The Regulation and Quality Improvement Authority

Unannounced Follow up Inspection Report
6 and 7 February 2018

Strule Ward

Western Health and Social Care Trust

Gransha Park

Clooney Road

Londonderry

BT47 6TF

Tel No: 028 71864371

Inspectors: Alan Guthrie and Dr John Simpson

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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

1.0 What we look for

2.0 Profile of service

Strule is a ten bedded acute care ward situated in Lakeview hospital. The purpose of the ward is to provide assessment and treatment to patients with a learning disability who require support in an acute psychiatric environment. Patients receive input from a multi-disciplinary team (MDT) which incorporates; psychiatry, nursing, social work, occupational therapy and behavioural support. Patients can also access the hospital's day care services unit. On the day of the inspection there were four patients admitted to the ward. Two patients were detained to the ward in accordance with the Mental Health (Northern Ireland) Order 1986.

3.0 Service details

Responsible person: Dr Anne Kilgallen	**Ward Manager:** Niall Gallagher (Hospital Services Manager)
Category of care: Learning Disability/Mental Health	**Number of beds:** Ten
Person in charge at the time of inspection: Niall Gallagher	

4.0 Inspection summary

An unannounced follow-up inspection took place over two days on 6 and 7 February 2018.

The inspection sought to assess progress with findings for improvement raised from the most recent unannounced inspection 7 – 11 September 2015. This inspection also assessed if Strule ward was well led.

The purpose of the inspection was to meet with patients and staff and to review 23 areas for improvement identified from the previous unannounced inspection completed on 7 – 11 September 2015. Findings from the inspection were generally positive and inspectors evidenced that on the days of the inspection patients were receiving a good standard of care.

On the days of the inspection inspectors evidenced the ward as being appropriately staffed. The atmosphere was relaxed and patients were moving freely throughout the ward. Patients presented as being at ease in their surroundings and staff were patient focussed and attentive. It was positive to note that patients presenting with behaviours that challenge were being closely supported in the least restrictive manner.

The ward was clean, well maintained and well presented. Patients who met with inspectors indicated no concerns regarding their relationships with staff and the care and treatment provided to them. Interactions between staff and patients were observed by inspectors as being patient centred, friendly and supportive. Staff who spoke with inspectors stated that they enjoyed their job and were motivated to provide patients with effective care and treatment.

Staff reported that significant changes continue to be introduced within the ward. A new management structure had been established since the last inspection and the ward was now supported by a senior manager and three deputy ward managers. The ethos and statement of purpose of the ward had been reviewed and updated. Inspectors were informed that the vision for the ward was to provide holistic comprehensive care and treatment to patients through an integrated care model. This included the provision of onsite day care and continued close coordination with community teams.

A number of nursing staff expressed concerns regarding the introduction of a new rota and associated shift patterns. Inspectors discussed these concerns with the senior management team, reviewed the duty rota and reviewed how the change in process was managed by senior staff. Inspectors evidenced that appropriate steps had been taken to ensure that ward staff were kept informed and provided with the opportunity to express their concerns. There was also evidence that staff issues were discussed, considered and shared with all relevant parties.

Inspectors reviewed 23 areas for improvement and evidenced that the trust had made significant progress in addressing each of the areas identified. 21 of these areas had been met. One area for improvement had been partially met and one area had not been met.

Areas for improvement which were assessed as met were in relation to: the ward's governance arrangements, management of staff bank shifts, nurses recording of the use of Pro Re Nata (PRN) medication, learning from incidents, patient behavioural and psychotherapeutic care plans, staff use of evidence based practices, MDT information and ward rounds and patient access to their consultant psychiatrist. The evidence verifying inspectors' findings for each of these areas for improvement is discussed below.

One area for improvement had been partially met. Inspectors reviewed four sets of patient care records. It was positive to note that nursing staff were recording the dispensing of PRN medication after administration to each patient and the effects of this medication. However, patient medication records (kardex) evidenced a number of inconsistencies. These included:

- Medical staff did not record date entries of PRN medication onto patient kardexs in full.
- Indications for use of PRN medication were not completed consistently.
- Inspectors evidenced PRN medications listed on patient kardexs that had not been dispensed to the patient during their admission.

This area for improvement will be restated for a second time in the quality improvement plan (QIP) accompanying this report.

One area for improvement had not been met. The trust had been unable to recruit an occupational therapist (OT). Subsequently, patients were unable to access ward based OT services. This area for improvement will be restated for a third time. In accordance to RQIA escalation policy and procedure, areas for improvement restated for a third time are required to be escalated. However, given that the inability to recruit an OT is not reflective of the trust's efforts to appoint an OT this area for improvement will be restated for a third time but will not escalated.

Inspectors identified one new area for improvement. The ward's MDT should ensure that patient care records are appropriately stored and maintained. Inspectors evidenced that three of the four care records reviewed contained records that were not secured and remained loose within the file. Inspectors were concerned that records could be misplaced or lost.

Inspectors reviewed four sets of patient care records. Generally, records were noted to be comprehensive, up to date and easy to follow. Each patient had a comprehensive assessment, risk assessment and care plan based on their assessed needs. The ward had introduced a new MDT template and patient behaviour management care pathway documentation. Nursing continuous care records were noted to be appropriately detailed, patient centred and linked to the patient's care plan.

Patients stated

Inspectors met with three patients. Patients presented as being content and at ease in their surroundings and with staff. Two of the patients were unable to verbally communicate. Inspectors observed patient staff interactions. Staff were observed as being supportive, attentive, patient centred and caring. Inspectors observed staff to be available throughout the ward. Patients moved freely and patients' requests were dealt with promptly and appropriately.

One patient informed inspectors that they were well cared for and that the staff were very nice. The patient completed a questionnaire detailing that they felt safe and that the care and treatment they were receiving was helping them.

Patient comments included:

> "Very nice staff".
>
> "There's loads of stuff to do".

Relatives stated

No relatives were available to meet with the inspectors on the days of the inspection.

Staff stated

Inspectors met with 11 members of staff representative~~s~~ of all professions within the ward's MDT.

Staff who met with inspectors stated they felt the care and treatment provided to patients admitted to the ward was effective and patient centred. A number of nursing staff stated that they felt the changes applied to the ward and the implementation of a new rota was a concern. Staff citied the change in shift patterns and the potential impact this might have on personal circumstances was worrying. Inspectors reviewed the changes implemented within the ward and the plans for the commencement of a new rota and shift patterns. Whilst it is understandable that change can be difficult inspectors were satisfied that the management of this process had been implemented in accordance to the required standards. It was positive to note that the ward's external senior management team continued to visit the ward on a regular basis.

The ward's medical staff stated that the ward's MDT was effective and that ward staff provided a high standard of care to patients. Inspectors noted that the ward was being supported by one consultant psychiatrist. The consultant was dividing their time between the ward and community clinics which provided a service cross a large geographical area. Inspectors were informed that another consultant psychiatrist position was about to be advertised. It was hoped that this position would be filled in the near future. Staff reported no concerns regarding the level of nursing staff available. Staff informed inspectors that they had no difficulties regarding their ability to access training and supervision.

Staff comments included:

> "Sometimes we can be a bit stretched".
>
> "There's good team work on the ward".
>
> "Not sure nursing staff are always kept up to date."
>
> "There are good training opportunities".
>
> "We have a lot of deputy managers and consistency between them is a challenge".
>
> "This is a good place to work".
>
> "There's a lot of change at present".
>
> "Care has improved".
>
> "There has on occasions been a breakdown in communication".
>
> "I feel safe here…it's great…I like it".
>
> "Nursing assistants are not listened to enough".
>
> "Sometimes I feel that things are done to us and not with us".

Four staff questionnaires were completed during the inspection. Staff were asked to rate a serious of questions relating to is the ward safe, is care compassionate, effective and well led. The rating scale ranged from 1 = very unsatisfied to 5 = very satisfied. Of the 20 areas rated staff responded with 17 ratings of very satisfied. The remaining three areas were rated also rated highly scoring four out of five for each of the three areas.

The findings of this report will provide the trust with the necessary information to assist them to fulfil their responsibilities, enhance practice and service user experience.

4.1 Inspection outcome

Total number of areas for improvement	Three

The three of areas for improvement comprise:

- 1 restated for a second time
- 1 restated for a third time
- 1 new of improvement

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

5.0 How we inspect

The inspection was underpinned by:

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

The following areas were examined during the inspection:

- Psychology and behaviour support service.
- Care Documentation in relation to three patients.
- Ward environment.
- Advocacy service.
- Activity schedule.
- Timetable for sharing best practice.

We reviewed the areas for improvements made at the previous inspection and an assessment of compliance was recorded as met/partially met and not met.

6.0 The inspection

6.1 Review of areas for improvement from the last unannounced inspection 7 – 11 September 2015

The most recent inspection of Strule Ward was an unannounced inspection. The completed QIP was returned and approved by the responsible inspector. This QIP was validated by inspectors during this inspection.

Areas for Improvement from last inspection		Validation of Compliance
Area for improvement 1 **Ref**: 5.3.1 (f) **Stated:** First time	The resuscitation trolley had not been checked in accordance with policy and procedure.	**Met**
	Action taken as confirmed during the inspection: Inspectors reviewed the wards resuscitation trolley review records. Inspectors were satisfied that the trolley had been maintained to a good standard	
Area for improvement 2 **Ref**: 5.3.2 (a)(c) **Stated:** First time	There was no evidence of trust governance mechanisms to review, analyse and learn from incidents.	**Met**
	Action taken as confirmed during the inspection: Information in relation to incidents was posted on the staff notice board in the main corridor. Weekly and monthly monitoring reports were also completed and forwarded to the ward's senior management team. Incidents reviewed by the inspectors were noted to have been managed in accordance to trust governance arrangements.	
Area for improvement 3 **Ref**: 5.3.2 (a)(c) **Stated:** First time	Relevant information from clinical and social care governance meetings was not shared with ward staff.	**Met**
	Action taken as confirmed during the inspection: Trust nurse management governance meetings were held on a bi-monthly basis. Minutes of those meetings were reviewed by the learning disability service lead and cascaded to ward staff and the	

	hospital services manager by email. The trusts learning disability strategic management meeting was convened monthly and information from those meetings were also cascaded to staff. Senior managers also visited the ward on a regular basis.	
Area for improvement 4 **Ref**: 5.3.2 (a)(c) **Stated:** First time	There was no mechanism in place for debriefing and learning from incidents at ward level.	Met
	Action taken as confirmed during the inspection: Since the last inspection the ward had undergone significant review and reorganisation. Subsequently, the ward was now supported by a hospital manager and three deputy ward managers. Learning and debriefing from incidents was shared through the ward staff meetings and incident information was also posted on the staff noticeboard. Incidents within the ward were also discussed at the ward's MDT meeting. Inspectors evidenced that patients' behaviour and support plans were amended in accordance to findings from incidents. These plans reflected best practice with each plan based on the patient's presenting needs.	
Area for improvement 5 **Ref**: 5.3.1(f) **Stated:** First time	There were a lot of medications prescribed as Pro Re Nata (PRN). There were no indications written, no minimum intervals indicated and there was no indication of which drugs should be used 1st line in the event that the indication for some different drug was the same. If PRN medications were used as prescribed patients would have received over the maximum 24-hour recommended dose as recommended in the British National Formulary (BNF). There was limited review of patients daily and PRN medication.	
	Action taken as confirmed during the inspection: Inspectors reviewed four sets of patient care records. It was positive to note that nursing staff were recording the dispensing of PRN medication	

<table>
<tr><td></td><td>after administration to each patient. However, patient medication records (kardexs) evidenced a number of inconsistencies.

Inspectors noted that:
• Medical staff did not record date entries of PRN medication onto patient kardexs in full. A number of entries were noted to contain the day and month but not the year. This was a concern as at least one patient had been admitted to the ward for over a year.
• Indications for use of PRN medication were not completed consistently. Inspectors were unable to identify specialist instructions for the use of some PRN medications for example Lorazepam and Zopliclone.
• Inspectors evidenced PRN medications listed on patient kardexs that had not been dispensed to the patient during their admission. There was no review of these PRN medications indicated.</td><td>Partially met</td></tr>
<tr><td rowspan="2">Area for improvement 6

Ref: 5.3.3 (d)

Stated: First time</td><td>Staff did not appear to have training to update their knowledge in relation to evidence based practice. Staff did not appear to have the necessary knowledge and skills to develop and implement preventative and proactive strategies to inform the action of patient's safety plans.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:

Staff who spoke with inspectors demonstrated knowledge, skill and understanding regarding the presenting needs of each patient.

Three members of nursing staff had completed positive behaviour support training and were in the process of cascading this information to the rest of the ward staff. Staff and patients could also access support from the trust's psychological therapies service (learning disability services) as required.

Nurse training records evidenced that staff completed their required mandatory training. Inspectors noted that the service manager had clear oversight of training for nursing staff. Subsequently, retraining dates and training gaps were quickly identified and retraining sought.</td></tr>
</table>

	Inspectors noted that the ward's management team were in the process of accessing further training in relation to the use and management of restrictive practices. Whilst there were deficits evident on the nurse training records inspectors were satisfied that appropriate steps had been taken to address identified training needs.	
Area for improvement 7 **Ref**: 5.3.1 (b) **Stated:** First time	All three of the safety plans reviewed were noted to be reactive. Safety plans did not draw on the personal strengths of the patients and were not enabling.	**Met**
	Action taken as confirmed during the inspection: Inspectors reviewed four sets of patient care records. Records evidenced that proactive and reactive behaviour and management strategies were available for each patient. These reflected appropriate strategies based on patients presenting need and drawing on the patient's personal strengths.	
Area for improvement 8 **Ref:** 5.3.3 (f) **Stated:** First time	Patients had not been appropriately referred to clinical psychology and / or behaviour support services.	**Met**
	Action taken as confirmed during the inspection: Patients could access the trust's psychological therapies service (learning disability) as required. This service comprised of clinical psychology, positive behaviour support and intensive support.	
Area for improvement 9 **Ref**: 5.3.3 (f) **Stated:** First time	All three of the patients reviewed did not have an evidenced based functional assessment of their behaviours and a subsequent behaviour management plan completed. This would have informed the actions recorded on the safety plan.	**Met**
	Action taken as confirmed during the inspection: Each of the four sets of patient care records reviewed evidenced that each patient had an evidenced based functional assessment of their behaviours completed. These assessments informed associated subsequent behaviour	

	management plans.	
Area for improvement 10 **Ref:** 5.3.3 (a) **Stated:** First time	2 out of 3 files reviewed did not include treatment goals, safety goals, family & social goals, health and lifestyle goals and support recovery and /or maximise health and well-being. **Action taken as confirmed during the inspection**: Outcome and treatment goals were indicated on each care plan for each patient. Patients had an average of ten care plans covering specific issues relevant to their presenting needs and treatment plan. Safety goals were stated in each patient's behaviour plan and recorded in MDT minutes and continuing care records. Care plans included treatment goals, safety goals, family and social goals, health and lifestyle goals and recovery goals.	**Met**
Area for improvement 11 **Ref**: 5.3.3 (f) **Stated:** First time	There was no evidence of the implementation any psychological therapeutic interventions by staff on the ward. **Action taken as confirmed during the inspection**: Behaviour support plans and positive and proactive support plans were available for each patient. These directed staff to best therapeutic support and strategies for each patient. Patients were also supported by onsite day care services and psychology support was available as required.	**Met**
Area for improvement 12 **Ref**: 5.3.3 (f) **Stated:** First time	There was limited behaviour support for patients and guidance for staff. **Action taken as confirmed during the inspection**: The ward's senior management team had introduced new behaviour support plans and positive and proactive support plans. These records were comprehensive, patient centred and completed to a high standard. They were easy to follow and provided a clear oversight of the patient's presentation and the most appropriate strategies. Guidance for staff was clearly indicated and staff were supported by three nursing	**Met**

	colleagues who had completed positive behaviour support training.	
Area for improvement 13 **Ref**: 5.3.1 (f) **Stated:** First time	Patients had been prescribed medication that was not in keeping with NICE guidelines "Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges" (2015) **Action taken as confirmed during the inspection**: Inspectors reviewed each patient's kardex. No concerns were evidenced regarding the prescribing of anti-psychotic medication. Two patients were receiving haloperidol (anti-psychotic medication). This medication was being prescribed in accordance to the National Institute of Health and Social Care Excellence (NICE) guidelines.	**Met**
Area for improvement 14 **Ref**: 5.3.1 (f) **Stated:** First time	Staff had not recorded the effectiveness of the PRN medication or had documented a clear rationale for its use every time the medication was administered. **Action taken as confirmed during the inspection**: The ward management team had introduced a recording proforma requiring staff to detail the rational and effect of PRN medication. Inspectors noted that these records were comprehensive, informative and appropriately completed.	**Met**
Area for improvement 15 **Ref**: 5.3.1 (a) **Stated:** First time	Recreational and therapeutic activity plans were not comprehensive. **Action taken as confirmed during the inspection**: Inspectors reviewed each patient's recreational and therapeutic activity plans within the ward and within the hospital's Berryburn Day Centre. These were evidenced as being comprehensive, appropriate and based on the individual assessed needs of each patient.	**Met**
Area for improvement 16	Due to the absence of functional behaviour assessments, behaviour management plans, and therapeutic interventions to address the needs of	

Ref: 5.3.1 (a) **Stated:** First time	the patients, the restrictions experienced by the patients could not be viewed as proportionate, necessary and not used as a last resort. **Action taken as confirmed during the inspection**: Inspectors reviewed four sets of patient care records. Records were noted to be comprehensive, well maintained and easy to follow. Patients' person centred care plans were based on each patient's presenting needs. Proactive and reactive strategies were based on the patients' activity of daily living assessment. Plans were evidenced as being patient centred, personalised and easy to follow. These assessments ensured that he need for any restrictive practices was proportionate had a clear rational and were used as a last resort.	**Met**
Area for improvement 17 **Ref:** 5.3.1 (a) **Stated:** First time	There was no cross reference to the previous ward round or the person responsible for implementing the agreed actions and the timeframe in the ward round minutes. **Action taken as confirmed during the inspection**: Inspectors reviewed MDT ward round records. Records were completed weekly and included a comprehensive report on each patient's progress. Sections on actions from the previous ward round and an action plan identifying the person responsible for implementing new action points on the plan was available.	**Met**
Area for improvement 18 **Ref:** 5.3.3 (a) **Stated:** First time.	Information about the multi-disciplinary team was not available for patients. Details about which staff were allocated 1:1 time with patients were not displayed. **Action taken as confirmed during the inspection**: Information regarding the MDT was available on the ward's main notice board located in the main corridor. This information was updated daily	**Met**
Area for	Average number of banking hours per week was 188 hours.	

improvement 19 **Ref: 4.3 (n)** **Stated:** First time	 **Action taken as confirmed during the inspection**: Inspectors reviewed the wards staffing rota during the previous four months. The rota evidenced that there had been a significant increase in use of bank staff in early January 2018 due to staff sickness. Inspectors evidenced that from the 1 to the 6 February 9 shifts (99 hours) had been covered by bank shifts. Four staff were off sick during this period. Inspectors reviewed the use of staff bank hours for October, November and December 2017. An average of 70 hours per month was noted. Given the time of the year and the associated sick leave inspectors had no concerns regarding the ward's use of bank shifts.	**Met**
Area for improvement 20 **Ref:** 5.3.1 (a) **Stated:** First time	There were few recorded medical contacts between the patients and the consultant psychiatrist outside the ward rounds. **Action taken as confirmed during the inspection**: Patient care records reviewed by inspectors evidenced that each of the four patients were reviewed by the consultant psychiatrist on a regular basis both inside and outside the ward rounds. Inspectors were informed that the consultant would meet with patients at their request or upon a request from staff.	**Met**
Area for improvement 21 **Ref:** 5.3.1 (a) **Stated:** First time	The door to the ward was locked and exit from the ward was controlled by staff, even though there was a high staff to patient ratio. **Action taken as confirmed during the inspection**: At the time of the inspection the entrance and exit from the ward was controlled by staff. In accordance to the assessed needs of each patient this was appropriate to ensure patient safety and wellbeing. Patients' risk assessments and care plans evidenced the necessity for this restriction.	**Met**

	Inspectors reviewed the ward's procedures and protocols for the use of a locked door. Inspectors noted that a swipe system was available and that those patients assessed as not requiring a locked door could be given a swipe card/key code to allow them to leave the ward as required. Inspectors also observed that patients could avail of time off the ward through request to staff. Inspectors evidenced patients coming and going from the ward on a regular basis.	
Area for improvement 22 **Ref:** 5.3.1 (f) **Stated:** Second time	Staff were not managing patient's finances in accordance with trust policy and procedure.	**Met**
	Action taken as confirmed during the inspection: Inspectors reviewed the ward's safe records and the procedures for managing patient's finances. Inspectors evidenced that monies retained for each patient were being managed in accordance to trust policy and procedure. This included adherence 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'.*	
Area for improvement 23 **Ref:** 5.3.3 (d) **Stated:** Second time	Patients could not access ward based occupational therapy support.	**Not met**
	Action taken as confirmed during the inspection: The trust had attempted to recruit an OT for the ward during 2017. Unfortunately a suitable candidate was not identified and the post remains unfilled. Inspectors spoke with senior managers and were informed that the post would be advertised and or reconfigured to ensure resources were not lost. This area for improvement has not been met and will remain on the QIP being restated for a third time. However given that he recruitment was beyond the trusts control this will not be escalated in accordance to RQIA policy and procedures.	

6.1 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

The ward was well maintained, spacious, bright and clean.

Patients were supported by an experienced and patient centred staff team.

Psychological and psychotherapeutic interventions had been increased and strengthened.

Inspectors evidenced that although the ward did not have an occupational therapist and the trust was in the process of recruiting another consultant psychiatrist, the MDT worked well together.

Challenges regarding the reconfiguration of the ward and the introduction of a new rota were being continually monitored. The senior management team had taken positive and appropriate steps to help minimise disruption to patient care and treatment and address staff concerns.

The ward's senior management team visited the ward on a regular basis and were accessible to ward staff as required.

The hospital's Berryburn day centre worked effectively with the ward.

Staff training was closely monitored and retraining was scheduled and completed as required.

Inspectors evidenced that the ward had appropriate governance arrangements in place to record and address safeguarding concerns, incident and accidents and complaints.

Patient experience was being monitored through relative/carer involvement, file audits and through the ward's patient/staff meetings.

Areas for Improvement

The recording and indications for use of PRN medication were not being properly recorded by medical staff. This area for improvement is being restated for a second time.

Patient files were noted to contain a number of loose records. Inspectors were concerned that these could be misplaced or lost.

Number of areas for improvement	Two

7.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with senior trust representatives, members of the multi-disciplinary team, ward manager and ward staff as part of the inspection process. The timescales commence from the date of inspection.

The responsible person must ensure that all areas for improvement identified within the QIP are addressed within the specified timescales. The responsible person should note that failure to comply with the findings of this inspection may lead to escalation action being taken.

7.1 Actions to be taken by the service

The quality improvement plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed provider compliance plan via the web portal for assessment by the inspector by 3 April 2018**.**

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">The responsible person must ensure the following findings are addressed:</td></tr>
<tr><td rowspan="2">Area for Improvement No. 1

Ref: 5.3.1 (f)
Stated: First Time

To be completed by: 7 March 2018</td><td>The ward's MDT should ensure that patient care records do not contain any records that are not secured within the patient's file.</td></tr>
<tr><td>Response by responsible individual detailing the actions taken:
The team have ensured that the medical notes have been secured properly into the respective patient's files.</td></tr>
<tr><td rowspan="2">Area for Improvement No. 2

Ref: 5.3.1 (f)

Stated: Second time

To be completed by: 8 March 2018</td><td>There were a lot of medications prescribed as Pro Re Nata (PRN). There were no indications written, no minimum intervals indicated and there was no indication of which drugs should be used 1st line in the event that the indication for some different drug was the same.

If PRN medications were used as prescribed patients would have received over the maximum 24-hour recommended dose as recommended in the British National Formulary (BNF).

There was limited review of patients daily and PRN medication.</td></tr>
<tr><td>Response by responsible individual detailing the actions taken:
The PRN plans have all been updated and are now reviewed regularly at ward round. The PRN plan is formally reviewed every 2 weeks and signed by Ryan McHugh Consultant.</td></tr>
<tr><td rowspan="2">Area for Improvement No. 3

Ref: 5.3.3 (d)
Stated: Third time

To be completed by: 8 August 2018</td><td>Patients could not access ward based occupational therapy support.</td></tr>
<tr><td>Response by responsible individual detailing the actions taken:
The Trust has attempted unsuccessfully on three occasions to recruit into a hospital-based Occupational Therapy Post. There is an intention to; recruit again/review service provision within the LD MH programme to avail of regular Occupational Therapy support on a rotational basis.</td></tr>
</table>

<table>
<tr><td>Name of person (s) completing the QIP</td><td colspan="3">Niall Gallagher</td></tr>
<tr><td>Signature of person (s) completing the QIP</td><td>Niall Gallagher</td><td>Date completed</td><td>30/03/18</td></tr>
<tr><td>Name of responsible person approving the QIP</td><td colspan="3">Trevor Millar</td></tr>
<tr><td>Signature of responsible person approving the QIP</td><td></td><td>Date approved</td><td></td></tr>
<tr><td>Name of RQIA inspector assessing response</td><td colspan="3"></td></tr>
<tr><td>Signature of RQIA inspector assessing response</td><td>Alan Guthrie</td><td>Date approved</td><td>19-4-2018</td></tr>
</table>

Please ensure this document is completed in full and returned to MHLD.DutyRota@RQIA.org.uk from the authorised email address

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Assurance, Challenge and Improvement in Health and Social Care