The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Cranfield Men, Muckamore Abbey Hospital

Belfast Health and Social Care Trust

12 and 13 January 2015

npm national preventive mechanism

informing and improving health and social care
www.rqia.org.uk

R1a

Contents

1.0 General Information

Ward Name	Cranfield Men
Trust	Belfast Health and Social Care Trust
Hospital Address	Muckamore Abbey Hospital 1 Abbey Road Muckamore BT14 4SH
Ward Telephone number	028 94462636
Ward Manager	Bert Lewis
Email address	Bert.lewis@belfasttrust.hscni.net
Person in charge on day of inspection	Denise Anderson (day 1) and Bert Lewis (day 2)
Category of Care	Acute assessment and treatment; intellectual disability
Date of last inspection and inspection type	PEI - 3 June 2014
Name of inspector(s)	Siobhan Rogan
Lay assessor	Robert Watson

2.0 Ward profile

Cranfield male is a fourteen bedded ward on the Muckamore Abbey Hospital site. The purpose of the ward is to provide assessment and treatment to male patients with an intellectual disability who need to be supported in an acute psychiatric care environment.

On the days of the inspection there were thirteen patients on the ward, nine of whom were detained under the Mental Health (Northern Ireland) Order 1986. There were six patients on the ward whose discharge from hospital was delayed.

Patients within Cranfield men receive input from a multidisciplinary team which incorporates psychiatry; nursing; psychology, behavioural support and social work professionals. Patients can also access occupational therapy, speech and language; dietetics and day care by referral. A patient advocacy service is also available.

On the days of the inspection, the inspector and lay assessor noted the ward was welcoming. The ward was well lit, well maintained, clean and fresh smelling. The ward was noted to be spacious. There were separate day spaces and dining areas and an additional quiet day spaces for patients who wished to access it.

The ward consists of 14 single ensuite rooms. Bedrooms were individualised with patients' personal items. Bathrooms were clean and clutter free. Entry to and exit from the ward was controlled via an electronic swipe system. Patients had access to the garden area.

There was a separate room for patients to meet with their visitors in private. Signage both outside and inside the ward was good and supported patients with orientation around the ward.

3.0 Introduction

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

3.1 Purpose and Aim of the Inspection

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

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

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

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

3.2 Methodology

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

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

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.
Specific methods/processes used in this inspection include the following:

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

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

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

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

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

4.0 Review of action plans/progress

An unannounced inspection of Cranfield Male was undertaken on 12 and 13 January 2015.

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

The recommendations made following the last announced inspection on 18 and 19 November 2013 were evaluated. The inspector was pleased to note that 14 recommendations had been fully met and compliance had been achieved in the following areas:

- visiting professionals document a summary of their intervention in ward records;
- staff record any instance when planned activity is cancelled due to low staffing levels or ward disturbances;
- individually patient assessed needs have a care intervention completed;
- the ward manager routinely formally audits patients care documentation;
- patients care documentation was individualised and person centred;
- care plans in relation to actual or perceived deprivation of liberty included a rationale for the deprivation of liberty;
- patients were assessed by the multi-disciplinary team for the most appropriate therapeutic activity;
- there was provision and access to therapeutic activity for all patients on the ward;
- all staff working on the ward at the time of the inspection had undertaken mandatory training in line with Trust policy relevant to their role;
- the frequency of ward staff meetings was reviewed following the November 2013 RQIA inspection. As a result, staff meetings are now taking place on a monthly basis;
- information relating to organisational structure, accountability arrangements and staff on duty was available in patient areas on the days of the inspection;
- the frequency of patient forums on the ward was reviewed following the November 2013 RQIA inspection. As a result, patient forums are now taking place on a monthly basis;
- information relating to location, services offered and contact details for Muckamore Abbey Hospital is available on the BHSCT website;
- corrections to errors in the care documentation reviewed on the days of the inspection were made in accordance with NMC record keeping guidance.

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

The recommendation made following the finance inspection on 31 December 2013 was evaluated. The inspector was pleased to note that the recommendation had been fully met and compliance had been achieved in the following area:

- the ward maintains a record of all staff who obtain the key to the drawer where patient‘s money and property is stored and the reason for access.

4.3 Review of implementation of any recommendations made following the investigation of a Serious Adverse Incident

A serious adverse incident had occurred on this ward on 9 November 2013. The final investigation report is not yet available therefore no recommendations were available for follow up.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection the inspector was pleased to note that all recommendations made from previous inspections had been fully met.

Patient forum meetings had commenced and occurred every month.

All staff working on the ward at the time of the inspection had undertaken mandatory training in line with Trust policy relevant to their role.

The Trust had introduced the electronic PARIS patient information system. The inspector was informed that the system would reduce the need for the ward to retain paper records and the system would also help to ensure that patients' care records were accessible to all staff involved in the patient's care and treatment.

The inspector was accompanied on the second day of the inspection by Robert Watson, a lay assessor for the Regulation and Quality Improvement.

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

Information in relation to Department of Health Guidance in relation to Capacity to Consent and Best Interests was available to guide staff on the ward. It was good to note that this guidance had been implemented for a patient who required treatment and was assessed as not having capacity to consent.

The inspector reviewed care documentation in relation to four patients. There was evidence of patient involvement in all four sets of care documentation. Patients had signed their care documentation. The inspector spoke with three patients who confirmed they had been assisted to understand their care and treatment plan and risk assessment.

Three staff interviewed by the inspector confirmed their knowledge on Capacity and Consent and informed the inspector of the steps they took to ensure the patient consented to care and treatment e.g. take time to explain to the patient or, try again at a different time of the day when the patient was more settled and their level of understanding was optimum. Staff informed the inspector of the actions they take if patients indicate either verbally or non-verbally that they were not consenting.

Staff interviewed had knowledge on when to use the best interest check list and decision making record.

Information on patients' capacity to manage and control their finances was included in the four sets of care documentation reviewed. Where appropriate, financial control forms had been completed and signed by the consultant psychiatrist.

The staff interviewed demonstrated their knowledge of patients Human Rights article 8 rights to respect for private and family life; this was also documented in the patients care documentation.

Each patient had an individualised assessment of needs, comprehensive risk screening tool and person centred care plan completed. Care plans had been reviewed 6 monthly or earlier where there were changes to the patients' needs and care plans were updated to reflect this. The inspector noted that comprehensive risk screening tools were not subject to regular review in line with accordance with Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010 for example in care documentation relating to one patient there was no evidence that the comprehensive risk screening tool had been reviewed since April 2012.

Assessments were noted to be individualised and person centred. A care plan had been developed for each need assessed. However, the inspector noted care plans were not comprehensive and lacked sufficient detail to fully inform care interventions in a safe way and did not include an evidence base for example a care plan associated with the management of a patient's epilepsy was not in line with NICE (2012) guidance.

Care plans reviewed in relation to responding to patients whom present with behaviours that challenge did not include information to guide staff on what proactive strategies should be used but instead focused on reactive interventions. Care practices observed by the inspector and lay assessor on the ward on the days of the inspection, and responses from patients interviewed by the inspector and lay assessor indicated that staff do use proactive interventions while working with patients.

The inspector also noted during direct observations that important care interventions being delivered to patients on the ward on the days of the inspection had not been captured or recorded in the patient assessment or care plan which should be used as a basis to guide care practices and interventions and help ensure a consistent approach to care delivery.

It was good to note that each patient had an assessment of their communication needs in the four sets of care documentation reviewed. There was consistent documented evidence of patient and relative involvement in the patients' daily progress notes.

Staff interviewed demonstrated their knowledge of patients' communication needs. Staff were familiar with individual patient needs, their likes, dislikes and choices.

Patients on the ward had access to a range of clinical specialisms including nursing, psychiatry, social work, behaviour nurse, psychology, speech and language therapy, occupational therapy and dietetics. Senior trust representatives highlighted that access to psychology was unavailable for a

period from June 2014 – December 2014 and it is now available 2 day/week which is a reduction in the level of psychological input available to patients on the ward prior to June 2014. In addition, patients and the multidisciplinary team no longer have the services of a pharmacist to attend multidisciplinary discussions which is also a service that was previously available.

On the days of the inspection, the inspector and lay assessor observed that patients on the ward were accessing both ward based activities and hospital based day care. Activities available in the hospital day care facility included art; multi-sensory room; music and cookery. Patients had access to outdoor spaces.

There was evidence of individualised assessments for therapeutic and recreational activities in the care documentation reviewed as part of this inspection. Information was displayed on the ward in relation to activities offered on the ward. The three patients who met with the inspector and lay assessor stated that they participated in activities both on and off the ward such as cookery box; shopping and playing PlayStation games.

There were nine patients detained in accordance with the Mental Health (Northern Ireland) Order 1986 on the days of the inspection.

Patient forum meetings were held on the ward once per month. The inspector reviewed the minutes of the meetings and noted there was a record of patients and staff attending the meetings and the agenda discussed. Agenda items discussed at the meetings included, RQIA easy read findings of a Patient Experience Interview inspection, kitchen menus, and social activities the patients wanted to participate in. Minutes included detail of how issues were addressed and outcomes were recorded.

Information in relation to how to make a complaint was available in several formats, such as the use of words, symbols and pictures**.** The inspector spoke to two patients in relation to how to make a complaint; both patients stated they knew who to speak to if they were unhappy about something.

The inspector interviewed three staff during the inspection. Staff were familiar with how to access and effectively utilise advocacy services. The inspector met with a patient advocate during the inspection. There was evidence of advocacy involvement in the care documentation reviewed.

The care documentation reviewed in relation to four patients and evidenced that each patient had an individualised restrictive practice and Deprivation of Liberty care plan completed. Each restriction was recorded, and a rationale identified. However, two of the four care plans reviewed contained insufficient detail to demonstrate that the restrictions were proportionate to the risk and the least restrictive option. Care plans were signed by patients and/or their relatives.

There was evidence in the care plans that the use of the restrictive practices was reviewed regularly.

There was evidence in the four sets of care documentation that consideration had been given to Human Rights; Article 3 right to be free from torture, inhuman or degrading treatment or punishment, Article 5 rights to liberty and security of person and Article 8 respect to private and family life.

Both the returned relative/carer questionnaires stated that relatives knew what the restrictions were on the ward.

The three staff interviewed by the inspector demonstrated their knowledge and understanding of the Deprivation Of Liberty Safeguards – Interim Guidance DHSSPS 2010.

Cranfield Men is categorised as an assessment and treatment ward. At the time of the inspection, six of the 13 patients have been assessed as medically fit for discharge and were delayed in their discharge from hospital. The inspector was informed by the head of service that delayed discharges were reported to the Health and Social Care Board (HSCB).

The inspector noted patients whose discharge was delayed had an individualised discharge care plan completed. The care plan guided how the staff should support the patient to prepare for discharge.

There was evidence of liaising and joint working between staff on the ward and staff from potential community placements. There was evidence of relative and independent advocacy involvement and the views of patients' relatives had been considered.

Details of the above findings are included in Appendix 2.

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

6.0 Consultation processes

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

Patients	**3**

The three patients who met with the inspector and lay assessor reported that they were very happy with their care and treatment. Patients also stated that they felt safe in hospital and that being in hospital was helping them. All of the patients indicated that they enjoy participating in the ward 'cookery box' and that they have the opportunity to meet with staff to discuss their care and treatment. The ward was described as
'very good the way it runs' and
'good as it keeps me safe'.

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

Ward Staff	**3**
Relatives	**0**
Other Ward Professionals	**3**
Advocates	**1**

Relatives/Carers

The inspection was unannounced. None of the relatives or carers who visited patients on the ward on the days of the inspection wished to meet with the inspector.

Ward Staff

Three ward staff met with the inspector during the inspection. Ward staff spoke enthusiastically regarding their role and contribution on the ward. Staff reported good multidisciplinary working relationships between the ward team.

All of the staff highlighted the importance of managing risk the range of patient needs on the ward with some patients presenting with acute illness while other were medically fit but delayed in their discharge from hospital.

Other Ward Professionals

The inspector met with two professional who provide care and treatment to patients on the ward. Both professionals indicated that they enjoyed working

on the ward and stated that they felt patients were provided with a good level of care on the ward. Professionals stated that the felt part of the ward multidisciplinary team.

The range of patients on the ward from acutely unwell patients to patients who no longer required to be in hospital and the associated difficulties of managing this were also discussed.

Advocates

The inspector met with a patient advocate on the first day of the inspection. The advocate reported that they were of the opinion that patients on the ward were well cared for and had their needs met. Ward staff and the wider multidisciplinary team were described as welcoming and keen to incorporate patient advocates into all aspects of patient care delivery.

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

Questionnaires issued to	Number issued	Number returned
Ward Staff	25	10
Other Ward Professionals	10	0
Relatives/carers	13	5

Ward Staff

Ten questionnaires were returned by staff in advance of the inspection. Information contained within the questionnaires demonstrated that staff were aware of the Deprivation of Liberty Safeguards (DOLS) interim guidance.

All staff indicated that they were aware of restrictive practices on the ward. Examples of restrictive practice as reported by staff included “MAPA and locked door to ward”.

Staff indicated in their returned questionnaires that they were aware of alternative methods of communication used the on the ward and that the ward had processes in place to meet each patients individual communication needs.

Other Ward Professionals

There were no questionnaires returned from other ward professionals.

Relatives/carers

Five questionnaires were returned from relatives in advance of the inspection. Care was rated as good by all respondents. Relatives and carers indicated

that staff on the ward keep them up to date regarding their relatives care and treatment.

One of the respondents highlighted concerns in relation to the level of assistance given to her relative by staff and the consistency of care delivery across the ward staff team. This is an area that the relative had previously made a complaint to the ward about. At that time the charge nurse had met with the relative and agreed a care plan. This care plan was available on the ward on the days of the inspection. The relatives concerns were discussed with the charge nurse. The charge nurse was not aware that the relative had ongoing concerns and agreed to revisit the relatives concerns to ensure that they are addressed to their satisfaction. A recommendation relating to care documentation and consistency of care delivery has also been made.

7.0 Additional matters examined/additional concerns noted

Complaints

The inspector reviewed complaints received by the ward between the 1 April 2013 and the 31 March 2014. There were three complaints made during this time period. The three complaints were managed in line with Trust policy and procedure. Two were recorded as fully resolved to the satisfaction of the complainant and the other was recorded as partially resolved. Information on how to make a complaint was available throughout the ward and in the ward information booklet. Complaints received were in relation to care practices.

8.0 RQIA Compliance Scale Guidance

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

Appendix 1 – Follow up on Previous Recommendations

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

Appendix 2 – Inspection Findings

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

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

Appendix 1

Follow-up on recommendations made following the announced inspection on the 18 and 19 November 2013

No.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that visiting professionals document a summary of their intervention in ward records.	2	Care documentation relating to four patients was reviewed by the inspector on the days of the inspection. Electronic care records (PARIS) went live on 6 January 2015. All professionals now record their input on this system.	**Fully met**
2	It is recommended that staff record any instance when planned activity is cancelled due to low staffing levels or ward disturbances.	2	A review of patient records indicated that patients on the ward had the opportunity to participate in planned activities.	**Fully met**
3	It is recommended the ward manager ensures that all individually patient assessed needs have a care intervention completed.	1	Care documentation relating to four patients was reviewed by the inspector on the days of the inspection. The inspector found that care interventions were available to address identified assessed needs.	**Fully met**
4	It is recommended the ward manager routinely formally audits patients care documentation.	1	There was a record available to demonstrate that the charge nurse and deputy ward sister now audit care documentation two times per month. The inspector noted that aspects of care records reviewed required further attention in terms of detail, appropriate review and ensuring that all aspects of care delivery are fully assessed, planned and recorded.	**Fully met**

			A new recommendation has been made in relation to this.	
5	It is recommended the ward manager ensures that all patients care documentation are individualised and person centred.	1	Care documentation reviewed on the days of the inspection was individualised to each patient.	**Fully met**
6	It is recommended the ward manager ensures that care plans in relation to actual or perceived deprivation of liberty are reviewed to ensure that there is clear rationale for the deprivation of liberty.	1	Care plans in relation to deprivation of liberty which included a rationale were available in the care documentation reviewed by the inspector.	**Fully met**
7	It is recommended the ward manager ensures all patients are assessed by the multi-disciplinary team for the most appropriate therapeutic activity.	1	Care documentation reviewed by the inspector included a multidisciplinary assessment which incorporated assessment of therapeutic activity needs.	**Fully met**
8	It is recommended the ward manager ensures that there is provision and access to therapeutic activity for all patients on the ward.	1	Patients on the ward at the time of the inspection had access to therapeutic activities.	**Fully met**
9	Is it recommended the ward manager ensures all	1	Staff training records reviewed demonstrated that all staff working on the ward at the time of the inspection had undertaken mandatory	**Fully met**

	staff attend mandatory training.		training in line with Trust policy relevant to their role.	
10	It is recommended the ward manager reviews the frequency of staff ward meetings.	1	The frequency of ward staff meetings was reviewed following the November 2013 RQIA inspection. As a result, staff meetings are now taking place on a monthly basis.	**Fully met**
11	It is recommended the ward manager ensures that Information relating to organisational structure, accountability arrangements and staff on duty is available in patient areas.	1	Information relating to organisational structure, accountability arrangements and staff on duty was available in patient areas on the days of the inspection.	**Fully met**
12	It is recommended the ward manager reviews the frequency of patient forums and ensures it is documented when patients do not attend.	1	The frequency of patient forums on the ward was reviewed following the November 2013 RQIA inspection. As a result, patient forums are now taking place on a monthly basis.	**Fully met**
13	It is recommended the BHSCT provide information on the trust web site on the location, services offered and contact details of Muckamore Abbey Hospital.	1	Information relating to location, services offered and contact details for Muckamore Abbey Hospital is available on the BHSCT website.	**Fully met**
14	It is recommended the ward manager ensures that	1	Corrections to errors in the care documentation reviewed on the days of the inspection were made in accordance with NMC record keeping	**Fully met**

	errors in care documentation are corrected in accordance with NMC record keeping guidance.		guidance.	

Appendix 1

Follow-up on recommendations made at the finance inspection on 31 December 2013

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward maintains a record of all staff who obtain the key to the drawer where patient's money and property is stored and the reason for access	A record of all staff who obtain the key to the drawer where patient's money and property is stored and the reason for access is maintained. In addition, the balance of cash in each drawer is checked three times per day by two members of staff.	**Fully met**

Follow up on the implementation of any recommendations made following the investigation of a Serious Adverse Incident

No.	SAI No	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	BHSCT/SAI/14/162	This incident occurred on 09/11/2014. The final investigation report is not yet available therefore no recommendations were available for follow up.	The incident was discussed with the ward manager and nurse in charge on the days of the inspection. As a result of this incident, the Trust took actions to ensure that individual place mats highlighting needs for each patient are developed to act as an additional prompt to promote patient safety.	**Not assessed**

Quality Improvement Plan

Announced/Unannounced Inspection

Cranfield Men, Muckamore Abbey Hospital

12 and 13 January 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with the charge nurse, consultant psychiatrist and senior trust representatives on the days of the inspection visit.

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

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	5.3.3 (b)	It is recommended that the charge nurse ensures that all staff record when they have sought consent before supporting or providing any care to patients.	1	Immediate and ongoing	In response to this recommendation, the charge nurse ensures all staff record how they seek consent/how the patient demonstrates consent before supporting or providing any care to patients through the assessment and care plan. The charge nurse carries out monthly internal audits within the ward to monitor care documentation.
2	5.3.3 (f)	It is recommended that the charge nurse ensures that patient assessments and associated care plans are comprehensively completed and any associated plans are individualised, evidence based and developed in line with NICE guidance .	1	31 March 2015	In response to this recommendation, the charge nurse carries out monthly internal audits within the ward to monitor care documentation. Through this audit the charge nurse ensures that assessments and care plans are comprehensive and associated plans of care are individualised and evidence based. Patients who have epilepsy have an epilepsy management plan. Staff have been reminded to refer to Nice Guidance for evidence base.
3	5.3.3 (f)	It is recommended that the Trust ensures that positive behaviour support strategies used on the ward to address behaviours that challenge are clearly documented to guide	1	31 March 2015	In response to this recommendation, plans of care detail praoactive strategies which reflect the positive behaviour support strategies used on the

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
		care practices and promote the development of alternative functional social appropriate behaviours.			ward to address behaviours that challenge
4	6.3.2 (b)	It is recommended that the charge nurse ensures that comprehensive risk screening tools and assessments are completed and reviewed 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.	1	28 February 2015	In response to this recommendation, the charge nurse carries out monthly internal audits within the ward to monitor care documentation. PQC documentation is monitored as part of this audit. All risk screening tools and assessments have been completed and reviewed 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.
5	5.3.1. (a)	It is recommended that the charge nurse ensures that all care plans in place in relation to restrictive practices have a clear rationale for the restriction in place in terms of necessity and proportionality.	1	31 March 2015	In response to this recommendation, the charge nurse carries out monthly internal audits within the ward to monitor care documentation. Care plans in relation to restrictive practice are part of this audit. Care plans have a clear rationale for any restrictions in place in terms of necessity and proportionality.
6	5.3.3	It is recommended that the charge nurse ensures that care plans are developed so that they clearly guide	1	28 February 2015	In response to this recommendation, the charge nurse carries out monthly internal audits within the

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
		all care interventions related to that assessed need to direct day to day care delivery on the ward and promote consistency of approach to patient care.			ward to monitor care documentation. Care plans have been reviewed and developed. Plans of care detail required interventions to meet assessed need in a clear and consistent manner
7	5.3.3 (d)	It is recommended that the Trust reviews the availability of clinical specialisms to patients on the ward. The views of clinicians working in the multidisciplinary team and evidence based practice should be incorporated into this review.	1	31 May 2015	In response to this recommendation, the Trust will undertake a review of the availability of clinical specialisms to patients on the ward. Any gap in service provision identified will be shared with the commissioners of the service for funding proposal. The review will consider the views of clinicians working in the multidisciplinary team, proposed planned Quality Network reviews once completed and evidence based practice where available to inform any recommendations to the commissioners at HSCB.

NAME OF WARD MANAGER COMPLETING QIP	Bert Lewis

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 CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Martin Dillon

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Rosaline Kelly	**11/03/15**
B.	Further information requested from provider				