The Regulation and Quality Improvement Authority

Rathlin

Knockbracken Healthcare Park

Belfast Health and Social Care Trust

Unannounced Inspection Report

Date of inspection: 2 July 2015

npm national preventive mechanism

informing and improving health and social care

www.rqia.org.uk

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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 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 inspector 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 inspector:

- 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

The Rathlin Ward is an acute admission ward for adult male and female patients and is situated on the Knockbracken Health Care Park site. The ward provides single room accommodation for up to 24 patients. There were 23 patients on the ward on the day of the inspection and 11 of these patients were detained in accordance with the Mental Health (NI) Order 1986. The purpose of the unit is to provide acute assessment and treatment for patients with a psychiatric illness who require care in an inpatient environment.

Patients have access to the multi-disciplinary team which includes input from nursing, psychiatry, social work, occupational therapy and psychology. Patients on the ward have access to an independent advocacy service.

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 4 and 5 February 2015 were assessed during this inspection. There were a total of 14 recommendations made following the last inspection.

It was noted that seven recommendations had been implemented in full.

One recommendation had been partially met and six recommendations had not been met. These recommendations will be stated for a second time following this inspection.

It was good to note that patients' had signed their care plans or a reason for not signing was recorded. The inspector also noted that the whole ward had been repainted and the ward looked clean and fresh. Staff were appropriately managing the care of patients who used a profiling bed. Shower facilities had been improved throughout the ward.

The inspector assessed the ward's physical environment using a ward observational tool and check list. The environment appeared relaxed, comfortable, clean and clutter free. There was ample natural lighting; good ventilation and the ward furnishings were well maintained. The ward manager had created a resourceful ward information booklet which also had a variety of information available in easy to read format. There were rooms available for patients to have quiet time on their own and there were areas for patients to spend time in the company of others. 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 inspector completed direct observations using the Quality of Interaction Schedule (QUIS) tool. This assessment rated the quality of the interactions and communication that took place on the ward between patients, nursing staff and ward professionals. Overall the quality of interactions between staff and patients were positive.

During the inspection the inspector met and spoke with four patients regarding their care and treatment. Patients made positive comments about how they had been treated on the ward.

Other inspection findings

Training

The inspector reviewed the training records for 26 staff working on the ward and noted that fire training was out of date for eight of the staff. There was no evidence that arrangements had been made for these staff to attend an update session. A recommendation has been made in relation to this.

Patients files

The inspector reviewed the paper care files for four of the 23 patients on the ward. The inspector noted that in three of the four files reviewed there were a number of loose pages; care files were untidy, disorganised and disjointed. The inspector was concerned that there was the potential for information to be lost due to the added difficultly of trying to source information. A recommendation has been made in relation to this.

4.1 Implementation of Recommendations

Four recommendations which relate to the key question "**Is Care Safe**?" were made following the inspection undertaken on 4 and 5 February 2015.

These recommendations concerned staff training, completion of promoting quality care documentation, management of profiling beds and the process for medical staff to record assessments and progress notes.

The inspector noted that one recommendation had been fully implemented:

- The ward now had systems and processes in place for the management of patients who use a profiling bed.

However, despite assurances from the Trust, three recommendations had not been fully implemented. This included concerns identified regarding the number of staff training in infection prevention and control, the completion of promoting quality care documentation and medical staff continue to record in patients files as oppose to the electronic recording system.

Two recommendations which relate to the key question "**Is Care Effective**?" were made following the inspection undertaken on 4 and 5 February 2015.

These recommendations concerned the review of patients care plans and the reporting of safeguarding concerns.

The inspector was pleased to note that one recommendation had been fully implemented:

- The ward manager reported that safeguarding concerns were being promptly reported and also subject to regular auditing. The trust also reassured that staff had been made aware that safeguarding referrals should be completed and processed within 24 hours of the incident taking place.

However, despite assurances from the Trust, one recommendation had not been fully implemented. This concerned the process for the review of patients care plans and lack of measurement of individual goals.

Eight recommendations which relate to the key question "**Is Care Compassionate**?" were made following the inspection undertaken on 4 and 5 February 2015.

These recommendations concerned patient and staff signatures on relevant documentation; incorporation of deprivation of liberty; repainting of the ward environment; assessment and recording of patients' consent; provision of recreational activities; review of patient washing facilities and the maintenance of the two patient garden areas.

The inspector was pleased to note that five recommendations had been fully implemented:

- Patient and staff signatures or a reason for no signature was evidenced in the files reviewed.
- Each patient file reviewed evidenced a deprivation of liberty care plan in place.
- The whole ward had been repainted.
- Shower facilities had been upgraded in each ensuite.

However, despite assurances from the Trust, three recommendations had not been fully implemented. This included the assessment and recording of

patients consent, provision of ward based activities at evening and weekends and ongoing maintenance of the two outside garden areas.

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

The inspector noted there was a comprehensive ward information booklet available. The booklet was supported with information in an easy to read format.

Information regarding Releasing Time to Care, incidents, admissions and the average length of stay on the ward was displayed on the notice board in the main communal area.

On the day of inspector there were six staff members on duty including the ward manager. There appeared to be sufficient staff available to meet the needs of the patients.

One patient was noted to be receiving enhanced observations. Enhanced observations were noted to be discreetly carried out.

Two large spacious rooms for patients to rest were available; the rooms were open and available to patients throughout the day. Patients sleep in single ensuite bedrooms. Sleeping areas were well maintained. On one of the bedrooms doors the window was missing however this had been appropriately reported. Bedrooms were noted to be open throughout the day for patient access.

There are two outside garden areas with seating available. The gardens were noted to be open throughout the inspection. Concerns were identified with cigarette butts littered throughout the garden areas; there was evidence of ongoing attempts to address this. A recommendation has been stated for a second time in relation to this.

The ward door was locked however patients can independently exit the ward using the access control switch. The ward had a visitor's room which can be used by families including children. The ward was clean and well maintained. There were enough seats for all patients'. Patients can use a payphone available on the ward.

The inspector observed that not all staff were wearing their name badges. Information regarding the staff on duty was displayed on a white board outside the main office, this is updated daily.

Staff use the ward office to make private telephone calls. There was no confidential information on public view. All confidential records are stored in locked cabinets and staff have individual passwords to access confidential information on the computer.

The ward based activity timetable was displayed on the notice board. The occupational therapy timetable was also on display. Patients have access to a range of activities; however these do not always take place. There was information displayed regarding the advocate who visits the ward. Information regarding the next patient forum meeting was not on display. Patients have individual activity schedules which are reviewed regularly. Staff do not currently record if an activity is cancelled. A recommendation regarding activities has been stated for a second time.

Patients can access water independently from the water dispenser in the main foyer. There was a tea and coffee machine available for hot drinks outside of set times for refreshments.

Meal times were protected. The food menu was reviewed and was noted to offer a choice of food at each meal time.

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.

The inspector completed a direct observation 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

The formal session involved an observation of interactions between staff and patients. Two interactions were noted in this time period. The outcome of these interactions were as follows:

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

The inspector noted that staff were available throughout the ward and responded to patients' requests promptly. The inspector witnessed that staff remained supportive and reassuring to patients throughout the day. Interactions were observed as positive between patients and nursing staff.

Although the ward appeared busy with numerous patients and staff coming and going, patients appeared relaxed and at ease.

The detailed findings from the observation session are included in Appendix 4.

7.0 Patient Experience Interviews

The inspector met with four patients who agreed to talk about their care, treatment and experience as a patient. A further five patients agreed to complete a questionnaire regarding their care, treatment and experience as a patient. Five of the patients had been admitted to the ward in accordance to the Mental Health (Northern Ireland) Order 1986. Patients largely reflected positively on their relationships with staff. Although one patient reported that they were not informed of their rights.

Each patient reported that they had been involved in planning their care although one patient felt they had not been fully involved. Four Patients' reported a positive experience of their admission although two patients stated they were not shown around the ward. Four patients stated that staff listened to them although two patients stated that they weren't sure if their views were always considered.
Patient's comments included:

"I feel involved without pressure"

"Staff are supportive"

“My experience has been very good”

“I feel better able to look after myself”

“The ward is clean”

“There could be more tea and coffee breaks”

“You can do OT, art and can also have ground leave to walk about”

“I would like to be able to go on ground leave on my own”

“Staff are friendly, very approachable and encouraging”

The detailed findings are included in Appendix 3.

8.0 Other areas examined

During the course of the inspection the inspector met with:

Ward Staff	**2 and 1 student nurse**
Other ward professionals	**0**
Advocates	**0**

Ward staff

The inspector met with two members of nursing staff, a student nurse and the ward manager, on the day of inspection. Staff and students who met with the inspector did not express any concerns regarding the ward or patients’ care and treatment.

The advocate

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

Appendix 4 – QUIS
This document can be made available on request

Appendix 1

Follow-up on recommendations made following the announced inspection on 4 and 5 February 2015

No.	Reference.	Recommendations	Number of time stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	5.3.3 (b)	It is recommended that patient signatures are made available on all relevant care documentation. Staff should record if they had been unable to attain a signature.	2	The inspector reviewed the care files for four patients and noted that signatures were recorded on all relevant care documentation. Staff had also recorded if they had been unable to obtain a patient's signature.	Fully met
2	5.3.1 (a)	It is recommended that the Charge Nurse ensures that Deprivation of Liberty Safeguards are incorporated in each patient's care plan.	2	In the case of three of the four files reviewed a deprivation of liberty care plan had been devised. In the other file this had not been created as the patient had only been admitted to the ward within the previous 24 hours.	Fully met
3	5.3.1 (f)	It is recommended that the ward is repainted.	2	The inspector visited all areas of the ward during the course of the inspection and can confirm that the whole ward had been repainted.	Fully met
4	4.3 (m)	It is recommended that the ward manager ensures that all staff receive Human Rights, Restrictive Practice, capacity, consent and infection prevention and control training.	1	The inspector reviewed the staff training records for the ward and noted that ten of the 26 staff currently working on the ward had attended bespoke training on human rights, restrictive practices, capacity and consent. In addition the ward manager had issued information in relation to the above topics to all staff working on the ward. The items are also retained on the agenda for staff meetings. Training records for infection prevention and control (IPC) evidenced that only six of the 26 staff working on the ward had up to date IPC training. This is despite efforts of the ward manager to obtain additional training to no avail. A new	Partially met

				recommendation has been made in relation to this.	
5	8.3 (j)	It is recommended that the Ward manager ensures that staff assess patients' consent to daily care and treatment. This should be recorded in the patients' individual care plans and continuous nursing notes.	1	The inspector reviewed the care files for four patients and noted that in two of the patient's files individual care plans provided clear evidence for assessing and obtaining patients consent in relation to care and treatment. In a further patient's file this had not been included and for another patient they had only been admitted to the ward within the previous 24 hours. In the case of all four patients, continuous nursing notes did not provide any evidence of assessing or obtaining patients consent to care and treatment. This recommendation will be stated for a second time.	Not met
6	5.3.1 (f)	It is recommended that the ward manager ensures that all patients' care documentation is signed and dated upon completion by the responsible person.	1	The inspector reviewed the care files for four patients and noted that on the day of the inspection all care documentation was appropriately signed and dated by the responsible person.	Fully met
7	5.3.3 (b)	It is recommended that the ward manager ensures that risk screening tools are completed in full. If a decision is made not to proceed to a full comprehensive risk assessment then a clear rationale must be recorded and signed by all relevant parties, as outlined in the Promoting Quality Care Guidance Document – Good	1	The inspector reviewed the Promoting Quality Care documentation for three patients and noted the following: Patient A: Comprehensive risk assessment was not signed by the registered nurse or social worker. Patient B: Risk screening tool was not signed by the patient or a reason for not signing recorded. It was also not signed by the consultant, social worker or registered nurse. The further action necessary section was also not completed.	Not met

		Practice on the Assessment and Management of Risk in Mental Health and Learning Disability Services- May 2010.		Patient C: Comprehensive risk assessment was not signed by the registered nurse or social worker. This recommendation will be stated for a second time.	
8	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. Patients who continue to use profiling beds should have a clear rationale in their care file supported by a risk assessment and supporting care plan.	1	The ward has now reduced the number of profiling beds in use from four to two. The inspector reviewed the use and management of profiling beds for two patients currently on the ward. In each case a comprehensive care plan had been devised which provided a clear rationale, management plan and had been regularly monitored. In addition the ward manager had provided information on a notice board in the nurse's station to guide staff on the management of care for patients using a profiling bed. The operations manager had also completed a risk assessment for the management of profiling beds in mental health wards.	Fully met
9	5.3.1 (a)	It is recommended that the ward manager ensures that all patients' care plans are reviewed as prescribed. Reviews of care plans should ensure that care plans are measured and that the outcome of goals is assessed.	1	The inspector reviewed the care plans for three patients currently on the ward. In each case the inspector did not identify any evidence that care plans had been reviewed in such a way that provided a clear assessment of the outcome of goals. Staff had alternatively provided their signature and	Not met

				date on each care plan weekly. This provided no reassurances that care plans had in fact been reviewed in terms of the individual's ongoing needs and the outcomes of this. This recommendation will be stated for a second time.	
10	6.3.2 (g)	It is recommended that the ward manager develops a flexible recreational activity schedule for weekends which will consider the individual needs and views of the patients.	1	The inspector reviewed the activity provision on the ward and noted that the activity notice board detailed activities on offer for evenings and weekends. Patients' who met with the inspector expressed concerns regarding the lack of activities provided at evening and weekends. The inspector reviewed the nursing progress notes for three patients and identified no evidence of activities facilitated at evening and weekends in each case over the previous fortnight. This recommendation will be stated for a second time.	Not met
11	5.3.1 (f)	It is recommended that the estates department review the shower and wash hand facilities in en-suite bathrooms, to ensure that patients have appropriate amenities to attend to personal hygiene needs.	1	The inspector visited the ensuite facilities of patients' bedrooms and was advised by the ward manager that all shower heads had been replaced throughout the ward. The inspector also spent a period of time observing the duration of time the shower remained on and no concerns were identified. Patients who met with the inspector expressed no	Fully met

				concerns in relation to the shower or ensuite facilities.	
12	5.3.1 (f)	It is recommended that the Trust review the arrangements for the maintenance of the outside garden/smoke area to ensure that the area is regularly visited and maintained.	1	The inspector visited the two outside garden/smoke areas on the ward. The inspector noted that in each case these areas remained littered with cigarette butts. The ward manager advised the inspector that nursing staff and on occasions patients will clean these areas. The ward manager advised that there had been no resolution to matter. The inspector reviewed evidence of ongoing liaison between the service manager, operations manager and colleagues from estate services. At present the matter is unresolved and ongoing. As a result this has been escalated to senior management. This recommendation will be stated for a second time.	Not met
13	5.3.1 (f)	It is recommended that the Trust ensures that all members of medical staff, in line with the rest of the MDT, begin entering progress notes and reviews onto the PARIS system.	1	The inspector reviewed the medical notes for four patients currently on the ward. The inspector noted that in each case medical staff continue to hand write their records into the patients paper files. The ward manager advised that as of the 20 July 2015 all information from medical staff will be recorded on PARIS in align with other members of the multi-disciplinary team. This recommendation will be stated for a second time.	Not met
14	5.3.2 (c)	It is recommended that the	1	The inspector met with the ward manager who	Fully met

		Trust review the Safeguarding policies and procedures to reflect a time guide that will assist staff in the escalation and timely forwarding of concerns for investigation.		advised that there were currently no ongoing concerns regarding the timely completion of safeguarding referrals. The trust further reassured that staff had been made aware that safeguarding referrals should be completed and processed within 24 hours of the incident taking place. The inspector reviewed the Adult Protection Policy and Procedure for the Trust. The inspector noted that the policy was due review in April 2015. However was advised that the Trust were awaiting release of the new regional Adult Safeguarding Policy for Northern Ireland. In addition the ward manager reassured the inspector that safeguarding activity is audited by the ward manager.	

Quality Improvement Plan

Unannounced Inspection

Rathlin, Knockbracken Healthcare Park

2 July 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 manager and other senior trust representatives on the day of the inspection visit.

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

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
Is Care Safe?					
1	5.3.3 (b)	It is recommended that the ward manager ensures that risk screening tools are completed in full. If a decision is made not to proceed to a full comprehensive risk assessment then a clear rationale must be recorded and signed by all relevant parties, as outlined in the Promoting Quality Care Guidance Document – Good Practice on the Assessment and Management of Risk in Mental Health and Learning Disability Services- May 2010.	2	Immediate and ongoing	A comprehensive risk assessment is provided for all patients who have been in an inpatient setting for more than two weeks. To-date this has been in paper format however the comprehensive risk assessment is now available on the Community Information System which should resolve this issue. Monthly audits of the multidisciplinary notes continue to take place by the Band 6s and issues are addressed with the patient's Primary Nurse. Spot checks are also undertaken by the Nurse Development Lead and any issues highlighted to the Charge Nurse.
2	5.3.1 (f)	It is recommended that the Trust ensures that all members of medical staff, in line with the rest of the MDT, begin entering progress notes and reviews onto	2	20 July 2015	This issue is being addressed by the senior management team. Dedicated support is being provided to medical staff to facilitate transition to the new system

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
		the PARIS system.			
3	4.3 (m)	It is recommended that the ward manager ensures that all staff receive fire safety and infection prevention and control training.	1	30 October 2015	Eight members of staff are undertaking Fire Safety Training on 04 September 2015 and eight members of staff are undertaking Infection Prevention and Control training at the end of September. Infection Prevention and Control and Fire Safety training are both included in the Freeze week in October.
Is Care Effective?					
4	5.3.1 (a)	It is recommended that the ward manager ensures that all patients' care plans are reviewed as prescribed. Reviews of care plans should ensure that care plans are measured and that the outcome of goals is assessed.	2	Immediate and ongoing	The Charge Nurse has raised this issue with staff. Care plans are also audited as part of the overall multidisciplinary team meeting and addressed with the Named Nurse. Mentoring will be provided to those staff with ongoing issues in both completing and reviewing their care plans. The capability procedure will be implemented where this proves unsuccessful.
5	8.3 (h)	It is recommended that the Trust review the arrangements for the	1	30 October	This issue has been raised with the Administration Services Manager within Acute Mental Health

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
		ongoing management and maintenance of patients' paper files to ensure the safe storage and filing of all documents and information.		2015	Services. A full time ward clerk will be appointed and in post by the end of October 2015 and training will be provided regarding expected standards of maintenance of patients' paper files. Other members of the multidisciplinary team have also been reminded of their responsibilities with regards to minute taking. The Administration Manager and Quality and Information Manager have now implemented a rolling programme of quarterly audit checks with regards to the management and maintenance of patients' paper files. They will address any issues with the relevant member of staff.
Is Care Compassionate?					
6	8.3 (j)	It is recommended that the Ward manager ensures that staff assess patients' consent to daily care and treatment. This should be recorded in the patients'	2	Immediate and ongoing	The Trust is undertaking a review of this issue as it has been raised in other ward inspections by RQIA. The Trust will engage with colleagues from other Trusts to identify best practise for responding

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
		individual care plans and continuous nursing notes.			to this recommendation in a meaningful way.
7	6.3.2 (g)	It is recommended that the ward manager develops a flexible recreational activity schedule for weekends which will consider the individual needs and views of the patients.	2	30 October 2015	The Charge Nurse has developed a flexible recreational activity schedule for the weekend.
8	5.3.1 (f)	It is recommended that the Trust review the arrangements for the maintenance of the outside garden/smoke area to ensure that the area is regularly visited and maintained.	2	30 October 2015	We continue to try to resolve responsibility for this issue and are looking at other options including engaging patients, who are smokers, in participating in maintaining the environment. The Trust will be implementing a ban on smoking in March 2016 which will resolve this issue.

NAME OF WARD MANAGER COMPLETING QIP	Paul Magowan
NAME OF CHIEF EXECUTIVE /	Martin Dillon, Deputy Chief

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

IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Executive

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Alan Guthrie	19 November 2015
B.	Further information requested from provider				