The Regulation and Quality Improvement Authority

Tobernaveen Upper

Holywell Hospital

Northern Health and Social Care Trust

Unannounced Inspection Report

Date of inspection: 8 June 2015

npm national preventive mechanism

informing and improving health and social care

www.rqia.org.uk

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Holywell Hospital

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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 Purpose and Aim of this Inspection

To review the ward's progress in relation to recommendations made following previous inspections.

To review the ward's progress in relation to recommendations made following a serious adverse incident.

To meet with patients to discuss their views about their care, treatment and experiences.

To assess that the ward physical environment is fit for purpose and delivers a relaxed, comfortable, safe and predictable environment.

To evaluate the type and quality of communication, interaction and care practice during a direct observation using a Quality of interaction Schedule (QUIS).

2.1 What happens on inspection

What did the inspectors do:

- reviewed the quality improvement plan sent to RQIA by the Trust following the last inspection(s)
- talked to patients, carers and staff
- observed staff practice on the days of the inspection
- looked at different types of documentation

At the end of the inspection the inspectors:

- 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 any necessary improvements

3.0 About the ward

Tobernaveen Upper is a 24 bedded admission ward set within the grounds of Holywell Hospital. The purpose of the ward is to provide assessment and treatment to adult male and female patients who require care and treatment in an acute psychiatric environment. The ward maintains an open door policy; on the day of inspection the main entrance doors to the ward were open.

On the day of the unannounced inspection there were seven patients detained in accordance with the Mental Health (Northern Ireland) Order 1986.

Patients in Tobernaveen Upper receive input from a multidisciplinary team which incorporates psychiatry, nursing, occupational therapy and social work. A patient advocacy service was also available.

The ward manager was the person in charge of the ward on the day of inspection.

4.0 Summary

Progress in implementing the recommendations made following the previous inspection carried out on 15 and 16 January 2015 were assessed during this inspection. There were a total of 17 recommendations made following the last inspection. 12 of these recommendations had been implemented in full.

Inspectors were pleased to note that patients' care plans were person centered, individualised and regularly reviewed by staff. Patients also had an opportunity to review their care plans. Staff were recording patients' property

and arrangements were in place to safeguard patients' finances. Patients consent was obtained prior to the delivery of care. Patient's human rights were considered. New beds had been fitted in the ward. Inspectors noted a positive improvement with completion of mandatory training. Trust policies and procedures were subject to regular review and inspectors did not identify any policies that required updating or review.

Three recommendations had not been met and two recommendations had been partially met. A new recommendation will be made for one of these and four of the recommendations will be restated for a second time.

There continues to remain no inpatient clinical psychology service available at present. Zoning documentation was not always completed in full. The inspectors identified concerns with the completion of Promoting Quality Care documentation. Records reviewed did not provide the inspectors with the assurances that therapeutic and meaningful activities were being offered on an individualised basis throughout the week to include evenings and weekends. The inspectors noted that there were no profiling's beds on the ward. However the removal of the profiling beds had to date not been reflected in the environmental and ligature risk assessment.

The ward environment was clean and clutter free. There was ample natural lighting, good ventilation and neutral odours. Ward furnishings were comfortable and well maintained. However the inspector was concerned regarding the availability of space in the patient dining area.

On the day of the inspection the inspectors evidenced that the ward was busy although the atmosphere was welcoming and patients presented as being relaxed and at ease in their surroundings. Nursing staff were available throughout the ward and it was positive to note that staff were responsive, attentive and respectful in their interactions with patients.

During the inspection the inspectors spoke to six patients regarding their care and treatment. Patients made positive comments about how they had been treated on the ward.

4.1 Implementation of Recommendations

Seven recommendations which relate to the key question "**Is Care Safe**?" were made following the inspection undertaken on 15 and 16 Januray 2015.

These recommendations concerned the safeguarding of patients' property and finances, care planning for restrictives practices and deprivation of patients' liberty, consideration of patient capacity and consent, use of profiling beds on the ward, staff training needs and the correct completion of promoting quality care (PQC) documentation.

The inspectors noted that five recommendations had been fully implemented:

- Staff had issued guidance to patients and relatives regarding the removal of items of property from the ward.
- The ward manager was auditing patients' finances.
- Care plans were individualised and person centred for the use of restrictive practices.
- Patients' capacity and consent was considered.
- There had been a noted improvement in mandatory staff training

However, despite assurances from the Trust, two recommendations had not been fully implemented. This included concerns identified with the completion of the PQC documentation and the environmental ligature risk assessment had not been updated post removal of profiling beds.

Six recommendations which relate to the key question "**Is Care Effective**?" were made following the inspection undertaken on 15 and 16 Januray 2015.

These recommendations concerned the provision of inpatient clinical psychology services, completion of person centred and individualised care plans, full completion of integretated care plans, review and evaluation of patients' care plans, completion of delegated tasks from zoning meetings and reviewing of trust policies and procedures.

Inspectors noted that four recommendations had been fully implemented.

- The care plans reviewed in each of the four patient's files evidenced individualised and person centred care plans.
- The integretated care plans in each case were fully completed apart from in one file were the interim care plan had not been signed by the admitting doctor.
- Patients' care plans were regularly reviewed and evaluated by the primary nurse in each case.
- A process was in place for reviewing and updating policies and procedures.

However, despite assurances from the Trust, two recommendations had not been fully implemented. There continues to remain no provision of inpatient clinical psychology service. In the case of one of the three patients' files reviewed the inspector noted that on three separate occasions the zoning documentation had not been completed to reflect who was responsible for taking forward the actions from the meeting, there was also no recorded timescale for completion.

Four recommendations which relate to the key question "**Is Care Compassionate**?" were made following the inspection undertaken on 15 and 16 Januray 2015.

These recommendations concerned meeting the needs of patients with an identified communication need, patients being provided with the opportunity to review their care plans, the consideration of patients' human rights and the

provision of activities for patients who do not avail of occupational therapy services.

The inspector noted that three recommendations had been fully implemented.

- Person centred care plans were noted to be in place for those patients with an identified communication need.
- There was evidence that patients were provided with an ongoing opportunity to review their care plans throughout their admission.
- Patients subject to any restrictive practice or deprivation of liberty had their human rights considered.

However, despite assurances from the Trust, one recommendation had not been fully implemented. Inspectors were informed by patients and staff that there were not always enough staff to facilitate recreational and therapeutic activities as a result activities were often cancelled. However this had not been documented. The provision of activities was subject to change due to the prioritising of other patient care and treatment needs. Inspectors reviewed the records for the provision of activities. Inspectors were concerned to note that the activity records had also been used to record personal information regarding care delivered to individual patients. Records reviewed did not provide the inspectors with the assurances that therapeutic and meaningful activities were being offered on an individualised basis throughout the week to include evenings and weekends.

The detailed findings from the follow up of previous recommendations are included in Appendix 1

4.2 Serious Adverse Incident Investigation

A serious adverse incident (SAI) occurred in this ward on 17 December 2014. Inspectors reviewed the Trust's progress in addressing recommendations made regarding ward practices following theTrust's investigation of the SAI.

The Trust had determined that as a result of the SAI a review of prescribing arrangements for individuals prescribed opiate substitute therapy on their discharge from acute psychiatric units was required. This would include the need for written communication between services and the need for a home safety plan for individual's being discharged with take home doses of opiate substitute therapy.

The Trust reassured inspectors that a copy of guidelines had been created following this SAI. The Trust agreed to provide inspectors with a copy of the guidance post inspection. Despite two requests the information was not provided.

5.0 Ward Environment

"A physical environment that is fit for purpose delivering a relaxed, comfortable, safe and predictable environment is essential to patient recovery and can be fostered through physical surroundings." Do the right thing: How to judge a good ward. (Ten standards for adult-in-patient mental health care RCPSYCH June 2011)

The inspector assessed the ward's physical environment using a ward observational tool and check list.

Summary

On the day of the inspection inspectors noted that staffing levels were appropriate to the assessed needs of the patient group. The main ward areas were clean and clutter free and the atmosphere was relaxed and welcoming. Staff were available throughout the ward and patients could access the support of a staff member as required. Patients' bedroom areas were noted as being well maintained and the bathrooms were clean and odour free.

It was good to note that patients could move freely throughout the ward and could access quiet spaces including the ward's garden area as required. The ward's notice boards were well maintained and included information on how to make a complaint, the advocacy service and the names of the nursing staff on duty.

Inspectors were concerned that the ward's dining area could only seat 16 patients despite the ward providing care and treatment to 24 patients. Inspectors also noted that the ward's back corridor linking it to the centre and lower wards required cleaning. Recommendations regarding both these issues have been made and are stated in the quality improvement plan accompanying this report.

The detailed findings from the ward environment observation are included in Appendix 2.

6.0 Observation Session

Effective and therapeutic communication and behaviour is a vitally important component of dignified care. The Quality of Interaction Schedule (QUIS) is a method of systematically observing and recording interactions whilst remaining a non- participant. It aims to help evaluate the type of communication and the quality of communication that takes place on the ward between patients, staff, and visitors.

Inspectors completed observations using the QUIS tool during the inspection and assessed whether the quality of the interaction and communication was positive, basic, neutral, or negative.

Positive social (PS) - care and interaction over and beyond the basic care task demonstrating patient centred empathy, support, explanation and socialisation

Basic Care (BC) – care task carried out adequately but without elements of psychological support. It is the conversation necessary to get the job done.

Neutral – brief indifferent interactions

Negative – communication which is disregarding the patient's dignity and respect.

Summary

Inspectors completed observation of interactions between staff and patients/visitors throughout the day of the inspection. The outcome of these interactions were as follows:

Positive	Basic	Neutral	Negative
100%	0%	0%	0%

Inspector's observations evidenced positive interactions between patients and nursing staff. Inspectors noted that staff were continually available throughout the ward and responded to patients' requests promptly. Inspectors witnessed that staff remained supportive and reassuring to patients throughout the day.

Although the ward was busy with numerous patients and staff coming and going, patients remained relaxed and at ease. Staff were observant and communication between patients and staff were informal, relaxed and friendly. Nursing staff and members of the ward's support staff demonstrated a high level of skill and compassion during their interactions with patients.

The detailed findings from the observation session are included in Appendix 3.

7.0 Patient Experience Interviews

Inspectors met with six patients. One of the patients had been admitted to the ward in accordance to the Mental Health (Northern Ireland) Order 1986. Patients generally reflected positively on their relationships with staff. Patients informed the inspectors that they had been informed of their rights and that they felt safe on the ward. Two patients recorded that when they did not feel safe they could talk to staff.

Each patient reported that they had been involved in planning their care although three patients felt they had not been fully involved. Patient's responses indicated that they felt care within the ward was effective although

communication with ward staff and the availability of activities could be improved.

Patient's experience of their admission was good although one patient reported that they felt staff did not always listen to them. Patient's comments included:

"Staff are wonderful";

"Staffs very, very friendly they go out of their way to help you…they are more than helpful";

"The wards unbelievable…remarkable";

"This ward has helped my mood slightly…I really like my Doctor";

"Staff are really nice nurses couldn't be better";

"I think the ward is limited for space".

The detailed findings are included in Appendix 4.

8.0 Other areas examined

During the course of the inspection the inspector met with:

Ward Staff	**4**
Other ward professionals	**2**
Advocates	**0**

Inspectors met with one member of nursing staff, two student nurses and three members of hospital and ward management team, including the ward manager, on the day of inspection. Staff who met with inspectors did not express any concerns regarding the ward or patients' care and treatment other than those matters identified from the inspection.

Student nurses informed inspectors that they had been well supported during their placement. Both reflected positively on the ward environment and on the quality of care and treatment provided to patients.

The inspection was unannounced. No advocates were available to meet with the inspectors during the inspection.

9.0 Next Steps

A Quality Improvement Plan (QIP) which details the areas identified for improvement has been sent to the ward. The Trust, in conjunction with ward

staff, must complete the QIP detailing the actions to be taken to address the areas identified and return the QIP to RQIA by 3 August 2015.

The lead inspector will review the QIP. When the lead inspector is satisfied with actions detailed in the QIP it will be published alongside the inspection report on the RQIA website.

The progress made by the ward in implementing the agreed actions will be evaluated at a future inspection.

Appendix 1 – Follow up on Previous Recommendations

Appendix 2 – Ward Environment Observation
This document can be made available on request

Appendix 3 – QUIS
This document can be made available on request

Appendix 4 – Patient Experience Interview
This document can be made available on request

Appendix 1

Follow-up on recommendations made following the announced inspection on 15 and 16 January 2015

No.	Reference.	Recommendations	Number of time stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	5.3.1 (a)	It is recommended that the ward manager ensures that care-plans are person-centred and individualised.	3	The inspectors reviewed the care files for four of the 24 patients on the ward. In each case the inspectors noted that care plans were individualised and person centred.	Met
2	5.3.1 (c)	It is recommended that the ward manager ensures that all items brought into the ward on admission that are removed by relatives are recorded. Record of receipt by the relative should be obtained.	2	The inspectors noted posters displayed at ward level advising patients, relatives and visitors of their responsibility to inform staff should items of property be removed from the ward.	Met
3	5.3.1 (c)	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.	2	From May 2015 cash statements have been provided to the ward from the cash office. The inspectors reviewed a sample of the statements and could confirm that these are audited monthly by the ward manager. A receipt is returned to the cash office to confirm that the statements have been checked and are correct.	Met
4	5.3.1 (f)	It is recommended the ward manager ensures all case notes including Integrated Care Plans (ICP) are completed in full. All patient referral forms and multidisciplinary records should be signed by the relevant staff.	1	In the three of the four care files reviewed the inspectors could confirm that the integrated care pathway (ICP) was completed in fully on each occasion. However in one file on an isolated occasion the inspectors noted that the interim care plan had not been signed by the admitting doctor, the ward manager agreed to follow this up.	Met

5	5.3.3.(f)	It is recommended that the Trust reviews the composition of 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.	1	Following discussion with ward management the inspectors were informed that there continues to remain no inpatient psychology service available. The inspectors however were provided, during a recent inspection of another ward on the hospital site, with a copy of a paper which sets out the proposals to fund a clinical psychology inpatient service in Holywell as part of 2015/2016 service developments. Despite this a commencement date for inpatient clinical psychology was not available. This recommendation will be restated for a second time	Not met
6	5.3.1 (a)	It is recommended that the ward manager ensures that a care plan is in place and regularly reviewed for any patient subject to any individual restriction, blanket restriction or deprivation of liberty. This should be discussed and agreed where possible with the patient and documented accordingly.	1	The inspectors reviewed the care files for four patients. A review of care files provided evidence that any form of restrictive practice or deprivation of liberty was considered on an individual basis with focus on blanket and individualised restrictions. There was evidence of discussion and agreement with the patient in each case where possible.	Met
7	5.3.1 (a)	It is recommended that the ward manager ensures that a person centred care plan is in place for all patients with an identified communication need.	1	The inspectors reviewed the care file for two patients whose first language was not English. A review of the patients' files evidenced an individualised care plan in place for each patient. Arrangements to support and facilitate communication needs were well documented.	Met
8	8.3 (j)	It is recommended that the ward manager ensures that	1	The inspectors reviewed the care files of four patients currently on the ward. A review of the records did not	Met

		patient's assessments, care plans and continuous nursing notes are reflective of the patient's capacity to consent to care and treatment.		identify any concerns associated with patients in relation to their capacity to consent. During the course of the inspection staff were observed obtaining patient consent prior to delivery or assistance with care needs.	
9	5.3.1 (a)	It recommended that the ward manager ensure that all patients care plans are reviewed as prescribed by the named nurse. Reviews of care plans should ensure that care plans are evaluated and that the outcome of goals is being assessed.	1	A review of the four patients' files evidenced that care plans in each case were regularly reviewed with a detailed summary in each case throughout the patient's admission.	Met
10	5.3.1 (a)	It is recommended that all members of the multi-disciplinary team, with delegated tasks following a Zoning meeting, ensure that tasks are completed. Where this is not achieved an explanation should be clearly documented in the patients notes.	1	The inspectors reviewed the care files and zoning documentation for four patients. The inspectors can confirm that in three of the four files zoning documentation had been completed in full. However in one of the three patients' files the inspector noted that on three separate occasions the zoning documentation had not been completed to reflect who was responsible for taking forward the actions from the meeting, there was also no recorded timescale for completion. This recommendation will be restated for a second time	Not met
11	5.3.3 (b)	It is recommended that the ward manager ensures that patients previously unable to review their care plans are	1	The inspectors could confirm from the review of the four patients files that in each case the care plans had been signed by the patient or a reason recorded for no signature. There was evidence of	Met

		provided with an ongoing opportunity to review their care plans as their mental state improves. This should be recorded and/or signed by the patient.		opportunities provided for patients to sign their care plans at a later date.	
12	5.3.1 (a)	It is recommended that the ward manager ensures that patients' care plans reflect consideration of the Human Rights Act, particularly for those patients that are subject to any form of restrictive practice.	1	The inspectors reviewed the care files for four patients. There was evidence that any form of restrictive practice or deprivation of liberty was considered on an individual basis with focus on blanket and individualised restrictions. Where this occurred consideration of respective human rights articles had been recorded.	Met
13	4.3 (i)	It is recommended that the trust urgently review the continued use of profiling beds on the ward. The outcome of the review should be clearly reflected in the environmental and ligature risk assessment.	1	The inspectors noted that there were no profiling beds on the ward. The inspectors were informed that the removal of the profiling beds had to date not been reflected in the environmental and ligature risk assessment. This was scheduled for 1 July 2015. A new recommendation will be made in relation to this.	Partially met
14	4.3 (m)	It is recommended that the ward manager ensures that all staff complete up to date mandatory training which includes; fire awareness; moving and handling; management of behaviours that challenge; Cardio-pulmonary resuscitation (CPR); Infection control;	1	Inspectors reviewed the staff training records for all nursing staff currently working on the ward. Inspectors were pleased to note that improvements had been made regarding number of staff with up to date mandatory training. Staff had attended training on capacity and consent; restrictive practices; deprivation of liberty; and human rights. Where there were staff with out of date training the inspectors review evidence in each case of scheduled training dates. The inspectors were further advised that since	Met

		Control of Substances Hazardous to Health (COSHH); and, Child Protection. The trust should also ensure that all ward based staff are provided with training in: Capacity and Consent; Restrictive Practices; Deprivation of Liberty; and, Human Rights.		the last inspection a weekly training meeting is convened with all ward managers, nursing service managers and the education facilitator. This allows each ward manager to discuss their teams training needs and for arrangements to be made to meet any identified gaps.	
15	6.3.2 (g)	It is recommended that the ward manager provides an opportunity for structured recreational activity for those patients who do not avail of OT services; this should consider the individual needs and views of the patients.	1	The occupational therapy (OT) notice board detailed the activities available for the fifteen patients involved with the ward's OT service. The patient information notice board displayed two activities available to patients on the day of the inspection. Inspectors were informed by patients and staff that there was not always enough staff to facilitate recreational and therapeutic activities. As a result activities would often be cancelled however it was not evidenced that this was being documented. The provision of activities was subject to change due to the prioritising of other patient care and treatment needs. The inspectors reviewed the records for the provision of activities. Inspectors were concerned to note that the activity records had also been used to record personal information regarding care delivered to individual patients. Records reviewed did not provide the inspectors with the assurances that therapeutic and meaningful activities were being offered on an individualised basis throughout the week to include evenings and weekends.	Partially met

				This recommendation will be restated for a second time	
16	5.3.1 (f)	It is recommended that the Trust ensures all policies and procedures are subject to a systematic and comprehensive three yearly review.	1	The inspectors met with the ward manager and other senior hospital managers who advised that the hospital convenes a monthly policy group meeting which is chaired by one of the nursing services managers. The monthly meeting provides a forum to review polices that have expired or are nearing expiry/review. When a policy requires reviewing or updating a working group is then set up to oversee the update. The inspector did not identify any policies that required updating or review.	Met
17	5.3.1.(a)	It is recommended that the ward manager ensures that all risk Screening tools are completed in accordance with the Promoting Quality Care (PQC) - Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services.	1	The inspectors reviewed the PQC documentation in four patients' files. The inspectors were concerned to note that in one of the patient's files there was evidence of the PQC documentation being regularly reviewed however the comprehensive risk assessment or the risk screening tool could not be located within the patient's files. In the other three patient's files the inspectors noted that in each case the risk screening tool had not been signed by the patient and in two of the files had not been signed by the registered nurse. In the same three files the inspector noted that the 'further action necessary' section of the risk screening tool had not been completed. This recommendation will be restated for 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)
1	SAI-15-03	A review of prescribing arrangements for individuals prescribed opiate substitute therapy on their discharge from acute psychiatric units is required. This will include the need for written communication between services and the need for a home safety plan for individual's being discharged with take home doses of opiate substitute therapy.	The trust reassured the inspector that a copy of guidelines had been created following this SAI. The trust agreed to provide the inspector with a copy of the guidance post inspection. Despite two requests the information was not provided.

Quality Improvement Plan

Unannounced Inspection

Tobernaveen Upper, Holywell Hospital

8 June 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 ward manger and other senior hospital managers on the day of inspection.

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
Is Care Safe?					
1	5.3.1.(a)	It is recommended that the ward manager ensures that all risk screening tools are completed in accordance with the Promoting Quality Care- Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services.	2	Immediate and ongoing	Risk assessments are fully completed as per Regional Guidance. The risk screening tool is reviewed and updated or completed on admission for all patients. They are reviewed weekly at zoning meetings and more frequently as required. Audited weekly by Ward Manager or Assistant Ward Manager .On discharge the updated risk screening tool is forwarded to the relevant key worker. .
2	4.3 (i)	It is recommended that the trust update the environmental ligature risk assessment for the ward following the management and removal of profiling beds.	1	3 August 2015	Updated ligature audit will be completed on 11th August 2015, a copy of which will be forwarded to RQIA by 18 August 2015.
3	5.3.1(e)	It is recommended that the ward manager ensures that the corridor interlinking the ward to Tobernaveen centre remains clean and clutter free.	1	Immediate and ongoing	Corridor now fully clear, clean and clutter free. Checked on a regular basis.

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

Is Care Effective?					
4	5.3.1 (a)	It is recommended that all members of the multi-disciplinary team, with delegated tasks following a zoning meeting, ensure that tasks are completed. Where this is not achieved an explanation should be clearly documented in the patient's notes.	2	Immediate and ongoing	Zoning sheets reviewed weekly by nurse in charge. Identified tasks are allocated at the zoning meeting. If these are not completed they are followed up and a rationale is recorded. Previous MDT Zoning Team Meeting Form 1's are reviewed at the beginning of each zoning meeting.
5	5.3.3.(f)	It is recommended that the Trust reviews the composition of 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.	2	31 December 2015	Funding approved for an In-patient Psychologist and is currently in the process of recruitment. Nursing staff are currently receiving training in WRAP, Depression and Anxiety self-help programme are available for appropriate patients. Short courses i.e. Motivational Interviewing, Psychotherapeutic Interventions are being offered to staff via CEC, commencing Autumn.
Is Care Compassionate?					
6	6.3.2 (g)	It is recommended that the ward manager provides an opportunity	2	31 August	Structured activities offered evenings and weekends depending on patient requests and ward situation. Patient

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

		for all patients to attend structured therapeutic/recreational activities which includes evenings and weekends. This should consider the individual needs and views of the patients.		2015	safety obviously a priority so at times with staffing restrictions activities may not be available. Information is displayed to inform patients in the event of cancellation.
7	5.3.1 (e)	It is recommended that the Trust reviews the ward's dining area and ensures that there is adequate space and seating to meet the needs of all patients admitted to the ward.	1	31 August 2015	Ward dining area has been reviewed with NSM and at present no possibility of building work to extend dining room. Vending machine relocation has also been considered but no other location available, patients are also keen to maintain them in dining area to allow for coffee/snacks with relatives. There are always a number of patients who enjoy their meals when dining area is less busy and are happy to wait. This is discussed regularly at patient/staff meetings. We do not currently have any complaints Consideration has been given to more spacious dining areas in the Outline Business Case for a replacement Mental Health Inpatient facility.

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	Janette Acton
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Tony Stevens

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