Mental Health Inpatient Inspection Report
7-9 February 2017

Clare Ward
Knockbracken Health Park
Saintfield Road
Belfast
BT8 8BH
Tel No: 028 90638448

Inspectors: Cairn Magill and Dr Shelagh Mary Rea

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of Service

Clare ward is a 20 bedded mixed gender ward located in the Knockbracken Health Care Park site. The purpose of the ward is to provide ongoing care and treatment to patients with chronic, long-term complex mental illnesses. Clare ward also has a role in preparing patients for discharge into the community.

The multidisciplinary team consists of nursing staff and health care assistants, a consultant psychiatrist, a general practitioner, an occupational therapist (OT) and an occupational therapy technician, a social worker and a recently appointed consultant clinical psychologist.

There were 15 patients on the ward during the days of inspection. All 15 patients were detained under the Mental Health (NI) Order 1986. There were 10 male patients and five female patients. Each patient had their own bedroom with on suite facilities. There are two corridors which are gender specific.

3.0 Service Details

Responsible person: Martin Dillon
Ward manager: Karen McGovern
Person in charge at the time of inspection: Declan McCusker on 7 February 2017 Karen McGovern on 8 & 9 February 2017

4.0 Inspection Summary

An unannounced inspection took place over three days on date from 7-9 February 2017.

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 Clare ward was delivering, safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to information shared with patients on their rights following their detention under the Mental Health (NI) Order 1986, patient's risk assessments were thorough and reviewed regularly, there was good evaluation of care plans and good multi-disciplinary working relationships, patients reported staff treated them with respect and dignity and responded to their needs in a compassionate timely manner.

Areas requiring improvement were identified with regards to maintaining up to date "live" documents such as the ward ligature risk assessment, the ward fire risk assessment and the management of patients smoking on the ward. Staff at all levels on the ward and senior managers are aware that there are one or more patients who consistently breach the no smoking policy and smoke on the ward. Patients conceal cigarettes and means of lighting cigarettes on their person, sometimes in intimate areas or others smuggle lighters and cigarettes to them. Patients refuse to cease smoking on the ward and staff struggle to enforce this policy as one particular patient's mental illnesses is such that they have no regard for the policy at times when they are acutely unwell. The search policy and prohibited items policy are

promoted however intimate searches of patients are prohibited. The trust is taking urgent action to ensure adherence to the no smoking policy.

There was inconsistency in the thoroughness of care plans and an absence of care plans for some physical health care needs.

There was an issue among staff in understanding the shared vision of the ward. Staff reported feeling unsettled as it was unclear on the future purpose or function of the ward. In meeting with senior members of the Trust it was evident that there was no definitive, clear strategic plan for the ward. This issue was discussed at length during feedback. It was acknowledged that a strategic direction is required so that adequate planning for the ward can be made. Clare ward is one of many that are being considered to be designated as one of three sub-regional low secure wards. However the Department of Health have not made a decision in relation to the status of Clare Ward as a sub-regional low secure unit.

Staff reported that there was a lack of cohesiveness within the nursing team which some staff stated is in part, attributed to the experience and culture of staff who came from two very different wards with different ethos, purpose, culture and practice coming together. Staff reported to the inspector that whilst there was an issue amongst nursing staff everyone was courteous to and respected one another. The ward and senior managers are aware of this issue and are working towards building a cohesive nursing team.

The inspector was informed by staff that Clare Ward previously had a higher ratio of male patients compared to female patients. At that time, rooms were allocated according to need. In more recent years a decision was made to have an even split of 10 male and 10 female patients and following a reconfiguration of the ward, corridors became gender specific. Occupancy levels show that there is 100% occupancy in the male assigned corridor and 50% or less occupancy of female inpatients at any one time. There was a disparity of rooms and room sizes available for male and female patients. During this inspection the inspector observed a number of rooms which were underutilised. During feedback the Trust agreed to review the assignment of rooms to ensure there is adequate space to accommodate ward based activities, sufficient quiet rooms for male and female patients and to accommodate visitors.

<u>Patients</u>

Five patients met with the inspector and four patients completed the patient questionnaire. Three of the four patients stated that they felt safe and secure on the ward and one patient stated that they sometimes do not feel safe but once they get an opportunity to speak with staff they feel reassured.

One patient stated *"staff can be nasty sometimes".* When the inspector sought to clarify what the patient meant by this statement and asked for an example of an incident where staff are nasty, the patient stated; *"Sometimes it's their attitude". Some patients get stopped going into the kitchen and some staff won't open it and others do. Some staff take things more in their stride than others do".* The patient concluded that there was a difference in approach amongst staff.

An area for improvement will not be made in relation to this however the different approaches by staff were discussed with the senior management team.

One patient stated that it was hard to get time to talk with a nurse; *"sometimes it's hard to get time to talk about the things in your head. If you don't get time to express yourself. Sometimes things are not the same as in your head".* The patient explained that there are times when the patient may wish to speak to a nurse and the nurse may have other duties to complete.

All patients stated that staff do respond compassionately when they need help and that staff always seeks their permission before supporting them with any aspects of their care and treatment.

Patients were generally happy with the food available although one patient stated *"It would be nice to see more things on the menu. Staff and patients have takeaways on Fridays. Sometimes I am hungry during the day it would be nice if I was allowed to order from a takeaway. I sometimes sleep in or if I go off the ward and I have missed the meal when I come back in."* This patient stated they would like more rehab work in the kitchen and asked that the rehab kitchen doors remain open so that patients would not have to wait for it to be opened at certain times.

Another patient stated they would like if there were more activities to do on the ward and if they could go out shopping more.

Relatives

One relative met with the inspector. The relative reported that they were very happy with the care and treatment of their relative. They stated that all staff is approachable and they stated they believed their relative was treated with privacy and dignity and was receiving the "best treatment they can get". The relative stated they disagreed with the no smoking policy and stated their relative's only enjoyment in life is cigarettes. Given the hospital has been the patient's home for over the past ten years the relative stated *"It is unfair. If they take that away from XXX what have they left?".*

Staff

Nine staff and one visiting professional met with the inspector. Five staff completed the questionnaire. The remaining four staff discussed issues with the inspector. Two staff reported that there was a clique amongst the nursing team. The inspector sought to ascertain how this arose and why this might be so. Staff reported that the clique did not impact on patient care rather it affected the cohesiveness of the nursing team. Other staff members reported an awareness of this lack of cohesiveness among nursing staff but stated it did not affect overall working relationships with other members of the multi-disciplinary team. All staff including the ward and deputy ward manager was aware that there was a lack of cohesiveness and that they were proactively working towards enhancing the team morale.

All staff were aware of their role and responsibilities and knew how to raise any concerns. All nursing staff had regular supervision. All staff reported that the multi-disciplinary team worked well together and that the structure of the multi-disciplinary team meetings were conducted in a patient focused, comprehensive, human rights based approach.

The patient advocate highlighted that patients had reported they were often bored at weekends and some patients found the lack of activities and outings prolonged the weekend. The

patient's advocate also stated that there were patients who stated they were feeling frustrated at the lack of community care options for them to move on to.

The patient's advocate reported that patients were having a challenge with the rotation of the OT every 12 months. The advocate stated the rotation affected the relationships with patients who had to continually build working relationships with each new therapist on an annual basis. The relationship with the OT was time limited and they were then rotated and a new OT was assigned to the ward.

The inspector noted that there were a number of patients on Clare ward who did not require ongoing hospital based treatment. It was acknowledged that there were a number of patients who had chronic long-term enduring severe mental health conditions however whilst these patients continue to receive treatment this could be delivered in specialised community based settings. Some patients had lived a decade or more of their lives in hospital setting. The inspector will write to the Department of Health to highlight the need for more appropriate community based settings for this group of patients.

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	Thirteen

Findings of the inspection were discussed with the ward manager and senior managers 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

The inspection was underpinned by:

- 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.

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

IN027068, Unannounced Inspection Report, Clare Ward

- The operational policy and 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 five service users, nine members of staff, one visiting professionals and one service users' visitors/representatives.

The following records were examined during the inspection:

- Care documentation in relation to three patients.
- Staff rota.
- Training records.
- Minutes of ward meetings
- Patient Kardexes
- Audits

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 (if required). 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

6.1 Review of Recommendations from the Most Recent Inspection dated 24/08/2015

The most recent inspection of Clare ward was an unannounced type inspection. The completed Quality Improvement Plan QIP was returned and approved by the responsible inspector. This QIP was validated by the responsible inspector during this inspection.

6.2 Review of Recommendations from Last Inspection dated 24 August 2015

Recommendations		Validation of Compliance
Number/Area 1 **Ref**: Standard 4.3 (i) **Stated:** Second Time	The responsible person must ensure that the Trust review the ligature risk assessment for the ward and consider the replacement of the water taps on the communal bath. Also the water taps within those patients' ensuite bathrooms where taps present as a risk.	**Met**
	Action taken as confirmed during the inspection: Inspector confirmed that the water taps on the communal bath were replaced with anti-ligature taps as were the taps in the 20 ensuite bathrooms. The ligature risk assessment needs to be updated to take cognisance of the work undertaken to date. Whilst work was completed to address this recommendation a new area of improvement will be made in relation to updating the risk assessment to accurately reflect the current ligature risks on the ward. Care plans for cables in rooms and the management of patients who self-harm sample risk assessments were forwarded to RQIA on 23 February 2017. These will enhance the management of risks identified in the ligature risk assessment.	
Number/Area 2 **Ref**: Standard 8.3 (h) **Stated:** Second Time	It is recommended that the ward manager reviews the current storage and maintenance of patients' paper care files to ensure that information is securely stored within each patient's file.	**Met**
	Action taken as confirmed during the inspection: Inspector confirmed that patient paper care files were stored securely. The Belfast Trust has moved to the Patient Record Information System PARIS an electronic information system. Access to the system is password protected and most patient information is in the process of being transferred on to this electronic system.	
Number/Area 3 **Ref:** 5.3.1 (f) **Stated:** Second	It is recommended that medical staff ensure that a clinical indication for the use of as and when required medication is clearly recorded on the kardex. The date of commencement and discontinue of all medications should be clearly	

time	recorded on the kardex.	**Met**
	Action taken as confirmed during the inspection: RQIA medical Inspector examined the kardexes available at the time of inspection and noted that there was clinical indication noted for as and when required (PRN) medications.	
Number/Area 4 **Ref:** 5.3.1 (f) **Stated:** Second time	It is recommended that the Trust ensures that all visiting professionals, complete patient progress records and reviews onto the PARIS system.	**Met**
	Action taken as confirmed during the inspection: Inspector confirmed that all members of the multi-disciplinary team now complete the patient care documentation onto the PARIS system. There is a standby login name for agency nurses and duty doctors who visit the ward to enable them to enter details against patient records. This standby login is secured and changed monthly.	
Number/Area 5 **Ref:** 5.3.3 **Stated:** First time	It is recommended that the ward manager ensures that all staff record when a recreational/therapeutic activity is cancelled and the reasons for this. This should be kept under review for any patterns or trends arising.	**Not Met**
	Action taken as confirmed during the inspection: Inspector discussed this with the Ward Manager and this is not current practice. This will be restated for the second time.	
Number/Area 6 **Ref:** 8.3 (j) **Stated:** Second time	It is recommended that the ward manager ensures that staff assess and document patients' consent to care and treatment. This should be recorded in the patients' individual care plans.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed patient's care documentation and care plans and was satisfied that staff regularly document patient's consent to care and treatment. All patients who met with the inspector confirmed that staff asks for their consent.	
Number/Area 7 **Ref:** 8.3 (f) **Stated:** First time	It is recommended that the Trust review the location of confidential patient information displayed at the main nurses station and the concerns regarding ensuring patient confidentiality is maintained at all times in relation to information displayed or overheard at the nurses station.	**Partially Met**

	Action taken as confirmed during the inspection: The inspector noted that the board containing information on patients has been moved out of sight from persons standing at the desk and the information board has doors that can be folded over to ensure confidentiality. However phone calls can still be overheard and staff frequently have to ask patients to remove themselves from the area around the nurses station while they make phone calls. This 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 of staff's effort to involve patients in the design of their risk assessments. However the patient's whose files were examined were too unwell to contribute to their risk assessments. One of the three risk assessments reviewed noted the patient had refused to sign.

All three risk management plans were reviewed regularly by members of the multidisciplinary team.

Patients' personal safety / risk management plans are individualised, have appropriate actions devised, are implemented and regularly reviewed by the multidisciplinary team and are used to inform personal well-being plans / care plans.

There was evidence in progress notes that staff sought consent from patients before delivering care and treatment.

Care plans were in place regarding patient's deprivation of liberty under the Mental Health (NI) Order 1986 and patients had their rights explained.

There was evidence that staff sought consent from patients to consult with their family members on their care and treatment.

Patients had signed the no smoking policy.

Patients reported they knew how to make a complaint.

The social worker reported that there are six patients who are scheduled for review with the Mental Health Review Tribunal.

All staff knew who to and how to raise concerns with.

No member of staff stated they were asked to work beyond their role experience or training.

Areas for Improvement

The ward ligature risk assessment was completed in 2016 however some areas of the risk assessment appeared to be copied from the year previous yet the ward manager reported that works which were listed as still to be completed were already actioned.

Action points in the Belfast Risk Assessment and Audit Tool 2 (BRAAT 2) was not enacted on the ward.

The Fire Risk assessment action plan is out of date – dated 9 September 2015. This document needs to reflect updated action points.

The Personal Emergency Evacuation Plans (PEEPs) did not record a date of review. However the inspector was shown a system whereby a designated fire officer does review PEEPS however this is recorded on white board but not on patient files.

Daily and weekly fire checks are completed but not on a consistent basis.

A Datix form was not completed for every occasion whereby a patient breeched the no smoking policy.

Number of areas for improvement	Six

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 initial assessment completed upon admission is very thorough.

There was evidence of onward referral for specialist assessments including podiatry, dietician, diabetic nurse etc.

There was evidence that the need for the use of restrictive practices, including deprivation of liberty, and restraint is based on individualised assessment of need.

There is evidence of discharge planning involving the patient. One patient had visits planned to their proposed supported living scheme. Community support mechanisms have been discussed with the multidisciplinary team and the patient in preparation for discharge.

The multidisciplinary team patient care meetings are thorough and evidenced due consideration of all patient's needs. Records are maintained to confirm decisions agreed at the ward round, the person responsible for implementing agreed actions is identified and the timeframe for implementation is reviewed.

The evaluation of care and treatment provided to patients considers the effectiveness of the interventions and changes are made when and where necessary. The inspector observed this during the ward round.

The ward had a medical practitioner who oversees the physical health care needs of patients.

A Clinical Forensic Psychologist has recently been appointed to the ward.

Areas for Improvement

There were inconsistencies on the standard and thoroughness of care plans. One patient had two care plans in place. There were at least two further care plans which required to be updated. One on smoking cessation and one was required in relation to the management of the patient's heart failure. One care plan for diabetes did not include sufficient detail in relation to monitoring blood sugars level and there was no reference to the normal ranges for the patient and what to do if results went above or below acceptable/normal levels. Another patient had 12 care plans which were very thorough and comprehensive. One patient's moving and handling assessment did not have the most important part of the assessment completed. Dates of when

this assessment was completed and reviewed were noted though they were not recorded in the correct place.

There was no evidence of the use of low-level psychological interventions. The Inspector spoke to the ward manager in relation to this matter. It was acknowledged that training opportunities on low level psychological interventions was sparse and places were filled immediately as the training is offered across the Trust.

The physical environment of Clare ward did not have any therapeutic enhancement. There was one incomplete attempt at enhancing the environment. The walls were neutral and there were no soft furnishings, or pictures to enhance the therapeutic environment.

There was an issue in relation to the recording of and storage of baseline occupational assessments on the PARIS system. Baseline assessments were inadvertently being overwritten by updating progress notes.

Number of areas for improvement	Four

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 emotional distress.

Four of the five patients who met with the inspector stated they were given the opportunity to have a representative of their choice attend any meeting where decisions are made about their care and treatment.

Information about the types of care and treatment options were discussed with patients at the ward round. There was evidence that patients were provided with appropriate information to make informed choices about the types of care and treatment options available.

There was evidence in patient progress notes that staff explain the need for the use of any restrictive practice, and ensure that patients understand this information as far as possible.

Three of the five patients and one representative stated they are satisfied with the care and treatment provided and the way staff treat them from admission to discharge. Two patients stated they believed they were restricted to the ward for too long. Both patients had limited insight into their illnesses or risks.

Patients have the opportunity to put their concerns in writing to the multidisciplinary team for discussion. This practice is encouraged outside the specific patient's multidisciplinary meeting. This process ensures patient's needs, and wishes are heard and given due consideration.

Patients can access an independent advocate who visits the ward weekly.

Areas for Improvement

No areas for improvement were identified during the inspection.

Number of areas for improvement	None

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 are aware of their roles and responsibilities and actions they should take if they have a concern (safeguarding, child protection, escalation, whistleblowing).

The multi-disciplinary team for the facility is agreed and all staff are currently available. This included the very recent appointment of the consultant clinical forensic psychologist.

There are good working relationships between members of the multi-disciplinary team.

Medication kardexes were reviewed and all prescribed medication was within the BNF guidelines. When there was a complex combination for antipsychotic medication prescribed, the clinical rationale for the use of such a combination was justified.

Kardexes were legible and indications for PRN medications were recorded.

There were instructions for the regime of administrating medication, such as what medication should be used in the first instance and what should be used thereafter if the desired result was not achieved. There was a rapid tranquilisation policy in place.

There was good information sharing and regular ward nursing and health care attendants' team meetings. Minutes of meetings evidenced a discussion of practice in adhering to policies and procedures pertaining to the ward such as; the personal search policy, opening times of the rehabilitation kitchen, the responsibility of staff holding and responding to the pager, and learning gained from serious adverse incidents (SAIs).

A learning board was in place in the staff room with up-to-date learning gained from audits, reviews or investigations.

Outcome of audits were displayed.

The ward manager had access to a training matrix for the staff team. All training that was in date and was colour coded to ensure that those staff who required updated training was prioritised as soon as the training became available. The ward manager had identified training weeks for staff in April to ensure all mandatory training was updated.

All staff received regular planned supervision.

Patients comprehensive risk assessments are regularly reviewed no less than every three months and there is a system in place to ensure timely reviews occur.

There are effective staffing arrangements in place which minimises disruption to patient care and treatment. Clare ward does not use agency staff.

Areas for Improvement

Clarity on the future direction, purpose and function of the ward is needed.

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 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 5 April 2017.

Provider Compliance Plan Clare Ward	
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:** **9 March 2017**	The ligature risk assessment was not updated to take cognisance of the work undertaken to date.
	Response by responsible person detailing the actions taken: Copy of general risk assessment and individual care plans sent 23.02.17 Ligature assessment was reviewed, updated and sent 17.03.17
Area for Improvement No. 2 **Ref:** 5.3.3 **Stated:** Second time **To be completed by:** 9 March 2017	It is recommended that the ward manager ensures that all staff record when a recreational/therapeutic activity is cancelled and the reasons for this. This should be kept under review for any patterns or trends arising.
	Response by responsible person detailing the actions taken: Ward sister has instructed that when activities are cancelled reasons are recorded in the ward diary.
Area for Improvement No. 3 **Ref:** 5.3.1 (f) **Stated: First time** **To be completed by:** 9 March 2017	A Datix form was not completed for every occasion when a patient breached the no smoking policy.
	Response by responsible person detailing the actions taken: All staff advised to complete incident form for contraband material Individual care plan for specific patient updated and forwarded 8.03.17
Area for Improvement No. 4 **Ref:** 5.3.1 (f) **Stated: First time** **To be completed by:** 9 March 2017	The Fire Risk assessment action plan is out of date – dated 9 September 2015. This document needs to reflect updated action points.
	Response by responsible person detailing the actions taken: Copy of 2016 forwarded on 28.02.17, copy of action plan included and details of action taken.

Area for Improvement No. 5 **Ref:** 5.3.1 (f) **Stated: First time** **To be completed by:** 9 March 2017	The Personal Emergency Evacuation Plans (PEEPs) did not record a date of review. However the inspector was shown a system whereby a designated fire officer does review PEEPS however this is recorded on white board but not on patient files.
	Response by responsible person detailing the actions taken: Staff have been advised to write date reviewed on PEEPS and a system is already in place to ensure that reviews take place.
Area for Improvement No. 6 **Ref:** 5.3.1(f) **Stated: First time** **To be completed by:** 9 March 2017	Daily and weekly fire checks are completed but not on a consistent basis.
	Response by responsible person detailing the actions taken: Daily sheet now at back of patient checklist , marked in diary and carried forward on a daily basis.
Area for Improvement No. 7 **Ref:** 5.3.3 (g) **Stated: First time** **To be completed by:** 9 March 2017	There was an issue in relation to the recording of and storage of baseline occupational assessments on the PARIS system. Baseline assessments were inadvertently being overwritten by updating progress notes.
	Response by responsible person detailing the actions taken: The OT in error, had been overriding previous assessments as they were not being given an "end date" on Paris. She is now aware that OT assessments when completed are to be closed with an end date, to ensure assessments cannot be altered, or overwritten. This means that for updated and review assessments, a new assessment will be opened on Paris, and comparison can be made by referring to the original closed assessment
Priority 2	
Area for Improvement No. 8 **Ref:** 5.3.3 (b, e & f) **Stated:** First time **To be completed by:** 9 May 2017	There were inconsistencies on the standard and thoroughness of care plans. One patient had two care plans in place. There were at least two further care plans which required to be updated. One on smoking cessation and one was required in relation to the management of the patient's heart failure. One care plan for diabetes did not include sufficient detail in relation to monitoring blood sugars level and there was no reference to the normal ranges for the patient and what to do if results went above or below acceptable/normal levels. Another patient had 12 care plans which were very thorough and comprehensive. One

	patient's moving and handling assessment did not have the most important part of the assessment completed. Dates of when this assessment was completed and reviewed were noted though they were not recorded in the correct place.
	Response by responsible person detailing the actions taken: All trained staff spoken to Supervision re feedback from RQIA given Ward sister will continue to audit and monitor.
Area for Improvement No. 9 **Ref:** 4.2 **Stated:** First time **To be completed by:** 9 May 2017	Clarity on the future direction, purpose and function of the ward is needed
	Response by responsible person detailing the actions taken: This remains an on-going concern, regional meetings are taking place to hopefully inform low secure provision in Northern Ireland Clare Ward continues to aspire towards low secure and is reviewed against royal college psychiatrists low secure standards.
Priority 3	
Area for Improvement No. 10 **Ref: 8.3 (f)** **Stated: Second time** **To be completed by:** 9 August 2017	Confidentiality - Phone calls can still be overheard when made from the nurse's station and staff frequently have to ask patients to remove themselves from the area around the nurses station while they make phone calls.
	Response by responsible person detailing the actions taken: Report now held in ward sister's office. There is a facility for private phone calls to be received and made.
Area for Improvement No. 11 **Ref:** 5.3.1(a) **Stated:** First time **To be completed by:** 9 August 2017	Action points in the Belfast Risk Assessment and Audit Tool 2 (BRAAT 2) was not enacted on the ward.
	Response by responsible person detailing the actions taken: Ward sister to arrange training for general risk assessors Training for health and safety remains on going and nearly all staff have completed on line training.

Area for Improvement No. 12 **Ref:** 5.3.3 (f) **Stated:** First time **To be completed by:** 9 August 2017	There was no evidence of the use of low-level psychological interventions.
	Response by responsible person detailing the actions taken: Staff trained in motivational interviewing and currently delivering as required. All staff have had recovery training and in addition 15 have been trained in WRAP Now have psychology input one day a week.
Area for Improvement No. 13 **Ref:** 6.3.1 (c) **Stated:** First time **To be completed by:** 9 August 2017	The physical environment of Clare ward did not have any therapeutic enhancement. There was one incomplete attempt at enhancing the environment. The walls were neutral and there were no soft furnishings, or pictures to enhance the therapeutic environment.
	Response by responsible person detailing the actions taken: Remains on going, Artscare are not involved and staff are carrying out projects with patients to enhance the environment.

Name of person(s) completing the provider compliance plan	Davy Martin/Karen McGovern/Boris Pinto		
Signature of person(s) completing the provider compliance plan	Davy Martin	**Date completed**	23/04/2017
Name of responsible person approving the provider compliance plan	Martin Dillon, Chief Executive, Belfast Trust		
Signature of responsible person approving the provider compliance plan	Martin Dillon	**Date approved**	23/04/2017
Name of RQIA inspector assessing response	Cairn Magill		
Signature of RQIA inspector assessing response		**Date approved**	26 April 2017

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