The Regulation and Quality Improvement Authority

Brooke Lodge

Lakeview Hospital

Western Health & Social Care Trust

Unannounced Inspection Report

Date of inspection: 6 & 7 May 2015

npm national preventive mechanism

informing and improving health and social care

www.rqia.org.uk

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Our Vision, Purpose and Values

Vision

To be a driving force for improvement in the quality of health and social care in Northern Ireland

Purpose

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

Values

RQIA has a shared set of values that define our culture, and capture what we do when we are at our best:

- **Independence** - upholding our independence as a regulator
- **Inclusiveness** - promoting public involvement and building effective partnerships - internally and externally
- **Integrity** - being honest, open, fair and transparent in all our dealings with our stakeholders
- **Accountability** - being accountable and taking responsibility for our actions
- **Professionalism** - providing professional, effective and efficient services in all aspects of our work - internally and externally
- **Effectiveness** - being an effective and progressive regulator - forward-facing, outward-looking and constantly seeking to develop and improve our services

This comes together in RQIA's Culture Charter, which sets out the behaviours that are expected when employees are living our values in their everyday work.

Contents

1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

RQIA's programmes of inspection, review and monitoring of mental health legislation focus on three specific and important questions:

Is Care Safe?

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

Is Care Effective?

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

Is Care Compassionate?

- Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support

2.0 Purpose and Aim of this Inspection

To review the ward's progress in relation to recommendations made following previous inspections.

To meet with patients to discuss their views about their care, treatment and experiences.

To assess that the ward environment is fit for purpose and delivers a relaxed, comfortable, safe and predictable environment.

To evaluate the type and quality of communication, interaction and care practice during a direct observation using a Quality of interaction Schedule (QUIS).

2.1 What happens on inspection

What did the inspector do:

- reviewed the quality improvement plan sent to RQIA by the Trust following the last inspection(s)

- talked to patients, carers and staff
- observed staff practice on the days of the inspection
- looked at different types of documentation

At the end of the inspection the inspector:

- discussed the inspection findings with staff
- agreed any improvements that are required

After the inspection the ward staff will:

- send an improvement plan to RQIA to describe the actions they will take to make any necessary improvements

3.0 About the ward

Brooke Lodge is a nine bedded ward situated in Lakeview hospital. The purpose of the ward is to provide assessment and treatment to male and female patients with a learning disability who require care and treatment in an acute psychiatric care environment.

Patients within Brooke Lodge are supported by a multidisciplinary team which includes: psychiatry; nursing; psychology and behavioural support. Patients can access also dietetics, podiatry and speech and language therapy by referral. A patient advocacy service is also available.

On the days of the inspection there were seven patients admitted to the ward. None of the patients had been admitted in accordance to the Mental Health (Northern Ireland) Order 1986. Three patients discharge from the ward had been delayed.

4.0 Summary

Progress in implementing the recommendations made following the previous inspection carried out on 13 and 14 October 2014 was assessed during this inspection. There were a total of 38 recommendations made following the last inspection. It was good to note that 34 recommendations had been implemented in full.

Two recommendations had been partially met and two recommendations had not been met. One of these recommendations will be restated for a third time following this inspection. The remaining three recommendations will be restated for a second time. The restated recommendations are recorded in the Quality Improvement Plan (QIP) accompanying this report.

On the days of the inspection the ward was noted to relaxed, appropriately staffed and well maintained. Patients presented as being at ease in their surroundings and staff were witnessed as being attentive and responsive to patient need. However, inspectors noted that there was no information

available to orientate patients to the day of the week, the date, when meals were held and what activities were available on the ward each day. Inspectors also recorded that the ward did not have an up to ligature risk assessment had not been completed. Recommendations regarding these issues have been made.

Staff who met with inspectors reflected that they felt the ward had implemented a number of significant changes since the previous inspection in October 2014. The changes included the introduction of new patient assessments and care plans.

Patient care documentation including: initial assessments, care plans and patient progress notes were recorded in hard copy. Records reviewed by inspectors were noted to be individualised to each patient, comprehensive and up to date. Patient signatures, or an explanation for the absence of a signature, were recorded as required. Inspectors evidenced that care records were well maintained and easy to follow.

The ward's senior management team had introduced up to date practices in relation to the use of restrictive interventions. Records examined by inspectors demonstrated that the use of restrictive practices with patients was continually monitored and regularly reviewed. Findings on the days of the inspection evidenced that the ward promoted a least restrictive environment in which to provide patient care and treatment. It was good to note that the use of restrictive intervention practices with patients was completed in accordance to Trust and regional guidance.

On the days of the inspection, inspectors witnessed staff engaging patients in activities, such as walks, supporting patients to attend "Berryburn" day centre and one patient was enjoying a foot spa. Patients had the opportunity to access the day care facility situated within the hospital site. The ward also had use of a minibus which was used to take patients shopping and for day trips. Inspectors were informed that patients on the ward did not have access to a ward based occupational therapy service. A recommendation regarding this has been made.

It was positive to note that the ward had made significant progress implementing the recommendations made following the inspection completed on the 13 and 14 October 2014. However, inspectors evidenced that four recommendations had not been fully implemented. This included one recommendation which will be restated for a third time.

Given the lack of progress in implementing a recommendation for a third time an escalation letter was forwarded to the Trust on the 13 May 2015. The lack of progress in implementing the recommendation was discussed. It was positive to note that the Trust had taken appropriate steps to address the recommendation. An action plan detailing the Trust's would provide finance training for ward staff by the 30 June 2015 was forwarded to RQIA on the 2 June 2015.

4.1 Implementation of Recommendations

Eight recommendations which relate to the key question "**Is Care Safe**?" were made following the inspection undertaken on 13 and 14 October 2014.

These recommendations concerned patient's care records, risk management processes and the use of restrictive practices.

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

- patient's files had been reviewed and updated. Inspectors noted files were tidy, comprehensive and easy to follow;
- the use of physical interventions with patients were being monitored and recorded in accordance to the Trust's policy and procedure;
- the ward's staff induction programme had been updated;
- the patient information booklet had been updated. Inspectors noted that contact details of outside agencies were available for patient use;
- the use of restrictive practices had been implemented in accordance to the assessed needs of the patient. Restrictive practice care plans were available and had been regularly reviewed by the ward's multi-disciplinary team;
- patient care record reviewed by inspectors evidenced that the use of restrictive practices were implemented in accordance to Trust policy and procedure;
- incidents occurring on the ward were being managed in accordance with regional safeguarding vulnerable adult procedures.

However, despite assurances from the Trust, one recommendation had not been fully implemented. Patient's comprehensive risk assessments were not being reviewed in accordance to regional guidance.

15 recommendations which relate to the key question "**Is Care Effective**?" were made following the inspection undertaken on 13 and 14 October 2014.

These recommendations concerned monitoring of physical interventions, management of patient finances, assessment of patient needs, management of challenging behaviour, therapeutic activities and discharge planning.

The inspector was pleased to note that recommendations in the following 12 areas had been fully implemented:

- appropriate arrangements were in place to monitor the use of physical interventions on the ward;

- regular statements were being received from the cash office to facilitate verification of transactions and expenditure;

- a policy and procedure in relation to operating individual patient saving accounts was available and noted to be appropriate;

- patient's assessments had been completed using appropriate recognised and evidenced based tools;

- patients and / or their representatives had been given the opportunity to contribute to their assessments and care plans;

- patients presenting with behaviours that challenge had a multi-disciplinary assessment completed using recognised appropriate evidenced based assessment tools;

- patients who had been assessed as presenting with behaviours that challenge had a plan in place that guided staff to proactively support and positively address the patient's needs;

- a ward / group therapeutic and recreational activity programme had previously been implemented in conjunction with patients and / or their representatives;

- patients who had been assessed as requiring a structured day were provided with a structured timetable and a plan to guide staff when supporting the patient;

- care and treatment plans completed for patients readmitted to the ward had been re-evaluated and reviewed to look at reducing the risk of future readmissions;

- collaborative working between hospital and community services was being completed;

- guidance and safety alerts issued by Northern Ireland Adverse Incident Centre (NIAIC), DHSSPSNI, HSCB, PHA and other organisations were available and being implemented.

However, despite assurances from the Trust, three recommendations had not been fully implemented. The ward had not:

- ensured that ward staff complete up to date training in the management of patient finances;

- appropriately implemented and reviewed patient therapeutic and social activity plans;

- ensured that patients had a discharge care plan and associated pathway.

15 recommendations which relate to the key question "**Is Care Compassionate**?" were made following the inspection(s) undertaken on 13 and 14 October 2014.

These recommendations concerned the use of restrictive practices, record keeping and patient involvement in their care and treatment.

- The inspector was pleased to note that 15 recommendations had been fully implemented:

- patient signatures, or a reason why a patient had been unable to sign their record, were available on all relevant care documentation;

- care and treatment programmes had been discussed with patients;

- patients subject to physical interventions had been informed of the reason why the intervention had been used;

- the Trust's personal searches policy had been reviewed and updated;

- where a patient had been unable to sign their care record(s) the reason for this had been documented. Staff had also reviewed the patient's capacity to understand the information contained within the record;

- patients had been involved in their care and treatment plan and staff had taken appropriate steps to ensure patients were continually informed and updated;

- ward staff continued to assess and gain patient consent to participate in care and treatment;

- patient attendance/non-attendance at multi-disciplinary meetings was consistently documented;

- patient progress records evidenced that ward staff continued to consider the potential impact of care and treatment on each patient's human rights;

- patient assessments had been completely fully and reflected the patient's needs including their likes and dislikes;

- care plans specific to each patient's communication needs were available and being implemented by ward staff;

- patients admitted to the ward on the days of the inspection had been informed of their rights;

- the Trust had reviewed the use of blanket restrictions on the ward. Inspectors evidenced that where restrictions were used these were implemented in accordance to the patient's assessed needs and Trust policy and procedure;

- patients and/or their representatives had been informed of restrictive interventions used on the ward;

- care documentation of patients whose discharge from the ward had been delayed included a rationale explaining the nature and reason for the delay.

5.0 Ward Environment

"A physical environment that is fit for purpose delivering a relaxed, comfortable, safe and predictable environment is essential to patient recovery and can be fostered through physical surroundings." Do the right thing: How to judge a good ward. (Ten standards for adult-in-patient mental health care RCPSYCH June 2011)

Inspectors assessed the ward's physical environment using a ward observational tool and check list.

Summary

On entrance to the hospital there was a reception area and Brooke Lodge was situated down a long corridor leading from the main entrance. Notice boards in the ward displayed information which detailed the philosophy of the ward and the patients' charter. The ward provided an up to date information booklet for patient/relative use and it was good to note that this was in easy read format.

There was information displayed in easy read format on the ward's main notice board in relation to the advocacy service, the Trust's complaints procedure, RQIA's recent inspection and the date of the next patient forum meeting. It was positive to note that the ward had a large amount of easy read information available for patients. This included information in relation to Human Rights, the Mental Health (Northern Ireland) Order 1986, The Mental Health Review Tribunal and patients' right to access information held about them.

Pictorial signage was available throughout the ward. This helped to orientate patients to the wards environment. Pictorial signs were displayed on the entrance to the dining room, bedrooms, shower rooms and toilets. However, there was no information displayed for patients in relation to the multi-disciplinary team, the timing of ward meetings, staff on duty and patients' named nurse/associate nurse. Inspectors also noted that there was no information available to orientate patients to the day of the week, the date, when meals were held and what activities were available on the ward each day.

The ward had three communal rooms, one of which was used as a quiet room. Patients were able to meet with their visitors in their bedroom or in the quiet room. Patients also had direct access to a garden area which was well maintained with flower beds and seated areas.

There was one patient on the ward who was receiving enhanced observations. Staff members providing this level of support throughout the day were observed engaging with the patient and treating them with respect and dignity

The inspectors were concerned to note that the ward did not have a ligature risk assessment and associated action plan completed. An overall health and safety assessment had been carried out which detailed that changes required to the window blinds and this had been carried out. However, the inspectors observed ligature points throughout the ward in relation to the ward environment and profiling beds.

The findings from the ward environment observation are included in Appendix 1

6.0 Observation Session

Communication and behaviour is a vitally important component of dignified care. The Quality of Interaction Schedule (QUIS) is a method of systematically observing and recording interactions whilst remaining a non-participant. It aims to help evaluate the type of communication and the quality of communication that takes place on the ward between patients, staff, and visitors.

The inspector completed a 20 minute direct observation using the QUIS tool during the inspection and assessed whether the quality of the interaction and communication was positive, basic, neutral, or negative.

Positive - care and interaction over and beyond the basic care task demonstrating patient centred empathy, support, explanation and socialisation

Basic – care task carried out adequately but without elements of psychological support. It is the conversation necessary to get the job done.

Neutral – brief indifferent interactions

Negative – communication which is disregarding the patient's dignity and respect.

Summary

The session involved observations of interactions between staff and patients/visitors. Three interactions were noted in this time period. The outcome of these interactions were as follows:

Positive	Basic	Neutral	Negative
66%	33%	%	%

The inspectors observed interactions between staff and patients throughout the day of the inspection. The inspectors noted that interactions between staff and patients were positive and respectful. Staff were engaging with patients throughout the day and there was evidence that they were providing person centred care. Inspectors also witnessed staff to be empathetic, reassuring and supportive towards patients.

One patient was observed receiving enhanced 1:1 observations. This patient appeared relaxed and at ease with all three staff members who were observed throughout the day providing this level of support. An inspector spoke to the patient. The patient was able to name the nurse who was working with them and described in short sentences what they had been doing throughout the day. This included watching a DVD, seeing their visitor, going for a walk and attending the day centre for a short period. The inspector observed positive interactions between all three staff members and the patient.

One patient was observed asking a staff member if they could "phone their mother". The staff member accompanied the patient into the ward manager's office were they were able to make this phone call. However the staff member continued to stay in the room with the patient and did not ask the patient if they would like to talk in private. The inspector spoke to this patient later in the day. The patient advised that they were able to make a private phone call in the office and explained that staff would usually leave the office to facilitate this.

The patients on the ward appeared relaxed and at ease in their surroundings. The staff appeared to have a good level of understanding in relation to each patient's individual needs. During the inspection there was evidence that staff treated patients with respect and dignity.

The findings from the observation session are included in Appendix 2

7.0 Patient Experience Interviews

One patient agreed to meet with an inspector on the day of the inspection. The patient completed a questionnaire regarding their experience of their care and treatment on the ward. The patient stated that staff were supportive and introduced themselves to them when they were admitted onto the ward. However, the patient stated they were not shown around the ward or given the opportunity to discuss the reasons why they were admitted. The patient stated that they had been very upset when they had arrived onto the ward and they were not in a "fit state".

The patient stated that they had not been informed of their rights however information in relation to the complaints procedure, the advocacy service and the next patient forum meeting was displayed on the ward's notice board. There was also easy read information available on the ward in relation to patients' Human Rights, the Mental Health (Northern Ireland) Order 1986, The Mental Health Review Tribunal and patients' right to access information held about them. The patient raised no concerns regarding their care and treatment on the ward and stated they always felt safe on the ward

The patient reported that they felt they had been treated with dignity and respect. The patient explained that they had been involved in their care and treatment plans. They advised that they felt they could refuse care and treatment as they had refused to attend their MDT meetings. The patient informed the inspector that staff updated them regarding the outcome of MDT meetings.

The patient reflected that they felt they had been listened to and their views had been taken on board. They stated that they do not need much support on the ward but stated that staff ask their permission before supporting them with any care and treatment.

The findings are included in Appendix 3

7.1 Other areas examined

During the course of the inspection the inspector met with:

Ward Staff	**5**
Other ward professionals	**0**
Advocates	**0**

Ward staff who met with inspectors reflected that the ward had undergone significant changes during the previous seven months. Staff highlighted that the ward continued to experience change. Concerns were expressed to inspectors that the proposed amalgamation of the Brooke Lodge and Strule Lodge wards would require readjustment to working practices including

nursing staff rotas. This issue was discussed with the head of service who assured inspectors that appropriate steps to address staff concerns had been taken.

Nursing staff reported that they felt a number of positive changes had been introduced to the ward.

8.0 Next Steps

A Quality Improvement Plan (QIP) which details the areas identified for improvement has been sent to the ward. The Trust, in conjunction with ward staff, must complete the QIP detailing the actions to be taken to address the areas identified and return the QIP to RQIA by 2 July 2015.

The lead inspector will review the QIP. When the lead inspector is satisfied with actions detailed in the QIP it will be published alongside the inspection report on the RQIA website.

The progress made by the ward in implementing the agreed actions will be evaluated at a future inspection.

Appendix 1 – Ward Environment Observation
(This document can be made available on request)

Appendix 2 – QUIS
(This document can be made available on request)

Appendix 3 –Patient Experience Interview

Appendix 4 – Follow up on Previous Recommendations

Appendix 1

Follow-up on recommendations made following the unannounced inspection on 13 & 14 October 2014

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	5.3.3(b)	It is recommended that patient signatures are made available on all relevant care documentation. Staff should record if they had been unable to attain a signature.	2	Inspectors reviewed three sets of patient care records. Patient signatures were available as required. Inspectors noted patient signatures on comprehensive assessments, risk assessments and care plans. One file recorded that the patient had asked not to sign their care plan(s) as they found the experience made them anxious. The patient's next of kin had signed the care plan. An explanation regarding the absence of the patient's signature was provided on each care plan record.	**Fully met**
2	5.3.1 (a)	It is recommended that the Nurse in Charge ensures that the ward's review of patient file structure is completed in accordance with the Trust's timetable.	2	The structure of patient files had been reviewed and updated. Files reviewed by inspectors were tidy, comprehensive and easy to follow.	**Fully met**
3	5.3 (a) & (b)	It is recommended that the ward sister ensures that all patients are aware of their diagnosis and treatment plan and the reason recorded when this is not appropriate.	2	Care records reviewed by the inspectors evidenced that an initial *'about me passport'* assessment was completed with each patient upon admission. The *'about me passport'* provided a comprehensive assessment of the patient's circumstances including an assessment of the patient's individual care needs. Records reviewed by inspectors evidenced that each	**Fully met**

				patient's communication, physical health and mental health needs and diagnoses had been reviewed and discussed with the patient. It was positive to note that assessments had been signed by the patient or their relative/carer. Patient care plans and multi-disciplinary team (MDT) meeting records had been discussed with the patient. Minutes from previous MDT meetings evidenced that patient progress and treatment plans were regularly reviewed. Patients were invited to attend the MDT meeting which was held each Friday morning. Minutes from the last MDT meeting held on the 1 May 2015 evidenced that each of the seven patients admitted to the ward had been invited to attend. Although none of the patients had chosen to attend two patients had signed their MDT meeting review record and five patients had not signed. An explanation as to why each of the five patient's had not signed was available in each patient's MDT review record.	
4	8.3 (h)	It is recommended that the ward sister ensures that all documentation in relation to physical interventions is completed in line with Trust policy and procedure.	2	Inspectors reviewed the ward's procedures for the management of the use of a physical intervention with a patient. Ward records evidenced that seven incidents where a physical intervention had been required had taken place between 4 February 2015 and the 1 May 2015.	**Fully met**

				Inspectors noted that a managing actual and potential aggression (MAPA) record had been completed in relation to each incident. A copy of each MAPA record had been forwarded to the Trust's governance department and a second copy was retained in the patient's care records. The Trust's DATIX electronic incident recording system had also been updated. Physical intervention records reviewed by inspectors were noted to be appropriate and completed in accordance to the Trust's *'Use of Restrictive Practices Policy'* and procedures. Inspectors were informed that the Trust was in the process of developing a use of physical intervention policy. A recommendation regarding the completion and introduction of this policy has been made.	
5	5.3.1 (f)	It is recommended that the Trust ensures that formal governance arrangements are in place to monitor the use of physical interventions on the ward.	2	Inspectors reviewed the wards governance arrangements to monitor the use of physical interventions on the ward. Where a physical intervention had been used with a patient a MAPA record was completed and the incident was recorded on the Trust's DATIX system. Inspectors reviewed the most recent record on the DATIX system. The record was noted to be comprehensive and completed in accordance to Trust policy. The record had been forwarded to the Trust's governance department, the Ward's Services Manager, the Community	**Fully met**

				Services Manager and the Hospital Manager. Inspectors were informed that the Trust's governance department reviewed each incident and reported their findings to the ward's senior management team.	
6	5.3.1 (a)	It is recommended that the ward sister ensures that all patients subject to physical interventions are informed of the reason and this is documented in the patients' care documentation.	2	Patient care records reviewed by inspectors evidenced that when a physical intervention had been required the reasons for this were discussed with the patient. This was recorded in the patient's progress notes. It was good to note that the ward had introduced a physical intervention post incident analysis record (*MAPA hands on post incident review*). The review detailed the patient's thoughts and feelings regarding the intervention and examined the reasons why a physical intervention had been required. Outcomes of physical intervention reviews were recorded in patient's files and shared with the staff during team and MDT meetings.	**Fully met**
7	5.3.1 (f)	It is recommended that the Ward Manager ensures that regular statements are received from the cash office to facilitate verification of transactions and expenditure.	2	Inspectors were informed that the patients admitted to the ward during the inspection did not have their money retained by the Trust's cash office. Patient's monies were held on the ward in the wards safe. Inspectors reviewed the safe records and noted that each patient had an individual cash record. Records had been completed in accordance to	**Fully met**

				the Trust's cash handling procedures. Inspectors noted that the Trust's policy directed that staff ensure that only small amounts of patients' monies (under £50) should be retained in the safe. The Trust's policy detailed that patients presenting with more than £50 should have their money deposited within the Trust's cash office. However, inspectors evidenced that one patient had received a sum of £170 one week prior to the inspection. Inspectors were informed that the money had been provided by the patient's relative to purchase essential items. Inspectors were concerned that retaining this amount of money was contrary to section 1.4.10 of the Trust's patient property procedures. Section 1.4.10 states that *'A maximum of £50.00 can be held at ward level for any patient'.* A new recommendation regarding this issue has been made. In circumstances where patients' money was retained by the Trust's finance department, statements of transactions and expenditure were provided to the patient on a monthly basis. It was good to note that the Trust's finance department conducted ongoing audits of the ward's petty cash, patient property, and the ward's safe and the safe records.	
8	5.3.1 (f)	It is recommended that the Trust develops and implements a policy	2	The Trust's Cash Handling Procedures detailed the steps to be taken by ward staff regarding the	**Fully met**

		and procedure in relation to operating individual patient saving accounts.		management of patient property. Section 2.1.2 of the Trust's patient property procedures detailed that upon admission a patient's cash/valuable items must be sealed in the patient's property envelope and forwarded to the Trust's finance department. A finance officer informed inspectors that patients' monies (above the sum of £50) were deposited in a Trust account, under the patient's name, within a local branch of a national bank. A Trust finance officer informed inspectors that the Trust's finance department reviewed each patient account and forwarded individual statements to the patient on a monthly basis.	
9	4.3 (m)	It is recommended that the Ward Manager ensures that updated training in the management of patients' finances is prioritised for all staff.	2	Updated training for nursing staff in relation to the management of patients' finances had not taken place since the last inspection. This recommendation will be restated for a third time in the quality improvement plan accompanying this report.	**Not met**
10	5.3.2	It is recommended that the Ward Manager ensures that *the aspect and risk of inpatients' possession and access to ignition materials* to be included in all staff induction programmes.	2	Inspectors reviewed the ward's staff induction programme. The programme included information and training in relation to fire precaution, fire points and evacuation points. The induction programme included a section entitled '*New staff members responsibilities in relation to the induction processes.* This section stated that staff should familiarise themselves	**Fully met**

				with policies, procedures and guidelines in relation to fire policy and the management of ignition materials.	
11	5.3.2	It is recommended that personal searches policy for inpatients is reviewed and updated.	1	A copy of the Trust's Personal searches policy was available in paper format on the ward. The '*Regional Guidelines for the Search of Patients, Their Belongings and the Environment of Care within Adult Mental Health/Learning Disability Inpatient Settings'* had been reviewed and implemented in September 2013. Inspectors noted that the policy would be further reviewed in September 2016.	**Fully met**
12	5.3.3 (b)	It is recommended that the Ward Manager ensures that where patients are unable to sign their care documentation that the reason for this is documented in relation to the patients' capacity to understand the information.	1	Care records reviewed by inspectors evidenced that where patients had not signed their care documentation a reason for this including, where appropriate, an assessment of the patient's capacity was recorded. Five of the seven multi-disciplinary team (MDT) meeting records reviewed by inspectors evidenced that patients had not attended the meeting or signed their MDT record. Inspectors noted that each record without a patient signature included an explanation as to the reason why the patient's signature was missing. Entries stated that the record had not been signed by the patient due to the patient's limited understanding. It was positive to note that patient care records	**Fully met**

				evidenced that ward staff had discussed the outcome of individual MDT reviews with each patient. Staff had also recorded their assessment of the patient's understanding and reaction to receiving the information.	
13	6.3.2 (b)	It is recommended that the Ward Manager ensures that there is documented evidence to show that all attempts and reasonable adjustments have been made to ensure patients are informed of their diagnosis and care treatment plans in a format suitable to their individual communication needs and are given time to understand the implication of their care and treatment. A clear rationale should be provided when this is not appropriate.	1	The *'about me passport'* assessment was completed with each patient upon the patient's admission. This assessment included a section regarding the patient's assessed care needs. Assessments reviewed by inspectors evidenced that each patient's communication, physical and mental health needs had been assessed and discussed with the patient. This included reference to the patient's diagnoses. Patients were invited to attend the ward's weekly multi-disciplinary team (MDT) meeting. The meeting reviewed each patient's progress and treatment plan. Minutes from the last MDT meeting prior to the inspection, held on the 1 May 2015, evidenced that each patient had chosen not to attend the MDT meeting. Patient progress records evidenced that nursing staff had informed patients of the outcome of the MDT review of their circumstances. This included discussion regarding the patient's current diagnosis, treatment plan, medication and discharge plan. Patients who met with inspectors reported that they had been given the opportunity to discuss their care and treatment with staff. Patients could	**Fully met**

				also discuss their progress and concerns at the patients' forum. The forum was held every two months.	
14	5.3.1 (f)	It is recommended that the Ward Manager ensures staff assess patients consent to participate in daily care activities and that this is recorded.	1	Patient progress records reviewed by inspectors evidenced that staff continually sought patient consent regarding the patient's participation in daily care activities. Patient care records reviewed by inspectors evidenced that in circumstances where a patient did not consent to participating in a daily care activity their determination was respected. One patient informed inspectors that they could refuse to attend daily activities. A second patient informed inspectors that staff continued to encourage them to have a shower. The patient explained that the decision to have a shower was theirs and they understood they had the right to refuse. The patient reported no concerns at being able to make their own choices regarding showering. Inspectors were informed that where refusal to participate in a care activity could have a detrimental effect on the patient for example: refusal to take medication, the patient's situation was assessed and reviewed by the MDT.	**Fully met**
15	5.3.3 (b)	It is recommended that the Ward Manager ensures patient attendance or non-attendance at the multi-disciplinary meetings is consistently	1	Inspectors reviewed patient records in relation to multi-disciplinary team (MDT) reviews held in March and April 2015**.**	**Fully met**

		documented. This should include a rationale when patients do not attend.		Patient attendance and non-attendance to MDT meetings was consistently documented within each record. MDT records included a rationale as to why a patient had not attended. Patient progress records reviewed by inspectors evidenced that nursing staff informed each patient of the outcome of MDT meetings.	
16	7.3 (c)	It is recommended that the Ward Manager ensures all staff working on the ward considers the potential impact of care and treatment on the patients Human Rights and that this is clearly documented in the patients care documents.	1	Inspectors reviewed three sets of patient care records. Patient comprehensive assessments, care plans and risk assessments evidenced that staff had considered the effect of the care and treatment provided on the patient's human rights. Patient risk assessments and associated management plans directed staff to assess the impact that risk management interventions had on the patient's rights. Patient progress records evidenced that staff continually reviewed the patient's circumstances. This included ongoing assessment of the patient's capacity to consent to care and treatment and the patient's right to choose. Inspectors noted numerous entries evidencing that nursing staff had respected patients' rights to privacy, dignity and self-expression.	**Fully met**
17	5.3.1 (a)	It is recommended the Ward Manager ensures that patient's assessments are undertaken using appropriate recognised and evidenced based tools that address	1	Patient care documentation reviewed by inspectors evidenced that a comprehensive risk assessment had been completed with each patient. Each assessment had considered the patient's personal, social and environmental	**Fully met**

		the complex needs of this population.		circumstances. A '*Risk Assessment & Associated Management Control'* assessment had also been completed for each patient. This assessment provided proactive plans to be used by all staff to help reduce the risk factors relevant to each individual patient. The plans were personalised and considered the impact that treatment and care interventions could have on the patient's human rights. It was good to note that staff were using evidenced based tools to help positively address challenging behaviour and promote behaviour change. This included the use of the Antecedent, Behaviour and Consequence (ABC) tool and use of physically intervention post incident analysis. Both these tools were completed in partnership with the patient.	
18	5.3.1 (a)	It is recommended that the Ward Manager ensures that assessments are completed fully, reflect patient's needs and include patient choices and likes and dislikes.	1	The *'about me passport'* assessment was completed with each patient on admission. Each of the three assessments reviewed by the inspectors were noted to have been completely fully. Each assessment referenced patient views in relation to likes, dislikes and habits. The assessment also recorded each patient's presentation when having a good or a bad day. It was good to note that the questions within the	**Fully met**

				assessment covered a comprehensive range of relevant patient information. This included information regarding individual patient habits, behaviours and hobbies.	
19	5.3.1 (a)	It is recommended that the Ward Manager ensures that patients and / or their representatives have the opportunity to contribute to their assessments and care plans and a rationale recorded when this is not appropriate.	1	Assessments and care plans reviewed by inspectors evidenced that patients/ or their representatives had been given the opportunity to contribute to their assessments and care plans. Two of the three comprehensive assessments reviewed had been signed by the patient. The third assessment provided a rationale detailing why the patient had not signed/been involved in the assessment. Patients could attend the ward's weekly multi-disciplinary team (MDT) meeting. The meeting reviewed each patient's progress and treatment plan. If patients chose not to attend the meeting nursing staff provided them with a post meeting update regarding the outcomes of the MDT review. The ward's senior nurse managers held a monthly discharge planning meeting. This was attended by the patient, the patient's relative(s) and the ward's senior nursing staff. The meeting reviewed each patient's progress and the patient's status regarding potential discharge form the ward.	**Fully met**
20	5.3.1 (a)	It is recommended that the Ward Manager ensures that patients who	1	A '*Risk assessment and associated management controls'* review and plan had been completed for	**Fully met**

		present with behaviours that challenge have a multi-disciplinary assessment completed using recognised appropriate evidenced based assessment tools.		each patient. Plans were assessed daily by nursing staff and weekly by the multi-disciplinary team. Patient behavioural management strategies were available and these included: ABC assessments; restrictive intervention post incident reviews and proactive management plans to support patients presenting with risk factors. Risk assessment and associated management control plans had been signed by the patient. Each plan also had a future review date. Inspectors were informed that the ward did not have on site occupational/sensory occupational therapy support. A recommendation regarding this has been made.	
21	5.3.1 (a)	It is recommended that the Ward Manager ensures that patients who have been assessed as presenting with behaviours that challenge have a plan in place that guides staff to proactively support and positively address presenting behaviours.	1	Patient risk management plans reviewed by inspectors were individualised and had considered the most appropriate proactive interventions to support patients presenting with challenging behaviour.	**Fully met**
22	5.3.1 (a)	It is recommended that the Ward Manager ensures that staff completing comprehensive risk screening tools and comprehensive risk assessments and management plans, do so in accordance with Promoting Quality Care Good Practice Guidance on the	1	Risk screening tools and comprehensive risk assessments (CRA) were available in each set of patient care records reviewed. Risk assessments had been completed in full and were noted to be appropriately detailed. However, two CRA had not been reviewed in accordance to the timeframe stipulated in regional guidance (Promoting Quality Care May	**Not met**

		Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010.		2010). One patient's CRA was noted to have been implemented in September 2014. A review date had been agreed for January 2015. The review had not taken place. This is contrary to Promoting Quality Care guidance: *'The level of risk and success of the management plan will determine the frequency of review, but in general it is expected that reviews should take place at least 6-monthly for those who have had a comprehensive or specialised risk assessment completed'.* PQC (DHSSPSNI, 2010) A second patient's CRA had been completed in April 2014. The CRA had not been reviewed during the previous 12 months.	
23	5.3.1 (a)	It is recommended that the Ward Manager ensures that all patients have an assessment of their communication needs and when identified that a patient has a particular communication need that a care plan is completed to guide staff on how to best communicate with the patient. All staff working on the ward who are familiar with the patients should contribute to this.	1	Upon admission to the ward each patient's communication needs were assessed as an integral part of the '*about me passport'* assessment framework. This included an assessment of the patient's ability to communicate. Inspectors evidenced that nursing staff had completed a comprehensive review of each patient's needs. This included the verbal and non-verbal communication needs of each patient. Inspectors reviewed a communication plan which had been implemented to support a patient who	**Fully met**

				had limited verbal communication. The plan was comprehensive and detailed the most appropriate way to communicate with the patient. The patient's progress records evidenced that all staff working with the patient had continued to use the care plan to support the patient's ability to communicate.	
24	5.3.1 (a)	It is recommended that the Ward Manager ensures that all patients have an assessment of their therapeutic and social activity needs and an individualised therapeutic and social activity plan developed.	1	Patients therapeutic and social activity needs were assessed upon admission. During their admission to the ward patients could access day care activities through the Trust's Berryburn day services facility located on the hospital site. Patients could also attend day services provided within the local community. However, patient care records reviewed by inspectors did not evidence that individualised therapeutic and social activity plans had been appropriately implemented. Inspectors noted that a therapeutic/activity plan was available in two of the three sets of patient records reviewed. Both sets of records contained a plan that had not been updated and did not reflect the patient's routine on the days of the inspection. Inspectors noted that patients on the ward could not access an occupational therapist to support the development of therapeutic and social activity plans. A recommendation regarding this issue has already been made.	**Partially met**

				It was good to note that ward staff facilitated a number of activities that patients could participate in. The activities available included: shopping trips, a walking group and a number of ward based activities.	
25	5.3.3	It is recommended the Ward Manager develops a ward / group therapeutic and recreational activity programme in conjunction with patients and / or their representatives.	1	A ward/group therapeutic and recreational activity programme was not available. Inspectors were informed that a patient group therapeutic and recreational activity plan had previously been implemented within the ward and had proven to be ineffective. Staff explained that not all patients chose to attend activity groups and that group activities were not always appropriate to the assessed needs of patients. Inspectors were informed that staff continued to monitor patient activities on the ward. This included the potential reintroduction of group activities if appropriate and in accordance to the assessed needs of each patient. Ward staff continued to provide a walking group, bus and shopping trips and patients could also access a number of ward based activities. These include board games, foot spa and film evenings.	**Fully met**
26	5.3.1 (a)	It is recommended that the Ward Manager ensures that patients who have been assessed as requiring a structured day have been provided with structured timetable and a plan in place to guide staff to support the	1	The individual needs of each patient were addressed in the patient's care plan(s). Plans reviewed by inspectors evidenced that patients could access the Trust's day care services. Patients could also access psychology and speech and language services as required.	**Fully met**

		patient.		Inspectors noted that individual risk management plans were being implemented by staff and reviewed weekly by the ward's MDT. Patient care plans were noted to have been reviewed on a regular basis.	
27	8.3 (k)	It is recommended that the Ward Manager ensures that the ward information booklet includes the details of the all outside agencies the patient may contact when concerned about their care and treatment for example RQIA, Ombudsman, Patient Client Council.	1	The ward's patient information booklet had been updated. Inspectors reviewed the booklet and noted it included the contact details of outside agencies patients, or their representatives, could contact if they were concerned about their care and treatment. Contact details for RQIA, the Patient Client Council and the regional Equality and Human Rights Unit were available. It was positive to note that patients could access this information in easy to read format.	**Fully met**
28	8.3 (k)	It is recommended the Ward Manager ensures that patients have been informed of their rights to make a complaint, access independent advocacy services and accept or refuse care treatment, and that this is clearly documented in the patients care records.	1	A copy of the ward's admission checklist was available in each set of patient care documentation reviewed by inspectors. The checklist directed staff to ensure that upon admission each patient received a ward information booklet. The booklet contained easy to read information regarding patient rights, how to make a complaint, the wards independent advocacy service and the patient's right to be involved in their care and treatment planning.	**Fully met**
29	5.3.1 (a)	It is recommended that the Ward Manager ensures patients who	1	Risk assessments and restrictive practice management and monitoring plans were	**Fully met**

		require restrictive interventions have an individual risk assessment and management plan in place that reflects the patients' complex needs.		available in each set of patient care records reviewed by inspectors. Plans were noted to be comprehensive and to reflect the individually assessed needs of each patient. Proactive interventions to support patients with challenging behaviours had been implemented. This included the use of distraction and de-escalation techniques to support the patient and attempt to minimise any associated risk. Patient progress records reflected that patient behaviour management strategies were being implemented in accordance to the patient's risk assessment and care plan(s). The Ward Manager had introduced a restrictive practice monitoring form. The form evidenced the restrictions implemented with a patient and demonstrated ongoing review regarding the need for and continued use of restrictive practices.	
30	5.3.2	It is recommended that the Ward Manager ensures that staffs adheres to the WHSCT Policy on the use of restrictive interventions with adult service users and any documentation completed when a restrictive intervention has been used is completed in accordance of this policy.	1	Restrictive intervention records reviewed by inspectors had been implemented in accordance to the Trust's restrictive interventions policy. The policy had been approved and implemented from 1 August 2014. Inspectors noted that restrictions in relation to: the use of physical interventions, enhanced observations, the wards locked door and the removal of items that may cause harm, had been	**Fully met**

				implemented in accordance to Trust procedures. It was positive to note that the ward's senior management team were in the final stages of implementing a separate policy in relation to the use of physical interventions with patients. A '*Use of Managing Actual and Potential Aggression Protocol'* was available in draft form. A recommendation regarding the implementation of this policy has already been made.	
31	5.3.1 (a)	It is recommended the Trust reviews all blanket restrictions on the ward including the locked exit door from the ward and the removal of ignition materials, and provides a clear rationale for these practices which should include individual patient assessments in line with DHSSPS Deprivation of Liberty Interim Guidance October 2010.	1	The ward's senior management team had completed a review of the ward's locked door policy and updated guidance regarding the removal of ignition materials. The use of restrictive practices had been individually assessed for each patient and a rationale for these practices was available in the patient's care records. Patient risk assessments and restrictive intervention care plans were available in each set of care records reviewed by inspectors. Assessments evidenced that restrictive practice care plans were based on the patient's individual needs and completed in accordance to DHSSPSNI guidance. It was good to note that the ward had introduced a restrictive practice monitoring form which was comprehensive. The form ensured that staff considered the impact of the use of restrictions	**Fully met**

				on each patient's human rights. The form also directed staff to ensure they continued to assess the patient's capacity to consent to their care and treatment.	
32	6.3.2 (b)	It is recommended that the Ward Manager ensures that patients and / or their representatives are fully informed of all restrictive interventions used on the ward and the rationale for their use and that this is recorded in the patients care documentation.	1	The ward's admission checklist directed that upon a patient's admission to the ward nursing staff discuss each patient's circumstances with the patient's relative/representative. Patient progress notes detailed that staff had continued to maintain contact with relatives/patient representatives throughout the patient's admission. In circumstances where a physical intervention was required staff completed the appropriate recording including an incident report. The incident report required that staff contact the patient's relative to inform them of the circumstances surrounding the intervention.	**Fully met**
33	5.3.3	It is recommended that the Ward Manager ensures that each patient has a discharge pathway documented in their care plan. This should include definitive action plans, responsible person for their delivery and timescales.	1	Inspectors were unable to evidence a discharge care pathway within any of the three sets of patient care records reviewed. One set of patient records contained minutes from a resettlement meeting. The minutes detailed the plan being implemented to support the patient's discharge. It was good to note that resettlement meetings had been held on a regular basis. Inspectors were informed that a new discharge care pathway had been agreed and would be	**Partially met**

				implemented in the near future.	
34	6.3.1 (a)	It is recommended that the Ward Manager ensures that each patient who is admitted for care and treatment has a clear rationale recorded when the patients discharge has been delayed.	1	Inspectors were informed that three patients were experiencing a delay in their discharge. Inspectors reviewed the care records of two of the patients. A clear rationale as to why the patient's discharge had been delayed was available. It was positive to note that the ward's senior management team and ward staff continued to proactively support patients who no longer required hospital treatment. This included continued review of the patient's resettlement plan and ongoing liaison with community teams/service providers.	**Fully met**
35	5.2.1 (a)	It is recommended that the Ward Manager ensures that care and treatment plans completed for patients who are readmitted are re-evaluated and reviewed on every admission and include a review of the reason why patients are readmitted. Patient's care plans should detail what therapeutic interventions have been considered during the admission to look at reducing the risk of future readmissions.	1	Inspectors reviewed the care records of one patient who had been admitted five days prior to the inspection. It was good to note that the patient's community care and behavioural plans were available and had been implemented in accordance to the patient's assessed needs during their admission. Inspectors were advised that ward staff continued to work closely with community teams. In circumstances where a patient was readmitted the patient's need for admission was reviewed in partnership with the patient and the community teams. It was positive to note that members of the community teams, including the Trust's behavioural support nurse, attended the ward's multi-disciplinary team meetings on a regular	**Fully met**

				basis.	
36	5.3.1 (a)	It is recommended that the Ward Manager ensures there is collaborative working between hospital and community service to ensure that information in care plans that are used in the community are shared with the hospital staff.	1	Minutes from multi-disciplinary team (MDT) meetings evidenced that the Trust's behavioural support nurse, community nurses/social workers and appropriate representatives from other community services attended MDT meetings as required. It was good to note that patient community care and behavioural plans were available. Inspectors were informed that the Trust's behavioural nurse continued to liaise with ward staff to help support patients during their admission.	**Fully met**
37	5.3.2 (a)	It is recommended that the Ward Manager ensures staffs complies with the guidance and safety alerts issued by Northern Ireland Adverse Incident Centre (NIAIC), DHSSPSNI, HSCB, PHA and other organisations.	1	Guidance and safety alerts issued by the DHSSPSNI, the Northern Ireland Adverse Incident Centre (NIAIC), the Health and Social Care Board and the Public Health Agency were available on the Trust's intranet. Inspectors were informed that each member of the staff team had an email address and that notifications relevant to the ward were forwarded to staff members email accounts. Monitoring of staff compliance to guidance was supported through staff supervision and patient care record audits. Safety alerts forwarded to the ward were also placed on the staff notice board and in the ward's message book.	**Fully met**
38	5.3.2	It is recommended that the Trust ensures that the response to and management of all incidents is in keeping with regional safeguarding	1	Inspectors reviewed the wards processes for the management of incidents. Inspectors evidenced that from the 5 November 2014, 29 incidents had been reported in accordance to the Trust's	**Fully met**

		vulnerable adult procedures.		vulnerable adult procedures. Vulnerable adult referrals were forwarded to the Trust's safeguarding team. Vulnerable adult referrals reviewed by inspectors were noted to be appropriate and in accordance to regional and Trust policy. This included continuous communication with the safeguarding team in relation to the outcomes of referrals made. It was good to note that ward staff could contact the safeguarding team as required and that vulnerable adults' referrals were managed in accordance to regional and Trust guidelines.	

Western Health and Social Care Trust

Ref EW.00823/JMcM

1st July 2015

The Regulation & Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Dear Sir/Madam

Please find enclosed completed quality improvement plan in relation to the unannounced inspection of Brook Lodge, Lakeview Hospital which was undertaken on the 6th and 7th May 2015.

Should you require any further information, please do not hesitate to contact me.

Yours sincerely

ELAINE WAY CBE
CHIEF EXECUTIVE

Encs

Western Health and Social Care Trust, Trust Headquarters, MDEC Building, Altnagelvin Hospital Site, Glenshane Road, Londonderry BT47 6SB Tel: 028 7161 1335 Fax: 028 7161 1336 www.westerntrust.hscni.net

R3

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Inspection

Brooke Lodge, Lakeview Hospital

6 and 7 May 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 hospital manager and the head of service on the day of the inspection visit.

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

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
Is Care Safe?					
1.	Section 5.3.1(a)	It is recommended that the Ward Manager ensures that staff completing comprehensive risk screening tools and comprehensive risk assessments and management plans, do so in accordance with Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010.	2	Immediate and ongoing	A database has been established to assist in monitoring review dates for patients on a comprehensive PQC. The oustanding reviews have been completed..
2.	Section 5.3.1 (f)	It is recommended that the ward manager ensures that patient's monies are managed retained in the ward's safe is managed in accordance to Trust policy and procedure.	1	Immediate and ongoing	Ongoing. Patients' monies are managed in the ward safe in accordance with Trust Policy and procedure..
3.	Section 5.3.1 (e)	It is recommended that the Trust complete a ligature risk assessment of the ward. This should include a subsequent	1	31 July 2015	Completed. Awaiting costs for suitable replacement beds, for consideration and approval by the Senior Management Team, in conjunction with Infection Control colleagues. An

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
		action plan to address any identified risks. Details of this action plan should be forwarded to RQIA by 31 July 2015.			action plan shall be forwarded within the specified timescales
Is Care Effective?					
4.	Section 5.3.1. (c)	It is recommended that the Ward Manager ensures that updated training in the management of patients' finances is prioritised for all staff.	3	30 June 2015	Completed - all staff in Lakeview Hospital have now received training in the management of patients' finances.
5.	Section 5.3.1 (a)	It is recommended that the Ward Manager ensures that all patients have an assessment of their therapeutic and social activity needs and an individualised therapeutic and social activity plan developed.	2	Immediate and ongoing	Completed.
6.	Section 5.3.3	It is recommended that the Ward Manager ensures that each patient has a discharge pathway documented in their care plan. This should include definitive action plans, responsible person	2	Immediate and ongoing	Completed.

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
		for their delivery and timescales.			
7.	Section 5.3.3 (d)	It is recommended that the Trust ensures that patients can access ward based occupational therapy support.	1	31 July 2015	The provision of Occupation Therapy for the ward is being discussed with Senior Management for the Adult Learning Disability programme. A response shall be forwarded regarding availability or alternative arrangements by the end July 2015.
8.	Section 5.3.3 (a)	It is recommended that the ward manager ensures that information in relation to the MDT, when the ward round is held, who is on duty and patients' named nurse/associate nurse is displayed. Information should also be displayed to assist in orientating patients to the day of the week, the date, when meals are held and what activities are available on the ward each day.	1	Immediate and ongoing	Completed.
Is Care Compassionate?					

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
		No recommendations made			

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	Donaha Clarke
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	

	Inspector assessment of returned QIP	Yes	No	Inspector	Date
A.	Quality Improvement Plan response assessed by inspector as acceptable	✓			14-7-15
B.	Further information requested from provider				