Donegore

Address: Muckamore Abbey Hospital, 1 Abbey Road, Muckamore, Antrim BT41 4SH

Dates of Inspection Visit: 28 – 30 June 2016

Names of Inspectors: Audrey McLellan, Wendy McGregor and Dr Oscar Daly

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

This report describes our judgement of the quality of care at Donegore ward. It is based on a combination of what we found when we inspected and from a review of all of the information available to The Regulation and Quality Improvement Authority (RQIA). This included information given to us from patients, the public and other organisations.

This inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in this service. The findings reported on are those that came to the attention of RQIA during the course of this inspection while assessing the four stakeholder outcomes under this year's theme of Patient Centered Care. The findings contained in this report do not exempt the Trust from their responsibility the Mental Health (Northern Ireland) Order 1986 and the Department of Health (DoH) standards. It is expected that the areas for improvement outlined in this report will provide the Trust with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

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1.0 Details of Ward

Donegore is a nine bedded ward situated on the Muckamore Abbey Hospital site. The purpose of the ward is to provide care and treatment to female patients with a learning disability who present with behaviours that challenge.

On the day of the inspection there were nine patients on the ward. Four of these patients had been detained appropriately in accordance with the Mental Health (Northern Ireland) Order 1986.

Patients in Donegore have access to a multi-disciplinary team (MDT). This incorporates: psychiatry; nursing; occupational therapy; clinical psychology; and behavioural support. Patients also have access to onsite day care services and independent advocacy services are also available.

2.0 Summary of this Inspection

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

RQIA found that Donegore provided compassionate care. Inspectors noted that communication and contact between staff and patients was warm, friendly, encouraging and supportive. Staff were observed showing patients respect and treating patients with dignity throughout all interactions.

On the days of inspection there was enough staff on the ward to attend to patients' needs. The inspectors observed staff carrying out a number of different activities with patients and staff were available in the communal room at all times.

The ward had an up to date environmental ligature risk assessment and action plan completed. One risk was identified regarding a handrail in the ensuite of a bedroom which was used for a patient with a disability.

Inspectors identified four areas for improvement in relation to aspects of safe and well led care:

- There was limited evidence of records being completed by the medical team to evidence that patients' clinical needs had been reviewed on a sufficiently regular basis.

- There was a lack of managerial and clinical input on the ward from senior medical staff.

- Concerns were raised in relation to the monitoring of medication which included the use of polypharmacy being sufficiently robust.

- The MDT for the facility was agreed. However, medical staff were not always available and due to this a number of the MDT meeting had been cancelled (out of 26 weeks 9 meetings had been cancelled).

These matters have been brought to the immediate attention of the Trust. An action plan was received to demonstrate that RQIA concerns were being urgently addressed.

Follow up on Previous Inspection Recommendations

No recommendations were made in the previous inspection.

3.0 How we Carried Out this Inspection

RQIA's programmes of inspection, review and monitoring of mental health legislation focus on four specific and important key stakeholder outcomes:

Is care safe?
Is care effective?
Is care compassionate?
Is the service well led?

What the inspector(s) did:

- Reviewed a range of information relevant to the facility sent to RQIA before the inspection. This included policies and procedures, staffing levels, ward aims and objectives and governance protocols.
- Talked to patients, carers and staff.
- Observed staff working practices and interactions with patients on the days of the inspection.
- Reviewed other documentation on the days of the inspection. This included care records, incident reports, multi-disciplinary procedures and staff training records.
- Reviewed progress since the last inspection.

At the end of the inspection the inspector(s):

- Commended areas of good practice.
- Shared the inspection findings with staff.
- Highlighted areas for improvement.

4.0 What People Said about this Service

Patients Stated:

During the inspection inspectors met with all nine patients. Six of the patients completed a questionnaire. Patients informed the inspectors that they were involved in their care and treatment and stated that the care they were receiving was helping them to recover. They stated they were safe and secure on the ward and that staff treated them with dignity and respect. They attend activities at the day centre and on the ward which they enjoy. Staff seek consent from them prior to providing them with care and treatment. Patients stated they are supported by staff when an incident occurs on the ward. Staff are always available to talk to them. They confirmed that they receive 1:1 time with their named nurse each week. They knew who their doctor was and attended their MDT meetings.

Patients Said:

“Very good, no problems…… I like it”,

“Plenty of young staff…very good….I only hang out with young staff”,

“More outings….half and half ……food is nice”,

“I like all the staff….I like the new staff”,

“I’m happy enough…best nurses….it’s good…. fun every day”,

“I love it here all the nurses a great…. I really, really love it”.

During the inspection patients’ relatives were invited to meet with inspectors. No relatives were available to speak with inspectors on the ward. However, the inspectors were able to speak with two relatives by telephone. Both relatives stated that they were involved in their relatives’ care and treatment and that staff were approachable and listened to their views. They stated that the care and treatment their relative received was beneficial. They confirmed they had been given information on how to support their relatives’ recovery and were happy with the level of therapeutic and recreational activities offered on and of the ward.

Relatives Stated:

“Staff are absolutely fantastic”,

“Happy 100% with the care”,

“If X is happy I’m happy”,

"Staff keep me well informed of everything…very positive",

"They do the best with what they have",

"To be honest I think they are all fantastic with X",

"X is comfortable and relaxed on the ward".

Staff Stated:

Inspectors met with 13 members of the ward's multi-disciplinary team (MDT). Staff told inspectors that felt the MDT worked well together. All staff stated that they enjoyed working on the ward and a number of nursing staff stated they were well supported by the ward manager. Staff reported no concerns regarding the care and treatment provided to patients on the ward. Staff confirmed that they had attended their mandatory training and had up to date supervision and appraisals in place.

Inspectors spoke to five nursing staff and one health care worker (HCA) who all stated they were happy working on the ward and were supported in their role. They were aware of their role in relation to adult safeguarding and child protection concerns and knew what to do when an incident occurred on the ward. They stated they had never been asked to work beyond their role and experience and they had the knowledge and experience to work on the ward. A number of staff discussed various courses they were attending to improve their skills. They discussed how they support patients who present with behaviours that challenge through the use of positive behaviour support plans and incentive plans. They reflected on how they use proactive strategies evidencing a good level of understanding in relation to relevant policies, procedures and evidence based practice.

The inspectors met with the Occupational Therapist (OT) who stated that there was, *"good team working on the ward".* They discussed the various different assessments they use and how the interventions they set up are based on these assessments. They advised they assess patients in relation to their activities of daily living when discharge arrangements are being organised when they receive a specific referral from the ward. They assisted in developing 'social stories' and have set up various groups in relation to areas such as money management and therapeutic work.

Inspectors met with a member of staff from the behaviour support service who advised that they visit the ward every day and on a number of occasions twice a day to support staff and patients. They stated that *"staff are doing a great job especially when there have been so many changes".* They discussed their role and how they have completed positive behaviour support plans and incentive plans for patients. They showed the inspectors examples of plans in easy read format that were patient centred and comprehensively completed with a strong evidence of patient involvement. They advised that they enjoy

working on the ward and were well supported by the behaviour support team within the hospital which includes five behaviour support therapists.

Inspectors spoke to a senior social worker who had the additional role of investigating safeguarding referrals since the designated officer retired from their post. They were able to evidence how the safeguarding referrals are monitored and reviewed. They were able to present up to date figures of safeguarding referrals received. They advised incidents are discussed and reviewed at the governance meetings every two months. They informed the inspectors that the trust had recently recruited a new member of staff who will be taking on the safeguarding role.

Inspectors spoke to one of the day care workers who does not work on the ward but works with all of the patients in the day centre located on the hospital site. They advised they work closely with the behaviour support team, patients and staff on the ward to implement positive behaviour support plans. They also attend the MDT meetings to provide an update on patients' progress over the week in the day centre. They confirmed that all patients on the ward had five sessions of day care each week. They advised the sessions are based on patients' assessed need. They take into account patients' likes and dislikes when planning their timetable.

A review of the care records was undertaken. The inspectors were concerned that senior medical staff were providing insufficient managerial and clinical input into the ward. There was evidence that a number of MDT meetings had been cancelled. Inspectors were concerned that there was limited evidence of records being completed by the medical team to evidence that patients' clinical needs had been reviewed on a sufficiently regular basis. Concerns were raised were raised, with senior medical and managerial staff, as a priority in relation to the monitoring of medication which included the use of polypharmacy being sufficiently robust. This will be included in the quality improvement plan as priority one.

5.0 Our Assessment of the Four Stakeholder Outcomes

5.1 Is Care Safe?

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

Key Indicator S1 - There are systems in place to ensure unnecessary risks to the health, welfare or safety of patients are identified, managed and where possible eliminated.

Examples of Evidence:

- ✓ Patient care records reviewed by inspectors were individualised and based on the assessed needs of the patient.
- ✓ Patient care records reviewed by inspectors evidenced that risk asessments, care plans, MDT records and continuous care notes were patient centred. Patients involvement was evidenced within their records.
- ✓ Patients' risk assessments were completed in accordance with the Promoting Quality Care – Good Practice Guidance on the Assessment of Risk and Management of Risk in Mental Health and Learning Disability Services, May 2010.

Area for Improvement:

- ✗ No areas were identified for improvement in relation to safe care.

Key Indicator S2 - The premises and grounds are safe, well maintained and suitable for their state of purpose.

Examples of Evidence

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

- ✓ The ward was clean, tidy and well maintained. There was ample lighting and neutral odours and clear signage was displayed to orientate patients and visitors. The ward had been specifically designed for patients who present with behaviours that challenge. It was divided into three separate living areas and patients were accommodated in each area due to their individualised assessed need.
- ✓ Patients had their own bedrooms with ensuite facilities and a call alert system was available. Each room was personalised with patients'

belongings. There was a notice board in each patient's room which had information displayed such as the patients' activity timetable and photographs of their families and friends. There was a good range of appropriate activities that met the patient's needs which included evenings and weekend activities. It was good to note that a number of patients had access to their bedroom door key. Patients also had access to their mobile phones when this was risk assessed as appropriate and safe.

- ✓ The ward had an up to date environmental ligature risk assessment and action plan completed and updated. One risk was identified regarding a handrail in the ensuite of a bedroom which was used for a patient with a disability. It was good to note that the patient using this room has an individualised risk assessment/management plan in place.
- ✓ Patients reported that they felt safe on the ward.

Area for Improvement:

- ✗ No areas were identified for improvement in relation to safe care.

Key Indicator S3 - There are at all times, suitably qualified, competent and experienced persons working in the facility.

Examples of Evidence

- ✓ On the days of inspection there appeared to be enough staff on the ward to attend to patients' needs. The inspectors observed staff carrying out a number of different activities with patients and staff were available in the communal room at all times
- ✓ Staff had up to date mandatory training in place.
- ✓ Staff supervision and appraisals were completed in accordance to the required standards.
- ✓ Staff informed inspectors that they enjoyed working on the ward and that the MDT worked well together.
- ✓ Staff confirmed that they never worked beyond their role and experience.

Area for Improvement:

- ✗ No areas were identified for improvement in relation to safe care.

Key Indicator S4 – Patients are detained appropriately with information provided about their rights and how to make a complaint.

Examples of Evidence:

- ✓ Inspectors evidenced robust arrangements in place to ensure the discharge of statutory functions in accordance to the Mental Health (Northern Ireland) Order 1986.
- ✓ Patients knew how to make a complaint and had access to an advocacy service.
- ✓ Easy read information was available in relation to patients' rights and the detention process, it was good to note this information was also displayed on the ward.

Area for Improvement:

- ✗ No areas were identified for improvement in relation to safe care.

5.2 Is Care Effective?

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

Key Indicator E1 - Comprehensive co-produced personal well-being plans/care plans are in place to meet the assessed needs of patients. Care and treatment is evaluated for effectiveness. Effective discharge planning arrangements are in place.

Examples of Evidence:

- ✓ Nursing care records reviewed by inspectors evidenced that patient care and treatment was provided in accordance to legislation, best practice standards and in the best interests of the patient. Staff maintained comprehensive records of each patient's progress.

- ✓ Assessments were comprehensively completed and used to inform care plans which were person centred. Care plans were completed with patients involvement and regularly reviewed.

Areas for improvement:

- ✗ Having reviewed the care records the inspectors were concerned that senior medical staff were providing insufficient managerial and clinical input into the ward. A number of MDT meetings had been cancelled and inspectors were concerned that records being completed by the medical team to evidence that patients' clinical needs had not been reviewed on a sufficiently regular basis. These concerns were discussed with senior medical and managerial staff as a matter of urgency and are included in the quality improvement plan as Priority one.

Key Indicator E2 - Autonomy and Independence is promoted and the use of restrictive practice(s) is minimised

Examples of Evidence:

- ✓ Staff promoted a least restrictive practice ethos.

- ✓ The ward was a locked ward. However, deprivation of liberty (DOLS) care plans were in place for each patient which detailed the rationale in relation to the locked door on the ward. The use of such practices were used proportionately, as a last resort and regularly reviewed in accordance with guidance.

✓ Inspector evidenced patients coming and going from the ward through the days of the inspection. A number of patients were observed going to the day care centre and to the ‘Cosy Corner’ restaurant.

Area for Improvement:

✗ No areas were identified for improvement in relation to safe care.

5.3 Is Care Compassionate?

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

Key Indicator C1 - **There is a culture/ethos that supports the values of dignity and respect and patients are responded to compassionately.**

Observations - Effective and therapeutic 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.

Inspectors completed direct observations using the QUIS tool during the inspection and assessed whether the quality of the interaction and communication was positive, basic, neutral, or negative.

- **Positive social (PS)** - care and interaction over and beyond the basic care task demonstrating patient centred empathy, support, explanation and socialisation
- **Basic Care (BC)** – 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.

Examples of Evidence:

Observations of interactions between staff and patients/visitors were completed throughout the days of the inspection. There were 14 interactions recorded in this time period. The outcomes of these interactions were as follows:

Positive	Basic	Neutral	Negative
100%	0%	0%	0%

✓ Patients informed the inspectors that staff treat them with dignity and respect. Communication and contact between staff and patients was very positive.

✓ Inspectors observed interactions between staff and patients throughout the three days of the inspection. Communication and contact between staff and patients was warm, friendly, encouraging and supportive. Staff showed patients respect and treated them with dignity throughout all

interactions. It was good to note the full achievement of 100% in this area.

- ✓ Staff have positive relationships with patients and their relatives. One patient was waiting on a family member to collect them and was observed becoming anxious whilst waiting. The nurse noticed this and spoke to the patient with empathy reducing the patient's anxiety.
- ✓ Staff were present in the communal areas and assisted patients with painting their nails, helping with art, watching the television with patients, styling their hair and giving hand massages.
- ✓ A patient was observed refusing their medication. The nurse did not pressurise the patient but offered to call back to see if they would take it at a later time. The nurse was observed coming back to the patient to offer the medication again which they took. The nurse advised that the patient usually takes their medication if she returns after a short period of time and offers this to them. It was good to note that the nursing staff were familiar with the patients' needs and have developed an effective working relationship.
- ✓ There were three patients receiving enhanced observations. The inspectors observed these observations being carried out discreetly with respect and dignity.

Area for Improvement:

- ✗ No areas were identified for improvement in relation to safe care.

Key Indicator C2 - There are systems in place to ensure that the views and opinions of patients, and/or their representatives are sought and taken into account in all matters affecting them.

Examples of Evidence:

- ✓ Patients were invited to attend their MDT meetings each week.
- ✓ Patients confirmed that they receive 1:1 therapeutic time with their named nurse.
- ✓ Patients had individual activity/therapeutic timetables in place which were person centred and in a format which each patient could understand.
- ✓ There was evidence that patients were actively involved in their discharge plans and links had been made with appropriate community teams prior to patients' discharge.

- ✓ Nursing staff demonstrated a good level of understanding in relation to relevant policies, procedures and evidence based practice.
- ✓ Patients were involved in decisions regarding their care and treatment.
- ✓ Patients had access to an advocacy service and the trust had secured funding for a carer advocacy service.
- ✓ There was comprehensive easy read information available for patients.
- ✓ Relatives made positive comments regarding patients' care and treatment.
- ✓ Patients confirmed that they were supported after incidents occurred on the ward.
- ✓ Patients who met with inspectors all stated that they were happy with the care and treatment they were receiving.
- ✓ Patients reported that they felt safe on the ward.
- ✓ There were enough staff on the ward to attend to patients' needs. The inspectors observed staff carrying out a number of different activities with patients and staff were available in the communal room at all times

Area for Improvement:

- ✗ No areas were identified for improvement in relation to safe care.

5.4 Is The Service Well Led?

Effective leadership, management and governance which create a culture focused on the needs and experiences of patients in order to deliver safe, effective and compassionate care.

Key Indicator WL1 - There are appropriate management and governance systems in place to meet the needs of patients.

Examples of Evidence:

- ✓ There were effective systems in place to monitor patient progress and to report and analyse incidents, accidents and serious adverse incidents.
- ✓ There was governance oversight of patients who were delayed in their discharge.
- ✓ There was evidence that learning was shared with nursing staff.
- ✓ Easy read information was available in relation to complaints and compliments

Area for Improvement:

- ✗ Concerns were raised in relation to the monitoring of medication which included the use of polypharmacy being sufficiently robust.

Key Indicator WL2 - There are appropriate management and governance systems in place that drive quality improvement.

Examples of Evidence:

- ✓ There were effective systems in place to report and analyse incidents, accidents and serious adverse incidents.
- ✓ Staff were aware of their role in relation to adult safeguarding and child protection concerns and knew what to do when an incident occurred on the ward. They stated they had never been asked to work beyond their role and experience and they had the knowledge and experience to work on the ward.
- ✓ Policies and procedures reviewed by inspectors were relevant and up to date. Staff evidenced a good level of understanding in relation to relevant policies, procedures and evidence based practice.

Area for Improvement:

- ✗ No areas were identified for improvement in relation to safe care.

Key Indicator WL3 - There is a clear organisational structure and all staff are aware of their roles, responsibility and accountability within the overall structure. There are appropriate supervision arrangements in place.

Examples of Evidence:

- ✓ Staff evidenced a good understood of their roles and responsibilities.
- ✓ There was a clear management structure identifying the lines of responsibility and accountability
- ✓ Staff had received up to date mandatory training, supervision and appraisal. They discussed various courses they were attending to improve their skills and how they support patients who present with behaviours that challenge through the use of positive behaviour support plans and incentive plans.
- ✓ Staff reflected on how they use proactive strategies and evidenced a good level of understanding in relation to relevant policies, procedures and evidence based practice
- ✓ Staff reported no concerns regarding the care and treatment provided to patients on the ward.

Area for Improvement:

- ✗ No areas were identified for improvement in relation to safe care.

Key Indicator WL4 - There are effective staffing arrangements in place to meet the needs of the patients.

Examples of Evidence:

- ✓ There were effective staffing arrangements in place and members of the staff team reflect no current concerns regarding staffing levels. On the days of inspection there were enough staff on the ward to attend to patients needs.
- ✓ Staff confirmed that there was good working relationships between the MDT.
- ✓ Staff confirmed that they enjoyed working on the ward and were supported by management.

Areas for improvement:

- ✘ The multi-disciplinary team for the facility was agreed. However, medical staff were not always available and due to this a number of the MDT meetings had to be cancelled. (Out of 26 weeks 9 meetings had been cancelled).
- ✘ There was a lack of managerial and clinical input on the ward from senior medical staff

6.0 Excellent Practice Noted

Inspectors evidenced that the nursing team worked effectively together to provide high quality care to patients. There was clear objective evidence that patients were treated in a caring and compassionate manner and that care planning was patient centred and inclusive.

7.0 Areas for Improvement

Areas for improvement are summarised below. The Trust, in conjunction with ward staff, should provide an improvement plan to RQIA detailing the actions to be taken to address the areas identified.

Key areas for improvement were discussed with the ward manager and other staff from the Trust involved in providing care/treatment to patients in this ward as part of the inspection process.

The timescale for action on the areas for improvement commenced from the day of the inspection. The QIP requires to be completed by the Trust detailing the actions the Trust intend to take to make the required improvement and returning to RQIA within 28 days of receipt.

On return to RQIA the QIP will be assessed by the inspector.

Areas for Improvement		Timescale for Implementation in Full
Priority 1 Recommendations		
1	There was limited evidence of records being completed by the medical team to evidence that patients' clinical needs had been reviewed on a sufficiently regular basis.	15 July 2016
2	There was a lack of managerial and clinical input on the ward from senior medical staff.	15 July 2016
3	Concerns were raised in relation to the monitoring of medication which included the use of polypharmacy being sufficiently robust.	15 July 2016
4	The MDT for the facility was agreed. However, medical staff were not always available and due to this a number of the MDT meeting had been cancelled (out of 26 weeks 9 meetings had been cancelled).	15 July 2016

Definitions for Priority Recommendations

PRIORTY	TIMESCALE FOR IMPLEMENTATION IN FULL
1	This can be anywhere from **24 hours to 4 weeks from the date of the inspection** – the specific date for implementation in full will be specified
2	Up to **3 months** from the date of the inspection
3	Up to **6 months** from the date of the inspection

HSC Trust Quality Improvement Plan

WARD NAME	Donegore	WARD MANAGER	Adrienne Creane	DATE OF INSPECTION	28-30 June 2016
NAME(S) OF PERSON(S) COMPLETING THE IMPROVEMENT PLAN	Adrienne Creane Karen Humphries Kerry Ng Carole Wilson Barry Mills Brendan Ingram Jenni Armstrong Esther Rafferty Colin Milliken	NAME(S) OF PERSON(S) AUTHORISING THE IMPROVEMENT PLAN	Martin Dillon		

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

The areas where improvement is required, as identified during this inspection visit, are detailed in the inspection report and quality improvement plan.

The completed improvement plan should be completed and returned to team.mentalhealth@rqia.org.uk from the HSC Trust approved e-mail address, by 26 August 2016.

Please password protect or redact information where required.

PRIORTY	TIMESCALE FOR IMPLEMENTATION IN FULL
1	This can be anywhere from **24 hours to 4 weeks from the date of the inspection** – the specific date for

	implementation in full will be specified
2	Up to **3 months** from the date of the inspection
3	Up to **6 months** from the date of the inspection

Part A

Priority 1: Please provide details of the actions taken by the Ward/Trust in the timeframe **immediately** after the inspection to address the areas identified as **Priority 1**.

	Area identified for Improvement	Timescale for full implementation	Actions taken by Ward/Trust	Attached Supporting Evidence	Date completed
	Key Outcome Area – Is Care Safe? No areas of improvement identified				
1	***Key Outcome Area – Is Care Effective?*** There was limited evidence of records being completed by the medical team to evidence that patients' clinical needs had been reviewed on a sufficiently regular basis *Quality Standard 5.3.1 a*	15 July 2016	In response to this recommendation the Clinical Director has issued communication to all medical staff to ensure that their clinical input and direction to manage patient care and treatment is evidenced in all patient case-notes as clinically indicated and		July 16

	This area has been identified for improvement for the **first** time		reviewed on a sufficiently regular basis.		
	Key Outcome Area – Is Care Compassionate? No areas of improvement identified.				
2	***Key Outcome Area – Is Care Well Led?*** There was a lack of managerial and clinical input on the ward from senior medical staff *Quality Standard 5.3.3d* This area has been identified for improvement for the **first** time	15 July 2016	In response to this recommendation The Trust has communicated to all senior medical staff that they must provide regular managerial and clinical input to their wards on a sufficiently regular basis. Consultant psychiatrist cover has been provided during a period of absence in Donegore to ensure this standard is met.		July 16
3	Concerns were raised in relation to the monitoring of medication which included the use of polypharmacy being sufficiently robust. *Quality standard 5.3.1f* This area has been identified for improvement for the **first** time.	15 July 2016	In response to this recommendation the Clinical Medical Lead for patient safety and governance and the Clinical Pharmacist have reviewed all current medication prescriptions in relation to the use of polypharmacy within Donegore ward, and have changed the prescription where possible or provided a rationale as to why the prescription has not been		27th July 16

			changed when not possible. Monitoring of medication will take place on at least an annual basis or more often if clinically indicated. Clinical Pharmacy input into the ward will be reviewed by the Clinical Director and any recommendations submitted to the Hospital Management Team for appropriate action.		 Ongoing October 16
4	***Key Outcome Area – Is Care Well Led?*** The MDT for the facility was agreed. However, medical staff were not always available and due to this a number of the MDT meeting had been cancelled (out of 26 weeks 9 meetings had been cancelled) *Quality standard 5.3.1f* This area has been identified for improvement for the **first** time.	15 July 2016	In response to this recommendation, the ward manager will ensure weekly multidisciplinary meetings take place. The ward manager will notify the clinical director and service management of cancelled or rescheduled meetings and the reason for same. Senior medical staff will ensure that medical managerial and clinical input to the MDT meeting is sufficiently regular and sustained.		July 16

TO BE COMPLETED BY RQIA

Inspector comment (delete as appropriate)	Inspector Name	Date
I have reviewed the Trust Improvement Plan and I am satisfied with the proposed actions or I have reviewed the Trust Improvement Plan and I have requested further information	Audrey McLellan	12/9/16
I have reviewed additional information from the Trust and I am satisfied with the proposed actions		