Mental Health Inpatient Inspection Report
22 – 24 November 2016

Tobernaveen Lower

Acute Psychiatric Admission
Holywell Hospital
60 Steeple Road
Antrim
BT41 2RJ

Tel No: 028 94413105
Inspectors: Cairn Magill
Dr Shelagh 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

Tobernaveen Lower is an acute admission ward with 20 beds for acute psychiatric admissions located in Holywell Hospital. The purpose of the ward is to provide assessment and treatment to adult male and female patients who requires care and treatment in an acute psychiatric environment. Patient sleeping accommodation is provided in two and three bedded dormitories and single bedrooms. All dormitories are gender specific. The ward maintains an open door policy. On the days of inspection the main entrance to the ward was open.

On the days of inspection there were 19 patients on the ward and one patient on leave. There were six patients detained appropriately in accordance with the Mental Health (NI) Order 1986. The multi-disciplinary team consisted of nursing, psychiatry, occupational therapy and social work and clinical psychology. At the time of the inspection the occupational therapy and social work services were based full time on the ward. An independent advocacy service and psychology service were available for patients on a referral basis.

3.0 Service Details

Responsible person:	**Mr. Tony Stevens, Chief Executive**
Ward manager:	**Dorothy Mc Gilton**
Person in charge at the time of inspection: Dorothy McGilton	

4.0 Inspection Summary

An unannounced inspection took place over three days on 22- 24 November 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 Tobernaveen Lower was delivering, safe, effective and compassionate care and if the service was well led

Evidence of good practice

Evidence of good practice was found in relation to; assessments of patient's needs; patient involvement in the production of their personalised care plans; regular monitoring of risk assessments and evaluation of care and treatment plans; appropriate reporting of concerns via agreed referral processes; informing patients and carers of their rights.

There was evidence of good discharge planning, good carer involvement, responding compassionately to patient needs, respecting patient's choice and access to independent advocacy support.

There was good governance oversight and audit of medication and care documentation. There were reports of good multidisciplinary working relationships.

The inspectors noted appropriate and timely onward referral of patients requiring specialised assessments.

The supervision of staff was up to date and there was evidence of good leadership in relation to mandatory training needs. There was forward planning for training staff in low level psychological intervention training.

The daily handover/ debriefing was a comprehensive and thorough process.

Medical staff reported that there are excellent relationships with the ward team. There is also input from members from the Eating Disorder Team, Forensic Team, Personality Disorder Team, AHP's and management.

Areas requiring improvement

Areas requiring improvement were identified in relation to the regularity of patient meetings; the delayed response from estates to address issues reported and of patients accessing the kitchen. In some cases PRN medication did not have indications of when it was to be used written in the kardex. Minutes of meetings did not identify specific professionals or disciplines to follow up on agreed actions.

Evening activities are planned and displayed for patients however staff do not record when these activities are cancelled and the reason for this cancellation.

The door to the day room situated in the male corridor was locked on two mornings during the inspection. The inspector requested that the door be open and this was actioned immediately.

The dining room did not have adequate space to accommodate all patients to sit together at meal times as it had four large round tables and three large vending machines. There was very limited room to comfortably accommodate patients who used wheelchairs. Staff reported that this was managed by some patient's choosing to wait until the dining room was less full or by eating in the occupational therapy room. One patient advised that they would have appreciated knowing the fridge in the canteen was available for patients use. Another issue which was reported by a patient to the inspector was in relation to the small selection of gluten free products/ meals available.

The font size of information contained in the patient information leaflet and patient notice board was too small. Whilst regular audits were completed on the wards performance and evidenced positive outcomes these findings were not displayed for patients or members of the public. The inspector was assured that the patient information leaflet and notices regarding the Mental Health Tribunal would be addressed by the Trust.

On the days of inspection the enclosed patio area/ courtyard was unkempt with inappropriately discarded cigarette butts. The ward manager reported that Estates department take

responsibility to tidy it up once a week and some patients who smoke will also take responsibility.

The above issues will not be noted as an area for improvement as they were addressed in feedback and are being actioned by the Trust.

Tobernaveen Lower is an old building An environmental ligature risk screening assessment was completed which highlighted significant anti-ligature works were required to ensure patient safety. Some ligatures are assessed as being locally managed. The cost to improve the environment to make the ward as ligature free as possible has been established and bids submitted and approved. The senior management are in the process of finalising the schedule of works and expects the work to start in January 2017 for completion within 16 weeks. The inspector remains concerned that there are significant risks to patients in the interim.

There was a domestic cleaner on the ward during all three days of the inspection. The inspector was assured that the surface cleaning of the ward was completed. However the ward was old in its construction and there were issues of mould and damp in bathrooms/ en-suites. Staff informed the inspector that these issues were longstanding and every so often a quick fix temporary solution would be applied such as a six monthly steam clean and repainting of affected areas. During the inspection the inspector met with an Estates officer who confirmed that the original plumbing of the ward no longer meets the needs of the ward and the Trust are in the process of planning and putting out to tender for sewage modification works to be updated. The estates officer stated that due to the age of the building and associated sewage works that the Trust anticipates that there will be ongoing issues. The Estates officer further advised that old piping encased in walls had leaks and it was almost impossible to eradicate all leaks throughout the building. Some shower trays leaked and one shower curtain was 2 inches too short. Water seeped out over the tray and eventually ran underneath the flooring causing smells.

RQIA has written to the Department of Health in relation to the three identified concerns highlighting the issues identified and the need for the Northern Trust to have significant investment to address the issues. A new build business case has been in place for some time and requires to be resourced.

Patients said

“The general feeling of the ward it’s quite calm even though they are very busy, the ward is calm”.

“I was told the other day that I would see the doctor but that day has come and gone and I haven’t seen the doctor”.

“The image I had of mental health services is now completely different from having experienced the last three weeks in Tobernaveen Lower.” (Referencing a positive experience)

“There is nowhere to hang clothes in the bathroom. I have to put my dressing gown on top of a bin. The shower leaks very badly. The shower curtain doesn’t come down fully. It is two to three inches short. There is mould in the shower room. I am asthmatic and it is not good for my asthma”.

“I would recommend complimentary therapies as essential especially counselling and aromatherapy”.

“Staff should ask if you are on a special diet. There aren’t enough gluten free snacks”.

“Staff are all very upbeat”.

Staff are very respectful even at night time they keep the noise level to an absolute minimum”.

“The royal blue curtains are very depressing especially if this is all you have to look at”.

“We made Christmas cakes…it was a homely experience… they said they wanted to do things properly and while we were making it we talked about our Christmas experiences”.

“Nordic walking is a brilliant activity the instructor took time to explain the benefit of it for your posture. I was impressed. It’s something new and different”.

“When staff are dealing with an incident they provide a quick response, stay calm and deal with it with a minimum of fuss. They handled it expertly”.

“Staff are very caring and patient. I am very grateful for their expert and compassionate care and support”.

Relatives said…

“The nursing staff and doctors are very professional at the same time as being sympathetic and helpful. They run a very tight ship”.

“I find the staff mostly to be very helpful and friendly. They always make time to talk to me and give me an update regarding my mother’s condition and care plan. I find the nursing staff to be much more helpful and understanding than the doctors as I suppose they are ones that spend most time with her. I am so grateful for the hard work they do and the care they give to my mum, they are amazing”.

Inspectors also spoke with eight members of the multi-disciplinary team; twomembers of medical staff, a registered nurse, a student nurse, a health care assistant, a social worker, a clinical psychologist and the ward manager.

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	Nine

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

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

The escalation policies and procedures are available on the RQIA website.
https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

5.0 How we Inspect

Prior to inspection we review 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 and associated action plans.
- Information in relation to governance, meetings, organisational management, structure and lines of accountability.
- Details of supervision and appraisal records.
- Policies and procedures.

During the inspection the inspector met with two service users, eight staff and one visiting professionals. No service users' visitors/representatives were available.

The following records were examined during the inspection:

- Care documentation in relation to four patients.
- Staff rota.
- Training records.
- Daily Debriefing records.
- Accident and incident logs.
- Safeguarding referrals.
- Kardexes.
- Patient welcome leaflet.
- Ward level complaints and compliments.
- Audit tool for individual Person Centred Care Plans.
- Minutes of staff meetings.
- Policy on Mobile Device use within Psychiatric Inpatient Units.
- Minutes of patient meetings.
- Supervision timetable.
- Records and record keeping audit/ checklist.
- Ligature point risk assessment update.
- Northern Trust Patient safety mental health audit.
- Work requested log.
- Weekly record of the inspection of means of escape.

- Weekly record of fire alarm checks.
- Temperature recordings of medication fridge.

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

We reviewed the areas for improvements/ recommendations/ made at the last inspection. An assessment of compliance was recorded as met/ partially met/ 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

The most recent inspection of Tobernaveen Lower was a follow up unannounced inspection. The completed provider compliance plan / QIP was returned and approved by the responsible inspector. The provider compliance plan / QIP was validated by the inspector during this inspection.

6.1 Review of Areas for Improvement / Recommendations from Last Inspection dated 14 May 2015

Areas for Improvement		**Validation of Compliance**
The responsible person must ensure the following recommendations are addressed;		
Number/Area 1 **Ref**: Standard 5.3.1 (a) **Stated:** First Time	The Trust provides reassurances on the completion of person centred care planning across all wards on the hospital site.	**Met**
	Action taken as confirmed during the inspection: Inspector reviewed the ward audit tool for individual Person Centred Care Plans. This tool is completed on a monthly basis and one file per team (there are four teams in Tobernaveen Lower) are audited on a monthly basis. Results of the last three audits attained 100%. The inspector reviewed four sets of patient care plans and was satisfied that staff were delivering person centred care planning.	
Number/Area 2 **Ref**: Standard 4.3 (m)	The ward manager ensures that all ward based staff are provided with training in Capacity and Consent, Restrictive Practices, Deprivation of Liberty and Human Rights.	**Met**

Stated: First Time	**Action taken as confirmed during the inspection**: The inspector reviewed the training status as of November 2016. All of the above aforementioned training is delivered under the deprivation of liberty training programme. 89% of staff had received their training and 3 members of staff still required training. These members were new to the staff team and were identified on the training schedule waiting for further dates of the training being offered.	
Number/Area 3 **Ref**: Standard 5.3.3 (f) **Stated:** Third Time	The Trust reviews the composition and clinical specialities offered within the multidisciplinary team and the availability of psychotherapeutic interventions to ensure that patients on the ward have access to the full range of evidence based therapeutic interventions to meet presenting needs.	**Met**
	Action taken as confirmed during the inspection: The Northern Trust appointed a consultant clinical psychologist in mid-July 2016. The consultant psychologist advised that she visits Tobernaveen Lower one day a week and sees patients on a referral basis. The Consultant Psychologist has developed a six module training course for staff on acute inpatient psychiatric wards. The Modules are; Building a collaborative alliance; Responding to distressed behaviour; Psychological formulation; Mindfulness; Emotional coping skills; Compassion focused practice.	
Number/Area 4 **Ref**: Standard 5.3.1 (f) **Stated:** First Time	The Trust replaces or repairs the bath on the ward.	**Not Met**
	Action taken as confirmed during the inspection: The inspector was advised that the bath had been repaired. The week prior to the inspection it had stopped working again and a part had been ordered from the bath suppliers. As this recommendation has not been met it will be restated for a second time.	

7.0 Review of Findings

7.1 Is Care Safe?

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

Areas of Good Practice

There was evidence in care documentation that patients were involved in the design and management of their own risk management plans. Where patients could not initially contribute to their risk management plan due to their mental health they were offered opportunities to contribute as and when their mental health improved. It was also recorded on file that some patients refused to participate in their risk management plan however files evidenced that they were continually offered opportunities to contribute on an on-gong basis.

The inspector reviewed four sets of care documentation. All four care plans evidenced that risk management plans were individualised.

It was noted that risk management plans were regularly monitored and reviewed on a frequent basis by members of the multidisciplinary team.

There was evidence in patient files of efforts made to encourage patients to build capacity to self-manage their mental health and anxiety. The evidence also showed consideration to the pace at which patients could begin to take ownership of and management of their symptoms.

All staff who met with the inspector knew who to raise concerns with and what the process was. There were no reports of concerns in relation to patient safety or care outside of those reported in the monitoring of patients mental health which was discussed at zoning meetings as well as recorded in care documentation.

In addition the daily debriefing/ handover file evidenced the sharing of;

- Patient specific information.
- Incidents/ accidents.
- Safeguarding.
- Vulnerable adults.
- Number of new admissions.
- Staffing levels.
- The number of special observations.
- Any infection control issues.

This indicated a focus on patient, environmental and staff safety.

There was evidence of the ward manager reporting concerns in relation to; environmental safety e.g. ripped floor covering in the office, blocked toilets and sinks and low temperatures on the ward.

All staff who met with the inspector advised that they were never required to work beyond their role.

The inspector noted in files patients who were detained in accordance with the Mental Health (NI) Order 1986 had a care plan in place in relation to their deprivation of liberty. Records evidenced that patients were informed of their rights. One patient who disagreed with their detention wished to appeal it and the correct process was followed and a Mental Health Review Tribunal was scheduled to take place.

Care documentation reviewed evidenced patients were informed of and supported to make a complaint if they wished. A review of the ward complaints log evidenced the efforts of ward based staff to locally resolve complaints. Records also evidenced that patients and relatives were made aware of the formal complaints process and procedure.

Compliments received from patients and relatives were also recorded.

Areas for Improvement

The temperature of a medical fridge was not logged/ recorded daily in accordance with the Trust policy. The lock on the medication fridge was broken.

PRN medication did not have an indication of when it was to be used and on some occasions the name of medications were not written in capital letters.

The trust's response to the report of the ripped floor covering was unsatisfactory and this was discussed at feedback. The initial report was made in January 2016. The estates manager reported that the delay was as a result of an error made in submitting a bid for the replacement covering against another ward and the process had to be restarted. The ward manager had tried to make alternative arrangements however the estates manager offered a mat on the last day of inspection to cover the increasing hole in the flooring until it was replaced.

The catering assistant raised a concern regarding patients accessing the ward kitchen in between meal and snack times. Whenever possible the catering assistant has agreed to make tea or coffee for patients outside of these times as long as the catering assistant has completed their other chores. However the catering assistant stated that they sometimes feel uncomfortable with patients who are newly admitted accessing the kitchen due to unknown risks and requested that this practice be stopped as they felt vulnerable on their own.

Number of areas for improvement	Four

7.2 Is Care Effective?

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

Areas of Good Practice

The inspector reviewed four patient care records and noted that all four patients had their needs comprehensively assessed on an ongoing basis with referrals to specialist services when required. Treatment plans were also reviewed regularly.

All care plans reviewed were patient specific and individualised. Patients were consulted on their recovery goals and the inspector noted patient signatures on the care plans. Patients who were not well enough to sign their care plans had this recorded as did patients who disagreed with their treatment plan. Throughout the patient's admission plans were revisited with the patient and staff afforded them opportunities to contribute and be involved. One patient refused to take prescribed medication and this was recorded regularly. Another patient had thoughts that one particular medication was poisoning them. Records show staff engaged with the patient to educate them on the benefits of the prescribed medication.

Care documentation evidenced that patient's needs and treatment plans were delivered in line with current evidence based guidance, best practice standards and defined care pathways. Tobernaveen Lower implements the integrated care pathway. On admission patient's needs are assessed and include Malnutrition Universal Screening Tool (MUST), manual handling, deprivation of liberty and National Early Warning Signs (NEWS) amongst other assessments as needs dictate. The medical inspector reviewed medication and kardex of four patients. All medication was within BNF guidelines and dosage. Occasionally PRN medication did not have the indication noted and some medication was not written in capital letters

Zoning meetings occur daily and the minutes of the zoning meeting are recorded. Those in attendance were noted and the named nurse or primary nurse indicated the date when the patient was informed of the discussion/outcome.

The inspector seen that onward referral to specialist services for specific assessments was evident in the care documentation. Specialist assessments from the respiratory clinic, the physiotherapist, eating disorder teams and personality disorder teams were evident in patient files.

There was further evidence in the review of care plans that the effectiveness of treatment and care plans were being discussed, shared and evaluated with patients and the multi-disciplinary team. Examples included the weight gain of patients and the oxygen saturation levels, patients participation in occupational therapy activities and ability to self -regulate anxiety.

There was strong evidence that discharge planning took place in a timely manner. There was evidence of substantial efforts made in two patient's notes to progress discharge. The two patients had complex needs which required a significant care package and support from community teams. There was evidence of meetings held and telephone conversations with

budget holders and community providers. The social worker also recorded several visits facilitated with patients to view various community settings. Patient's views were recorded and considered.

The ward door was open during inspection. Staff informed the inspector the door is closed from 8pm to 8am for security at night time. Access to outside space is closed from midnight to 8am. Patients are made aware of these times upon admission or as soon as they can absorb and understand the information.

Patients who were detained in accordance with the Mental Health (Northern Ireland) Order 1986 had their rights explained and a copy of this was also held in their care records. A poster outlining their rights was displayed on the patient information board. The inspector noted the font size was not user friendly and asked that this be increased.

Care documentation evidenced ongoing review and consideration of least restrictive interventions. Two patients were under special observations and this was regularly reviewed. In one patient file the length of time the patient was subject to special observations was reduced in line with the patient's progress.

Areas for Improvement

Actions arising from the zoning meeting were recorded however the person responsible for completing an agreed action point often stated "MDT" and did not identify any one member of staff or professional discipline responsible.

Number of areas for improvement	One

7.3 Is Care Compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Areas of Good Practice

Patients reported staff treat them with dignity and respect and that staff respond compassionately to their physical and/or emotional distress.

Patients are given the opportunity to have a representative of their choice and attend any meeting where decisions are made about their care and treatment. One patient's care notes evidenced that their spouse and a patient advocate were in attendance at a meeting to discuss their care, treatment and discharge plan. Although there is no regular formal opportunity for carers or patient's representative to discuss the patient's care and treatment, the medical staff on the ward informed the inspector that if a patient requested to have a meeting this would be facilitated to accommodate the attendance of their carer/representative. Care documentation evidenced in progress notes ongoing liaison with patient families when appropriate. One patient stated they did not want their family contacted and this was respected.

Medical staff reported to the inspector that if a patient's discharge was complex then a meeting would be convened to discuss issues. Relatives, carers and representatives would be invited to this meeting when the patient consented.

Patients are provided with appropriate information to make informed choices about the types of care and treatment options available.

Patients and their representatives are satisfied with the care and treatment provided and how staff treat them from admission to discharge. Two patients who met with the inspector had noted in the patient questionnaire that their mental health has improved since their admission. Both patients stated that their experience of admission was good, staff introduced themselves and showed the patients around the ward and explained the purpose of their admission. They were also given the opportunity to comment on their care.

Patients can access independent advocacy support when required.

Discharge planning was evident in care documentation which also evidenced members of the MDT facilitating meetings with providers, family members and community teams and visits to various units; residential and nursing homes with patients to assist them make an informed decision.

There is information on display about staff whichincludes nursing staff and MDT team.

Patients can access occupational therapy off the ward in Oasis day care facility in the main hospital. There is an occupational therapy room in Tobernaveen Lower. A schedule of activities is displayed on the whiteboard in the room which is open.

There are evening activities scheduled three to four nights of the week and these are listed on the door of the activity room.

On the days of inspection there were cigarette butts in the enclosed patio area which looked unkempt and untidy.

Areas for Improvement

There were no regular patient meetings/ forums. There was no evidence that progress was made on the previous issues raised. The longest gap between meetings was five months.

Nursing staff do not record when evening activities do not happen or the reasons why.

Number of areas for improvement	Two

7.4 Is the Service Well Led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

Areas of Good Practice

All staff who met with the inspector stated they were aware of their roles and responsibilities and what actions they should take in they have a concern. The inspector reviewed the incident and accident book from 1 April 2016 to 21November 2016, the locally held complaints book and all childcare and adult safeguarding referrals log. The incident and accident logs evidenced appropriate reporting. There were three complaints which were locally resolved. All referrals of safeguarding under the vulnerable adults protection from abuse policy and child protection policy appeared appropriate.

There is daily pharmacy input into the ward to; ensure adequate supply of medication; renew kardexes; review medication for new patients admitted to the ward; reconcile with community pharmacies and provides advice. There is also a regular medication audit completed.

The medical inspector examined four kardexes and reported that all medications were prescribed within BNF guidelines and dosages.

Information and oversight of patient plans are subject to monthly audits completed by a member of the nursing team and reported to the Ward Manager. Discharge planning was evident in care documentation

On the daily debrief handover sheet which is pre-populated with items for discussion the following items are covered; new/pending admissions, the number of patients requiring special observations, accidents & incidents, safeguarding issues, infection control, estates issues, staffing levels, courses/ training opportunities, policy development and any learning gained upon reflection.

The inspector reviewed the minutes of the previous three Mental Health &Disabilities Governance Team Meetings. SAI's and other learning issues are captured in the minutes such as General Risk Assessment Northern Trust (GRANT) update, Datix, Policy reviews, joint service user forum, restraint, seclusion and restricted practice, mandatory training, adult safeguarding, risk register, recent reports are discussed as well as professional issues.

The minutes of these meetings are disseminated to ward managers who share the learning with their staff team.

There were a number of audits completed which provided evidence of key performance indicators on;

- Care planning and patient co-production,
- Releasing time to care,
- Cleanliness/hygiene and infection control audits,

- Northern Trust Patient Safety Mental Health audit and
- Records and record keeping Audit checklist.

All members of the multi-disciplinary team reported good working relationships with each other.

Medical staff reported that there is excellent relationship with the ward team and members from the Eating Disorder Team, Forensic Team, Personality Disorder Team, AHP's and management.

The ward had an educational audit completed with a very positive outcome. Tobernaveen Lower can now accommodate six student nurses on placement.

Within the ward there are defined lines of responsibilities and accountabilities assigned to the role of each champion nurses. Health care assistants were aware of the responsibilities and limits of their role. All staff who met with the inspector knew who to address concerns with and who the next person was in the chain of command.

There was good oversight of staff training needs. The ward clerical support had completed a list of staff who required up to date mandatory training. Staff had dates identified and were scheduled to attend training as dates became available.

Areas for Improvement

The outcome of audits were not displayed for patients carers or members of the public visiting the ward to view.

Number of areas for improvement	One

8.0 Provider Compliance Plan

Areas for improvement identified during this inspection are detailed in the provider compliance plan. Details of the provider compliance plan were discussed at feedback, as part of the inspection process. The timescales commence from the date of inspection

The responsible person should note that failure to comply with the findings of this inspection may lead to further /escalation action being taken. It is the responsibility of the responsible person to ensure that all areas identified for improvement within the provider compliance plan are addressed within the specified timescales.

8.1 Areas for Improvement

This section outlines recommended actions, to address the areas for improvement identified, based quality care standards, MHO and relevant evidenced based practice.

8.2 Actions to be taken by the Service

The provider compliance plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed provider compliance plan by 19 January 2017.

Provider Compliance Plan Tobernaveen Lower	
Priority 1	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref: 5.3.1 (f)** **Stated:** First time **To be completed by:** 24 December 2016	PRN medication did not have an indication of when it was to be used and on some occasions the name of medications were not written in capital letters.
	Response by responsible person detailing the actions taken: There will be awareness-raising with the Tobernaveen Ward medical staff, and also with the wider group of trainee doctors in Holywell Hospital who are involved in the generation of PRN prescriptions out-of-hours.
Area for Improvement No. 2 **Ref: 5.3.1 (f)** **Stated:** First time **To be completed by:** 24 December 2016	Temperature of medical fridge was not logged/ recorded daily in accordance with Trust policy. The lock on medication fridge was broken.
	Response by responsible person detailing the actions taken: New clinical room fridge has been ordered and temperatures are being recorded on the fridge currently being used.
Area for Improvement No. 3 **Ref: 5.3.1 (e)** **Stated:** First time **To be completed by:** 24 December 2016	The catering assistant raised a concern regarding patients accessing the ward kitchen in between meal and snack times. Where possible the catering assistant has agreed to make tea or coffee for patients outside of these times as long as the catering assistant has completed their other chores. However the catering assistant stated that they sometimes feel uncomfortable with patients who are newly admitted accessing the kitchen due to unknown risks and asked that this practice be stopped.
	Response by responsible person detailing the actions taken: Catering assistant feels that there was a misinterpretation of facts regarding this issue, and reports that patients do not enter the main kitchen itself, but the dining area. Advised to speak with nursing staff should there be any concerns.
Area for Improvement No. 4 **Ref: 6.3.2 (g)** **Stated:** First time	There was not consistent patient meetings/ forums. There was a gap between meetings of five months. Upon reviewing the minutes of meetings there was no evidence that progress was made on the previous issues raised.
	Response by responsible person detailing the actions taken: A new meeting form is now in use that allows staff to identify actions

To be completed by: 24 December 2016	required from issues raised, and a section where outcome of an issue can be identified. Meetings are being held monthly and a member of the patient user forum is in attendance
Area for Improvement No. 5 **Ref: 5.3.1 (f)** **Stated:** First time **To be completed by:** 24 December 2016	Actions arising from the zoning meeting were recorded however the person responsible for completing an agreed action point often stated "MDT" and did not identify any member of staff or discipline responsible.
	Response by responsible person detailing the actions taken: The appropriate member of staff is identified on the Zoning Sheet and This staff member will complete all actions required.
Priority 2	
Area for Improvement No. 6 **Ref: 5.3.1 (e)** **Stated:** First time **To be completed by:** 24 February 2017	The trusts should ensure damaged flooring is repaired or replaced as and when required.
	Response by responsible person detailing the actions taken: Requisition for flooring had been completed in 2016 a further requisition was submitted 09/02/17 and is with estates manager for action and to identify a date for completion
Area for Improvement No. 7 **Ref: 5.3.1 (f)** **Stated:** Second time **To be completed by:** 24 February 2017	The Trust replaces or repairs the bath on the ward.
	Response by responsible person detailing the actions taken: The plug required for the bath has now been fitted by the Arjo company.
Area for Improvement No. 8 **Ref: 5.3.1 (f)** **Stated:** First time **To be completed by:** 24 February 2017	Nursing staff do not record when evening activities are cancelled or the reasons why.
	Response by responsible person detailing the actions taken: All cancelled activities are recorded with the reason for same.

Area for Improvement No. 9 **Ref: 5.3.3 (j)** **Stated:** First time **To be completed by:** 24 February 2017	The outcomes of audits were not displayed for patients' carers or members of the public visiting the ward to view. **Response by responsible individual detailing the actions taken:** Audits are displayed on the notice board
	Priority 3
	There are no priority three areas of improvement.

Name of person(s) completing the provider compliance plan	Sr Dorothy McGilton		
Signature of person(s) completing the provider compliance plan		**Date completed**	
Name of responsible person approving the provider compliance plan	Oscar Donnelly		
Signature of responsible person approving the provider compliance plan		**Date approved**	24 March 2017
Name of RQIA inspector assessing response	Cairn Magill		
Signature of RQIA inspector assessing response		**Date approved**	7 April 2017

The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower
5 Lanyon Place
BELFAST

BT1 3BT

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