The Regulation and Quality Improvement Authority

Unannounced Inspection
19 - 21 July 2016

Erne Ward
Muckamore Abbey Hospital

Inspectors: Cairn Magill, Wendy McGregor, Dr Shelagh-Mary Rea

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

Erne is a 19 bed mixed gender continuing care/resettlement unit for patients with a learning disability based in Muckamore Abbey Hospital site. On the days of inspection there were 16 patients on the ward and three patients who were off the ward on trial resettlement placements. There were 12 male and 4 female patients. The ward had six separate areas. Two areas were designated for two patients who presented with challenging behaviours and four areas for the remainder of the patients. There were separate areas for male and female patients.

The multi-disciplinary team consisted mainly of nursing and psychiatry. At the time of the inspection social work, speech and language, physiotherapy, occupational therapy, behaviour support, advocacy and psychology services was available on a referral basis.

Resettlement meetings took place on a weekly or two weekly basis depending on the patient need and there were monthly multidisciplinary team meetings held for each patient.

3.0 Service Details

Responsible person: Michael McBride	**Position:** Chief Executive
Person in charge at the time of inspection: Audrey Lewis, Deputy Ward Manager	

4.0 Inspection Summary

An unannounced inspection took place over three days from 19 to 21 July 2016.

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

Evidence of good practice was found in relation to the range of therapeutic and recreational activities offered to patients. Patients were referred to specialists for assessment as the need arose. There were regular medication audits. Staff consulted regularly with relatives. Aroma therapists and music therapists attend the ward every week.

12 areas requiring improvement were identified. These included;

1. ward hygiene and cleanliness standards;
2. fire risk assessment and evacuation procedures;
3. adherence to Trust policy on checking of emergency equipment;
4. staffing levels;
5. recording keeping;
6. adherence to Trust's financial policies;
7. patient's experience and advocacy service;
8. ward signage and the provision of information that met the needs of patients who require support with communication;
9. adherence to data protection policy;
10. displaying ward's performance;
11. informing relatives of the purpose of meetings in advance; and
12. ward environmental risk assessment.

Escalation action was taken following this inspection. A meeting took place to address the concerns. An urgent action plan to address the issues was supplied by the Trust.

The findings of this report will provide Erne Ward 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	**12**

Findings of the inspection were discussed with the Deputy Ward Manager and other senior members of the Trust, as part of the inspection process and can be found in the main body of the report.

Escalation action resulted from the findings of this inspection.

The escalation policies and procedures are available on the RQIA website.

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

4.2 Escalation Action Taken Following the Most Recent Erne Inspection

Other than those actions detailed in the quality improvement plan no further actions were required to be taken following the most recent inspection on 23 June 2015.

5.0 How We Inspect

This inspection was underpinned by:

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

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

- Belfast Risk Audit & Assessment Tool (BRAAT) Phase 2
- Accidents and Incidents record 1 April 2015 – 31 March 2016 (199 incidents during this period)
- Copy of Safeguarding Referrals 1 April 2015 – 31 March 2016 (42 referrals during this period)
- Fire Inspection Report 16 November 2015
- Minutes of Governance Meetings held on November 2015, January 2016 & March 2016
- Minutes of Senior Nurses' Meeting held 25 May 2016

- Nurse Management Structure
- Erne Operational Policy
- Pre-Inspection information which was requested and included staff rota, policies and procedures, supervision and annual appraisal dates

During the inspection inspectors met with all patients, six members of staff, two members of senior management, four visiting professionals and the relatives of one patient.

All patients required support with communication and had limited verbal communication however one patient said;

> "I like my room".

The relatives stated;

> "There is free dialogue. Staff are open and honest. Staff do all they can to ensure X accesses community activities, i.e. cinema, beach, walks and they try and do new things. X gets enough to eat and drink. X is always clean and tidy. We are very reassured that X is receiving good care from a consistent team of people".

The following records were examined during the inspection:

- three patient assessments;
- three care plans;
- three risk assessments;
- 16 personal emergency evacuation plans;
- four body charts;
- four financial records;
- two copies of Maximiser, a NHS cleaning audit tool;
- minutes of Erne Ward meetings held on 9 & 10 February 2016, 23 March 2016 and 16 June 2016; and
- the Trust's PARIS electronic recording system.

A quality interaction schedule tool and ward environmental check list were used during this inspection.

RQIA reviewed the recommendations made at the last inspection. An assessment of compliance will be recorded as met, partially met or not met.

The findings of the inspection were provided to the service at the conclusion of the inspection.

6.0 The Inspection

6.1 Review of Recommendations from the Most Recent Inspection Dated 23 June 2015

The most recent inspection of Erne Ward was an unannounced inspection. The completed Quality Improvement Plan (QIP) was returned and approved by the inspector who conducted the inspection. The QIP identified three recommendations for improvement. This QIP will be validated by the Lead inspector at the next inspection.

Recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 5.3.3(d) **Stated:** Second Time	It is recommended that the ward manager ensures that nursing staff receive infection control training in accordance to Trust standards and a record of training is maintained.	**Met**
	Action taken as confirmed during the inspection: Inspectors reviewed the training records and confirmed all staff had received up-to date infection control training.	
Recommendation 2 **Ref**: Standard 5.3.1 (e) **Stated:** Second Time	It is recommended that the Trust reviews the use of mental framed beds. This review should also be reflected in the ward's ligature risk assessment.	**Partially Met**
	Action taken as confirmed during the inspection: During the inspection, metal frame beds were in use for two patients which were appropriate to the patients' need. However there was no ward ligature risk assessment.	
Recommendation 3 **Ref**: Standard 5.3.1 (f) **Stated:** First Time	It is recommended that the ward gardens are properly maintained to include regular weeding, pruning and tidying.	**Met**
	Action taken as confirmed during the inspection: Inspectors viewed the ward's gardens during the inspection. One garden did have weeds growing through a small number of slabs and underneath a garden seat. However a patient who had access to this garden and who enjoyed gardening was tending to this garden with support. The other gardens were very well maintained.	

6.2 Is Care Safe?

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

Areas of Good Practice

There was evidence in the care documentation reviewed that staff consulted with carers about the care and treatment of patients.

Staff reported to inspectors that they knew how to raise and if necessary, escalate concerns to senior management about environmental safety, patient safety or the level of care provided to patients.

All staff reported that they do not work beyond their role, experience and training.

Staff informed inspectors of how consent was obtained. Staff could distinguish the difference between informed consent and implied consent and when best interests meetings were held for those patients who were assessed as lacking capacity to give consent.

Areas for Improvement

A significant number of areas that were highlighted in the 2015 Fire risk assessment had not been actioned or completed. The fire evacuation plan was assessed as inadequate. A number of personal emergency evacuation plans were not up to date and did not take account of the changing needs of patients or new patients admitted to the ward. During the inspection the fire alarm sounded. Inspectors observed that there was a lack of guidance and direction given to staff that came from other wards to assist. Emergency exits were blocked with disused or broken furniture.

The standard of the health and hygiene of the ward were unsatisfactory. The ward appeared cluttered and cleaning materials were evident throughout the ward. Bathroom hygiene was unsatisfactory. Cleaning schedules were not adhered to and were insufficient and all staff were not aware of their role and responsibilities in relation to health and hygiene.

Some windows did not have appropriate coverings to safeguard patient's dignity or privacy.

The ward did not have a ligature risk assessment or action plan completed. Inspectors asked to see the ward's ligature risk assessment. The deputy ward manager shared with inspectors a copy of an email which evidenced a request to have a ligature risk assessment completed. In the reply email, the estates officer outlined that in their opinion *"as the ward was classed as a re-settlement ward, the patients would not be of a high risk of self- harm of strangulation. The units the patients would be going to in the community would not have anti-ligature fixtures or fittings …also the nature of patients would not lend to pre-plan self-harm by strangulation"*.

There was no specific ward environmental risk assessment for Erne Ward.

The resuscitation trolley and other emergency equipment had not been checked in accordance with the Trust's policy.

Staff reported that there were times when the ward was short staffed.

There were a number of ill-fitting mattresses on beds.

Signage throughout the ward did not meet the communication needs of patients.

On the days of inspection some gardens did not have adequate seating or shelter.

Three members of nursing staff did not know the needs of two patients even though they had been admitted to the ward within the previous three months. Staff could not inform inspectors about the patient's care plans.

A number of patient records were not stored securely (although they were in a locked office).

Patient hygiene and body charts were held in bathrooms and were not securely locked away and could be accessed by anyone. Some charts were in the wrong patient's file. There was no evidence of charts being audited, analysed or reviewed by registrants.

Financial records were not stored in any systematic manner or in a designated place. Adherence to the Trust's financial record keeping policy was not always observed.

6.3 Is Care Effective?

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

Areas of Good Practice

Patients who required specialist assessments were referred to the appropriate professional and records evidenced this.

The care records reviewed, evidenced that the need for the use of restrictive practices, including deprivation of liberty, restraint and seclusion was based on individualised assessment of need.

Areas for Improvement

The electronic system (PARIS) for recording information proved challenging to navigate for some staff and not all staff were recording information in the same section. This impacted on the care delivered as some staff did not know patient specific information and did not know where to look for it.

The three assessments that were reviewed were not up-to date and did not reflect of the changing needs of each patient.

Care plans were not always up to date in line with the changing needs of patients. There were inconsistencies between progress notes and care plan recordings of reviews having taken place. Care plans did not contain specific, detailed information to ensure any new staff coming onto the ward could deliver appropriate and effective care to patients. Progress notes and review recordings did not identify the effectiveness of any pain relief, treatment or behaviour support plans. Care plans were not updated with information from specialist multi-disciplinary assessments e.g. physiotherapist. There was no evidence of evaluation in care documentation.

Patients who were prescribed medication for pain not have an evidenced based pain scale assessment completed.

All risk assessments which were reviewed by inspectors were not reviewed in line with current Promoting Quality Care: Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disabilities Services May 2010.

Multi-disciplinary hard copy files were disorganised and difficult to navigate. Some papers were not secured in the file appropriately.

6.4 Is Care Compassionate?

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

Areas of Good Practice

Patients had the opportunity to attend daily activities. All patients could attend day care or go on outings.

Patients had free access to an outside and quiet space and there was a private space available for relatives and visitors to meet with their family member. Staff were committed to ensuring patients had contact with their family and supported patients with home visits when staffing levels permitted.

Meal times are protected and there was a good menu choice.

An aroma therapist and music therapist visit the ward on a weekly basis.

Areas for Improvement

Not all staff wore their name badge and there was no accessible information on display to inform patients who was on duty, or who their named nurse was. There was no information about daily activities.

Curtains and blinds were broken or dishevelled and needed repair or replaced. Some beds did not have duvet covers on or pillows.

It was extremely warm on the first day of inspection. One patient was observed to be wearing a heavy woollen jumper and another was observed to be wearing a sweatshirt. Despite windows being open there was little air flow and rooms were hot. Inspectors drew attention to the clothing attire of patients who appeared to be inappropriately dressed according to the weather. This resulted in one patient being assisted to change into more appropriate clothing.

During the inspection the fire alarm sounded. A patient was observed to be distressed. No-one went to reassure the patient. It was noted in the patient's care records that they became distressed at loud noises. Post incident the inspectors made comment to staff and staff offered the patient reassurance and support.

Staff reported that when staffing numbers were low that they find it difficult to respond to requests from patients to get them a drink as this required them to leave a communal area where they were supervising a group of patients. Staff also reported that a number of activities or planned events were cancelled as a result of staff shortages on the ward.

Relatives stated that they would like advanced information on the purpose of meetings to enable them to prepare for meetings.

6.5 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

All staff who spoke to inspectors were able to identify how they would escalate concerns in relation to safeguarding, child protection, escalation and whistleblowing and stated they were aware of their direct lines of accountability and of the organisational management structure.

There was a recent service improvement initiative whereby the Trust agreed to have a General Practitioner session to carry out chronic disease management – epilepsy, diabetes, COAD etc. This post was funded and a job description agreed. RQIA welcome this initiative.

There was good medication and medical care governance arrangements and audits in place.

There was governance oversight of patient discharge plans and evidence of multi-disciplinary collaboration to enhance discharges. However this was dependent on community resources such as supported living or nursing home placements.

Areas for Improvement

There was no information displayed about the ward's performance in relation to incidents accidents, compliments or complaints.

Given the communication challenges and the profile of the patient population within Erne, patients would need the support of relatives and advocacy services to assist them in providing

feedback about their experiences. Whilst access to an advocacy service was available onsite there was no input from advocacy service to the ward.

There was no minutes of patient forum meetings available to evidence the ward was addressing any areas for improvements by patients, carers or their advocates.

Staff training records were not easily accessible for ward management to have oversight of training completed or to assist in planning.

Staff roles and responsibilities in relation to cleaning duties between ward staff and cleaning staff were not clear.

Health care assistants stated they were not asked for feedback on patients that they were supporting and/or providing direct care to every day. Therefore this information could not be included in patient progress notes.

Staffing levels on the ward did not reflect the needs of patients on the ward. There were six areas on the ward requiring staff presence. Health care assistants reported that they are frequently left to supervise patients or groups of patients without oversight from qualified nurses. They further reported that they are unable to leave those areas to respond to individual requests or needs due to the supervision needs of the patient group. In addition health care assistants also reported that there has been a lack of support from qualified nurses when supervising patients who present with challenging behaviour.

The Maximiser audit tool outcome did not accurately reflect the environmental cleanliness of the ward.

There was an anomaly in the information provided to inspector regarding supervision as per Trust's policy. This did not reflect what staff told inspectors.

7.0 Provider Compliance Plan

Areas for improvement identified during this inspection are detailed in the Provider Compliance Plan. Details of the Provider Compliance Plan were discussed with the deputy ward manager and senior managers of the Trust, as part of the inspection process. The timescales commence from the date of the inspection as detailed in the Provider Compliance Plan.

The responsible person should note that failure to comply with the findings of this inspection may lead to further escalation action being taken. It is the responsibility of the responsible person to ensure that all areas identified for improvement within the provider compliance plan are addressed within the specified timescales.

7.1 Areas for Improvement

This section outlines recommended actions, to address the areas for improvement identified, based on research, recognised sources and best practice standards. They promote current good practice and if adopted by the responsible person may enhance service, quality and delivery.

7.2 Actions to Be Taken By the Service

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

Provider Compliance Plan Erne Ward	
Priority 1	
Area for Improvement No.1 **Ref**: Quality Standard 5.3.1 (e) **Stated:** First Time **To be completed by:** 18 August 2016	The responsible person must ensure that: All urgent actions identified in the fire risk assessment are addressed. Patient's personal emergency evacuation plans are updated and regularly reviewed. Staff are aware of and can respond appropriately to each patient's individual needs in the event of a fire. Staff that come to assist in the event of a fire are given clear guidance and direction. Emergency exits are free from obstruction.
	Response by Responsible Person Detailing the Actions Taken: In response to this area of improvement the responsible person(s) has addressed the urgent issues in fire risk assessment, an action plan is in place with agreed review dates for the other issues. Patient's personal emergency evacuation plans have been reviewed and updated. A further review takes place if there is a change in the patient's needs. A walk talk fire drill took place in the ward on 26th August 2016 by the Trust Designated fire officer to ensure staff were aware of and can respond appropriately to each patient's individual needs in the event of a fire. Patient's personal emergency evacuation plans have been shared with all staff at staff meetings. Fire safety is a standing agenda item at ward meetings. Guidance for staff attending fire alarms has been devised and shared with all staff in the hospital. Emergency exits have been freed from obstruction, fire checks are undertaken daily. If an issue is highlighted, this is reported and acted on.
Area for Improvement No.2	The responsible person must ensure the resuscitation trolley and other emergency equipment is checked in accordance with the Trust's policy

Ref: Quality Standard 5.3.1 (f) **Stated:** First Time **To be completed by:** 28 July 2016	**Response by Responsible Person Detailing the Actions Taken:** In response to this area of improvement, the responsible person ensures the resuscitation trolley is checked daily and all emergency equipment is checked in accordance with the Trust's policy. This is monitored by the ward sister and reported on monthly as part of the Ward Sister/operations manager monitoring report.
Area for Improvement No.3 **Ref**: Quality Standard 5.3.1 (f) **Stated:** First Time **To be completed by:** 18 August 2016	The responsible person must ensure that: The hygiene, maintenance and tidiness of the ward are improved and maintained to a satisfactory level. Patient's privacy, dignity and comfort are upheld and enhanced by the provision of appropriate, clothing, soft furnishings, window coverings, mattresses and garden shelter.
	Response by Responsible Person Detailing the Actions Taken: In response to this area of improvement, a full environmental review has been completed and included Estates, PCSS, Nursing and senior management. The ward has been thoroughly cleaned and an action plan has been developed which has reviewed and updated cleaning schedules for nursing and support services staff; this will be reviewed monthly by the ward sister and operations manager to ensure hygiene standards are fully maintained. The programme of environmental improvements that had been requested through the minor capitol works has now been completed. Patient's privacy, dignity and comfort has been reviewed. An assessment of the patient's ability to select appropriate clothing is included in each person's care plan and where assistance is required, this is documented. Appropriate Soft furnishings have been purchased. Appropriate window coverings and new better fitting mattresses have been ordered to replace what is currently in place. New garden furniture has been acquired and shelter provided when required.
Area for Improvement No.4 **Ref**: Quality Standard	The responsible person must ensure staffing levels in Erne Ward reflect the needs of the patients, to include safe supervision, address the environmental design and ensure patients have access to planned activities.

5.3.3 (d) **Stated:** First Time **To be completed by:** 18 August 2016	**Response by Responsible Person Detailing the Actions Taken:** In response to this area of improvement, the responsible people have completed a thorough review of the staffing roster. This review has reflected the assessed needs of the patients and environmental design of the ward. It also provides the minimum staffing levels in the event of ad hoc absence or vacancies pending or long term sick leave. The ward sister continues to monitor the needs of the patients and will provide regular updates in the event of changing patient profile or changes in patient numbers on the ward and submit to the operations manager and duty nursing office. If staffing is not available to meet the assessed minimum staffing levels following all required actions taken to fill shift gaps on the roster, this will be escalated through line management and a datix incident form will be completed. It has been recognised the patient numbers have recently increased due to the internal transfer of patients to this ward The management and leadership capacity on the ward has been reviewed and a second deputy ward sister appointed. Activities for the patients are held on the ward and are also supported through daily access to the hospital therapeutic day services.
Area for Improvement No.5 **Ref**: Quality Standard 5.3.1 (a) **Stated:** First Time **To be completed by:** 18 August 2016	The responsible person must ensure: Assessments, care plans and risk assessments are thorough, up-to-date, reflect changing needs and specialist assessments; Care plans are evaluated, reviewed and recorded in a timely manner in accordance to trust, regional policies and professional guidance; Progress notes are accurate, complete and are easily accessible to all staff delivering care.
	Response by Responsible Person Detailing the Actions Taken: In response to this area of improvement, The Trust has reviewed the management of the ward and has appointed a second deputy ward Sister. Assessments, care plans and risk assessments are audited in a timely manner and issues addressed. This will ensure assessments, care plans and risk assessments are thorough, up-to-date and reflect changing needs and specialist assessments if required. Care plans are evaluated, reviewed and recorded in a timely manner in accordance with trust, regional policies and professional guidance. Progress notes are accurate, complete and are easily accessible to all staff delivering care. The ward sister has ensured staff who require additional support to complete care records have access to further training as required in

	Paris and IT recording to enable competent completion of care documentation.
Area for Improvement No.6 **Ref**: Quality Standard 5.3.1 (c) **Stated:** First Time **To be completed by:** 18 August 2016	The responsible person must ensure that patient financial transactions are in accordance with Trust policies and procedures.
	Response by Responsible Person Detailing the Actions Taken: In response to this area of improvement a checklist has been devised and is now in place on the ward. This includes ensuring patient financial transactions are checked twice daily.
Priority 2	
Area for Improvement No.7 **Ref**: Quality Standard 6.3.2 (a) **Stated:** First Time **To be completed by:** 30 November 2016	The responsible person must ensure patients have; • Access to advocacy on the ward. Advocates should take into consideration the communication support needs of the patients • Patient representative forum meetings which are recorded and ensure all actions identified are followed up
	Response by Responsible Person Detailing the Actions Taken: In response to this area of improvement, patients continue to have access to advocacy services when required. All patients have a referral to advocacy in place, the advocate will then meet with the patient and assess their needs in relation to advocacy services, if this includes communication support needs, this will be considered. Advocates routinely attend monthly resettlement meetings. The patient forum is now in place on a bi monthly basis. Minutes of patient forum meetings are taken; actions identified and included in the agenda of the next meeting for follow up. A staff nurse has been allocated the responsibility of co-ordinating the patient forum meetings. The advocates are invited to the bi -monthly patients forum.
Area for Improvement No.8 **Ref**: Quality Standard 6.3.2 (a, b & c)	The responsible person must ensure patients have information in a format that meets the communication needs of patients to; • assist in orientation around the ward • know who is on duty and;

Stated: First Time **To be completed by:** 30 November 2016	• what activities are on offer
	Response by Responsible Person Detailing the Actions Taken: In response to this area of improvement, Speech and Language Therapy have helped develop signage throughout the ward to assist in orientation around the ward. A white board has been ordered for the front hall to record staff on duty. In addition to this, staff that are on duty are also displayed in patient areas. All patients have an individual activity schedule. Speech and Language Therapy are working with ward staff to develop an activity schedule that is in a format that meets the communication needs of patients.
Area for Improvement No.9 **Ref**: Quality Standard 5.3.1 (f) **Stated:** First Time **To be completed by:** 30 November 2016	The responsible person must ensure that patient records and files and are managed and stored in accordance with Trust and Data protection policies and procedures and Nursing Midwifery Council Guidance on record keeping.
	Response by Responsible Person Detailing the Actions Taken: In response to this area of improvement, the ward Sister has robustly addressed with registrants to ensure that patient records and files are managed and stored in accordance with Trust and Data protection policies and procedures and Nursing Midwifery Council Guidance on record keeping. Guidance has been reissued to all members of the MDT regarding appropriate filing in the MDT file. All MDT files are being put in order and filed in accordance with Trust and Data protection policies and procedures and Nursing Midwifery Council Guidance on record keeping. The ward sister will monitor compliance as part of the monthly ward audit processes.
Priority 3	
Area for Improvement No.10 **Ref**: Quality Standard 5.3.1 (f) **Stated:** First Time **To be completed by:** 30 November 2016	The responsible person must ensure that the ward's performance is audited and outcomes are displayed for patients' carers, relatives and staff.
	Response by Responsible Person Detailing the Actions Taken: In response to this area of improvement, there is a ward notice board indicating the number of complaints, safeguarding incidents, accidents, details of next patient forum etc
Area for Improvement No.11 **Ref**: Quality Standard 6.3.2 (b)	The responsible person must ensure relatives are informed in advance of the purpose of meetings

Stated: First Time **To be completed by:** 30 November 2016	**Response by Responsible Person Detailing the Actions Taken:** In response to this area of improvement The Trust sends a letter to relatives prior to the meeting, inviting them to attend. The nature of the meeting will be included and explained in the letter as well as a named contact and a contact number if any further information is required prior to attending.
Area for Improvement No.12 **Ref**: Quality Standard 5.3.1 (e) **Stated:** Second Time **To be completed by:** 30 November 2016	The responsible person must ensure there is a ward specific environmental assessment completed and an action plan is completed which should include a timeframe / responsible person for action.
	Response by Responsible Person Detailing the Actions Taken: In response to this area of improvement, a ward specific environmental ligature risk assessment for the ward was completed in July 2016. Actions identified have an action plan which includes a timeframe and responsible person for action.

Name of person completing the provider compliance plan	Helen Burke		
Signature of person completing the provider compliance plan	Helen Burke	**Date completed**	18th October 2016
Name of responsible person approving the provider compliance plan	Martin Dillon		
Signature of responsible person approving the provider compliance plan	Martin Dillon	**Date approved**	18th October 2016
Name of RQIA inspector assessing response	Cairn Magill		
Signature of RQIA inspector assessing response	Cairn Magill	**Date approved**	26 October 2016

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