The Regulation and Quality Improvement Authority

Ward 11

Lagan Valley Hospital

South Eastern Health & Social Care Trust

Unannounced Inspection Report

Date of inspection: 16 June 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

Ward 11 is a 16 bedded facility situated on the ground floor in Lagan Valley Hospital. The ward comprises a 10 bedded inpatient unit which provides assessment and treatment to older persons with dementia. The ward also has a six bedded inpatient service for older people with functional mental illness. The two patient groups are accommodated in different parts within the unit and have separate day, dining and bedroom areas.

On the days of the inspection there were 15 patients admitted to the ward; nine patients had been detained in accordance with the Mental Health (Northern Ireland) Order 1986.

Patients are supported by the ward's multi-disciplinary team which includes nursing, medical, social work and occupational therapy staff.

4.0 Summary

Progress in implementing the recommendations made following the previous inspection carried out on 18 & 19 February 2015 were assessed during this inspection. There were a total of fourteen recommendations made following the last inspection.

Seven recommendations had been implemented in full. Seven recommendations had not been met and will be stated for a second time. It was good to note that staff had received up to date training in relation to safeguarding vulnerable adults and the management of behaviours that challenge. Staff had received up to date supervision and appraisals. There was some improvement noted in relation to record keeping. The ward

manager had developed an audit process of patients' care documentation and the inspector noted that medical records were completed in full.

However, patient's ulcer risk assessment (Braden) and malnutrition universal screening tool (MUST) assessments had not been reviewed in accordance with clinical standards. The inspector noted that there was no rationale recorded when a patient was not involved in their care and treatment plans.

Improvements were noted to the occupational therapy room with the addition of tables, chairs, shelving and storage. A programme of activities was available in the evenings and weekends. Staff were also keeping a record if activities had to be cancelled and the reason why.

The inspector met with eight patients and two relatives on the ward. Patients and relatives spoke positively about the care and treatment and stated staff were compassionate, caring and they were treated with dignity and respect. Relatives commented their family member was more settled now than they had been before admission. Relatives stated that they believed this was due to the care and treatment their relative received on the ward.

The ward environment was observed to be fit for purpose and delivered a relaxed and safe environment. The ward had a dementia friendly design. The ward was spacious which enabled patients to walk around independently. Signage around the ward was of a good size and easily seen. The use of contrasting colours on the ward promoted orientation and mobility.

All patients slept in a profiling bed however; there was no evidence of an individualised ligature risk assessment in place for the patient. A recommendation has been made.

4.1 Implementation of Recommendations

Four recommendations which relate to the key question "**Is Care Safe**?" were made following the inspection undertaken on 18 & 19 February 2015.

These recommendations concerned staff training in relation to safeguarding vulnerable adults, behaviours that challenge and staff supervision. A recommendation was made to make improvements to the occupational therapy room.

The inspector was pleased to note that all of the recommendations had been fully implemented. All staff working on the ward had received up to date training in relation to safeguarding vulnerable adults and training in the management of behaviours that challenge. Supervision and appraisals were up to date for all staff. Improvements were made to the occupational therapy room.

Seven recommendations which relate to the key question "**Is Care Effective**?" were made following the inspection undertaken on 18 & 19 February 2015.

These recommendations concerned record keeping in accordance with policy and procedure, the availability of occupational therapy services and restrictive practices.

The inspector noted that two recommendations had been fully implemented. The ward manager had introduced and maintained an audit of patient records and patient documentation had been completed by medical staff.

However, despite assurances from the Trust, five recommendations had not been fully implemented. Minutes from the Multi-disciplinary team assessment meetings (TAM) had not been fully completed. Assessment documentation had not been reviewed in accordance with policy and procedure. Patients could not access occupational services Monday to Friday. The inspector also identified that patients did not have individualised restrictive practice care plans in place.

Three recommendations which relate to the key question "**Is Care Compassionate**?" were made following the inspection(s) undertaken on 18 & 19 February 2015.

These recommendations concerned the availability of an advocacy service, evidence that patients were involved in their care plans and the provision of therapeutic activities in the evenings and weekends.

One recommendation had been fully implemented; therapeutic activities were now available in the evenings and weekends.

However, despite assurances from the Trust, two recommendations had not been fully implemented. The advocacy service had not been formalised for the six bedded inpatient service for older patients with mental illness. Evidence was not available to confirm that all patients were involved in their care plans or a reason recorded where this was not appropriate.

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 ward interior was designed as a dementia friendly environment. The ward's environment presented as clean, clutter free and well maintained. There was good ventilation and neutral odours. Ward furnishings were well maintained and comfortable. There was good natural light. The ward was

spacious which enabled patients to walk around independently. Signage around the ward was of a good size and easily seen. The use of contrasting colours on the ward promoted orientation and mobility.

There was a good mechanism in place for patient and relative feedback. On the day of the inspection there was adequate staffing to meet the needs of the patients. Staff were observed to be available in the patients communal area at all times. Staff were considerate to patients needs, offered constant reassurance when patients presented as confused and disorientated and were skilled at supporting and reassuring patients who were distressed.

A pay phone was available for patients and patients could also retain their personal mobile phones. Exit from the ward is controlled by a swipe system. Information was displayed in relation to Deprivation of Liberty guidance and included in the ward welcome pack. There was a good range of activities available on the ward. Seating around the ward promoted social interaction, however there were quiet areas for patients to retreat to. There was space for patients to eat together and ample seating for staff or relatives to assist at mealtimes.

A ward specific ligature risk assessment had been completed. All of the beds in the ward were profiling beds. There was no individualised ligature risk assessment in place or a subsequent risk management plan to address any identified risks related to the use of profiling beds. A recommendation has been made in relation to this.

The detailed findings from the ward environment observation are included in Appendix 3

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

On the day of the inspection the inspector observed interactions between staff and patients/visitors. Ten interactions were noted in this time period. The outcomes of these interactions were as follows:

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

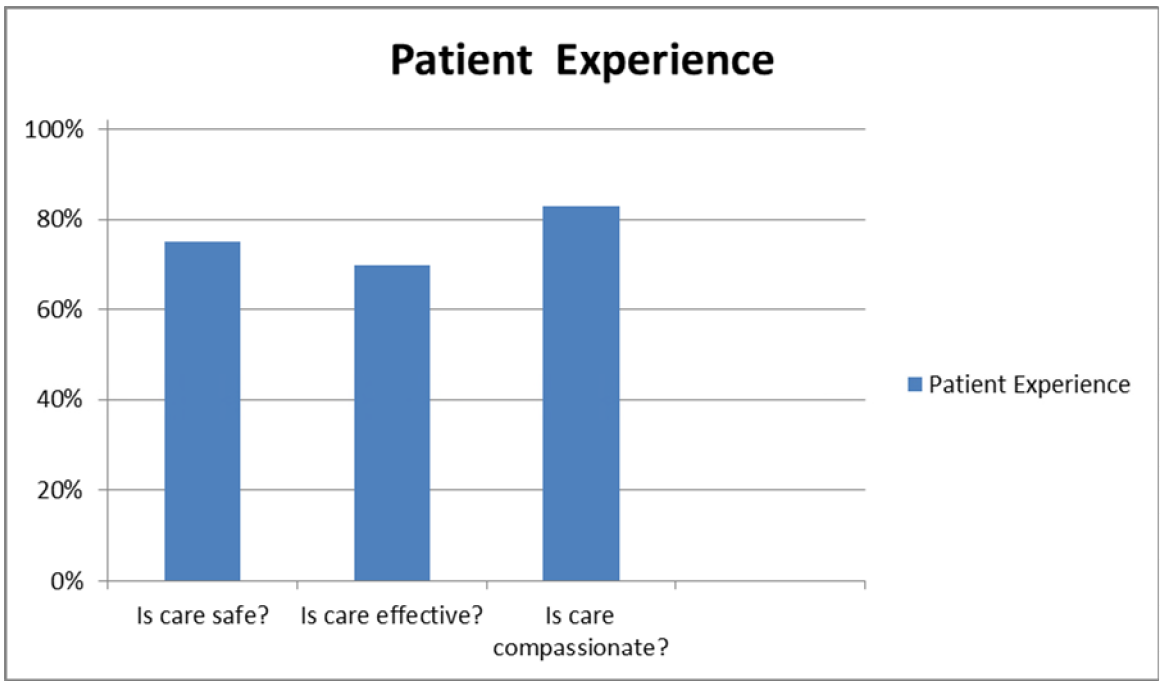
The inspector observed interactions between patients, relatives and staff. Staff were observed to be attentive to patient's needs. Staff were observed responding promptly to any queries raised by patients and relatives. All interactions were observed as positive. Staff were kind and compassionate, treated patients with dignity and respect and were observed to be considerate to relatives. Staff demonstrated their knowledge and skill of supporting patients with dementia and were noted to be skilled in supporting patients who were distressed. Staff were observed to be actively engaging with patients, offering a choice of activity, encouraging patients to participate and commenting and praising patients on their chosen activity.

Overall patients appeared relaxed and comfortable with their surroundings.

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

7.0 Patient Experience Interviews

Two patients met with the inspector and and agreed to complete a patient experience questionnaire. A further two relatives agreed to meet with the inspector and complete the questionnaire on behalf of their family member.



Overall patients and their relatives commented that care was safe on the ward. One patient stated they mostly felt safe but they could talk to staff at times when they did not.

The majority of patients and both relatives indicated that care was effective. Two patients interviewed indicated that they are not always involved in their care and treatment plans. This was addressed with the ward manager. This discussion evidenced that both patients had been offered the choice to participate but did not always wish to be involved in decisions about their care. This will be addressed in the recommendation in relation to recording the rationale when a patient is not involved in decisions about their care and treatment. One patient and both relatives stated they are informed of the results of any assessment or investigations. One patient stated they are informed when they asked.

Patients and relatives stated that staff actively tell them how they are progressing and one patient stated that staff do not tell them how they are progressing. Patients and relatives stated there was opportunity to attend activities every day and these were helpful. Relatives and patients both stated that being on the ward was helping them. Relatives in particular stated they were pleased at how their family member was more settled and less distressed since admission.

Patients and relatives indicated that they felt care on the ward was compassionate. The majority of patients had a positive experience of their admission and felt they had been treated with dignity and respect. Patients and relatives stated staff were always warm, empathetic and respected their privacy. Patients also stated that staff always listened to them and took their views into account.

Patients and relatives were asked what was good about the ward and commented that;

"Nurses are helpful"
"Domestics are kind and caring"
"Good meals"
"I like the staff and food"
"My relative has got better from being on the ward; they are settled and more content"

Patients and relatives were asked if there was anything that could be improved;

"More activities"
"Having the O.T girl everyday"

Patients were asked to describe their experience from admission to now;

"Very good"
"Well looked after"
"My experience on admission was dramatic as the police treated me poorly. The staff treated me nice on admission"

The detailed findings are included in Appendix 2

8.0 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 11 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 – Patient Experience Interview
This document can be made available on request
Appendix 3 – Ward Environment Observation
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 unannounced inspection on 18 and 19 February 2015

No.	Reference.	Recommendation	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	Section 5, 5.3.3(c)	It is recommended that updated training in protection from abuse appropriate to the job role is provided as a matter of urgency for those staff who have not attended update training within the last three years.	The inspector reviewed the training records for staff working on the ward. All staff had received up to date training in Safeguarding Vulnerable Adults.	Fully met
2	Section 5, 5.3.3(C)	It is recommended that deficits in staff training in relation to behaviours that challenge are addressed as a matter of urgency.	The inspector reviewed the training records for the 19 staff working on the ward. All staff had received up to date training in relation to behaviours that challenge. Thirteen staff have also attended additional non-mandatory training on behaviours that challenge using the Newcastle Model.	Fully met
3	Section 4, 4.3(i)	It is recommended that that there is recorded formal supervision and appraisal of all grades of staff in accordance with policies and procedures. Documents must be signed and dated by all relevant parties.	The inspector reviewed the record for supervision and appraisal dates for the 19 staff working on the ward. All staff had received up to date supervision in accordance with trust policy and procedure. 18 out of 19 staff had received an up to date appraisal. One staff member had just started on the ward and was scheduled to have their appraisal in August 2015.	Fully met
4	Section 5, 5.3.3(g)	It is recommended that audit of compliance with record keeping requirements is carried out in accordance with policies and procedures. Records should be dated and signed by relevant parties.	The inspector reviewed the audit of patient records. Audits were noted to have been completed on all patients care documentation every month by a band 6 nurse. Following the audit the band 6 nurse developed an action plan for the responsible staff to correct / amend any discrepancies. This audit form was signed by the	Fully met

			auditor and responsible staff member.	
5	Section 5. 5.3.3(g)	It is recommended that the records of the multi-disciplinary team meeting are completed in full.	The inspector reviewed records of multi-disciplinary team (MDT) meetings for four patients. The MDT meeting records were not completed fully for all four patients. This recommendation will be restated a second time.	Not met
6	Section 5, 5.3.1 (a)	It is recommended that medical records are completed in accordance to the required standards.	The inspector reviewed medical records in relation to four patients. Medical records had been completed fully and in accordance with standards in all four sets of care documentation reviewed.	Fully met
7	Section 5, 5.3.3(a)	It is recommended that the Trust ensures that the advocacy service on the functional care side of the ward is formalised to include weekly visits by the advocate.	The ward manager informed the inspector that the trust were waiting on costings in relation to providing a formalised advocacy service for patients on the functional side. This recommendation will be restated a second time	Not met
8	Section 5.3.1.(a)	It is recommended that the Trust reviews the ward's procedure in relation to the implementation of the pressure ulcer risk assessment (Braden scale) and ensures that the scale is implemented in accordance to each patients assessed need.	The inspector noted that three out of four patient's pressure ulcer risk assessment had not been reviewed weekly in accordance with trust policy and procedure. This recommendation will be restated a second time	Not met
9	Section 5.3.1.(a)	It is recommended that the ward manager ensures that the malnutrition universal screening tool (MUST) assessment is implemented in accordance to the required standard.	The inspector noted that three out of four patient's malnutrition universal screening tool (MUST) had not been reviewed weekly in accordance with the required standard. This recommendation will be restated second time	Not met
10	Section 5, 5.3.3(a)	It is recommended that the ward manager ensures that patients sign their care records as required. In circumstances where a	The inspector noted patient's signatures or a rationale for a non-signature was recorded in three out of the four sets of care documentation reviewed. There was also	Not met

		patient is unable or refuses to sign this should be recorded.	evidence of next of kin signatures where the patient was not able to sign the documentation. There was no evidence of a patient signature or a rationale why the patient had not signed in one set of care documentation.	
11	Section 5, 5.3.3(d)	It is recommended that the Trust ensures that occupational therapy services are available daily ,Monday to Friday, on ward 11	The inspector noted that occupational therapy services were available on a Wednesday afternoon, Thursday and Friday every week. The ward manager stated there has been an on-going issue with recruiting occupational therapy staff. The ward manager stated that there should be some improvement next month as one of the occupational therapy staff are due to return from long term leave. This recommendation will be restated a second time.	Not met
12	Section 5, 5.3.3(d)	It is recommended that the Trust ensures and the ward's occupational therapy room is appropriately equipped. This should include shelving, suitable storage, a clock, suitable tables and chairs and appropriate signage	The inspector reviewed the occupational therapy room and noted that the room was appropriately equipped with shelving, suitable storage, a clock, tables and chairs. Appropriate signage was now in place.	Fully met
13	Section 5, 5.3.3(d)	It is recommended that therapeutic activities for patients are available in the evenings and at weekends. Activities should be facilitated by staff whose time is protected to ensure that the activity programme is provided on a regular basis.	The inspector noted that an activity programme was available during the evenings and weekends. The ward manager stated staff provide activities for patients who do not have visitors in the evenings. A record of all activities was maintained in the ward activity diary. Staff had also recorded when an activity did not occur and the reason. The inspector reviewed the ward activity diary for the previous week and noted that staff had offered patients activities during the evening and weekend. A record of the patients who attended the activity was recorded.	Fully met

14	Section 5, 5.3.1(a)	It is recommended that the ward manager ensures restrictive practices within the ward are used in accordance to the assessed needs of each individual patient. This should include a clear rationale for the use of a restriction and adherence to Deprivation of Liberty Standards-Interim guidance DHSSPSNI 2010.	The inspector noted that information in relation to deprivation of liberty was displayed on the ward and included in the ward welcome pack. This information stated "The main doors are locked. Liberty is restricted. This is in the best interests of the patients who may lack capacity and require a safe environment." However the inspector noted that this restrictive practice was either not documented or an individualised risk assessment in place with a clear rationale recorded why each patient required this level of restriction. As follows: Care documentation set 1 – Deprivation of liberty or a rationale was not recorded; Care documentation set 2 – Deprivation of liberty or a rationale was not recorded; Care documentation set 3 – Deprivation of liberty was recorded but the rationale was not clearly documented. The rationale stated the patient required the restriction as they were "vulnerable". However it was not recorded what the patient was vulnerable to; Care documentation set 4 – Deprivation of liberty care plan had a line through it which would indicate that this care plan was discontinued. However the patient remained in the locked environment, with no care plan in place to address this restriction; This recommendation will be restated a second time.	Not met

Quality Improvement Plan

Unannounced Inspection

Ward 11, Lagan Valley Hospital

16 June 2015

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with the charge nurse, the operations manager, the nurse manager, the quality and information manager and ward staff 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	5.3.1 (a)	It is recommended that the ward manager ensures that each patient has an individualised ligature risk assessment completed for use of the profiling beds. This should include a subsequent risk management plan to address any identified risks, in accordance with the Northern Ireland Adverse Incident Centre (NIAIC) – EFA/2010/006 safety alert self-harm associated with profiling beds.	1	Immediate and on-going	The care pathway has been reviewed and each patient has an individualised ligature risk assessment completed for use of profiling beds. Were a risk has been identified with a patient, a risk management plan is in place. All hand controls on profiling beds have been removed to remove the potential ligature risk of same. Ward manager /deputy Ward manager will monitor compliance monthly & take all corrective action necessary where compliance falls below the expected standard. This is included in the HQS Audit tool check
Is Care Effective?					

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
2	5.3.3(g)	It is recommended that the records of the multi-disciplinary team meeting are completed in full.	2	Immediate and on-going	All staff have been informed with immediate effect and the records of the multi-disciplinary team meeting are completed in full. Ward manager /deputy Ward manager will monitor compliance monthly & will take all corrective action necessary where compliance falls below the expected standard. This is included in the HQS Audit tool check.
3	5.3.1 (a)	It is recommended that the Trust reviews the ward's procedure in relation to the implementation of the ulcer risk assessment (Braden scale) and ensures that the scale is implemented in accordance to each patients assessed need.	2	Immediate and on-going	All staff have been informed with immediate effect that the Braden scale is completed on a weekly basis and appropriate actions taken as per assessments. Ward manager /deputy Ward manager will monitor compliance monthly & will take corrective action necessary where compliance falls below expected standard . This is included in the HQS Audit tool check.
4	5.3.1 (a)	It is recommended that the ward	2	Immediate	All staff have been informed with immediate effect

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
		manager ensures that the malnutrition universal screening tool (MUST) assessment is implemented in accordance to the required standard.		and on-going	that the MUST screening tool is completed on a weekly basis and appropriate actions taken as per assessments. Ward manager /deputy Ward manager will monitor compliance monthly & take corrective action where compliance falls below expected standard. This is included in the HQS Audit tool check.
5	5.3.3 (d)	It is recommended that the Trust ensures that occupational therapy services are available daily ,Monday to Friday, on ward 11.	2	30 November 2015	Occupational Therapy team for MHSOP is relatively small therefore the ability to deliver the expected range of services within Ward 11 has been impacted due to long tern sickness and a maternity leave, for which the provision of temporary cover has not been possible. There has been a delay in replacing a vacant band 6 OT post which is currently being filled. It is anticipated that the full complement of OT staff will be available with the very near future.
6	5.3.1 (a)	It is recommended that the ward manager ensures restrictive	2	Immediate	The restrictive practice care plan has been

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
		practices within the ward are used in accordance to the assessed needs of each individual patient. This should include a clear rationale for the use of a restriction and adherence to Deprivation of Liberty Standards-Interim guidance DHSSPSNI 2010.		and on-going	reviewed & updated to include the rationale as to why restrictions are in place for each individual patient, including Deprivation of Liberty. Ward manager /deputy Ward manager will monitor compliance monthly & take corrective action necessary where compliance falls below expected standard. This is included in the HQS Audit tool check.
Is Care Compassionate?					
7	5.3.3 (a)	It is recommended that the Trust ensures that the advocacy service on the functional care side of the ward is formalised to include weekly visits by the advocate.	2	30 November 2015	Negotiations have taken place with the outcome being that the Trust Peer Advocacy Service will provide a formal advocacy service that includes an established weekly visit to patients receiving functional care in the ward. This service is due to commence w/c 3rd August 2015. .

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
8	5.3.3 (a)	It is recommended that the ward manager ensures that patients sign their care records as required. In circumstances where a patient is unable or refuses to sign this should be recorded.	2	Immediate and on-going	All staff have been informed with immediate effect that they must ensure appropriate documentation with regard to patients signing their care records. In circumstances where a patient is unable or refuses to sign this must be recorded. Where a patient is unable to sign their NOK will be requested to sign the care records. Ward manager /deputy Ward manager will monitor compliance monthly & take corrective action where compliance falls below the expected standard. This is included in the HQS Audit tool check.

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

NAME OF WARD MANAGER COMPLETING QIP	Roisin Keown Ward Sister
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Brenda Arthurs Assistant Director Primary Care & Nursing

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	✓		Wendy McGregor	**3 August 2015**
B.	Further information requested from provider				