# Unannounced Follow Up Inspection Report
# 17- 19 October 2017

## Rathlin Ward
## Knockbracken Healthcare Park
## Saintfield Road
## Belfast
## BT8 8BH

## Tel No: 02890 638856

## Inspectors: Audrey McLellan & Dr John Simpson

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

Rathlin is a 24 bedded acute admission ward for patients with acute mental health needs. The ward provides assessment and treatment for both male and female patients. There were 23 patients on the ward during the inspection and one patient on leave. There were 16 patients who were detained appropriately in accordance with the Mental Health (NI) Order 1986.

Patients had access to a multidisciplinary team (MDT) which included input from nursing, psychiatry, social work, pharmacy and occupational therapy. Access to clinical psychology was by referral. The Trust had recruited a THORN practitioner nurse to work as part of the MDT team. THORN has become synonymous with best practice for the care and treatment of people with a diagnosis of severe mental illness and psychological interventions. Patients on the ward also had access to an independent advocacy service.

## 3.0 Service details

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| **Responsible person:** Martin Dillon | **Ward Manager:** Kevin Mackell |
| **Category of care:** Assessment and Treatment | **Number of beds:** 24 |
| **Person in charge at the time of inspection:** Steve McKenna | |

## 4.0 Inspection summary

An unannounced follow-up inspection took place over three days on 17-19 October 2107.

The inspection sought to assess progress with findings for improvement raised from the most recent unannounced inspection on 14 -16 November 2016.

Inspectors noted that the ward had made improvements from the previous inspection. The Trust had employed a caretaker to attend to the garden areas outside and screening had been placed on a bedroom window overlooking the garden. A THORN practitioner now formed part of the MDT and their role involved providing therapeutic interventions. They had also developed a training plan for nursing staff in relation to completing psychological formulations that will underpin and direct care on the ward.

Areas for improvement were restated in relation to the completion of risk assessments, medical staff not recording patient information on the patient electronic recording system (PARIS), the absence of appropriate recording of information discussed at the MDT meetings and patients' attendance at these meetings.

New areas for improvement were made in relation to patient records held in two separate places (paper files and on the PARIS system), staff using a number of different care plan templates to complete care plans, a number of care plans were not signed by patients and were not signed and reviewed by staff. One patient had a diagnosis of type 1 diabetes and there was no care plan in place to direct staff on how to manage this patient's condition. There was no comprehensive nursing assessment in place to assess patients' overall physical health care needs. There was evidence of nurses completing their own type of assessment with different headings to assess patients' physical health needs. In a number of patients' bedrooms there were no curtains on the windows and the front of the bedside locker drawers had been removed and not replaced.

The entrance to the ward appeared to be a very busy area as there were three main functions to this area. This included a seating area for patients, the nurses' office and access to the ward. The inspectors observed a number of incidents occurring in this area between patients and staff, between two patients and between a visitor and a patient which all required the intervention from nurses to ensure patients and visitors were kept safe. This area should be reviewed in light of these concerns.

**Patients Views**

The inspectors spoke to four patients on the ward. Patients were very complimentary about the care and treatment they were receiving. Patients confirmed they knew who to speak to if they were unhappy and that staff were always available for them to talk to. Three patients stated they felt safe on the ward and one patient stated they sometimes feel safe on the ward but this depends on other patients' presentation. Three patients confirmed there were activities on the ward for them to take part in each day and they stated that they felt these activities were very beneficial to their recovery. One patient said there were not enough activities on the ward for them to take part in. Patients advised that staff treat them with dignity and respect.

All four patients stated they do not get the opportunity to attend their MDT meetings each week and three patients said they would like more time with their consultant psychiatrist. One patient stated that they would like access to tea and coffee facilities as the machine on the ward only takes coins and on many occasions patients do not have coins for the machine. This was discussed at the conclusion of the inspection with senior Trust representatives who advised they will review patients' access to tea and coffee. An area for improvement was restated in relation to patients attending their MDT meeting each week whereby they will be able to meet all members of the MDT to discuss their care and treatment. Patients made the following comments.

"I don't attend my MDT meetings….I see Dr X about twice a week but the time is very short and I can't see how X does an assessment of my mental health in such a short time (5 minutes) I don't have enough time with the doctor……accommodation is good…..nurses are very caring…...you can't get tea and coffee whenever you want…we never have enough coins….I would like more activities on the ward and access to a larger fridge for my food in the occupational therapy room"

"Nurses, carers and cleaners are great….medication is making me better…..nurses and doctors are fantastic they all treat me with dignity...this is like a 4½ star hotel… the staff are fantastic…I feel I pass information on to the nurses for the doctor and it takes ages for an answer to come back".

"I do not attend my MDT meetings….I feel like a king in here……the nurses are great and all the health care assistants, they treat everyone with dignity and respect…Doctor X is nice but I haven't seen her much…more attention from the doctor would be nice".

"I have never went to meetings but I would like to go…the majority of staff have been nice to me…there is a good variety of food in here….I enjoy the art and I like to sing."

**Relatives Views**

The inspector spoke to one relative who advised they were very happy with the care and treatment offered to their relative. The relative made the following comments:

"Interactions between staff and patients is excellent. Staff are very compassionate….my X seems happy with the accommodation and food"

**Staff Views**

The inspector spoke to five ward staff. Staff stated the ward was very busy but they enjoyed working on the ward and felt well supported. They advised the ward team was effective and all staff supported each other. They stated the MDT worked well together and they felt well supported by the ward manager and deputy ward managers. One of the nurses stated they had been involved in the training programme with the THORN practitioner and they felt this was very beneficial. They advised they could see changes happening in the ward which was improving the service. The deputy ward manager stated they had implemented changes to the ward and had developed a 'safety brief' where issues concerning the ward and patients are discussed with all staff each morning.

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 |
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The total number of areas for improvement comprise of:

- One restated for a fourth time
- Three restated for a second time
- Five new areas for improvement

These are detailed in the Quality Improvement Plan (QIP). Areas for improvement and details of the QIP were discussed with senior Trust representatives and members of the multi-disciplinary team as part of the inspection process. The timescales for completion commenced from the date of inspection.

Escalation action resulted from the findings of this inspection. An area for improvement in relation to members of the medical staff not recording patient information on the patient

electronic recording system (PARIS) was assessed as partially met and therefore required to be restated for a fourth time. A serious concerns meeting was held on 9 November 2017 to seek assurance from the Trust that immediate action will be taken to ensure this area for improvement is met.

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.

The following areas were examined during the inspection:

- Care Documentation in relation to seven patients.
- Ward environment.
- DATIX records.
- Training plans set up by the THORN practitioner.

During the inspection the inspectors observed staff working practices and interactions with patients using a Quality of Interactions Schedule Tool (QUIS). All interactions observed between staff and patients were noted to be positive. Staff were observed reassuring patients when they appeared upset, sitting talking with patients and answering patients' queries regarding aspects of their care. When patients returned from leave staff were observed welcoming them back to the ward and spending time discussing how their leave went. Staff were also observed ensuring no prohibited items were brought on to the ward upon patients return from leave. This was to ensure patients were kept safe. During all interactions patients were treated with dignity and respect by staff.

Areas for improvements made at the previous inspections were reviewed 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 14-16 November 2016

The most recent inspection of Rathlin Ward 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 | | Validation of Compliance |
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| **Number/Area 1**<br><br>**Ref**: Standard 5.3.1(f)<br><br>**Stated:** Third Time | Members of the medical staff were not recording patient information on the patient electronic recording system (PARIS). | **Not Met** |
| | **Action taken as confirmed during the inspection**:<br><br>The inspectors reviewed seven sets of care records and there was evidence that the junior medical staff were completing regular reviews of the patients on the PARIS system.<br><br>However there was limited evidence of reviews by one consultant psychiatrist in either the PARIS records or paper records and one consultant psychiatrist was recording information on both the PARIS records and the paper files.<br><br>It is concerning to note that this is the fourth time RQIA have had to raise this issue with the Trust. In light of the seriousness of these concerns a serious concerns meeting was held on 9 November 2017 to seek assurance from the Trust that immediate action will be taken to ensure this area for improvement is met.<br><br>This area for improvement will be restated for a fourth time. | |

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| **Number/Area 2**<br><br>**Ref**: Standard 5.3.1(f)<br><br>**Stated:** Third Time | The garden/smoking area had not been maintained.<br><br>**Action taken as confirmed during the inspection**:<br><br>The Trust had employed a caretaker whose job is to ensure the garden areas are maintained and kept free of rubbish. The inspectors reviewed the two gardens and were satisfied that there was no rubbish on the ground and the graffiti on the sheltered area had been removed. | **Met** |
| **Number/Area 3**<br><br>**Ref**: Standard 5.3.1(a)<br><br>**Stated:** First Time | There were two profiling beds in use on the ward. At the time of the inspection, both patients did not have a ligature/self-harm risk assessment/care plan in place in accordance with the Estates and Facilities Alert from the Department of Health; June 2010, on self-harm associated with profiling beds. This was raised as a priority one finding. The ward manager agreed to complete a care plan for both patients and forward to RQIA by 18 November 2016.<br><br>**Action taken as confirmed during the inspection**:<br><br>There was one patient on the ward who was using a profiling bed and had been assessed as requiring this type of bed. A care plan was in place for the use of bed rails and in relation to the ligature risks and there was a regular review of the patient's mental health**.** | **Met** |
| **Number/Area 4**<br><br>**Ref**: Standard 5.3.2(f)<br><br>**Stated**: First Time | There were a number of incidents classed as medication errors on the incident recording system (DATIX). Of note, not all of these were related to the administration of medication. Inspectors were assured that this had been addressed by the practice development nurse and an action plan had been developed to reduce the risk of medication errors reoccurring. Inspectors observed that medication is dispensed in the clinical room and taken to the patient. Inspectors also observed during the inspection the number of times staff were approached by patients during the administration of medication. Inspectors were concerned that due to these distractions there were potential risks involved with the administration of medication by this process. | **Met** |

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| | **Action taken as confirmed during the inspection**:<br><br>The inspector reviewed medication incidents recorded on the DATIX from January 2017 to September 2017. There was evidence that medication incidents had reduced considerably. It was also evident that all medication incidents had been reviewed by the practice development nurse and an action plan had been developed to reduce the risk of medication errors occurring.<br><br>A number of patients did come to the clinical room to receive their medication and this was continually encouraged by nursing staff. However some patients still refused to come to this room therefore staff have to bring medications to these patients to ensure they are compliant with their prescribed medication.<br><br>None of the incidents reported were in relation to administration and supply of medication from the clinical room to the patients on the ward. | |
| **Number/Area 5**<br><br>**Ref**: Standard 5.3.1(a) & 5.3.3(b)<br><br>**Stated:** First Time | The ward round template was not completed consistently and minutes of the ward round were either completed on PARIS or in the patients paper record. The minutes were not comprehensive, there was no record of each patient's progress during the week from MDT and there was no action plan completed for the forthcoming week.<br><br>Patients were not offered the opportunity to attend their weekly multi-disciplinary meeting. There was no evidence in the documentation that staff met with patients prior to the ward round to give them the opportunity to share their views at this meeting. | **Partially Met** |
| | **Action taken as confirmed during the inspection**:<br><br>The inspectors reviewed seven sets of care records. There was evidence that the MDT records had been transferred over to the PARIS system. However these records were not consistently completed each week. In a number of records there was no action plans, sections were missing and in a number of records there was limited information recorded on the patients' summary | |

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| | section. One summary stated "presentation over last week relayed by nurse". This was in contrast to a number of other records whereby the summary section had been completed in full with a comprehensive review of the patients' presentation over the previous week.<br><br>There were also a number of different versions of the MDT template on the system and there was no record of a meeting held on 5/10/17 and 12/10/17 in one patient's file and in another patient's file there was no record of an MDT meeting held on 5/10/17.<br><br>There was no evidence in the care records of patients attending their MDT meetings each week and patients confirmed they did not get the opportunity to attend their MDT meetings.<br><br>This area for improvement will be reworded and restated for a second time. | |
| **Number/Area 6**<br><br>**Ref**: Standard 6.3.2(a)<br><br>**Stated:** First Time | One relative informed inspectors that there was offensive graffiti etched on the mirror in their family member's bedroom. This was discussed during feedback and immediate action was requested.<br><br>Patients accessing the garden area could see into one patient's bedroom. There was no screening on the bedroom window overlooking the garden area.<br><br>**Action taken as confirmed during the inspection**:<br><br>On inspection of the ward environment there was no concerns raised regarding graffiti and screening had been placed on the bedroom window which over looked the garden area. | **Met** |
| **Number/Area 7**<br><br>**Ref**: Standard 6.3.2(b)<br><br>**Stated:** First Time | The ward information folder was retained in the ward office and not readily available for patients.<br><br>**Action taken as confirmed during the inspection**:<br><br>There is a copy of the ward information folder in the main ward for patients to access. | **Met** |
| **Number/Area 8** | There was no record in the minutes of the patient | |

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| **Ref**: Standard 6.3.2(g)<br><br>**Stated:** First Time | forum meetings that areas for improvement raised by patients at previous meetings had been addressed. The patient forum template was not consistently completed and did not always indicate who attended. | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>The template for recording the minutes of patient forum meetings had been updated and the deputy ward manager had stated this will be the format the ward will use to ensure that areas for improvement raised by patients at previous meetings will be recorded with the outcome.<br><br>Patients confirmed that issues they had raised with staff at the patient forum meetings had been dealt with appropriately. | |
| **Number/Area 9**<br><br>**Ref**: Standard 5.3.1(a) & 6.3.2(b)<br><br>**Stated:** First Time | The service user involvement section of the comprehensive risk safety assessment was not completed in two out of three of the assessments reviewed. In the one completed service user's involvement section staff had recorded the patient's perception of their risks but did not detail the patient's understanding of their risk assessment, or whether they had agreed to the assessment.<br><br>One out of the three comprehensive risk safety assessments had a risk management plan in place and this was documented in the "summary of risks" section of the template. Of note there was no template on the PARIS system to record the risk management plan.<br><br>Comprehensive risk safety assessments were not reviewed in accordance with Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Service May 2010. The review either detailed the outcome of a ward meeting or the details about an incident. The review did not reflect if the risk had reduced, remained the same or increased. For example the alteration to risk management plan stated the patient could access community leave, however there was no detail recorded in the "update/change in risk" to confirm why this decision was taken. | **Not Met** |

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| | **Action taken as confirmed during the inspection**:<br><br>The inspector reviewed seven patient care records and there was evidence that staff were reviewing patients' risk assessments each week and updating the risks associated with each patient. However concerns were raised regarding the following issues:<br><br>• The risk assessments had been transferred onto the PARIS system but there was no section on the risk assessment to record a risk management plan.<br>• Risk assessments were completed by only one member of staff.<br>• A number had not been reviewed on admission as per policy.<br>• In a number of assessments the summary of risks did not include all risks identified in the assessment. In one assessment the risks included "risk to self/physical injury, thoughts to cut himself". However the summary of risks stated "X is vulnerable due to paranoid ideation and lack of insight" there was no record of the risk of self-harm.<br>• One patient who had been on the ward for over two weeks did not have a comprehensive risk assessment or a risk screening tool in place.<br>• One patient was admitted on the ward for 12 weeks before a comprehensive risk assessment was completed and there was no evidence that a risk screening assessment had been completed on admission. | |
| **Number/Area 10**<br><br>**Ref**: Standard 5.3.1(a) & 5.3.3(f)<br><br>**Stated:** First Time | On review of the nursing care plans, it was evident that nursing interventions focused mainly on administration of medication, building a therapeutic relationship with patients and one to one time. There was no evidence that nursing staff provided any other therapeutic interventions. Although it was noted that nursing staff were keen to deliver such interventions, this would require some additional training, supervision and time to plan and deliver. There was no joint work by the MDT in relation to planning and delivery of either recreational or therapeutic interventions. Activities | **Partially Met** |

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| | on the ward were led in the main by the occupational therapist.<br><br>Access to the psychology service was by referral. The clinical psychologist was not a member of the MDT working on the ward and during the inspection there was no evidence of ongoing, planned psychological interventions. The National Institute for Health and Clinical Excellence, Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care 2009 recommends patients have access to one psychological intervention per week in inpatient services. The psychologist confirmed that there should be more referrals to the service and there were no interventions in areas such as substance misuse, Cognitive Behaviour Therapy (CBT) or challenging behaviours. There were no psychological formulations evident in the four files reviewed. | |
| | **Action taken as confirmed during the inspection**:<br><br>In the seven sets of care records reviewed there was no evidence of staff completing psychological formulations to underpin care plans and to direct a model of intervention/treatment. However progress had been made in relation to this area of improvement as follows:<br>• A THORN practitioner had been recruited to the ward to work as part of the MDT.<br>• The THORN practitioner was involved in providing therapeutic interventions on the ward with a number of patients and they worked closely with Home Treatment Team (HTT).<br>• The THORN practitioner had developed a training plan for staff in relation to completing psychological formulations that will underpin and direct care on the ward. This will focus on a more therapeutic role for nurses.<br><br>This area for improvement will be restated and reworded to reflect the progress that has been made to date. | |

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| **Number/Area 11**<br><br>**Ref**: Standard 6.3.1(c)<br><br>**Stated:** First Time | The age range of patients on the ward was from 23 years to over 65 years. There were two patients over the age of 65 years in Rathlin. This meant both patients could not access the old age psychiatry service available in the Mater Ward L which is the over 65 functional mental health ward in the BHSCT. Of note there were 10 patients under 65 years in Ward L during the inspection to Rathlin. | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>On the days of the inspection there was one patient on the ward who was 66 years old. This was discussed with ward staff who advised as this patient had just turned 66 it would be inappropriate to transfer this patient during their admission. The ward staff advised that if a patient is admitted to the ward and is over 65 years old once a bed is available in Ward L in the Mater hospital they will be transferred if this is deemed appropriate. Each patient is discussed on an individual basis as some patients prefer to stay on the ward. Senior trust representatives confirmed that all patients over 65 years have input from old age psychiatry services | |

## 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 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 via the Web Portal for assessment by the inspector by 8 December 2017**.**

## Quality Improvement Plan

**The responsible person must ensure the following findings are addressed:**

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| **Area for Improvement No. 1**<br><br>**Ref**: Standard 5.3.1(f)<br><br>**Stated:** Fourth Time<br><br>**To be completed by:**<br>16 November 2017 | Members of the medical staff were not recording patient information on the patient electronic recording system (PARIS). |
| | **Response by responsible individual detailing the actions taken:**<br>Consultant Psychiatrists within Rathlin Ward are now recording on the PARIS system. |
| **Area for Improvement No. 2**<br><br>**Ref**: Standard 5.3.1(a) & 5.3.3(b)<br><br>**Stated:** Second Time<br><br>**To be completed by**:<br>16 November 2017 | The ward round template was not completed consistently each week. In a number of records minutes were not comprehensive, there was no record of each patient's progress during the week from the MDT and there was no action plan completed for the forthcoming week.<br><br>Patients were not offered the opportunity to attend their weekly multi-disciplinary meeting. |
| | **Response by responsible individual detailing the actions taken:**<br>The prescribed template is now printed out and completed by ward staff prior to the multidisciplinary team meeting. A copy of this is held in the patient's notes.<br>A multidisciplinary team meeting template has also been agreed by the multidisciplinary team quality improvement group. A pilot will take place in Ward K, Mater Hospital early in the New Year and this template will subsequently be rolled out to the rest of Acute Mental Health Inpatient Services including Rathlin by the end of April 2018.<br><br>Patients were being offered the opportunity to attend their weekly multidisciplinary team meeting however the Trust acknowledges that this was not being recorded. A record is now made within patient notes to reflect that they have been offered the opportunity to attend the weekly multidisciplinary team meeting. |
| **Area for Improvement No. 3**<br><br>**Ref**: Standard 5.3.1(a) & 6.3.2(b)<br><br>**Stated:** Second Time | Comprehensive risk safety assessments were not completed in accordance with Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Service May 2010. |
| | **Response by responsible individual detailing the actions taken:**<br>A change request form will be submitted to the PARIS team regarding |

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| **To be completed by:**<br>16 November 2017 | a risk management plan section on the comprehensive risk assessments.<br><br>A spot check on patient records will be undertaken by the Charge Nurse and the Deputy Charge Nurse/Ward Sister who will ensure that all patients have a comprehensive risk assessment tool or risk screening tool (where the patient has not been admitted for two weeks) in place.<br>This issue will also be discussed with staff at their staff meeting and during supervision sessions. |
| **Area for Improvement No. 4**<br><br>**Ref**: Standard 5.3.1(a) & 5.3.3(f)<br><br>**Stated:** Second Time<br><br>**To be completed by:**<br>19 March 2018 | In the seven sets of care records reviewed there was no evidence of staff completing psychological formulations to underpin care plans and to direct models of intervention/treatment.<br><br>On review of the nursing care plans, it was evident that nursing interventions focused mainly on administration of medication, building a therapeutic relationship with patients and one to one time. There was no evidence that nursing staff provided any other therapeutic interventions.<br><br>There was no joint work by the MDT in relation to planning and delivery of either recreational or therapeutic interventions. Activities on the ward were led in the main by the occupational therapist. |
| | **Response by responsible individual detailing the actions taken:**<br>Nursing staff provide a number of therapeutic interventions including music group, cinema group, 1:1 time and recovery group however the Trust acknowledges that this was not being recorded. The THORN Nurse continues to provide psychosocial interventions to patients.<br><br>The THORN nurse also continues to provide training to staff regarding psychological formulations to underpin care plans. This training is currently being cascaded. Care plans will be reviewed and amended to include psychological formulations within the inspector's timescale. |
| **Area for Improvement No. 5**<br><br>**Ref:** 5.3.1 (f)<br><br>**Stated:** First Time<br><br>**To be completed by:**<br>19 March 2018 | Patients' records were stored in both paper files and on the PARIS system therefore it was difficult to review the patients' journey on the ward. |
| | **Response by responsible individual detailing the actions taken:**<br>The Trust continues to work towards the total migration of patient records onto the PARIS system. |
| **Area for Improvement** | Staff were using a number of different care plan templates. A number |

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| **No. 6**<br><br>**Ref:** 5.3.1 (a)<br><br>**Stated:** First Time<br><br>**To be completed by:**<br>16 November 2017 | of care plans were not signed by patients and not signed and reviewed by staff. One patient had a diagnosis of type 1 diabetes and there was no care plan in place to direct staff on how to manage this patient's diabetes. |
| | **Response by responsible individual detailing the actions taken:**<br>The prescribed form contained within the Acute Inpatient Multidisciplinary Team notes is now the solely used care plan template on the ward. Patient records continue to be audited by the Deputy Charge Nurse and Deputy Ward Sister; issues in relation to the care plans will be addressed with staff during staff meetings and supervision. |
| **Area for improvement No. 7**<br><br>**Ref**: 5.3.1(f)<br><br>**Stated:** First Time<br><br>**To be completed by:**<br>19 February 2018 | There was no comprehensive nursing assessment in place to assess patients' overall physical health care needs. There was evidence of nurses completing their own type of assessment with different headings to assess patients' physical health needs. |
| | **Response by responsible individual detailing the actions taken:**<br>A physical healthcare pathway is now in place for every patient within Rathlin Ward. |
| **Area for improvement No. 8**<br><br>**Ref**: 6.3.2 (a)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>19 January 2018 | In a number of patients' rooms there were no curtains on the windows and the front section of the drawers on the bedside lockers had been removed and not replaced. |
| | **Response by responsible individual detailing the actions taken:**<br>Ward staff have submitted numerous requests to Estates Services in relation to this however have not responded. This will now be escalated to Senior Management for intervention. |
| **Area for improvement No. 9**<br><br>**Ref**: 5.3.1 (f) & 6.3.1 (c)<br><br>**Stated:** First Time<br><br>**To be completed by:**<br>19 February 2018 | The entrance to the ward appeared to be a very busy area as there were three main functions to this area. A seating area for patients, the nurses' office and access to the ward.<br><br>The inspectors observed a number of incidents occurring in this area between patients and staff, between two patients and between a visitor and a patient which all required interventions from nursing staff to ensure patients and visitors were kept safe.<br><br>This area should be reviewed in light of these issues. |
| | **Response by responsible individual detailing the actions taken:** |

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| | The seating area in Rathlin Ward is being reviewed. Patients will also be given more protected 1:1 time with nursing staff which will hopefully minimise the activity around the entrance of the Ward. |

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| **Name of person (s) completing the QIP** | Kevin Mackel, Charge Nurse, Rathlin<br>Blanca Bjourson, Consultant Psychiatrist, Rathlin<br>Cahal McKervey, Service Manager, Acute Mental Health Inpatient Services<br>Paul McCabe, Senior Nurse Manager, Acute Mental Health Inpatient Services<br>Patricia Minnis, Quality and Information Manager | | |
| **Signature of person (s) completing the QIP** | | **Date completed** | 01/12/2017 |
| **Name of responsible person approving the QIP** | Martin Dillon, Chief Executive | | |
| **Signature of responsible person approving the QIP** | | **Date approved** | 08/12/2017 |
| **Name of RQIA inspector assessing response** | Audrey McLellan | | |
| **Signature of RQIA inspector assessing response** | | **Date approved** | 11/12/17 |

***Please ensure this document is completed in full and returned to RQIA via the Web Portal.***

The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower
5 Lanyon Place
BELFAST

BT1 3BT

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