Unannounced Follow Up Inspection Report
16 August 2018

Neuro-behavioural Rehabilitation Unit
Knockbracken Healthcare Park
Saintfield Road
Belfast
BT8 8BH

Tel No: 028 95042047

Inspectors: Cairn Magill and Marie McCann

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

The Neuro-behavioural Rehabilitation Unit (NRU) is a 10 bedded inpatient service situated on the Knockbracken Health Care Park site. The purpose of the ward is to provide rehabilitation to male patients who required continuing care due to an acquired brain injury.

There has not been any admissions to NRU over the past two years as NRU has been scheduled for closure and NRU is closed to new admissions. The Trust has not yet finalised the closure plans for NRU however there are discussions happening to consider options.
There has been no definitive date set for when NRU will close.

Since the previous inspection four patients are in the process of resettling into supported living accommodation in the community. These patients will not be discharged from NRU until the multidisciplinary team are satisfied the patients are settled and their placements are secure. To date, each patient's community placement has been going well. There are three patients who remain on the ward and who require a community placement. One of these patients has a placement identified and discussions are underway to plan transition visits. Another patient has begun the transition phase of resettlement and he returns to the ward at the weekend.

3.0 Service details

Responsible person: Martin Dillon	**Ward Manager:** Joanne McNally
Category of care: Neuro-behavioural Rehabilitation Unit.	**Number of beds:** 10
Person in charge at the time of inspection: Matthew Twomey	

4.0 Inspection summary

An unannounced follow-up inspection took place on 16 August 2018.

The inspection sought to assess progress with findings for improvement identified at the most recent previous unannounced inspection completed 15- 17 August 2017.

There were 26 areas for improvement made during the previous inspection of NRU. Of these, 16 areas were met, 9 areas were not met and one area was partially met. Of the 9 areas not met, four areas of improvements were removed. These areas of improvement were removed in consultation with the Assistant Director of MHLD team as the risks are either locally managed or have become dormant. The areas of improvement relate to;

1. The action points on the ligature risk assessment were not actioned.
The inspector reviewed the risk documentation of the remaining (three) patients on the ward. No patient was assessed as being at risk from ligatures. Patients are in view of staff at all times

when on the ward and staff locally manages ligature risks on the ward. As NRU is scheduled for closure in the near future RQIA have been assured that staff are locally managing ligature risks. Therefore RQIA have removed this area for improvement.

2. Pull cords in patient bathrooms were not working.
Staff informed the inspector that patients are either supported with all aspects of personal care while in bathrooms and that staff are aware when patients enter the bathroom and would be available to respond immediately to any patient requiring assistance.

3. The ward design did not meet the needs of some patients who presented with behaviours that challenge.
NRU was moved into the current building which pre-dates the Royal College of Psychiatrists' Standards for Acute Inpatient Wards for Working Adults 2009. Since the previous inspection, the patient population within NRU has significantly reduced and the ward now has sufficient space to manage behaviours that challenge in a dignified manner away from other patients.

4. There was no occupational therapy kitchen or occupational therapy room on the ward to conduct activities in private or in peace or quiet.
As noted above (point 3) the ward pre-dated the Standards for Acute Inpatient Wards. The inspector was satisfied from reviewing patient care records and from verbal reports of staff that it is the view of the multidisciplinary team that the remaining patients have reached their optimum level of functioning and would not have the capacity to develop any further skills of independent living. The ward has significantly fewer patients since the last inspection and given only one of the three remaining patients will engage in activities the inspector is satisfied that these can now be conducted in peace and quiet.

The ward had undergone significant improvements since the previous inspection. The ward had been painted throughout and new floor covering had been laid. New furniture had been purchased and the ward presented as clean, bright, airy and welcoming.

Patients Views

At the time of inspection there were three patients in the ward. Inspectors met two of the three patients. Both patients engaged with the inspectors for a brief time in an informal manner. Inspectors observed each patient to be calm and at ease and relaxed in the presence of staff.

Inspectors observed patient centred practice. Staff accommodated the preference of one patient who preferred to have a lie on in the morning. Staff were also observed to be respectful when carrying out one to one observations by facilitating the observation from a discrete distance and responding in a warm, friendly and appropriate manner to the patient when the patient choose to initiate some interaction.

Relatives Views
No relatives were available to speak with inspectors on the day of inspection. However the inspectors left questionnaires for relatives to complete and return to RQIA following the inspection. One questionnaire was returned and an inspector made contact with the relative post inspection.

Staff Views
Inspectors met with five members of staff, three of whom completed the staff questionnaire.

Overall, staff stated they were happy working on the ward and that staff and patient morale had improved following the repainting and refurbishing of the ward. Staff also commented that there are much better lines of communication with senior staff regarding the planned closure of NRU. Staff made the following comments;

"There is good teamwork here."
"I am aware of management, organisational structure – I could raise any issue I need to."
"Senior management are approachable."
"We are kept informed of any changes in needs following visits and appointments. This is shared in handovers and care plans."
"There are no cliques within the staff team."
"It's the best ward I have worked in for staff support."
"I am up to date with my training."

The findings of this report will provide the Trust with the necessary information to assist them to fulfil their responsibilities, enhance practice and service user experience.

4.1 Inspection outcome

Total number of areas for improvement	Nine

There are a total nine of areas for improvement which were identified during this inspection:

- Six areas for improvement have been restated for a second time
- Three new areas for improvement have been identified

These are detailed in the Quality Improvement Plan (QIP).

Areas for improvement and details of the QIP were discussed with senior Trust representatives, members of the multi-disciplinary team, the acting ward manager and ward staff as part of the inspection process. The timescales for completion commenced from the date of inspection.

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.

The following areas were examined during the inspection:

- Care Documentation in relation to two patients.
- Ward environment.
- Learning from serious adverse incidents.

- Ward ligature risk assessment.
- Fire risk assessment.
- Minutes of staff meetings.
- Minutes of governance meetings.
- Adult safeguarding referrals.
- Training records.

Inspectors requested that the charge nurse place an RQIA 'Have we missed you?' card and a "Your Care, Your View" card in a prominent position in the ward to allow patients, relatives and staff who were not available on the day of the inspection to give feedback to RQIA regarding the quality of service provision. At the time of writing the report, two "Your Care, Your View" cards were received post inspection. One response indicated the respondent would be very likely to recommend NRU to their friends and family if they were ever to need similar care and another respondent said they were unlikely to recommend NRU.

During the inspection inspectors observed staff working practices and staff patient interactions using a Quality of Interactions Schedule Tool (QUIS) and had witnessed all staff interactions to be respectful, warm, and compassionate.

We reviewed the areas for improvements made at the previous inspections and an assessment of compliance was recorded as met/partially met and not met.

6.0 The inspection

6.1 Review of areas for improvement from the last unannounced inspection dated 15-17 August 2017

The most recent inspection of Neuro-behavioural Rehabilitation Unit was an unannounced inspection. The completed QIP was returned and approved by the responsible inspector. This QIP was validated by inspectors during this inspection.

Areas for Improvement from last inspection		Validation of Compliance
Area for Improvement No. 1 **Ref:** Standard 5.3.1	The responsible person must ensure that all staff completes their required mandatory training.	**Met**

(f) **Stated:** Second time **To be completed by:** 4 October 2017	**Action taken as confirmed during the inspection**: Inspectors reviewed the record of mandatory training. Inspectors evidenced that all staff had completed their mandatory training with the exception of staff off on long term sick leave.	
Area for Improvement No. 2 **Ref:** Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 4 October 2017	Reviews of risk assessments were not completed in accordance with the Promoting Quality Care; Good Practice Guidelines on the Assessment and Management of Risk in Learning Disability and Mental Health Services 2010. **Action taken as confirmed during the inspection**: Inspectors reviewed two risk assessments which were completed in accordance with the Promoting Quality Care; Good Practice Guidelines on the Assessment and Management of Risk in Learning Disability and Mental Health Services 2010.	**Met**
Area for Improvement No. 3 **Ref:** Standard 5.3.1 (a) **Stated:** First time **To be completed by:** 4 October 2017	All staff were not aware of patient's food allergies. There were no care plans or risk assessments in place to manage food allergies. **Action taken as confirmed during the inspection**: No patient within NRU has any food allergies. NRU staff have an arrangement to ensure a care plan will be put in place to manage allergy where this arises. Allergies will also be referenced in the patient's Comprehensive Risk Assessment.	**Met**
Area for Improvement No. 4 **Ref:** Standard 5.3.1 (a) **Stated:** First time **To be completed by:** 4 October 2017	There was no evidence that Adult Safeguarding Protection plans had been reviewed. **Action taken as confirmed during the inspection**: The inspector reviewed two patient's files and noted there was evidence that adult safeguarding protection plans had been reviewed and when appropriate closed in accordance with the Trust's Adult Safeguarding Policy. One safeguarding investigation was ongoing at the time of inspection.	**Met**
Area for Improvement No. 5 **Ref:** Standard 4.3 (g)	There was a 10 month gap between the "talk through" fire drills. Records also evidenced a lack of adherence to completing the weekly fire alarm test from 14/01/2016 to 6 June 2017. This evidences a lack of adherence to the Trust's Fire	**Met**

Stated: First time **To be completed by:** 4 October 2017	Policy and procedure and a lack of governance oversight. **Action taken as confirmed during the inspection**: The inspector reviewed fire records and noted that there were weekly fire alarm tests recorded in accordance with the Fire Policy. Two "talk through" fire drills were completed in accordance with the Trust standards since the previous inspection.	
Area for Improvement No. 6 **Ref**: Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 4 October 2017	Staff reported that there was no de-briefing sessions or reflective practice sessions offered to them following an incident on the ward to offer support or identify any learning from the incident. **Action taken as confirmed during the inspection:** Staff reported that the Consultant Clinical Psychologist chairs reflective practice meetings regularly to provide support and learning opportunities to staff. Staff also reported that there are very few incidents on the ward since a number of patients are in the process of resettling and there are fewer patients on the ward. Staff informed inspectors that there had been a debrief session following incidents and staff stated they feel supported. The inspector reviewed the incidents and confirmed there have been significantly fewer incidents on the ward.	**Met**
Area for Improvement No. 7 **Ref:** Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 4 October 2017	The ward had a number of staff shortages and there was a high use of bank and agency staff. **Action taken as confirmed during the inspection**: NRU has eight registered nursing staff. Included in these numbers are the ward manager and two deputy ward managers one of whom is currently acting up as the ward manager is on sick leave. There are four health care nursing assistants, one of whom is on long term sick leave. In addition there are three members of staff that have retired but who regularly cover bank shifts. With the reduction in patients and the ongoing resettlement programme, inspectors are satisfied that the current staff cover is acceptable.	**Met**
Area for Improvement No. 8	The ward's maintenance and hygiene was not satisfactory.	**Met**

Ref: Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 4 October 2017	**Action taken as confirmed during the inspection**: The inspectors completed an orientation of the ward at the beginning of the inspection. The inspectors observed patient services staff completing their cleaning duties to the required standards. The inspectors were satisfied that the ward's hygiene was maintained to a good standard.	
Area for Improvement No. 9 **Ref:** Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 4 October 2017	The contents of the emergency resuscitation equipment were out of date. **Action taken as confirmed during the inspection**: Inspectors checked the monitoring arrangements of the emergency resuscitation bag. There was a check list that outlined the expiry date for pieces of equipment and a mechanism was put in place for nursing staff to re-order equipment one month before expiry date. However the process was not future proofed and no audit conducted to see if pieces of equipment were ordered. (One item was due to be replaced in July). No one person was assigned overall responsibility to conduct an audit on the resuscitation bag.	**Not met**
Area for Improvement No. 10 **Ref:** Standard 5.3.3 (e) **Stated:** First time **To be completed by:** 4 October 2017	There were five different records for each patient. A hardcopy nursing care plan record, a hardcopy medical file, a hardcopy psychology file along with records held on T-drive which linked in with records on the electronic patient recording system (PARIS). **Action taken as confirmed during the inspection**: Inspectors reviewed patient records and there still remained five different records for each patient although some improvements were noted. Staff prepared notes for the MDT meeting using the template stored on the T- drive. Once the MDT minutes were completed these were then uploaded to the patient's PARIS record. These are uploaded weekly. There was evidence of medical notes recorded on PARIS system and in hardcopy medical files. However there were inconsistent recording systems from medical staff. Medical entries made on PARIS system did not generate a new case note and multiple entries were made under the same date. This practice has the potential to	**Not met**

	confuse others and create risk in the management of patients if entries are not made in a contemporaneous date order in the one system. A new area of improvement will be made.	
Area for Improvement No. 11 **Ref:** Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 4 October 2017	Patient records and files were not managed and stored in accordance with Trust and Data protection policies and procedures and Nursing Midwifery Council Guidance (NMC) / General Medical Council (GMC) on record keeping. **Action taken as confirmed during the inspection**: There had been improvement noted in record keeping with hardcopy files being maintained in an orderly fashion and secured appropriately. Some hand written entries in the medical files were illegible. This area for improvement will be re worded to address the illegibility of handwritten entries and restated for the second time.	**Partially met**
Area for Improvement No. 12 **Ref:** Standard 5.3.3 (a) **Stated:** First time **To be completed by:** 15 November 2017	There was no evidence that care plans were analysed or evaluated. In some cases alternative care plans could have been considered, tried or implemented. Care plans were not goal focused and could therefore not be evaluated or measured. There were no care plans in place to support the rehabilitation of patients. **Action taken as confirmed during the inspection**: Inspectors noted progress in this area for improvement. NRU have introduced a new template to prepare for the weekly MDT meeting. Nursing staff review and evaluate each patient's progress notes and care plans from one week to the next and record their evaluation on the MDT meeting template. This is then discussed at the MDT meeting. Inspectors noted that there were thorough detailed behavior support plans in place that were written to support the rehabilitation of patients.	**Met**
Area for Improvement No. 13 **Ref:** Standard 5.3.3 (g)	There was no evidence that audits of multidisciplinary files were undertaken. **Action taken as confirmed during the inspection**: The inspector was informed that there were still no	**Not Met**

Stated: First time **To be completed by:** 15 November 2017	single multidisciplinary files for each patient. However each discipline on the ward involved in patient care held their own professional file. There were nursing records, clinical psychology records and medical records. There was no evidence presented to the inspectors of any audits having been conducted of these files.	
Area for Improvement No. 14 **Ref**: Standard 4.3 (n) **Stated:** First time **To be completed by:** 15 November 2017	The inspector had been informed that timescales for the planned closure of NRU had changed which resulted in uncertainty. This had a destabilising impact on staff and on the upkeep of the ward. There was no memorandum of understanding shared with staff in relation to submitting requests for the upkeep of the ward. **Action taken as confirmed during the inspection**: Inspectors noted definite progress towards the ward's closure. Three patients still require community placements to be secured. The inspectors were satisfied that discharge/ resettlement plans were actively being progressed for each patient. The inspectors are satisfied that ward staff are more informed and that staff and senior management have a shared understanding of the forthcoming closure and how this is being planned for.	**Met**
Area for Improvement No. 15 **Ref:** Standard 6.3.2 (a) **Stated:** First time **To be completed by:** 15 November 2017	Staff reported patient's clothing frequently went missing when sent to the laundry department. **Action taken as confirmed during the inspection**: This area for improvement has been met. A new partition and system was implemented to separate patient and ward laundry to good effect. Some patients are assisted to complete their laundry on the ward.	**Met**
Area for Improvement No. 16 **Ref:** Standard 6.3.2 (c) **Stated:** First time	There was no support in place to assist patients who required support with communication to make choices in relation to meals. **Action taken as confirmed during the inspection**: This area for improvement was made in response to feedback from relatives. Speech and language	**Met**

To be completed by: 15 November 2017	therapy and psychology services assess communication needs and plan according to individual patient need. There are currently no patients who require or who are willing to accept support with communication in relation to meal choice. This area for improvement has therefore been met.	
Area for Improvement No. 17 **Ref:** Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 15 November 2017	There was no record of how frequent patient activities were cancelled or the reasons why. **Action taken as confirmed during the inspection**: A diary for recording if patient activities are cancelled is now in place. Staff informed the inspectors this is now a very rare occurrence. Inspectors reviewed the diary and are satisfied that this area for improvement has been met.	**Met**
Area for Improvement No. 18 **Ref:** Standard 6.3.2 (c) **Stated:** First time **To be completed by:** 15 November 2017	Only the names of nursing and healthcare assistant staff were displayed. This was hand written on a white board. There were no photographs of staff or members of the full multidisciplinary team on display. **Action taken as confirmed during the inspection**: The names of all members of the multi-disciplinary staff were on the notice board. Nursing staff names changed daily in accordance to shift patterns. The names of allied health professionals and consultants remained on the board. Some photographs of nursing staff were also displayed.	**Met**
Area for Improvement No. 19 **Ref:** Standard 6.3.2 (a) **Stated:** First time **To be completed by:** 15 February 2018	The visitor's room was bare and uninviting. **Action taken as confirmed during the inspection**: The visitors room was freshly painted had new furniture in it, a television and appropriate leaflets were displayed. It was comfortable and inviting.	**Met**
Area for Improvement No.	There were no private areas for patients to retreat to.	**Met**

20 **Ref:** Standard 5.3.3 (f) **Stated:** First time **To be completed by:** 15 February 2018		
	Action taken as confirmed during the inspection: The inspectors are satisfied that there are a number of private areas/quiet places now where patients could retreat to given the footprint of the ward and the low number of patients present.	
Area for Improvement No. 21 Ref: Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 15 February 2018	There were a number of BHSCT policies which required a review.	**Not met**
	Action taken as confirmed during the inspection: This area for improvement remains. There are still a significant number of BHSCT policies that require review.	
Area for Improvement No. 22 **Ref:** Standard 6.3.1 (c) **Stated:** First time **To be completed by:** 15 February 2018	There was no information displayed in relation to the wards performance.	**Not met**
	Action taken as confirmed during the inspection: This area for improvement was not met. Inspectors discussed this at feedback.	

Areas of Good Practice

Areas of good practice were found in relation to meeting the physical /medical needs of patients. A General Practitioner continues to visit the ward regularly and there is onward appropriate referrals made for specialist assessment and input. The ward has established good working relationships with allied health professionals, including podiatry and diabetes specialist nurse services.

There was evidence of good preparation for rehabilitation and ensuring each patient's individual needs could be met in the identified placement. There was evidence of good transition planning and co-working with placement staff. NRU staff facilitated placement (community staff) staff

with the opportunity to shadow them working with patients and NRU staff also accompanied patients to their new placements to help them settle in.

Areas for improvement

One patient's nursing care plan referred the reader to follow the recommendations made by the Speech and Language Therapist's Dysphagia Assessment however this assessment was not on the patient's file. During discussion it was noted that the dysphagia assessment was filed in an old file that was sent to medical records for storage. This finding will be stated in the new quality improvement plan.

There were inconsistent recording systems from medical staff. Medical entries made on PARIS system did not generate a new case note and multiple entries were made under the same date. Other entries were made in the hardcopy medical file. This practice has the potential to confuse others and create risk in the management of patients if entries are not made in a contemporaneous date order in the one system.

Upon review of NRU's fire risk assessment the inspectors noted a number of items re-listed in the fire risk assessment action plan from 2016. A number of action plan points did not have any progress noted on it. There was no reference to combustible material such as oxygen cylinders on the fire risk assessment. This finding will be stated in the new quality improvement plan.

7.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the Quality Improvement Plan (QIP). Details of the QIP were discussed with senior Trust representatives; members of the multi-disciplinary team, acting ward manager, and ward staff as part of the inspection process. The timescales commence from the date of inspection.

The responsible person must ensure that all areas for improvement identified within the QIP are addressed within the specified timescales. The responsible person should note that failure to comply with the findings of this inspection may lead to escalation action being taken.

7.1 Actions to be taken by the service

The quality improvement 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 quality improvement plan to RQIA via the web portal for assessment by the inspector by **23 October 2018**.

Quality Improvement Plan

The responsible person must ensure the following findings are addressed:

Area for Improvement No. 1 **Ref:** Standard 5.3.1 (f) **Stated:** Second Time **To be completed by** 16 September 2018	The contents of the emergency resuscitation equipment were out of date.
	Response by responsible individual detailing the actions taken: There were no items out of date in the emergency resuscitation bag and this had been recorded in the daily checklist. The Trust acknowledges that the checklist outlining the expiry date of each item had not been updated. Checks are now in place to ensure that all records in relation to equipment are up to date.
Area for Improvement No. 2 **Ref:** Standard 5.3.3 (e) **Stated:** Second Time **To be completed by**: 16 November 2018	There were five different records for each patient. A hardcopy nursing care plan record, a hardcopy medical file, a hardcopy psychology file along with records held on T-drive which linked in with records on the electronic patient recording system (PARIS).
	Response by responsible individual detailing the actions taken: The ward will amalgamate all unidisciplinary notes into one multidisciplinary team file by 22 October 2018 and a hard copy of any documents saved on the T:Drive will be inserted into the multidisciplinary team notes. Progress notes will now be recorded on PARIS by all disciplines.
Area for Improvement No. 3 **Ref:** Standard 5.3.1(f) **Stated:** Second Time **To be completed by:** 16 September 2018	Patient records and files were not managed and stored in accordance with Trust and Data protection policies and procedures and Nursing Midwifery Council Guidance on record keeping. (Some entries in hard copy medical records were illegible.)
	Response by responsible individual detailing the actions taken: As stated in the inspection report there has been an improvement noted in record keeping with hardcopy files being maintained in an orderly fashion and secured appropriately. This area for improvement was in the context of illegibility of handwritten entries by medical staff in medical notes. Medical staff are now recording their progress notes on the PARIS system.
Area for Improvement No. 4 **Ref:** Standard 5.3.3 (g)	There was no evidence that audits of the various discipline files were undertaken.
	Response by responsible individual detailing the actions taken:

Stated: Second Time **To be completed by:** 16 November 2018	The inspector was provided with evidence that nursing files were being audited during the course of the inspection however, the Trust acknowledges that there was no evidence that other disciplines' files had not been audited. The Ward will amalgamate unidisciplinary notes into one multidisciplinary team file by 22 October 2018. The Band 6s will audit the multidisciplinary team notes from that point forward.
Area for Improvement No. 5 **Ref:** Standard 5.3.1 (f) **Stated:** Second time **To be completed by:** 16 November 2018	There were a number of BHSCT policies which required a review. **Response by responsible individual detailing the actions taken:** The Divisional Nurse for Mental Health will continue to escalate this.
Area for improvement No. 6 **Ref**: Standard 6.3.1 (c) **Stated:** Second Time **To be completed by:** 16 November 2018	There was no information displayed in relation to the wards performance. **Response by responsible individual detailing the actions taken:** The ward's performance is now clearly displayed.
Area for improvement No. 7 **Ref**: Standard 5.3.1 (f) **Stated:** First Time **To be completed by:** 16 September 2018	The action points identified in the Fire Risk Assessment were not actioned or updated. Some action points were on the action plan since 2016. There is no reference in the fire risk assessment of the ward storing oxygen cylinders. **Response by responsible individual detailing the actions taken:** The ward's fire risk assessment is due for renewal in October 2018 and will include the storage of oxygen cylinders. Ward staff have been reminded of the need to record any actions taken in relation to addressing action points identified in the fire risk assessment and of the need to escalate any issues in addressing same to their Operations Manager.
Area for Improvement No. 8	One patient's nursing care plan refers the reader to follow the recommendations made by the Speech and Language Therapist's Dysphagia Assessment however this assessment is not on file.

Ref: Standard 5.3.1.(a) **Stated:** First Time **To be completed by:** 16 September 2018	**Response by responsible individual detailing the actions taken:** The dysphagia assessment was located in the medical file on the ward the day following the inspection. This will be inserted into the multidisciplinary team notes by 22 October 2018.
Area for Improvement No. 9 **Ref:** Standard 5.3.1(a) **Stated:** First Time **To be completed by:** 16 September 2018	There were inconsistent recording systems from medical staff. Medical entries made on PARIS system did not generate a new case note and multiple entries were made under the same date. Other entries were made in the hardcopy medical file. This practice has the potential to confuse others and create risk in the management of patients if entries are not made in a contemporaneous date order in the one system. **Response by responsible individual detailing the actions taken:** Medical staff have been advised of the need to generate new case notes for each interaction with patients. They will now use PARIS to record all progress notes. Psychology staff will also be instructed to record any patient interaction on PARIS. Arrangements are being made to register the ward's GP on PARIS; they will also start to record progress notes on PARIS from date of access.

Name of person (s) completing the QIP	Mel Carney, Divisional Nurse, Mental Health Services Cahal McKervey, Service Manager, Acute Mental Health Services Peter Trimble, Consultant Psychiatrist, NRU Rowan McClean, Clinical Director Noel McDonald, Operations Manager Davy Martin, Led Nurse Mary Scott, Deputy Ward Sister, NRU Patricia Minnis, Quality and Information Manager		
Signature of person (s) completing the QIP		**Date completed**	05/10/2018
Name of responsible person approving the QIP	Martin Dillon		
Signature of responsible person approving the QIP		**Date approved**	
Name of RQIA inspector assessing response	Cairn Magill		
Signature of RQIA inspector assessing response		**Date approved**	08/02/2019

Please ensure this document is completed in full and returned to RQIA via the web portal

The Regulation and Quality Improvement Authority

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