Mental Health Inpatient Inspection Report
6 – 8 February 2017

Ward 11
Dementia and Over 65 Functional care

Lagan Valley Hospital
39, Hillsborough Road
Lisburn
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Inspectors Wendy McGregor Dr Shelagh Mary Rea

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of Service

Ward 11 is a 16 bedded mixed gender facility situated on the ground floor in Lagan Valley Hospital. The ward provides assessment and treatment to patients with dementia who may present with behaviours that are distressing and older persons over 65 years with a 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 twelve patients on the ward; nine patients on the dementia unit and three patients on the functional mental health unit. Six patients had been detained in accordance with the Mental Health (Northern Ireland) Order 1986. There was one patient whose discharge was delayed.

Patients have access to a multi-disciplinary team consisting of psychiatry, medical, nursing, occupational therapy and social work. Access to clinical psychology, physiotherapy, speech and language therapy, palliative care and dietetics was by referral. Advocacy services were available every week.

3.0 Service Details

Responsible person: Mr Hugh McCaughey
Ward manager: Roisin Keown
Person in charge at the time of inspection: Roisin Keown

4.0 Inspection Summary

An unannounced inspection took place over three days on 6-8 February 2017.

This inspection focused on the theme of Person Centred Care. This means that patients are treated as individuals, and the care and treatment provided to them is based around their specific needs and choices.

We assessed if Ward 11 was delivering, safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to compassionate care. Staff were observed supporting patients who were confused and disorientated. Staff were respectful and effectively provided appropriate support to patients who were distressed. Staff were observed to be patient and caring and were observed to be empathetic to the needs of relatives also. There was a high level of therapeutic engagement observed during the inspection between patients and staff. There was a good level of appropriate activities on the ward delivered mostly by the occupational therapist. It was good to note that the advocacy service had improved and that advocates had proactive input to the ward.

Areas requiring improvement were identified. A letter of serious concerns has been sent to the trust in relation to deficits in environmental, fire and ligature risk assessments. The trust are expected to return an action plan to address these areas of concern by Wednesday 8 March 2017.
Other areas requiring improvement were in relation to person centred goal orientated care plans, the electronic recording system, staff meetings, and governance review of physical

interventions and safeguarding vulnerable adults. An area for improvement is also required in relation to the displaying patient and relative experiences of the service.

The inspector spoke to six patients.

Patients all stated that they felt safe, knew how to make a complaint and that staff were always available to speak to. Patients said that they felt being in hospital was helping and that they were being well cared for and that there were activities on the ward. Patients also said that it was easy for them to see their friends and family. Overall patients were happy about their care and treatment and all were complimentary about the staff.

Patients said

"The staff don't get paid enough money to do this job".
"The staff are very nice".
"I am getting well looked after".
"I don't take part in activities but I see them happening on all the time".
"I have no complaints at the moment. The ward is comfortable. There is some noise at night, but it is ok".
"The staff and doctors are very good".
"The ward is clean and comfortable".

Feedback was received from nine relatives.

Relatives said staff were accessible, available and approachable and that they felt listened to. Relatives knew who was involved in their family member's care and treatment and they were also included in any decisions involving their family member's care. Relatives said that the care and treatment that their family member was receiving was beneficial. One relative completed the "your care your view" card and stated would very likely recommend the ward to friends and family who need similar care.

Relatives said

"Staff are very supportive and empathetic towards the needs of patients and families. Atmosphere is conducive to the needs of patients with dementia. Staff actively engage with patients and families. Staff allow families time and opportunity to talk about their feelings. Staff really develop an understanding of the person as an individual and provide person centred care".

"My father has Alzheimer's and needs assistance with all aspects of his life. Ward 11 staff are very friendly and supportive, and have developed great rapport with him. They have kept us informed of developments and have acted instantly in times of crisis to ensure my father's safety and security".

"The team are outstanding".

"The staff in Lagan Valley hospital have respected my father's condition and treat him with care and dignity".

"I find the ward is very good and all the staff absolutely excellent".

“My husband has been an inpatient for nearly a year now and I have never any cause for concern re any members of staff or of his treatment. I have nothing but praise for the staff’s patience and friendliness in the face of what at times can be very challenging behaviour”.

“We as a family couldn’t have coped with my mother’s illness without the care given by staff of Ward 11”.

Inspectors spoke with ten members of the multi-disciplinary team.

Staff stated that the multi-disciplinary team worked well together. Staff said they were valued and their opinions listened to and considered. Staff all said they were supported in their role and did not raise any areas for concern in relation to safe and effective care. Staff were compassionate in their response when asked about providing care and support to patients and also emphasised the importance of involving relatives and supporting relatives to cope with their family member’s illness.

Staff said

“The only challenge I have is when I ask myself am I doing enough for my patient, and what more can I do to support and care for patients”.

“I treat patients as I would want my mother or father to be treated”.

“I am very much supported in my role”.

“I am in a very privileged position as I care for people who come in very distressed and leave more settled”.

“I feel comfortable approaching the ward manager”.

The findings of this report will provide the service with the necessary information to enhance practice and service user experience.

4.1 Inspection Outcome

Total number of areas for improvement	10

Findings of the inspection were discussed with the ward manager, ward staff, members of the multi-disciplinary team, and a staff member from estates, the ward advocates and the nurse consultant as part of the inspection process and can be found in the main body of the report.

There were three areas for improvement that required attention by 8 March 2017. These were in relation to the fire safety survey and fire risk assessment, ligature risk assessments, the

procedure for the use of profiling beds and the completion of an environmental health and safety assessment and audit.

The escalation policies and procedures are available on the RQIA website.
https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

5.0 How we Inspect

The inspection was underpinned by:

- The Mental Health (Northern Ireland) Order 1986.
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.
- The Human Rights Act 1998.
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

Prior to inspection we review a range of information relevant to the service. This included the following records:

- The operational policy.
- Statement of purpose for the ward.
- Incidents and accidents.
- Safeguarding vulnerable adults.
- Complaints
- Health and safety assessments and associated action plans.
- Information in relation to governance, meetings, organisational management, structure and lines of accountability.
- Details of supervision and appraisal records.
- Policies and procedures.

During the inspection the inspector met with six service users, ten staff, and an advocate and received feedback from eight relatives.

The following records were examined during the inspection:

- Care documentation in relation to five patients.
- Staff rota.
- Training records.
- Staff meetings.
- Governance reports.
- Minutes from governance meetings.
- Compliments.
- Key Performance Indicators.

During the inspection the inspector observed staff working practices and interactions with patients using a Quality of Interaction Schedule Tool (QUIS).

We reviewed the areas for improvement / recommendations/ made at the last inspection. An assessment of compliance was recorded as met/ partially met/ not met.

The preliminary findings of the inspection were discussed at feedback to the service at the conclusion of the inspection.

6.0 The Inspection

6.1 Review of Areas for Improvement / Recommendations from the Most Recent Inspection dated 16 June 2015

The most recent inspection of Ward 11 was an unannounced inspection. The completed Quality Improvement Plan (QIP) was returned and approved by the responsible inspector. This QIP was validated by the inspector during this inspection.

6.2 Review Recommendations from Last Inspection dated 16 June 2015

Areas for Improvement		**Validation of Compliance**
Number 1 **Ref**: Standard 5.3.1 (a) **Stated:** First Time	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	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed care documentation in relation to five patients. Each patient had risk assessment completed. This was in the form of a flow chart. According to the flow chart none of the patients on the two wards were assessed at risk of self-harm therefore there was no care plan in place. All beds on the ward were profiling beds. These were required to meet the physical needs of the patients admitted to the dementia ward. However all of the beds on the functional mental health ward were profiling beds and even though it was recorded that none of the patients were at risk of self-harm, there was no reason recorded to confirm that any of the patients had a clinical need for this type of bed. In addition to this it was noted in one set of records reviewed that since admission	

	one patient had expressed thoughts of life not worth living. There was no care plan in place to address the risk in relation to using the profiling bed. None of the risk assessments had been reviewed since admission. **A new finding for improvement has been recorded in relation the over 65 functional mental health ward and review of regular review of risk assessments.**	
Number 2 **Ref**: Standard 5.3.3(g) **Stated:** Second Time	It is recommended that the records of the multi-disciplinary team meeting are completed in full.	**Met**
	Action taken as confirmed during the inspection: The records of the multi-disciplinary team meetings were reviewed in relation to five patients these were noted to have been completed in full.	
Number 3 **Ref**: Standard 5.3.1 (a) **Stated:** Second Time	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.	**Met**
	Action taken as confirmed during the inspection: This recommendation has been fully implemented. Pressure sore risk assessments were completed and reviewed in accordance with policy and procedure.	
Number 4 **Ref**: Standard 5.3.1 (a) **Stated:** Second Time	It is recommended that the ward manager ensures that the malnutrition universal screening tool (MUST) assessment is implemented in accordance to the required standard.	**Met**
	Action taken as confirmed during the inspection: This recommendation has been fully implemented. MUST records were reviewed in relation to five patients were completed and reviewed in accordance with the policy and procedure.	
Number 5 **Ref**: Standard 5.3.3 (d) **Stated:** Second Time	It is recommended that the Trust ensures that occupational therapy services are available daily, Monday to Friday, on Ward 11.	**Met**
	Action taken as confirmed during the inspection: The occupational therapy service has increased and is now available on the Ward 11 Monday to Friday.	
Number 6 **Ref**: Standard	It is recommended that the ward manager ensures restrictive practices within the ward are used in accordance to the assessed needs of each	**Met**

5.3.1(a) **Stated:** First Time	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.	
	Action taken as confirmed during the inspection: Inspector reviewed care documentation in relation to five patients. Each patient had a care plan in place that explained the need for the blanket restriction of controlled exit from the ward. Although the care plans were core, staff had individualised these with the individual risk and rationale. Each care plan considered patients human rights. The reason for the deprivation of liberty was clear and was proportionate to the risk. There was information displayed on the ward and in the patient handbook explaining why the exit from the ward was controlled by staff.	
Number 7 **Ref**: Standard 5.3.3(a) **Stated:** Second Time	It is recommended that the Trust ensures that the advocacy service on the over 65 functional mental health care side of the ward is formalised to include weekly visits by the advocate.	
	Action taken as confirmed during the inspection: The advocacy service for the functional care side of the ward has been formalised. The advocate attends the ward two times a week. More detail in overall inspection findings.	**Met**
Number 8 **Ref**: Standard 5.3.3(a) **Stated:** Second Time	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.	
	Action taken as confirmed during the inspection: The inspector reviewed care documentation in relation to five patients. Patients had signed their care records. There was evidence in the five sets of records that patients and their relatives were involved in their care and treatment plans.	**Met**

7.0 Review of Findings

7.1 Is Care Safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Areas of Good Practice

A risk assessment was completed for each patient on admission. These were reviewed every week and were noted to be up to date. There was evidence of patient and / or relative involvement. Any risks identified were managed through patient's care plans.

When a risk was identified in relation to a physical health need, i.e. weight loss, eating and drinking, skin care, there was an appropriate and timely referral made to the appropriate specialist team. There was also evidence that patients on the ward had received a timely assessment from the relevant specialist e.g. dietetics speech and language therapy, or physiotherapy. Care plans were updated accordingly and the guidelines / recommendations made were available in the patient's care documentation.

There were "huddles" at least twice a day for nursing staff on the ward that included health care assistants. There was an individual written handover for each patient which included risks. Members of the multi-disciplinary team read the written handover on entering the ward.

All staff interviewed knew how to raise concerns about safety on the ward.

Staff, patients and relatives stated that they did not have any issues in relation to safety.

Information was available and displayed on how to make a compliment, comment or complaint.

Staff were aware of the policy and procedure in relation to complaints. There were two recorded complaints between April 2015 – March 2016, in relation to patient laundry and these had both been resolved.

A governance mechanism was in place to review compliments and complaints every three months.

Staff were observed seeking consent prior to any care delivery. Capacity and consent was detailed in patient's documentation.

Detention was in accordance with the Mental Health (Northern Ireland) Order 1986. Each patient who was detained had a care plan in place. Detention was reviewed every week at the weekly Team Assessment Meetings (TAM). There was evidence of appropriate re-grading. Patients who were detained had been informed of their rights.

Staff stated they do not work beyond their role, experience and training. Junior staff stated they acknowledged their limits and said that other staff were supportive.

Risk management and care plans detailed that de-escalation and distraction techniques should be implemented as a first line strategy to support patients who were presenting with behaviours that were distressing. This support was also observed on the ward by the inspector.

The use of Pro Re Nata (PRN) was recorded in patients' care plans this included when first line and second line medication could be used.

The frequency of the use of physical interventions (Care and Responsibility) was low (10) between 1 April 2015 and 31 March 2016. This demonstrated that staff were using de-escalation and diversionary methods to avoid the use of physical intervention. It also evidenced that this restriction was used as a last resort.

The medical room was organised and the emergency equipment was checked according to trust policy and procedure.

The risk of falls was assessed on admission and a care plan was in place if a patient was assessed at risk.

Falls were recorded as an incident and reviewed by senior management at the quarterly governance meeting.

All staff knew how to access the on call out of hours rota service for contact with senior management and the duty social worker.

Key Performance Indicators were completed every month in relation to falls and pressure sores. The outcomes from the key performance indicators were displayed on the ward.

All medication was prescribed in accordance with British National Formulary (BNF) guidelines.

Areas for Improvement

<u>Self-harm and ligature risk assessments</u>

The flow chart in relation to self-harm and the use of profiling beds in place for each patient had not been reviewed since each patient's admission. All beds in the ward were profiling beds which were required for patients admitted to the dementia ward side of the unit because of their physical needs. However it was unclear why all the beds on the over 65 functional mental health side of the ward were profiling beds. None of the patients who were admitted to the over 65 functional mental health side had a care plan in place to clarify the clinical need for this type of bed. The inspector was concerned to note that one patient was assessed at risk of self-harm on admission and had also complained of life not worth living since admission. The patient risk assessment flow chart had not been updated, and a care plan was not in place to address the risk in relation to the use of the profiling bed.

Ligatures were assessed as part of the general risk assessment. Each section of the ward was assessed as high, medium or low. In relation to self-harm the over 65 functional mental health ward was highlighted as red. Some changes had been made however the inspector observed that not all ligature points had been removed e.g. taps and some door handles. It was also recorded that one of the control measures was that staff have Applied Suicide Intervention Skills Training (ASIST) training. The training records reviewed evidenced that only four staff had received ASIST training.

Environmental and fire safety

The fire risk assessment had been updated in January 2017. The previous fire risk assessment was completed in July 2014. This was outside the timeframe of one year. One recommendation in relation to fire drills remains outstanding since July 2014.

The inspector was concerned that there were difficulties with the locking mechanism on the ward doors during the inspection. Both doors did not secure shut immediately and if staff / visitors were not aware of the issue the doors would remain unsecure. This was addressed at feedback with the staff member from estates services. One door was repaired during the inspection. Assurances were given by estates staff that this issue would be addressed immediately.

From the incidents reviewed from 1 April 2015 - 31 March 2016 it was noted that patients have been injured by trapping their fingers in the doors. Inspectors were also informed by the ward manager that staff have been also injured. Inspectors observed some of the doors on the ward and noted because of the heavy nature of the doors and the closing mechanism the doors slammed shut. This was addressed with estates staff at feedback and an action plan agreed.

There was no environmental health and safety audit completed for Ward 11.

Number of areas for improvement	2

7.2 Is Care Effective?

The right care, at the right time in the right place with the best outcome

Areas of Good Practice

Each patient had an individualised comprehensive assessment of their needs completed by the multi-disciplinary team.

Each patient had individualised nursing care plans in place and these were reviewed every day.

Multi-disciplinary progress notes were comprehensive, contemporaneous, and reflected the interventions as recorded in the care plans.

Each patient had an occupational therapy assessment completed and there was an occupational therapy intervention plan in place. Occupational therapy goals were person centred and recorded with an achievement date.

There was evidence of patient and / or relative involvement in care and treatment plans.

There was a range of care and treatment options available and delivered in line with evidence based guidance, best practice standards and defined care pathways. The inspector noted that care pathways were in use in relation to the prescription of Lithium, Clozapine and the administration of Electro convulsive therapy (ECT).

Two members of the multi-disciplinary team had attended training on palliative care and dementia.

Each patient had a physical and nutritional assessment of their needs and a care plan in place that addressed any needs that were identified.

Referrals were made to the palliative care team. The inspector observed that the palliative care team visited a patient during the inspection.

Team assessment meetings are held every week and were attended by the multi-disciplinary team.

Discharge planning commenced early following admission. There was good liaison with community teams and evidence of good social work support in relation to discharge. There was evidence of family involvement when planning for discharge. A dementia risk assessment is completed when a patient has been assessed ready for discharge. Anecdotal reports from nursing homes confirm that the risk assessment is working well. This improvement initiative should be formally reviewed. The community psychiatric nurse (CPN) also received a copy of the dementia risk assessment.

The ward environment was reviewed January 2017 using the dementia design audit tool and improvements to be made noted. The ward manager and nurse consultant stated that staff are planning to meet to collate the findings from the audit and complete an action plan. RQIA will review progress during the next inspection.

The ward social worker was recording their contact with patients and their relatives in the patient's care documentation.

Each patient had a care plan in place in relation to deprivation of liberty which was reviewed weekly. The care plan detailed the rational for the restriction. Staff were knowledgeable about deprivation of liberty and were committed to ensuring that where appropriate patients got time of the ward.

Staff were committed to encouraging and supporting family contact.

There was a good range of therapeutic / recreational activities available. On the days of the inspection, the inspector observed patients participating in art and cookery.

The ward environment was enabling and there was open access to the garden.

Areas for Improvement

Person centred goals

It was unclear in the occupational therapy documentation if patient's goals had been achieved.

Nursing care plans were not goal orientated. Goals were recorded as interventions with no time frame recorded and the inspector found it difficult to establish if the interventions were effective.

Occupational therapy resource

There was a limited occupational therapy budget of £50 between three services. This limited community living activities.

Patient recording system

There were two systems for recording patient information. Some information was recorded in patient's paper files and some on the electronic recording system (MAXIMS).

Number of areas for improvement	3

7.3 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.

Areas of Good Practice

Staff were observed to treat patients with dignity and respect

Staff confirmed they had time to support patients and their relatives with their emotional needs.

Relatives stated that their family member's privacy and dignity was respected.

Staff were observed to respond to physical and emotional distress with compassion.

Staff were observed to be understanding of the needs of patients, were observed to be patient focussed and used effective and discreet techniques to divert patients who were presenting with distress, confusion and disorientation.

Staff interviewed knew each patient very well, including details about their families, their interests and previous occupations. Staff used this information to interact with patients.

The use of physical interventions was low and this demonstrated the effectiveness of the diversionary techniques used. Staff should be commended in relation to this.

Patients appeared comfortable in their surroundings.

An advocacy service was available on both wards two days every week. The advocates played an active part on the wards. The advocate who visits the over 65 functional mental health ward holds a communication group every Monday. The inspector observed the advocate attending the dementia ward and engaging with patients and their relatives. The advocates did not raise any concerns about the unit.

Patients and relatives were complimentary about the staff.

Patients and their relatives were happy with the care and treatment they were receiving on the ward.

Staff were observed to be present on the ward for patients and families throughout the inspection.

Staff were observed supporting patients with eating and drinking, and observed offering patients a choice of food. Staff ensured patients were comfortable and maintained an atmosphere that was calm and relaxed during meal time.

Staff were observed to be polite, courteous, and professional. The inspector also observed staff communicate effectively with patients and their relatives, used active listening, and provided patients and their relatives with clear and correct information.

The ward environment was clean, comfortable, warm and welcoming.

Areas for Improvement

No areas for improvement were identified during the inspection.

Number of areas for improvement	0

7.4 Is the Service Well Led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

Areas of Good Practice

Monthly staff meetings were held and minutes were available.

A quarterly governance report was completed and included details in relation to incidents, vulnerable adults, compliments, complaints, patients experience, service improvement initiatives, staff sickness and the use of bank and agency staff. The report was discussed at the quarterly Primary Care and Mental Health Services for Older people governance meetings.

Staff were aware of their roles and responsibilities in relation to referring and reporting safeguarding vulnerable adults, whistleblowing and child protection.

Trust policies and procedures were easily accessible for staff and staff knew how to access these.

There was governance oversight of delayed discharges, length of stay and over occupancy.

Staff reported good working relationships between the multi-disciplinary team.

Staff supervision and appraisals were up to date.

Staff felt supported, valued and listened to.

Training records reviewed evidenced that staff had received up to date mandatory training.

The ward manager completed an audit of care documentation every month.

The trust has developed a Primary Care and Older People Management Plan for Safety Quality Experience (SQE) service improvements which included corporate and directorate objectives and an action plan for completion by March 2017.

Areas for Improvement

Trust policy and procedures

A number of trust policies and procedures were out of date. These were previously highlighted and included in the provider compliance plan relating to the inspection of Downe Dementia Ward on 4 – 6 October 2017. Therefore this area for improvement will not be included in the provider compliant plan attached to this report.

Staff meetings

Attendance at staff meetings was low. The minutes reviewed evidenced that seven staff attended in October 2016, four staff attended in November 2016 and ten staff attended the meeting in January 2017. Attendance was only from nursing staff.

The following was not included in the team meeting agenda:
Learning from incidents / accidents
Up to date evidence based practice, new guidelines etc.
Feedback from any courses / study days attended by staff this would enable shared learning and encourage service improvement.

Skill mix

There was no Band 6 nurse working on the ward. The nurse consultant stated that an expression of interest will be circulated in February 2017 and an advertisement for permanent post will be issued before the end of February 2017.

Governance

The use of physical interventions should be reviewed and included in governance review. Staff were not aware of the number of times physical interventions were used on the ward. The inspector established the number of times physical interventions were used by reviewing all of the incidents that had occurred from April 2015 to March 2016. Although the frequency is low (10), this should be acknowledged both through governance and staff meetings.

There was no mechanism in place to review the number of vulnerable adult referrals. The ward manager confirmed she had to trawl through emails to collate this information.

Patient / relative experience

There was no information displayed in relation to patient and relative experience.

Number of areas for improvement	5

8.0 Provider Compliance Plan

Areas for improvement identified during this inspection are detailed in the provider compliance plan. Details of the provider compliance plan were discussed at feedback, as part of the inspection process. The timescales commence from the date of inspection
The responsible person should note that failure to comply with the findings of this inspection may lead to further /escalation action being taken. It is the responsibility of the responsible person to ensure that all areas identified for improvement within the provider compliance plan are addressed within the specified timescales.

8.1 Actions to be taken by the Service

The provider compliance plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed provider compliance plan by 5 April 2017.

Provider Compliance Plan Ward 11 Priority 1	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** Quality Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 8 March 2017	Self-harm and ligature risk assessments The flow chart in relation to self-harm and the use of profiling beds in place for each patient had not been reviewed since each patient's admission. All beds in the ward were profiling beds which were required for patients admitted to the dementia ward side of the unit because of the physical needs. However it was unclear why all the beds on the over 65 functional mental health side of the ward were profiling beds. None of the patients who were admitted to the functional mental health side had a care plan in place to clarify the clinical need for this type of bed. The inspector was concerned to note that one patient was assessed at risk of self-harm since admission and had also complained of life not worth living. The patient risk assessment flow chart had not been updated, and a care plan was not in place to address the risk in relation to the use of the profiling bed. Ligatures were assessed as part of the general risk assessment. Each section of the ward was assessed as high, medium or low. In relation to self-harm the over 65 functional mental health ward was highlighted as red. Some changes had been made the inspector observed that not all ligature points had been removed e.g. taps and some door handles. It was also recorded that one of the control measures was staff have Applied Suicide Intervention Skills Training (ASIST) training. The training records reviewed evidenced that only four staff had received ASIST training.
	Response by responsible person detailing the actions taken: The Functional Mental Health Patient profiling bed risk assessment flow chart has been reviewed. All Functional Patients are being reviewed on and throughout their admission regarding specific clinical need for a profiling bed and have a care plan implemented. These are being reviewed daily and recorded on Maxims. On admission when a patient is assessed as at risk of self-harm they will be placed on level one special observations until assessed and reviewed by the Consultant. The hand controls had previously been removed from every bed when the Safety Alert was issued and the activation remote secured to the

	bottom of the bed, thus shortening the cable to reduce risk but still enable use. The profiling beds are generally required to meet the physical needs for the age profile of this patient group. The procedure regarding monitoring of profiling beds has been raised at safety huddles and staff meeting to ensure all staff are aware. New anti-ligature door handles were ordered on 06/02/17 and installed on 28/03/17. New replacement anti-ligature taps are included in an estates job scheme. The Ward Sister is actively pursuing progress. Any patient identified as at risk of ligature self-harm will be placed on level one observations. In line with availability of CEC training provision, staff will attending STORM training (Skills Training On Risk Management) at CEC 05/07/17 and 11/08/17. Further training will be accessed as required for the team.
Area for Improvement No. 2 **Ref:** Quality Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 8 March 2017	<u>Environmental and fire safety</u> The fire risk assessment had been updated in January 2017. The previous fire risk assessment was completed in July 2014. This was outside the timeframe of one year. One recommendation in relation to fire drills remains outstanding since July 2014. The inspector was concerned that there were difficulties with the locking mechanism on the ward doors during the inspection. Both doors did not secure shut immediately and if staff / visitors were not aware of the issue the doors would remain unsecure. This was addressed at feedback with the staff member from estates services. One door was repaired during the inspection. Assurances were given by estates staff that this issue would be addressed immediately. From the incidents reviewed from 1 April 2015 - 31 March 2016 it was noted that patients have been injured by trapping their fingers in the doors. Inspectors were also informed by the ward manager that staff have been also injured. Inspectors observed some of the doors on the ward and noted because of the heavy nature of the doors and the closing mechanism the doors slammed shut. This was addressed with estates staff at feedback and an action plan agreed. There was no environmental health and safety audit completed for Ward 11.

	Response by responsible person detailing the actions taken: Fire Safety Survey and Fire Risk Assessment was completed on 27/01/17 by FRSNI. This will be reviewed again in February 2018 or before if required. Fire Safety Drill Evacuation completed on 27/02/17 by FRSNI. Locking Mechanism of Doors - All doors were reviewed on 09/02/17 and all maintenance work has been completed satisfactorily. The doors are reviewed daily by staff to ensure the mechanism continues to function. Estates have a plan in place to review all doors regularly. All staff are aware to report faults immediately via phone to the estates department. There have been no injuries of trapped fingers since March 2016. Environmental health and safety audit has been completed and forwarded to RQIA on 3rd March 2017. A copy is kept in the health and safety file.
Priority 2	
Area for Improvement No. 3 **Ref:** Quality Standard 6.3.1 **Stated:** First time **To be completed by:** 3 May 2017	<u>Occupational therapy resource</u> There was a limited occupational therapy activity budget of £50 between three services. This limited community living activities.
	Response by responsible person detailing the actions taken: The current unstable political environment with no agreed budget as yet, has serious restraint implications for this coming year's spend. However we will keep this matter under review to determine if this budget can be increased. Ward Sister will actively pursue progress and will escalate if this need cannot be met.
Area for Improvement No. 4 **Ref:** Quality Standard 5.3.3 (c) **Stated:** First time **To be completed by:** 3 May 2017	<u>Staff meetings</u> Attendance at staff meetings was low. The minutes reviewed evidenced that seven staff attended in October 2016, four staff attended in November 2016 and ten staff attended that meeting January 2017. Attendance was only from nursing staff. The following was not included in the team meeting agenda: Learning from incidents / accidents Up to date evidence based practice, new guidelines etc. Feedback from any courses / study days attended by staff this would enable shared learning and encourage service improvement.
	Response by responsible person detailing the actions taken: All disciplines of staff are being invited to the ward staff meeting, this

	this is now held at a regular time and day on the month to improve attendance further and agenda items will be requested prior to the meeting. Minutes of meetings to be emailed to staff trust email accounts. Standing agenda items amended and now incorporates: Adult Protection Plans Learning from incidents/accidents New initiatives to include evidence based practices Staff feedback from study days, conferences and training etc. and AOB from staff.
Area for Improvement No. 5 **Ref:** Quality Standard 6.3.2 (g) **Stated:** First time **To be completed by:** 3 May 2017	<u>Patient / relative experience</u> There was no information displayed in relation to patient and relative experience.
	Response by responsible person detailing the actions taken: The ward Peer Advocate and Dementia Advocate are developing a questionnaire proforma for patients, relatives and carers. The information gathered will be discussed with Ward Sister/Acting Ward Sister, any concerns, requests or developments will be addressed. This information will be formatted and displayed for the appropriate sides of the ward.
Area for Improvement No. 7 **Ref:** Quality Standard 4.3 (j) **Stated:** First time **To be completed by:** 3 May 2017	<u>Skill mix</u> There was no Band 6 nurse working on the ward. The nurse consultant stated that an expression of interest will be circulated in February 2017 and an advertisement for permanent post will be issued before the end of February 2017.
	Response by responsible person detailing the actions taken: A staff nurse was recruited through an expression of interest and interview and appointed Acting Band 6 on 20/02/17 The permanent vacancy has been raised via eRec and it is estimated will be advertised in April / May.

Priority 3	
Area for Improvement No. 8 **Ref: Quality Standard 5.3.1 (a)** **Stated:** First time **To be completed by:** 9 August 2017	<u>Person centred goals</u> It was unclear in the occupational therapy documentation if patient's goals had been achieved. Nursing care plans were not goal orientated. Goals were recorded at interventions with no time frame recorded and the inspector found it difficult to establish if the interventions were effective.
	Response by responsible person detailing the actions taken: The ward Occupational Therapist has reviewed their documentation which now clearly shows if a patient's goals have been achieved. Nursing Care Plans have also been reviewed and are now goal orientated and incorporate appropriate time frames for patients to achieve these goals.
Area for Improvement No. 9 **Ref:** Quality Standard 5.3.1 (a) **Stated:** First time **To be completed by:** 9 August 2017	<u>Patient recording system</u> There were two systems for recording patient information. Some information was recorded in patient's paper files and some on the electronic recording system (MAXIMS).
	Response by responsible person detailing the actions taken: All patients with a diagnosis of dementia have fully paper files. All function patient information is recorded electronically on MAXIMS with a printout of their admission put into their patient file. Medical staff record in the patients notes. All Risk assessments for this client group are recorded electronically on Maxims. All staff have access to both systems. This process is still under development within older people inpatient services and will be discussed further at the Integrated Care Pathway Workshop.

Name of person(s) completing the provider compliance plan	Roisin Keown		
Signature of person(s) completing the provider compliance plan		**Date completed**	7th April 2017
Name of responsible person approving the provider compliance plan	Brenda Arthurs		
Signature of responsible person approving the provider compliance plan		**Date approved**	10th April 2017
Name of RQIA inspector assessing response	Wendy McGregor		
Signature of RQIA inspector assessing response		**Date approved**	18 April 2017

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