out of the three relatives stated their family member had not received information in a format to meet their communication needs on the following; The Mental Health Order, detention processes, making a complaint and accessing independent advocacy services. Two of the three relatives stated they had not been informed of advocacy services for them or their family member. Two out of the three relatives stated their family member did not have a person centred discharge plan completed. All three relatives stated they were aware of restrictive practices on the ward. One relative wrote a letter to accompany the questionnaire which was very complimentary

of the staff and the care their family member received. The following are quotes from the relative questionnaires;

"*The ward staff are very helpful*"

"Holywell has been thorough and consistent with my relatives' assessment and care. Both in Tobernaveen and Inver 4. Very relieved and pleased thank you".

"Care outstanding. I have never seen nursing like it. We as a family can go home at night and know our relative will be looked after, the helpfulness of staff is outstanding the cleanness of the ward is something else……the care the nurses have given my relative is outstanding what I see is beyond training. I can say is what my relative gets is just the kind of care they would give their own relatives".

Due to the feedback from the questionnaire a recommendation will be made in relation to patients who require additional support with their communication needs.

7.0 Additional matters examined/additional concerns noted

Complaints

Prior to the inspection the ward submitted a record of complaints from 1 April 2013 and 31 March 2014. The inspector reviewed records in relation to complaints and confirmed that both complaints were in relation to care practice and documented as informal complaints. Both complaints were noted to have been resolved locally.

8.0 RQIA Compliance Scale Guidance

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.

Appendix 1 – Follow up on Previous Recommendations

The details of follow up on previously made recommendations contained within this report are an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Appendix 2 – Inspection Findings

The Inspection Findings contained within this report is an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Contact Details
Telephone: 028 90517500
Email: Team.MentalHealth@rqia.org.uk

Appendix 1

Follow-up on recommendations made following the unannounced inspection on 19 March 2014

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	17 4.3 j	It is recommended that all staff undertake vulnerable adults training as per Trust policy. (1)	Training records reviewed showed that all staff working in Inver 4 had received up to date training in safeguarding vulnerable adults.	**Fully met**
2	17 8.3 k	It is recommended that complaints including locally resolved complaints are consistently recorded as per Trust policy and that this is monitored at team meetings. (2)	The inspector reviewed records in relation to complaints. It was noted that records of formal and informal complaints, compliments and comments were held on the ward. The inspector noted that any complaints are discussed every morning at the debriefing meetings and at the team meetings.	**Fully met**
3	17 8.3 h	It is recommended that information leaflets on the rights of patient to access information held about them are made available for patients and relatives. (2)	Information leaflets to inform patients' and relatives how to access information held about them were available on the ward and in the ward information booklet.	**Fully met**
4	17 6.3.1 c	It is recommended that there is a designated OT for this ward. (2)	The inspector spoke to the occupational therapist (OT). There is now a designated full time OT for Inver 4.	**Fully met**
5	17 8.3 f	It is recommended the ward reviews its method for recording multi-disciplinary meetings so the actions of all disciplines are reflected in the documentation. (1)	The inspector reviewed the minutes of the multi-disciplinary meetings and noted that the actions of all disciplines were reflected in the documentation.	**Fully met**
6	17 5.3.1 f	It is recommended the ward manager ensures that bed rail	The inspector observed the ward environment and noted that bed bumpers were available and used when bed rails	**Fully met**

	24 5.5	bumpers are used when bed rails are in situ. (1)	were in situ.	
7	17 4.3 j	It is recommended the ward manager ensures that staff have sufficient time to complete the Inver Model of Care. (1)	The Inver model includes the Montessori and Newcastle model of care. The inspector reviewed care records in relation to four patients and noted that all patients had an "Inver model of care" completed in all records reviewed. There was a record displayed in the ward office which indicated that all patients had the "Inver model of Care" completed, this incorporates the Montessori model and Newcastle model of care.	**Fully met**

Follow-up on recommendations made following the patient experience interview inspection on 8 September 2014

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	N/A	N/A	N/A	N/A

Appendix 1

Follow-up on recommendations made at the finance inspection on 2 January 2014

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensures that a record of all staff who obtain the key to the safe where patients' money is temporarily stored including the reason for access.	The inspector was informed by the ward sister that patients' money is held in hospital accounts. There was no patient money held on the ward. Therefore this recommendation is no longer applicable.	**Not applicable**
2	It is recommended that the ward manager ensures that a system to verify clothes and other items purchased for patients are checked by ward staff against the receipt and confirmed as received by the patient.	The inspector reviewed care documentation in relation to four patients and noted a record of patients clothing was retained. There were two patients on the ward where staff had purchased clothing. The inspector noted that these items were recorded in the patients records and records maintained in the cash ledger where receipts were reviewed. All receipts were returned to the hospital cash office.	**Fully met**
3	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.	The ward sister informed the inspector that patients' money is retained in the hospital cash office and not held on the ward. Therefore this recommendation is no longer applicable.	**Not applicable**
4	It is recommended that the ward manager ensures that individual patient statements are received from the cash office in order to verify that transactions are correct.	The ward manager stated that they do not routinely request patient statements from the hospital cash office. This recommendation will be restated a second time.	**Not met**

Appendix 1

Follow up on the implementation of any recommendations made following the investigation of a Serious Adverse Incident

No.	SAI No	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	N/A	N/A	N/A	N/A

Quality Improvement Plan

Unannounced Inspection

Inver 4, Holywell Hospital

21 & 22 January 2015

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with the deputy ward sister, consultant psychiatrist and the nursing services manager on the day of the inspection visit.

It is the responsibility of the Trust to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	5.3.1 (c)	It is recommended that the ward sister ensures that individual patient statements are received from the cash office in order to verify that transactions are correct.	2	Immediate and on-going	The ward manager in conjunction with the hospital cash office manager has made arrangements to receive regular statements for inpatients currently under OCP. The ward manager will verify all transactions and will document this outcome in the individual patient's records in the relevant ICP section .
2	5.3.3 (b)	It is recommended that the ward sister ensures that all staff seek consent before supporting or providing any care to the patient. This should be recorded in the patients care records.	1	Immediate and on-going	The practice of seeking consent is embedded as part of person centred practice in Inver 4 as was witnessed and acknowledged by the inspecting officer in the report. Staff have been advised and guided regarding ensuring patient's care records reflect this practice. Posters have been devised and are in place to further promote this practice and remind all staff to record consent or indicators of consent/ implied consent. CEC were involved in this process.
3	6.3.2 (b)	It is recommended that the ward sister ensures that comprehensive risk screening tools and assessments are	1	22 April 2015	The completion process of comprehensive risk screening assessment tools was reviewed by the MDT and more involvement of the patient and

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		completed in accordance with Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010 and patient and relative involvement is documented.			family has been built in to the admission procedure. This will now include a review of the PQC assessment at the first family meeting if it has not been discussed prior to this date. This will be documented as per guidance.
4	5.3.1 (a)	It is recommended that the ward sister ensures that all patients care plans are person centred and incorporate the holistic and individualised needs of the patient.	1	22 May 2015	The ward manager has worked individually with the named nursing staff and MDT to ensure careplans include all personalised information gained during the assessment process, including the life biography work and information from families/others. This has ensured all care plans are person-centred and individualised.
5	5.3	It is recommended that the ward sister ensures that all care documentation is accurate, current, personalised and in keeping with relevant published professional guidance documents including NMC record keeping.	1	22 May 2015	The ward manager has provided staff with the most recent NMC guidelines and has undertaken an audit for record keeping. Outcomes of audits will be discussed at the weekly clinical leads meeting and monthly MDT business meeting, reviewed and any actions taken forward.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
6	4.3 (m)	It is recommended that the ward sister ensures that all staff working on the ward receive up to date training in the use of physical interventions.	1	22 May 2015	Dates have been sourced for all staff who require a MAPA update session. (24/3/15 x 1, 24/3/15 X 1, 26/4/15 X 4, 27/3/15 X 1, 13/5/15 X1). By 13th May 2015 all ward staff on duty will have had their MAPA update training completed. The ward manager has established an updated system to strengthen the monitoring of mandatory training.
7	5.3.1 (a)	It is recommended that the ward sister ensures that care documentation in relation to Deprivation of Liberty is in keeping with Deprivation of Liberty Safeguards (DOLS) – interim guidance (2010). Care documentation is individualised and person centred.	1	22 April 2015	All Deprivation of Liberty Care Plans have been reviewed, are individualised and are person centred in accordance with the DoLs interim guidance (2010).
8	6.3	It is recommended that the ward sister ensures that patients who require additional support with their communication needs are referred to speech and language therapy, and a clear rationale recorded when patients are not	1	22 May 2015	All inpatients who would benefit from additional support with their communication needs will be referred to SLT who will offer edvice to patients, staff and relatives. The SLT has also agreed to provide awareness session for staff.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		referred.			

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

NAME OF WARD MANAGER COMPLETING QIP	Patricia Scullion
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Dr Tony Stevens

Inspector assessment of returned QIP		**Yes**	**No**	**Inspector**	**Date**
A.	Quality Improvement Plan response assessed by inspector as acceptable	✓		Wendy McGregor	**13 March 2015**
B.	Further information requested from provider				