The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Ward 11, Lagan Valley Hospital

South Eastern Health and Social Care Trust

18 and 19 February 2015

npm national preventive mechanism

informing and improving health and social care

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Contents

1.0 General Information

Ward Name	Ward 11, Lagan Valley Hospital
Trust	South Eastern Health and Social Care Trust
Hospital Address	39 Hillsborough Road Lisburn BT28 1JP
Ward Telephone number	028 9263 3518
Ward Manager	Roisin Keown
Email address	roisin.keown2@setrust.hscni.net
Person in charge on day of inspection	Roisin Keown
Category of Care	Functional mental illness over 65 and dementia assessment and treatment
Date of last inspection and inspection type	20 June 2014, patient experience interview inspection
Name of inspector(s)	Alan Guthrie and Dr S.M. Rea

2.0 Ward profile

Ward 11 is a 16 bedded facility situated on the ground floor in the psychiatric department, Lagan Valley Hospital and is managed by the South Eastern Health and Social Care Trust. 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.

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

On the days of the inspection there were 14 patients admitted to the ward; seven patients had been detained in accordance with the Mental Health (Northern Ireland) Order 1986.

3.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Northern Ireland's health and social care services. RQIA was established under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to drive improvements for everyone using health and social care services. Additionally, RQIA is designated as one of the four Northern Ireland bodies that form part of the UK's National Preventive Mechanism (NPM). RQIA undertake a programme of regular visits to places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment, upholding the organisation's commitment to the United Nations Optional Protocol to the Convention Against Torture (OPCAT)**.**

3.1 Purpose and Aim of the Inspection

The purpose of the inspection was to ensure that the service was compliant with relevant legislation, minimum standards and good practice indicators and to consider whether the service provided was in accordance with the patients' assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

The aim of the inspection was to examine the policies, procedures, practices and monitoring arrangements for the provision of care and treatment, and to determine the ward's compliance with the following:

- 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.

Other published standards which guide best practice may also be referenced during the inspection process.

3.2 Methodology

RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the inspection standards.

Prior to the inspection RQIA forwarded the associated inspection documentation to the Trust, which allowed the ward the opportunity to demonstrate its ability to deliver a service against best practice indicators. This included the assessment of the Trust's performance against an RQIA Compliance Scale, as outlined in Section 6.

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.

Specific methods/processes used in this inspection include the following:

- analysis of pre-inspection information;
- discussion with patients and/or representatives;
- discussion with multi-disciplinary staff and managers;
- examination of records;
- consultation with stakeholders;
- file audit; and
- evaluation and feedback.

Any other information received by RQIA about this service and the service delivery has also been considered by the inspector in preparing for this inspection.

The recommendations made during previous inspections were also assessed during this inspection to determine the Trust's progress towards compliance. A summary of these findings are included in section 4.0, and full details of these findings are included in Appendix 1.

An overall summary of the ward's performance against the human rights theme of Autonomy is in Section 5.0 and full details of the inspection findings are included in Appendix 2.

The inspectors would like to thank the patients, staff and relatives for their cooperation throughout the inspection process.

4.0 Review of action plans/progress

An unannounced inspection of **Ward 11** was undertaken on **18 and 19 February 2015**.

4.1 Review of action plans/progress to address outcomes from the previous announced inspection

The recommendations made following the last announced inspection on 12 March 2012 were evaluated. Inspectors were pleased to note that 18 recommendations had been fully met and compliance had been achieved in the following areas:

- formal independent advocacy services were available and proactive on the ward on a regular basis;
- the Mindwise Advocacy Service was being actively promoted on the ward for patients with functional mental illness;
- information about the Mental Health Review Tribunal was available in different languages and through the ward's independent advocate and social worker;
- inspectors evidenced that patients attending the Mental Health Review Tribunal would have a robust multi-disciplinary contingency plan put in place prior to the review;
- carer's information was available for patients' relatives on the functional side of the ward;
- documentation in relation to the records of the use of a physical intervention had been reviewed;
- Trust policy guidance for the use of physical interventions was available and was up to date;
- nursing staff had completed up to date safeguarding vulnerable adults training;
- the ward manager had audited the nurse training records to identify gaps in knowledge and skills and staff were attending training as required;
- the Trust had up dated the safeguarding vulnerable adults training. The ward manager had ensured that appropriate policies and procedures in relation to safeguarding were available for staff use;
- the policy and procedures in relation to the safeguarding of vulnerable adults had been updated to include a definition, types, and indicators of abuse, and steps to be taken including reporting processes and recording responsibilities;
- the wards procedure for reporting and recording vulnerable adult concerns, including incidents of patient abuse involving another patient, had been updated and included a referral protocol to the Trust's safeguarding team;
- information on how to make a complaint was displayed inside the main ward in a format suitable to the needs of patients;
- detail in relation to how relatives/carers could access information was being communicated to relatives/carers;

- the policies, procedures and processes in relation to ensuring the safety of patients' property whilst on the ward had been reviewed. Inspectors noted that the ward's safety of patients' property procedures were appropriate and up to date;
- a policy and procedure in relation to children visiting the ward was available;
- the Trusts' policies and procedures were subject to a defined systematic and timely review, at a minimum of at least once every three years;
- the ward environment had been improved in line with best practice for patients who have dementia.

However, despite assurances for the Trust, four recommendations had not been fully implemented. Three recommendations had been partially met and one recommendation had not been met. Four recommendations will require to be restated for a second time, in the Quality Improvement Plan (QIP) accompanying this report.

4.2 Review of action plans/progress to address outcomes from the patient experience interview inspection

The recommendations made following the patient experience interview inspections on 12 December 2013 and 20 June 2014 were evaluated. Inspectors were pleased to note that both recommendations had been fully met and compliance had been achieved in the following areas:

- the Trust had ensured the continuity of the advocacy service;
- the ward manager had ensured that patient hoists were stored safely and appropriately in areas that are not used by patients.

4.3 Review of action plans/progress to address outcomes from the previous finance inspection

The recommendations made following the finance inspection on 3 January 2014 were evaluated. Inspectors were pleased to note that four recommendations had been fully met and compliance had been achieved in the following areas:

- the ward manager had ensured that an audit trail of patient's money received by the ward was available. Inspectors noted patient's' monies retained by the ward were being managed in accordance to Trust guidance;
- patients' money withdrawn from the cash office was being given directly to the patient an appropriate receipt was available;
- all items brought into the ward on admission were being listed and stored appropriately. Patients' property removed from the ward was being receipted;
- all staff had attended relevant training in the management of patient finances.

5.0 Inspection Summary

Since the last inspection the ward has addressed a number of previous recommendations and implemented a number of positive changes. This included environmental change, the review and improvement of care and treatment records and updating of the ward's policies and procedures.

The ward's management team had ensured that patients could access independent advocacy services as required. It was positive to note that the ward had been runner up in the 2013 dementia design innovation award. Relatives and staff had also secured funding to help improve the garden and provide a relaxation room.

The following is a summary of the inspection findings in relation to the Human Rights indicator of Autonomy and represents the position on the ward on the days of the inspection.

Inspectors met with five patients, interviewed ten members of the ward's multi-disciplinary team, met with three relatives and reviewed a number of the ward's policies, procedures and patient care records. At the time of the inspection there were 14 patients admitted to the ward. This included five patients who were admitted to the functional care side of the ward and nine patients who had been admitted to the dementia care side of the ward. Patients who met with the inspectors reported no concerns regarding the care and treatment they received. Patients reflected positively on their relationships with staff.

Patient care records evidenced that on admission each patient received a medical assessment, a risk assessment, nursing assessment and had a care plan completed. The medical and nursing assessments included a mental state assessment which reviewed the patient's general appearance, mood, thought form and content, orientation, concentration and memory. Patient progress notes recorded that patients' capacity to consent to their care was reviewed on a daily and weekly basis. Inspectors noted that patients' multi-disciplinary team meeting records and medical notes had not been completed in accordance to the agreed standards. Recommendations regarding the completion of patients' care pathways have been made.

Inspectors noted that patients' needs were considered on an individual basis. Alongside a mental health assessment each patient also received a physical health assessment. This included a falls/manual handling assessment, malnutrition universal screening tool assessment (MUST) and a pressure ulcer assessment (Braden scale). Patient progress records evidenced that the physical health needs of each patient had been addressed and staff continued to monitor each patient closely. However, the MUST and Braden scale assessments had not been completed in accordance to the identified review timescales.

The Braden scale stipulates that a patient's risk status should be re-evaluated on a weekly basis in an acute care setting and on a monthly basis in long term

care settings. Inspectors were informed by the ward manager that the Trust had agreed that the ward be considered as a long term care setting. The MUST screening tool records that a patient should be reassessed weekly. Care records reviewed by inspectors evidenced that patients were being assessed however; assessments were not completed on a weekly basis. Recommendations regarding the Braden scale and the MUST assessments have been made.

Patient care plans identified the patient's physical, psychological/emotional and social needs. Nursing staff used a combination of standardised and personalised care plans to set objectives to support the patient's care, treatment and recovery. Inspectors found that patient care plans were reviewed on a regular basis. Records detailed that patients and, were appropriate, their relative/carer had been involved in decisions regarding patient care and treatment. However, two of the patient care plans reviewed did not contain patient signatures and there was no record detailing if the patient was unable to sign. A recommendation regarding patient signatures has been made.

Inspectors met with ten staff members all of whom reflected positively on their experience of the ward. Staff were also complimentary regarding the support they received from the multi-disciplinary team. Staff explained that they felt the multi-disciplinary team worked effectively. Decisions taken on behalf of patients' were comprehensively assessed, appropriate to the patient's needs and carried out in accordance to DHSSPSNI standards.

The consultant psychiatrist relayed that they felt supported by medical colleagues. The involvement of the local consultant geriatrician was viewed as integral to patient care. The consultant highlighted concerns regarding the availability of medical staff. The consultant explained that there were three doctors supporting four consultant psychiatrists within acute adult psychiatry. Although medical cover for the ward was assessed as appropriate the absence of a second doctor impacted on ward processes and consultant time. A recommendation has been made.

Relatives who met with inspectors reported that they felt involved in patient care. Relatives informed inspectors that staff had kept them informed and up to date regarding the patient's treatment. Relatives could access a carers support service and a carers advocate as required.

Advocate support for patients on the dementia care side of the ward was provided by the Alzheimers society advocacy service. The advocate visited the dementia care side each Wednesday morning. Patients on the functional care side of the ward could access the Mindwise advocacy service. This service did not provide a consistent weekly presence on the ward. A recommendation has been made.

Therapeutic and recreational activities for patients were facilitated by the ward's occupational therapist assistant (OT), five mornings per week, and by ward staff. At the time of the inspection the ward's OT was not available.

Patients on the ward were being supported, on a part time basis, by an OT who also worked in another ward within the Trust. Subsequently, the OT was not able to provide a daily programme of activities for patients. Inspectors were concerned that the ward was not providing patients with an appropriate therapeutic and recreational activity programme.

Inspectors met with the OT. The OT explained that they attended the ward every Thursday and Friday. The OT relayed that the majority of their time was spent supporting patients with their discharge plans and attending ward meetings. It was positive to note that the OT supported patient discharge planning by completing assessments of patients' needs and identifying any modifications or supports a patient may require before returning to their home. However, because of the limited time available the OT was unable to provide a consistent daily programme for patients.

The OT reported that the Trust had responded to this issue and had recently appointed a new OT. Inspectors were informed that the appointment of the OT would help ensure that a consistent and daily activity programme would be provided to patients on the ward. A recommendation regarding the OT support available to patients has been made. A further recommendation in relation to the design and upgrading of the ward's OT room has also been made.

Inspectors reviewed the ward's current therapeutic and recreational activity programme. Patients could attend a weekly music group facilitated by a musician each Monday afternoon. Patients could also use the ward's relaxation room where they could listen to music and access a quiet space away from the main ward. Other activities provided on the ward included doll therapy, a small ward library, art activities and the use of reminiscence boxes.

It was good to note that a member of nursing staff was undertaking a reminiscence course and staff encouraged patients' relatives/carers to participate in the 'reach out to me' project. This project involved relatives/carers helping to complete a patient history. The patient history included information regarding the patients' likes and dislikes, topics of conversation that the patient enjoyed and questions in relation to patients' hobbies and interests. Inspectors were informed that this information helped staff to ensure that they met the individual needs of each patient.

Activities at night and during the weekends were provided by ward staff. Inspectors noted that patient progress records evidenced that staff had facilitated ward sing a longs, hand massages and nail painting. Inspectors were informed that nurse led activities were provided on a consistent basis although staff time was not protected to provide activities. Subsequently, activities were not provided or had to be cancelled as staff had to prioritise other nursing duties.

Patient involvement in activities was recorded in the patient's care records. Records reviewed by the inspectors evidenced that activities were provided in accordance to each patient's assessed needs. A recommendation to support

the protection of ward staff time to ensure the delivery of therapeutic activities at night and during the weekend has been made.

Patients on the ward could access speech and language therapy, social work support, psychology, podiatry, dietetics and physiotherapy services as required. The ward's social worker and occupational therapist provided community support and liaison to assist patients with their discharge from the ward.

The ward provided a comprehensive range of information for patients and relatives. This included the availability of a ward information folder on each side of the ward. The folder provided patients with details regarding the ward's ethos, routine, the roles of staff and contact information for community groups. The folders also contained a statement encouraging patients and relatives to discuss any concerns they might have with the patient's primary nurse or the ward manager.

The ward's notice boards were well presented and contained information that was up to date and relevant to patients and their families. It was good to note that one of the notice boards recorded that the ward's advocate attended the ward each Wednesday and as required. Relatives who spoke with inspectors reported no concerns regarding their ability to access information.

The ward's main entrance doors were locked and access/exit to the ward could be gained through the use of a swipe card or via a buzzer system. . Care records evidenced that a locked door care plan had been completed for each patient. However, inspectors noted that locked door plans had not fully considered the individual needs of each patient. This was evidenced by the lack of a rationale as to why a patient required the use of a locked door. A recommendation has been made.

Inspectors reviewed the ward's processes for the management of restrictive practices. Inspectors were informed by the ward manager that one patient was receiving enhanced observations during the inspection. The patient's care records evidenced that the use of observations had been agreed by medical and nursing staff. Inspectors found that observations were being managed in accordance to Trust policy and procedure. This included daily review of the patient's progress and reassessment of the need for continued enhanced observations.

Ward staff informed inspectors that the use of a physical intervention with a patient occurred occasionally within the ward. Inspectors reviewed the ward's procedures for the management of physical intervention and noted this to be in accordance to Trust policy. Staff who met with inspectors demonstrated appropriate knowledge and understanding of the ward's procedures for the management of patients requiring a physical intervention.

Nursing staff training records reviewed by inspectors evidenced that 16 of the ward's 19 nursing staff (from wards compliment of 23 staff-four staff on long term leave) had completed up to date managing aggression training. Three staff members were booked to complete further refresher training. Training

records also evidenced that five members of staff required further refresher training in relation to safeguarding vulnerable adults training. Inspectors also noted that five staff had not completed the Trust's behaviours that challenge training. Recommendations in relation to nursing staff training have been restated for a second time.

Each patient's discharge from the ward was discussed with the patient and their relative/carer during the patient's admission. This was evidenced through the completion of the ward's admission checklist and by the provision of a patient information folder. A patient's discharge from the ward was supported by the ward's multi-disciplinary team in partnership with Trust community teams and residential and nursing care providers.

Relatives who met with inspectors reported that they were kept informed regarding the patient's progress and that discharge plans were discussed and reviewed with them. Relatives were provided with advice and support regarding nursing and care homes. It was positive to note that the ward worked in partnership with a local nursing home to provide accommodation for patients. Staff advised inspectors that in circumstances where a patient was discharged from the ward, staff worked closely with community teams and provided short term outreach support as required.

Details of the above findings are included in Appendix 2.

On this occasion ward 11 has achieved an overall compliance level of substantially compliant in relation to the Human Rights inspection theme of "Autonomy".

6.0 Consultation processes

During the course of the inspection, the inspector was able to meet with:

Patients	5
Ward Staff	10
Relatives	3
Other Ward Professionals	1
Advocates	1

Patients

Patients who met with inspectors reported no concerns regarding the treatment and care they received on the ward. Patients presented as relaxed and at ease in their surroundings. Patients moved freely around the ward and interactions between patients and staff were noted to be positive, friendly and supportive. Staff were consistently available on both sides of the ward. Patient comments included:

“Staff are very kind. They really do know how to look after people”;

“Some of the staff are all right”;

“Staff are there when I need them”;

“Staff are excellent…nine out of ten”.

Relatives/Carers

Inspectors met with three relatives during the inspection. Relatives reflected positively on their experiences of the ward and the care and treatment the patient had received. Relatives explained that they felt staff were approachable and the information available was good. Relative’s comments included:

“Really good ward”;

“Staff are really good…very attentive”;

“Experience all good”;

“Staff consider my feelings and where I am”;

“At the start I was on edge”;

“Staff need more time to spend with patients”;

“Can’t fault staff they have been there for me at every turn”;

“Some staff are amazing”;

“Staff are very good at providing me with information”;

“I have good access to all staff”;

“Staff look exhausted at times…there is not enough of them”.

Inspectors reviewed the ward’s rota and noted that staffing levels were provided in accordance to Trust standards. The ward manager reported that the Trust had recently appointed two more band three posts to the ward. The manager reported that staffing was reviewed continually and staffing numbers available on the ward could be increased as required.

Ward Staff

Inspectors met with ten members of the ward’s multi-disciplinary team (MDT). Nursing staff reported that they enjoyed working on the ward and that they felt supported by the manager and the MDT. The consultant psychiatrist reflected that the ward team was effective and patient focussed. The consultant expressed concerns about medical support. This concern has been addressed in the quality improvement plan accompanying this report.

The ward’s occupational therapist and the ward’s social worker reported that they felt their roles were valued by the MDT and their service was an integral part of the ward. Staff comments included:

“The ward has seen great improvements”;

“Team work is brilliant”;

“I feel reasonably well supported”;

“This is a good team”;

“Team work well together…everyone shares planning”;

“Fantastic ward; I love working here”;

“I feel supported”;

“I have nothing negative to say”;

“Nursing staff are very good, very dedicated”.

Other Ward Professionals

Inspectors met with one of the ward chaplains'. The chaplain was very complimentary regarding the ward's staff team and the quality of care provided. The chaplain explained that they attended the ward unannounced. The chaplain's comments included;

"They staff on the ward are all angels";

"The care and treatment provided by the ward is excellent".

Advocates

Inspectors met with the advocate who supported patients on the dementia care side of the ward.

The advocate informed the inspector that they found the ward staff to be supportive and responsive to the needs of patients. The advocate reflected that they had attended patient discharge meetings and they felt the support for patients was really good. The advocate reported that they were continuing to work alongside the ward's staff team to ensure advocacy was fully integrated. The advocate's comments included:

"The ethos on the ward is excellent and the atmosphere is fantastic";

"All staff listen to me and respect my role";

"Staff are sensitive to the needs of all the patients".

Questionnaires were issued to staff, relatives/carers and other ward professionals in advance of the inspection. The responses from the questionnaires were used to inform the inspection process, and are included in inspection findings.

Questionnaires issued to	Number issued	Number returned
Ward Staff	13	2
Other Ward Professionals	6	0
Relatives/carers	13	6

Ward Staff

Two nursing staff returned questionnaires prior to the inspection. Both members of ward staff reported awareness of the restrictive practices used on the ward. Neither member of staff reported awareness of the Deprivation of Liberty Safeguarding (DOLS) - Interim guidance. Staff listed restrictive practices to include: observations, controlled access to the ward and use of physical intervention.

Each of the staff documented that they felt patients on the ward could access therapeutic and recreational activities. One of the staff recorded that they felt the activities provided did not meet the needs of the patients.

Other Ward Professionals

No other ward professionals returned questionnaires.

Relatives/carers

Six questionnaires were returned by relatives prior to the inspection. Three relatives commented that they felt that the treatment of patients on the ward was excellent and three described it as good. Four of the relatives reported that they had been offered the opportunity to be involved in decisions in relation to the care and treatment of their relative. Two relatives stated that they had not been offered this opportunity.

One relative recorded that they had been involved in discharge planning. Four relatives reported that the patient's discharge plan had not been completed. One relative did not respond to this question. Relative's comments recorded on the questionnaires included:

"Satisfactory" (Respond to question regarding the care on the ward);

"My husband has been and is treated as an individual who has special needs";

"Staff in ward 11 show a genuine commitment to caring for their patients in a dignified manner. The caring also extends to immediate family";

"I feel my relative has been very well cared for and looked after by the staff of ward 11";

"The staff are very warm and friendly as well as being very professional. They provide a listening ear and touch of reassurance when it is needed";

"I am happy that my wife is well cared for".

7.0 Additional matters examined/additional concerns noted

No additional matters were examined/additional concerns noted during the inspection.

Complaints

Inspectors reviewed complaints received by the ward between the 1 April 2013 and the 31 March 2014. Four complaints had been received from relatives during this period. One of the complaints related to concerns about care practice, one related to staff attitude and two complaints had been made

as a result other concerns. All of the complaints were recorded as having been resolved to the full satisfaction of the complainant.

Inspectors found the ward's complaint procedure to be in accordance with the Trust's policy and procedure. Inspectors noted that information relating to the complaints procedure was available to patients and their carer/relatives.

8.0 RQIA Compliance Scale Guidance

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable	Compliance with this criterion does not apply to this ward.	A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant	Compliance will not be demonstrated by the date of the inspection.	A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the inspection year.	In most situations this will result in a recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a recommendation, being made within the Inspection Report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and being made within the inspection report.

Appendix 1 – Follow up on Previous Recommendations

The details of follow up on previously made recommendations contained within this report are an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Appendix 2 – Inspection Findings

The Inspection Findings contained within this report is an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Contact Details
Telephone: 028 90517500
Email: Team.MentalHealth@rqia.org.uk

Appendix 1

Follow-up recommendations made following the announced inspection on 12 March 2012

No.	Reference.	Recommendations	Number of times previously stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1		It is recommended that formal independent advocacy services are available and proactive on the ward on a more regular basis.	2	Independent advocacy support for patients was available within both the functional and dementia care sides of the ward. Patients admitted to the dementia care side of the ward were supported by the Alzheimer's society advocacy service. The advocate visited the ward every Wednesday morning and as required. The inspector met with the advocate who reported that they found ward staff to be welcoming and supportive of the advocacy service. Patients admitted to the functional care side of the ward were supported by the Mindwise independent advocacy service. Mindwise staff attended the ward as required and it was good to note that since December 2014 the ward's multi-disciplinary team had referred four patients to the Mindwise advocacy service. Inspectors reviewed the ward's patient information folders for the functional and dementia care sides of the ward. Both folders contained information regarding the availability of advocacy services. Inspectors noted that posters and information leaflets regarding the advocacy services were also available on each side of the ward.	Fully met
2		It is recommended that Mindwise Advocacy Service is actively promoted on the ward for patients with functional mental illness.	2	Information regarding the Mindwise advocacy service was available on a poster, in information leaflets and within the patient/relative information book on the functional care side of the ward. Inspectors were informed that an advocate from Mindwise did not regularly attend the ward. However; patients were referred to the Mindwise service as required. The ward manager explained that the advocate visited the	Fully met

				ward upstairs and could be contacted as required. Subsequently, patients could access the advocate who attended the ward promptly upon receiving a referral from the multi-disciplinary team (MDT) or a patient. Whilst inspectors evidenced that ward staff and the MDT actively promoted the Mindwise advocacy service. Inspectors were concerned that an advocate did not attend the functional care side of the ward on a regular basis. A new recommendation regarding the provision of regular (weekly) advocacy clinics for patients on the functional care side of the ward has been made. The recommendation is recorded in the quality improvement plan accompanying this report.	
3		It is recommended that information about the Mental Health Review Tribunal is available in a format suitable to the communication needs of the patients on this ward.	2	Inspectors reviewed the availability of information for patients regarding the Mental Health Review Tribunal (MHRT). Inspectors evidenced that MHRT information was available in English, Polish and Portuguese. Patients who presented as being unable to speak or understand any of these languages were supported by the Trust's interpreter service which was available 24 hours a day by phone. Staff could also access an interpreter for meetings via prearranged appointment. Patients diagnosed with dementia were supported by an independent advocate who attended the ward every Wednesday morning and as required. The advocate met with patients regularly and also provided patient's carers/relatives with information, support and advice. Inspectors met with the ward's social worker who was responsible for providing an assessment report to the MHRT in circumstances where a patient, or their relative, had requested a MHRT review. The social worker informed inspectors that they provided patients and carers/relatives with information and assistance regarding the MHRT.	Fully met

				Inspectors noted that MHRT information was not available in easy to read format. A new recommendation regarding the provision of MHRT information in easy to read format has been made and is recorded in the quality improvement plan accompanying this report.	
4		It is recommended that patients attending the Mental Health Review Tribunal have a robust contingency plan in place which all staff involved are familiar with prior to the hearing.	2	Inspectors were informed that none of the patients admitted to the ward had applied to the Mental health Review Tribunal (MHRT). Inspectors reviewed the ward's procedures for supporting patients who apply to the MHRT. Inspectors discussed the ward's MHRT procedures with the ward manager, the ward social worker and one of the patient advocates. The ward manager informed inspectors that patient applications to the MHRT were supported by ward staff. The manager explained that staff informed patients, admitted to the ward in accordance to the Mental Health (Northern Ireland) Order 1986 (the Order), of their right to apply to the tribunal service to have their admission reviewed. In circumstances where a patient forwards an application to the tribunal service, the ward's multi-disciplinary team agree a contingency plan. This is put in place to support the patient if the tribunal service rules that the patient should not be subject to admission to hospital in accordance to the Order. Inspectors were informed that the contingency plan included continued liaison with community services, the patient and the patient's relatives/carers. The ward's social worker reported that it was their role to provide the tribunal service with a social circumstances report detailing the patient's personal and social situation. The social worker also liaised directly with community services to ensure that appropriate support and assistance would be available for the patient should the tribunal discharge them	Fully met

				from the Order and the patient choose to leave hospital. One of the patient advocates informed the inspectors that the advocate service helped to ensure that patients' rights were adhered to during admission to the ward. The advocate reflected positively on the information provided to patients and they described ward staff as being patient centred and proactive regarding patients' rights.	
5		It is recommended that a carer's information leaflet is available for patients' relatives on the functional side of the unit.	2	A patient/relatives information folder was available within the functional care side of the ward. The folder included information regarding the ward's philosophy of care, daily routine, visiting times, comments and complaints procedures, a directory of local support services and a number of information leaflets relevant to patients and their relatives/carers. Inspectors met with two relatives who were visiting patients admitted to the functional side of the ward. Both relatives were complimentary regarding the care and treatment provided to patients and neither relative reported any concerns regarding their ability to access information.	Fully met
6		It is recommended that documentation which records physical intervention is reviewed.	2	The ward's use of physical intervention policy and procedures had been reviewed. A copy of the Trust's policy for the management of violence and aggression and use of restraint was available on the Trust's intranet. The policy was up to date and due for renewal in September 2015. In circumstances where use of a physical intervention with a patient was necessary staff were required to complete a physical intervention form and an incident report. These were noted to be comprehensive and appropriate. Both reports were reviewed by the ward manager and forwarded to the hospital services manager and the Trust's governance department.	Fully met

				The last governance report for the ward, completed in December 2014, reflected that there had been 31 incidents reported during the previous three months. Three of these incidents related to staff having to manage aggressive behaviour.	
7		It is recommended that the policy guidance for the use of restraint and physical interventions is developed as a matter of urgency.	2	The policy for the management of violence and aggression and use of restraint was developed and made operational in September 2012. The policy is due to be reviewed in September 2015.	Fully met
8		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.	1	Inspectors were informed that all staff had completed updated safeguarding vulnerable adults and safeguarding children training. Inspectors reviewed the nursing staff training records. The records evidenced that 19 of the ward's 23 nursing staff had completed up to date safeguarding vulnerable adults training. Four members of staff were noted to be on long term leave. 14 staff had completed updated safeguarding children training. Five members of staff were scheduled to complete updated training in May 2015. Inspectors met with the ward's social worker, occupational therapist and consultant psychiatrist. Each member of staff reported no concerns regarding their access to training. Training records for non- nursing staff were retained by professional managers located in other departments within the Trust. The ward's senior management team continued to monitor staff training to ensure that all staff received training commensurate to their role and position within the ward.	Partially met
9		It is recommended that the ward manager audits training records to identify gaps in knowledge and skills and ensure attendance at required training.	1	The nursing staff training matrix evidenced that the ward manager continued to audit nursing staff training and to identify staff who were required to complete updated mandatory training. The training matrix identified training that staff had completed and dates for retraining. Inspectors noted that the matrix did not evidence the last date of completed training for those staff who had been booked to	Fully met

				complete retraining. A new recommendation regarding the availability of previous training dates for all nursing staff has been made and is detailed in the quality improvement plan accompanying this report.	
10		It is recommended that deficits in staff training in relation to behaviours that challenge are addressed as a matter of urgency.	1	The ward's training records evidenced that 14 of the 19 (four staff on long term leave) nursing staff had completed training in relation to behaviours that challenge. Five staff had no record of having completed the training. Inspectors were informed that all staff had completed care and responsibility training. The training included a focus on providing staff with the appropriate knowledge and skills to assist them in managing situations where a patient may present with challenging behaviour. However, inspectors noted that the Trust continued to provide a specific behaviour(s) that challenge training course and five staff of the 19 staff had completed the course in 2014. This included a member of staff whose training was provided in October 2014.	Partially met
11		It is recommended that the ward manager reviews the format of and content of training in protection from abuse to ensure that it is appropriate to the needs of staff and addresses any identified deficit.	1	The nursing staff training record evidenced that 19 of the ward's 23 nursing staff (four members of staff not available for duty due to long term leave) had completed updated safeguarding vulnerable adults training. The ward manager had introduced a safeguarding vulnerable adult information and resource folder which included the training materials from the safeguarding training. Inspectors reviewed the resource folder and noted that the information available was appropriate to the needs of patients and staff in relation to safeguarding vulnerable adults. Staff who met with the inspectors demonstrated appropriate knowledge and understanding of the Trust's and regional guidance regarding the safeguarding of vulnerable adults.	Fully met
12		It is recommended that t there is recorded formal supervision and appraisal of all grades of	1	Inspectors reviewed the staff supervision procedures. The staff supervision and appraisal templates were noted to be appropriate and in accordance with Trust guidance.	Not met

		staff in accordance with policies and procedures. Documents must be signed and dated by all relevant parties.		However, staff supervision records evidenced that 17 of the 23 nursing staff had received one supervision session and only five staff had completed their appraisal since the 1 April 2014. Inspectors noted that records evidenced that each member of the nursing staff team would complete a further supervision and appraisal session before the end of May 2015. Records demonstrated that three members of the nursing staff team will have received two supervision sessions by the 31 March 2015. Subsequently, 14 staff will not have received supervision as required and in accordance to the agreed standard. Inspectors were informed by the ward manager that the nursing staff supervision deficits had been recognised and a new supervision matrix was being developed to help ensure that staff received supervision in accordance with policies and procedures.	
13		It is recommended that the policy and procedure for protection of vulnerable adults is amended to provide detail for staff in relation to a definition, types, and indicators of abuse, and steps to be taken including reporting processes and recording responsibilities.	1	The Trust's policy and procedure for the protection of vulnerable adults had been amended to provide detail for staff in relation to definition, types, and indicators of abuse, and the steps to be taken in relation to the management of a vulnerable adult (VA) referral. Inspectors noted that the Trust's policy was up to date (operational from December 2013 to be reviewed in December 2016) and the ward manager had provided 12 specific information sheets regarding vulnerable procedures. These included: • recording and reporting VA referrals; • protection of adults the seven signs of abuse; • united against elder abuse; • see something say something; • safeguarding adults good practice guide; • safeguarding vulnerable adults process; • safeguarding vulnerable adults policy. Inspectors noted that each member of the nursing staff team	Fully met

				had signed and dated each information sheet to confirm they had read and understood the information provided. Staff who met with the inspectors reported that they understood the ward's vulnerable adult procedures. They reported no concerns regarding the support they received from the ward's designated vulnerable adult officer.	
14		It is recommended that the ward manager ensures that all incidents of patient abuse involving another patient are referred to the appropriate Safeguarding Team and appropriate records maintained.	1	Inspectors reviewed the ward's processes for the completion and management of vulnerable adult (VA) referrals. Records reviewed by inspectors evidenced that vulnerable adult referrals had been managed in accordance to regional and Trust policy and procedures. In circumstances were there was a concern regarding an incident of patient abuse involving another patient a VA referral was forwarded to the ward's designated officer (DO). A record of the referral was placed in the patient's file (alleged victim) and a copy retained by the ward manager. The ward manager forwarded details of all VA referrals to the Trust's governance department. Referrals were also recorded in the weekly ward progress report which was forwarded to the Trust's responsible services manager. Referrals generated within the ward were also reflected in the Trust's quarterly governance reports. Staff who met with inspectors demonstrated appropriate understanding of the VA process and reported no concerns regarding the support they received from the ward's designated officer. It was positive to note that all staff knew who the DO was and could make contact as required if they needed advice or clarification.	Fully met
15		It is recommended that information on making complaints is displayed inside the main ward in a format	1	A poster placed on notice boards located in each side of the ward informed patients and carers how they could make a complaint. The poster stated '*If you have a complaint to make please speak to the nurse in charge'.* The poster was	Fully met

		suitable to the needs of patients.		presented in large typeface with the above statement recorded in black set against a yellow background. The ward also provided complaints leaflets which were available in several languages and information of how patients/relatives could contact the patient client council if they required help to make a complaint. Patients were also support by the ward's advocates who could be contacted as required and were noted to have visited the ward on a regular basis.	
16		It is recommended that the ward manager ensures that information in relation to access to information is communicated to relatives.	1	Relatives could access information within the patient information booklet available on both sides of the ward. The ward also provided a relatives notice board which posted details of carers support groups, advocacy services and general information regarding ward routine. It was good to note that the information available was comprehensive and provided relatives with an overview of the ward's procedures and processes. The notice boards also posted contact details for advocacy services, displayed pictures of the ward staff and explained the ward's laundry service. Relatives were informed that access to information regarding the patient would be provided by ward staff. In circumstances where a relative requested access to a patient's care records. The relative was provided with the appropriate application form and advised of the process.	Fully met
17		It is recommended that the ward manager reviews the policies, procedures and processes in relation to ensuring the safety of patients' property whilst on	1	The Trust's handling of patients' cash and property policy was available and had been reviewed and updated in April 2014. The ward manager had reviewed the wards procedures and processes regarding the management of patients' property and introduced new procedures. Inspectors reviewed these procedures and noted that the records and receipts in relation to cash deposits and	Fully met

		the ward.		withdrawals from the hospitals cash office had been completed in accordance to Trust standards. The ward's safe drawer records and records of patients' property had also being completed appropriately. Patients and relatives who met with inspectors reported no concerns regarding the safety of patients' property.	
18		It is recommended that the ward manager develops a policy and procedure in relation to children visiting the ward that ensures that children visiting the ward are safeguarded.	1	The Trust's policy in relation to children visiting adult mental health facilities was available. The policy had been made operational in December 2011 and was being renewed. The ward manager had reviewed the ward's policy and procedure in relation to children visiting and had introduced safeguards to ensure the safety and well-being of child visitors. A copy of the child visiting procedures was posted on a notice board on each side of the ward. The notice informed relatives that all child visits must be prearranged and children visiting the ward must be accompanied by an adult. The notice also detailed that upon arrival all child visitors and their accompanying adult should report to the nurse in charge. Child visits were facilitated in separate rooms within each ward. Inspectors reviewed nursing staff training records and noted that 14 of the ward's current compliment of 19 staff had completed updated safeguarding children training and five staff were scheduled to complete refresher training in May 2015.	Fully met

19		It is recommended that policies and procedures are subject to a defined systematic and timely review, at a minimum of at least once every three years.	1	Inspectors reviewed a number of the Trust's policies relevant to the ward. This included policies regarding the handling of patient's cash and valuables, the observation and engagement policy, the fire safety policy, the entry and exit policy for acute inpatient units, the admission and discharge policy and the child visiting policy. Inspectors evidenced that the handling of patient's cash and valuables, the fire safety policy and the admission and discharge policy were up to date. The child visiting policy and entry and exit to acute ward policy were being updated as these had required review in December 2014. The observation and engagement policy had not been reviewed since April 2014. Inspectors noted that the Trust had commissioned a patient observation and engagement working group. The group was reviewing the Trust's policies and procedures for managing enhanced/continuous observations. The terms of reference for the group included the publication of revised policy and procedures. The new observation policy was to be made available by January 2015. Inspectors were informed that the new policy was being reviewed by the senior management team and would be available in the near future. This information had been shared with ward staff and the Trust had directed that staff continue to work in accordance to the previous policy until the new policy became operational.	Fully met
20		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.	1	A patient record and content continence service audit proforma was available and inspectors reviewed audit records completed in January and February 2015. The records were noted to be comprehensive and evidenced that four files had been audited each month. However, records of audits prior to December 2014 were not available.	Partially met
21		It is recommended that the ward environment is improved	1	Section 5 of the inspection report completed as a result of the inspection carried out on the ward on the 12 March 2012	Fully met

		in line with best practice for patients who have dementia, as detailed in section 5 of this report – Additional Concerns		recorded eight concerns in relation to the ward's environment and the needs of patients' on the ward. These concerns related to the ward's décor, the use of signage, flooring, patient access to information, seating handrails and water damage within one of the shower rooms. Inspectors reviewed each of these concerns and evidenced that they had been addressed.	
22		It is recommended that the damp patch on the common wall between the toilet and the toilet/shower room facing the bedrooms on the dementia care side of the ward should be investigated and addressed.	1	Inspectors reviewed each of the toilet and shower areas. The wall between the toilet and shower room facing the bedrooms on the dementia care side of the ward had been repaired. Inspectors noted no damp and the paintwork presented as clean and fresh.	Fully met
23		It is recommended that a risk assessment in relation to the need for and type of handrails should be completed. Any required resulting actions should be implemented in a timely manner.	1	A risk assessment in relation to the need and type of handrails was completed by the ward's occupational therapist (OT). The need for handrails on the ward had been assessed and a decision to not install handrails had been taken. The decision was based on concerns that handrails could negatively impact on a patients' ability to rehabilitate and return to their homes where the patient may not be able to access handrails. Inspectors met with the ward's OT. The OT explained that the needs of each patient were considered individually and patients requiring support were provided with alternative aids to assist them with their mobility.	Fully met
24		It is recommended that additional and varied styles of seating are made available	1	Inspectors reviewed the seating available within the functional and dementia care sides of the ward. Both sides of the ward provided various styles of seating. These included settees, high back seating and easy seating. Inspectors noted that the seating was of a high quality, in good repair and appropriate to the needs of the patient groups.	Fully met
25		A copy of the proposed	1	A proposed timeline for the implementation of the agreed	Fully met

		timeline for implementation of the agreed environmental improvements should be forwarded to RQIA.		environmental improvements was forwarded to RQIA. Inspectors noted that each of the recommendations had been implemented.	

Follow-up on recommendations made following the patient experience interview inspection on 12 December 2013

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	6.3.2	It is recommended the Trust reviews any decision to terminate the current independent advocacy service to the ward with a view to ensuring the continuity of the advocacy service.	Inspectors reviewed the provision of independent advocacy services on both sides of the ward. Inspectors noted that the Alzheimers Society continued to provide an independent advocacy service within the dementia care side of the ward. The advocate attended the dementia care side of the ward on a weekly basis and as required. The advocate informed inspectors that they felt the service was part of the care service provided to patients. Patients on the functional care side of the ward were supported by the Mindwise independent advocacy service. Patients could access the service as required and inspectors evidenced that the ward's multi-disciplinary team had referred four patients to the service within the previous two months. An advocate did not attend the ward on a weekly basis but was available as required. A new recommendation regarding the provision of a weekly visit by an advocacy service to support patients on the functional side of the ward has been made. The recommendation is detailed in the quality improvement plan accompanying this report.	Fully met

Follow-up on recommendations made following the patient experience interview inspection on 20 June 2014

No.	Reference.	Recommendations	Action Taken	Inspector's

			(confirmed during this inspection)	Validation of Compliance
1	Section five, 5.3.1 (f)	It is recommended that the ward manager ensures that patient hoists are stored safely and appropriately in areas that are not used by patients.	Inspectors reviewed the storage locations of both hoists and noted the hoists were stored safely and appropriately in areas that were not used by patients.	Fully met

Follow-up on recommendations made at the finance inspection on 3 January 2014

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensures that there is a clear and transparent audit trail of patient's money received by the ward, purchases made and change appropriately accounted for and verified by another staff member.	Inspectors reviewed the ward's patient property book and patient cash deposit and withdrawal receipt books. The books recorded an inventory of all items brought into the ward by each patient. Patients were able to access the Trusts general hospital cash office, located on the same site as the ward. The cash office receipt book detailed the deposits and withdrawals made by patients. Entries into the patient property and cash books, retained by the ward, had been signed by two members of staff and patient's property and monies were noted to have been managed in accordance to Trust policy and procedure.	Fully met
2	It is recommended that the ward manager ensures where patient money is withdrawn from the cash office and given directly to the patient an appropriate receipt is maintained.	The ward manager had introduced a cash lodgement and a cash withdrawal receipt book to record patient transactions with the Trust's cash office situated in the general hospital located opposite the building housing the ward. Inspectors reviewed both books and noted that they provided a clear record of patient monies deposited and withdrawn from the Trust's cash office. Each entry to the books included a receipt from the cash office confirming the amounts lodged and withdrawn.	Fully met
3	It is recommended that the ward manager ensures that all items brought into the ward on admission are listed appropriately, the area of their storage or transferred recorded and appropriate receipting undertaken,	Inspectors reviewed the ward's patient property book and patient cash deposit and withdrawal receipt books. The books recorded an inventory of all items brought into the ward by each patient. Records within each of the three books had been signed by two	Fully met

	particularly where relatives remove items from the ward.	members of staff and patient's property and monies were noted to have been managed in accordance to Trust policy and procedure. Patient property removed from the ward by relatives was recorded in the corresponding receipt book and noted in patients' progress records.	
4	It is recommended that the ward manager ensures that all staff attend relevant training in the management of patient finances.	Nursing staff training records evidenced that 19 nursing staff had completed up to date safeguarding vulnerable adults training. This training promotes the protection of patients and highlights the impact and implications of financial abuse. Training in the management of patient finances was provided to staff through the Trust's staff induction programme. The ward's financial policy and procedures were reviewed on a regular basis during staff meetings and the management of patient finances remained a standing item on the staff team meeting agenda. Team meeting records reviewed by inspectors evidenced that team meetings had been held on a monthly basis. The ward's property and receipt books evidenced that the ward manager audited records on a regular basis.	Fully met

Quality Improvement Plan

Unannounced Inspection

Ward 11, Lagan Valley Hospital

18 and 19 February 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, nursing staff, the occupational therapist and the social worker 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
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.	2	31 May 2015	All staff who have not attended training in the last 3 years have been booked onto training . Completed training for staff will be recorded on a visual aid board and Training Matrix. Staff are booked onto the Safeguarding Children training in May 2015. A training report is updated on a monthly basis for each member of staff with regard to adherence with mandatory training. The Ward Sister /deputy will carry out monthly audits of individual training records to ensure staff are attending/completing training. Any deficit will be raised immediately with individual staff. Training will remain a standing item on the agenda at staff meetings .
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	2	30 June 2015	Staff have been booked into 2 and 3 day Care and Responsibilty Training . All training for current staff will be completed by 31May 2015. Further training dates are available in September 2015 for any new staff and those currently off on long term sick that may have returned to work by then. Completed training for staff will be recorded on a visual aid board and Training Matrix. A training report is updated on a monthly basis for each member of staff with

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					regard to adherence with mandatory training. The Ward Sister /deputy will carry out monthly audits of individual training records to ensure staff are attending/completing training. Any deficit will be raised immediately with individual staff. Training will remain a standing item on the agenda at monthly team meetings.
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.	2	Immediate and ongoing	All staff as necessary have been provided with dates for their supervsion and Apprasials - to be completed by June 2015. Dates have been brought forward in the ward dairy and also put onto the visual aid board in the sisters office. All documentation will signed and dated appropiately. Supervision and Appraisals are a standing item on the montly staff meetings.
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	2	Immediate and ongoing	Ward sister/deputy will audit 5 - 10 patient records per month. Any deficits with record keeping will be immediately brought to the attention of the staff member and records will be re-audited to ensure compliance. Audit report will be discussed at the monthly staff meeting. All members of the

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		signed by relevant parties.			Multi Disciplinary Team will be responsible for completing their relevant sections of the notes. Ward sister will ensure compliance of this.
5	Section 5. 5.3.3(g)	It is recommended that the records of the multi-disciplinary team meeting are completed in full.	1	Immediate and ongoing	The Team Assessment Meeting Proforma has been reviewed and updated. All staff have been made aware of the new Team Assessment Meeting Proforma. The ward sister /deputy ward sister will audit the Proforma on a monthly basis to ensure it is completed in full. If any deficits are noted the member of staff will receive a written copy of the audit and the sister will monitor for immediate compliance.
6	Section 5, 5.3.1 (a)	It is recommended that medical records are completed in accordance to the required standards.	1	Immediate and ongoing	The admitting doctor will be provided with a patient admission pack and will be requested to complete it appropriately. The Consultant will review medical notes to ensure that medical staff are completing the notes in accordance with the required standards.
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	1	Immediate and ongoing	We are currently exploring the provision of a weekly visit service from Peer Advocacy Service, with consideration being given to the remit & funding of same. We are awaiting feedback at this time. Should additional funding be required

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 formalised to include weekly visits by the advocate.			then we will seek same. Ward sister will monitor the progress of this proposal.
8	Section 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.	1	Immediate and ongoing	Current pressure ulcer policy is with SET scrutiny panel for review. Following advice from the Trust's lead Tissue viability nurse the Braden will be completed on a weekly basis within in- patient MHSOP. Ward staff have been made aware of this. Ward sister /Deputy will audit notes to ensure compliance. Any compliance issues will be recorded on an action plan and discussed with the invidual primary nurse who is also provided with a written copy. Outcomes of audits will be discussed at monthly team meetings for wider learning.
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.	1	Immediate and ongoing	The Must tool will be completed for all patients on a weekly basis. This will be monitored for immediate compliance.The ward manager will complete monthly audits to ensure compliance. Any compliance issues will be recorded on an action plan and discussed with the invidual primary nurse who is also provided with a written copy. Outcomes of audits will be discussed at monthly team

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
					meetings for wider learning.
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 patient is unable or refuses to sign this should be recorded.	1	Immediate and ongoing	All care plans have been reviewed and signed . When a patient cannot sign due to cognitive impairment their NOK will be asked to read and sign the careplans as appropiate. If a patient cannot or will not sign due to their current mental state this will be documented on the appropiate care plan. All registered staff are aware of this. The Ward Sister /deputy will carry out monthly audits of care records to monitor and ensure staff are complying with this . Any deficit will be raised immediately with individual staff.
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	1	30 April 2015	New Occupational Therapy assistant recruited and will be in post from 21st April 2015. She will work along with the Occupational Therapy band 7 to provide daily Monday to Friday, Occupational Therapy activities for patients in Ward 11.
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	1	30 June 2015	Equipment including additional shelving , storage, clock, tables and chairs have been ordered. Appropiate signage has also been ordered. Currently awaiting delivery of these

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
		should include shelving, suitable storage, a clock, suitable tables and chairs and appropriate signage			items.
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.	1	Immediate and ongoing	The ward manager has reviewed the ward staffing levels . Staff will be allocated via eroster to ensure that a range of therapeutic activities will be avaialble in evenings and weekends in so far as is possible. This protected time will however be subject to the acuity of patients in the ward at that time. Ward sister will monitor the provision of activities to ensure time is protected on a regular basis. There will be an increased focus regarding activities at staff meetings.
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	1	Immediate and ongoing	All care-plans will include a rationale as to why the patient requires the use of a locked door and their specific individual need.This will be audited as part of the monthly records audit. There are patients on the ward who can leave the ward unaccompanied e.g. the patient can request to go to shops or for a walk etc following discussion with the Ward

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
		guidance DHSSPSNI 2010.			Consultant

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
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Nicki Patterson, Director of Nursing, Older Peaople and Primary Care

Inspector assessment of returned QIP		**Yes**	**No**	**Inspector**	**Date**
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Alan Guthrie	14 April 2015
B.	Further information requested from provider				