The Regulation and Quality Improvement Authority

Gillis Memory Centre

St. Luke's Hospital

Southern Health and Social Care Trust

Unannounced Inspection Report

2 – 6 November 2015

npm national preventive mechanism

Ward Address: Gillis Memory Centre
St. Luke's Hospital
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Our Vision, Purpose and Values

Vision

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

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

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

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

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

Contents

1.0 Introduction

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

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

Is Care Safe?

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

Is Care Effective?

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

Is Care Compassionate?

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

2.0 Inspection Outcomes

This inspection focussed on the theme of

Person Centred Care

This means that patients are treated as individuals, with the care and treatment provided to them based around their specific needs and choices.

On this occasion Gillis Memory Centre has achieved the following levels of compliance:

Is Care Safe?	**Partially met**
Is Care Effective?	**Met**
Is Care Compassionate?	**Met**

3.0 What happens on Inspection

What did the inspector do:

- reviewed information sent to RQIA before the inspection
- talked to patients, carers and staff
- observed staff practice on the days of the inspection
- reviewed other documentation on the days of the inspection
- checked on what the ward had done to improve since the last inspection

At the end of the inspection the inspector:

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

After the inspection the ward staff will:

- send an improvement plan to RQIA to describe the actions they will take to make the necessary improvements
- send regular update reports to RQIA for the inspector to review

4.0 About the Ward

Gillis Memory Centre is a 24 bedded mixed gender ward. The ward provides assessment and treatment to patients who have a diagnosis of dementia or have a presentation suggesting dementia with associated behaviours that are challenging. There is no age barrier to admissions.
On the day of the inspection there were 13 patients on the ward includingone patient who was admitted to an acute general hospital. There were no patients detained in accordance with the Mental Health (Northern Ireland) Order 1986. The multi-disciplinary team included three consultant psychiatrists, a staff grade doctor, nursing staff, an occupational therapy assistant and a pharmacist. A patient advocacy service is also available. The ward manager was in charge on the day of the inspection.

5.0 Summary

5.1 What patients, carers and staff told inspectors

During the inspection patient representatives were asked to complete questionnaires. **7** patient representatives returned completed questionnaires.

During the inspection the inspector was able to meet with:

6 patients
7 carers
7 staff

Patients told inspectors that:
Although they wanted to go home, they were happy with their care and treatment. Patients stated the staff were “friendly and nice”. Patients indicated that staff were approachable. Patients stated the food was good and the environment, although could be noisy at times was generally comfortable.

Relatives told inspectors that:
They were very happy with their relatives care and treatment. Relatives were very complimentary about the staff working on the ward. Relatives stated that staff were approachable and listened. Relatives confirmed they were involved in decisions about care and treatment. All relatives stated that their family member’s privacy and dignity was respected. Relatives although aware of the prognosis felt that the admission to Gillis Ward had helped their family member. Their family member was generally more settled and improvements were noted for two patients in relation to mobility since admission.

Relative’s quotes;

"Gillis Memory Centre is a centre of excellence. The staff are so caring and helpful, nothing is a bother, and my husband is looked after so well. I cannot thank them enough. They are very special people."

"As a family we are delighted with all the aspects of Gillis, the staff are like our family, they are so good to our mum, in all ways. We don't worry about leaving mum because we are content in the knowledge that mum is in good hands. Thank you."

"I found the staff excellent; they kept me informed of my father's progress throughout his stay in Gillis ward."

"Care is second to none, staff know how to engage, stay calm, and know how to deal when patients are unsettled and agitated."

Staff told inspectors that:

They felt well supported and valued. Staff enjoyed working on the ward and that there was good multi-disciplinary team work. Staff demonstrated their knowledge and skills in caring for people who have dementia, are confused, and present with behaviours that challenge. Staff all stated they were offered plenty of opportunities for professional development and were encouraged to share new learning with the rest of the team. Staff highlighted the challenges around patient discharge and the difficulties due to poor liaison from the community staff. Staff stated that they spend a considerable amount of time "chasing up" community staff in order to process patient's discharge and this can take away from time spent with patients.

5.2 What inspectors saw during the inspection

The ward was clean and tidy. The ward environment was adapted to be as dementia friendly as possible and was spacious which allowed patients to move around independently. Signage was good and helped patients with orientation. There were quiet areas for patients to retreat to. The garden area was therapeutic and had won the Southern Health and Social Care Trust Best Garden Award 2015.
Information was displayed in relation to the wards performance, compliments, patient / relative experience and areas for improvement.
The ward had a welcoming and relaxed atmosphere and staff were friendly and approachable. Staff were observed to be in the communal areas at all times during the inspection. Staff were observed reassuring patients who were distressed. Activities were offered and staff actively encouraged patients to participate andstaff maintained a calm, low stimulus environment. Patients were treated with dignity and privacy was respected. Staff were considerate to visitors and answered questions promptly.

Further detail is contained in the ward physical environment observational tool / checklist and the Quality of Interaction Schedule (QUIS).
See attached Appendices 2 and 3.

5.3 Key outcomes

5.3.1 Is Care Safe?

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

Compliance Level	**Partially met**

See appendix 4 for details.

What the ward did well

- ✓ Promoting quality risk screening tools had been completed by the multidisciplinary team.
- ✓ Risk management plans were incorporated and formed part of the patients Person Centre Plan of Nursing Care.
- ✓ Risk management plans were reviewed and updated if required every week by the multi-disciplinary team.
- ✓ Risk management plans were individualised, actions recorded were appropriate and addressed each risk identified.
- ✓ The management of risks focused on personal strengths. Patients had an "About me" booklet, completed by their relatives. The information from the booklet was used to inform care plans. The information was also used to maintain health, well-being and independence particularly in relation to safety and mobility.
- ✓ The Person Centre Plan of Nursing Assessment included a section which prompted staff to complete a care plan in relation to the risks associated with using a profiling bed.
- ✓ The ward was spacious, clean and comfortable
- ✓ There was a room for patients to meet with their relatives in private.

- ✓ There were enough staff available during the inspection to meet the needs of the patients in the ward.
- ✓ The number of falls / pressure areas were collated every month and sent to patient safety officer, this was audited and results returned to the ward. This information was displayed on the ward and discussed at the monthly staff meeting.
- ✓ A monthly audit report was completed by the ward support and included nursing quality indicators and nursing quality clinical indicators – the outcomes were discussed at the monthly staff team meeting.
- ✓ The ward has good administration support. The staff member was an integral member of the team.
- ✓ All staff interviewed stated that they had knowledge of safeguarding vulnerable adult's processes and the management of accidents and incidents.
- ✓ Family members confirmed they knew how to make a complaint.
- ✓ All staff had received up to date mandatory training.
- ✓ There was a good system in place to manage staff training.
- ✓ All staff interviewed felt well supported and valued as a member of the team.
- ✓ There was a robust system in place to review, manage and ensure staff supervision was up to date.
- ✓ Nursing staff had attended regular supervision meetings with their line manager in the last year.
- ✓ 75% had received an annual appraisal. A plan was in place and dates identified in November for the remaining staff.
- ✓ The multi-disciplinary team has been agreed and will be increasing to include a psychologist and social worker. The staff teamhave been consistent for some time..
- ✓ There was a full time staff grade doctor who provides medical cover 9am – 5pm Monday – Friday.
- ✓ Practice development is actively encouraged on the ward.
- ✓ Complaints are managed appropriately, reviewed, discussed at staff team meetings. Information was available on how to make a complaint.

- ✓ Staff were observed to respond promptly when help was needed.
- ✓ Intra Muscular Pro Re Nata medication was not routinely used.

Areas for improvement

- ✓ **Risk assessments**

Promoting Quality Care risk screening tools had not been signed by carer and patient and the reason for this was not recorded. *Quality Standard 5.3.3 (b)*

- ✓ **Staff supervision**

The administration staff had not received supervision since they commenced employment several years previously. *Quality Standard 4.3 (i)*

- ✓ **Medical cover**

There is a degree of isolation as Gillis Memory Centre is the only ward left on the St Luke's Hospital site. The current provision for out of hours medical cover is obtained by contacting the Bluestone Duty doctor at Craigavon hospital. *Quality Standard 6.3.1 (a)*

- ✓ **Policies and procedures**

Clinical supervision policy and complaints management was out of date. *Quality Standard 5.3.1 (f)*

- ✓ **Safeguarding Vulnerable Adults**

The ward manager was noted to be the investigating officer (IO) in a vulnerable adult investigation in relation to a concern about their ward. This is contrary to regional VA policy and procedures. *Quality Standard 5.3.1(c)*

5.3.2 Is Care Effective?

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

Compliance Level	Met

See appendix 5 for details.

What the ward did well

- ✓ Relatives were involved in their family member's assessments and care plans.
- ✓ Relatives confirmed they are fully involved in any decision relation to their family members care and treatment.
- ✓ Health Care Assistants were recording the care they delivered in the progress notes.
- ✓ There was a sense of openness and transparency with information displayed on the ward i.e. number of falls, accidents and incidents, complaints.
- ✓ Assessments and care plans were person centred, and holistic.
- ✓ Care plan goals were clearly, specific, measurable, enabling and timely.
- ✓ Patients progress, health and well-being, care and treatment was evaluated every day.
- ✓ Care plans were reviewed every week and updated with changes in each patient's health and well-being needs.
- ✓ All of the multi-disciplinary team, including visiting professionals i.e. physiotherapy, speech and language therapy, tissue viability updated patient's care plans.
- ✓ Ward rounds were held every week
- ✓ Relatives confirmed that the admission had helped their family member.
- ✓ Improvements had been noted in the ward environment in relation to restrictions. Whilst ensuring patients safety and appropriate levels of security, the environment was open and patients experienced the least restrictive environment possible.
- ✓ The ward does not use lap belts. The reason for controlled exit was reflected in the care documentation.
- ✓ Staff had considered appropriately how every care and treatment intervention may impact on the patient's human rights and deprivation of liberty.
- ✓ Patients care and treatment was reviewed every week by their consultant psychiatrist.

- ✓ Appropriate recreational activities were available every day which were co-ordinated currently by the occupational therapy assistant.

- ✓ Staff demonstrated their competence in supporting patients who were distressed, confused and disorientated. Staff promoted a low stimulus environment.

- ✓ Staff demonstrated their knowledge in caring for patients with dementia.

Areas for improvement

- ✗ **Personal well-being plans**

The ward round template was not always completed with the responsible person / team for completing the actions or a time frame. *Quality Standard 5.3.1 (a)*

- ✗ **Patient discharge**

In reach from community teams was poor. Patients who were also using the service for the first time may not have a community key worker allocated. There was poor attendance by staff from community teams, even leading up to patient's discharge. This resulting in ward staff spending time linking in with community teams, to gain information about the patient once admitted and sharing information when the patient was fit for discharge. *Quality Standard 5.3.1 (a)*

5.3.3 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

Compliance Level	**Met**

See appendix 6 for details.

What the ward did well

- ✓ Staff were compassionate and considerate.

- ✓ Staff maintained privacy and dignity.

- ✓ Staff supported patients who were distressed confused and disorientated with dignity, were discreet, remained calm and used appropriate communication to reassure patients.
- ✓ Staff sought consent to care delivery and respected patient's right to refuse.
- ✓ Relatives were complimentary about the staff and were satisfied with their family member's care and treatment.
- ✓ Relatives commented that staff were skilled in supporting patients who were distressed.
- ✓ Staff all wear name badges with first name only.
- ✓ Staff were observed using patients preferred name.
- ✓ Staff were available for visitors, relatives etc, promptly addressed any concerns, answered any queries and updated relatives on the progress of their family member
- ✓ Patient's spiritual and cultural needs were clearly identified in their assessments and needs addressed appropriately.
- ✓ Relatives get an appointment with consultant within two weeks of admission and can request an appointment at any time.

Areas for improvement

- ✘ There were no areas for improvement in relation to compassionate care identified during the inspection.

6.0 Follow up on Previous Inspection Recommendations

Nine recommendations were made following the last inspection on 21 May 2015. Inspectors were pleased to note that eight recommendations had been implemented in full. One recommendation was partially met and will require to be restated for a second in the Trust Improvement plan accompanying this report.

See appendix 1 for details.

7.0 Other Areas Examined

Whilst RQIA had no concerns about safe care on the ward, RQIA isconcerned about the degree of isolation which exists since this ward became the last in-

patient facility on the St Luke's site. Although there is adequate administrative infrastructure and pharmacy input, it is difficult to see how a ward with this patient group and its range of clinical needs can be sustained in this isolated environment in the longer term. The level of physical health care requirements is such that a unit of this nature should be ideally embedded within or very close to a general hospital with all the medical / surgical assessment and treatment infrastructure which would provide "around the clock" medical cover. The current provision using the duty doctor from Bluestone Unit out of hours or when the staff grade is unavailable does not appear to be sustainable in the longer term. RQIA wrote to the trust and requested the trusts plan to address this area of concern in order to ensure that patients have access to immediate medical care when it is required. The inspection team were informed by ward staff and at feedback that there is a proposal that Gillis Memory Centre will eventually move to the Bluestone site, although no timeline has been agreed for this transition

8.0 Next steps

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.

	Area for Improvement	Timescale for implementation in full
Priority 1 recommendations		
	There are no priority one recommendations	
Priority 2 recommendations		
1	Promoting Quality Care risk screening tools had not been signed by carer and patient and the reason for this was not recorded.	02/02/2016
2	The administration staff had not received supervision since they commenced employment several years previously.	02/02/2016
3	The ward manager was the investigating officer (IO) in a safeguarding vulnerable adult investigation on their ward.	02/02/2015
4	In reach from community teams was poor. Patients who were also using the service for the first time may not have community key worker. There was poor attendance from staff from community teams, even leading up to discharge. Resulting in ward staff spending time linking in with community teams, to gain information about the patient once admitted and sharing information when the patient was fit for discharge.	02/02/2016

Priority 3 recommendations		
5	There is a degree of isolation as Gillis Memory Centre is the only ward on the St Luke's site. The current provision for out of hours medical cover is obtained by contacting the Bluestone Duty doctor at Craigavon hospital.	02/05/2016
6	Clinical supervision policy and complaints management was out of date.	02/05/2016
7	The ward round template was not always completed with the responsible person / team for completing the actions or a time frame.	02/05/2016

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

Appendix 1 – Previous Recommendations

Appendix 2 – Ward Environmental Observation Tool

This document can be made available on request.

Appendix 3 – Quality of Interaction Schedule

This document can be made available on request.

Appendix 4 – Is Care Safe?

This document can be made available on request.

Appendix 5 - Is Care Effective?

This document can be made available on request.

Appendix 6 - Is Care Compassionate?

This document can be made available on request.

Appendix 1

Follow-up on recommendations made following the unannounced inspection of Gillis Memory Centre on 21 May 2015

No.	Reference.	Recommendations	Number of time stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	5.3.1 (a)	It is recommended that the ward manager ensures that all risk assessments are completed in accordance with the Promoting Quality Care –Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (May 2010).	2	The inspector reviewed care documentation in relation to four patients. A Promoting Quality Care Risk screening tool had been completed in all four sets of care documentation reviewed. These were noted to have been completed in accordance with the Promoting Quality Care –Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services. The screening tools had been completed by the multi-disciplinary team and the decision about whether risks were to be managed through a comprehensive risk assessment or by a multi-disciplinary team care plan were recorded. In all four files reviewed, the decision to manage risks through the multi-disciplinary care plan was recorded. In these instances the inspector noted that the risks identified were recorded in the patients care plans and there was evidence of carer involvement in the completion of these.	Met
2	5.3.1 (f)	It is recommended that the ward manager completes regular audits of the care documentation to ensure accurate up to date information is recorded on the care the patients are receiving on the ward in accordance with,	2	The inspector noted that information recorded in the four sets of care documentation reviewed was accurate and up to date. The inspector noted that an audit, using the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC), of the care documentation	Met

		Good Management, Good Records, (DHSSPS) December 2014 guidelines		was completed every week by the ward manager. The ward manager stated that an external audit if the care documentation was completed in August 2015. The ward manager had not received formal feedback from this audit but stated verbal feedback was positive and staff addressed any improvements during the audit.	
3	5.3.1 (f)	It is recommended that the ward manager reviews the MDT template to ensure it reflects patients' attendance at MDT meetings. If patients have not attended this should be documented to explain their absence.	1	The inspector evaluated the multi-disciplinary team meeting minutes in the four files reviewed and noted that these reflected if patient attended or not. The minutes included if the patient was invited, refused to attend or was unable to attend. It was recorded where a patient did not attend that the consultant met with the patient following the meeting.	Met
4	5.3.1 (a)	It is recommended that the ward manager ensures patients assessed needs are indicated in a care plan to direct staff on the ward and when patients are reassessed by other professionals on the ward with further recommendations that a care plan is developed to reflect the care and treatment for the patient	2	In the four sets of care documentation reviewed the inspector noted that patients had been referred and reassessed by another professional not from the ward team i.e., speech and language therapy, physiotherapy, tissue viability and/or dietetics. The inspector noted that each of the professionals had recorded their assessment and had made amendments to the patients care plan. All care plans reviewed were noted to be relevant and up to date.	Met
5	5.3.1 (a)	It is recommended that the ward manager ensures that all information received pertaining to the care and treatment of the patients on the ward is reflected in the patients care plans and this includes updated information received from patient's relatives	2	The inspector reviewed care documentation in relation to four patients. There was evidence of the involvement of patient's relatives and carers in the patient's assessment and care plans. Relatives and carers had also completed an "About me" booklet. The information from the booklet was also used to complete the assessment and care	Met

		and carers to ensure patients are provided with the appropriate care on the ward.		plans. Relatives interviewed stated they were involved in any decisions in relation to their family members care and treatment and had the opportunity to meet with the consultant psychiatrist. There was evidence of relative's signatures in all of the care plans reviewed.	
6	5.3.1 (f)	It is recommended that the ward manager ensures that all staff record a detailed account of the multi- disciplinary ward round meetings in the ward round template . Each section of this template should be completed in full to include who was in attendance, what the outcome of the meeting was, medical, nursing, occupational therapy and social work input and family/patients views. This template should be signed by all members of staff and family members/patients who were at the meeting. Signatures should be recorded with the staff members full name.	2	There was evidence in the four sets of care documentation reviewed that the multi-disciplinary team ward round template had been completed and reflected who was in attendance, the outcome of the meeting was also recorded. Signatures of all attending the meeting were recorded. The inspector noted that in two sets of minutes the family views were not recorded, however on the review of the care documentation, there was evidence that family / patient's views were sought and discussed at the ward round. This was addressed with the ward manager during the inspection.	Met
7	5.3.1 (a)	It is recommended that the ward manager ensures patients have an individualised therapeutic and recreational activity care plan in place which has been developed from their 'personal profile assessment' and their 'person centred nursing assessment.	2	In the four sets of care documentation reviewed the inspector noted that each patient had an individualised therapeutic and recreational care plan in place. This was noted to have been developed from their assessment and the patients "About Me" booklet completed by the patient's relatives.	Met

8	5.3.1 (a).	It is recommended that the occupational therapist (OT) ensures that patients have assessments completed and from these assessments an individualised therapeutic/recreational activity plans should be devised with goals for patients to work towards. A record should be maintained of the patients' participation and progress in toward these goals.	1	The inspector noted that none of the patients reviewed had an assessment completed by the occupational therapist. The occupational therapist (OT) was on maternity leave during the inspection. However an occupational therapy assistant was available time on the ward and thisincluded weekend cover. The OT assistant had completed a weekly list of activities that covered four categories; exploratory, reflex, planned and sensory levels. These activities included the length of time each patient participated, the level of enjoyment, the level of participation, any redirection each patient needed and any other comments. A daily record was maintained of the patient's participation and progress. It was noted that when the OT assistant was not on duty, staff on the ward provided activities. Staff members all recorded patients participation and progress in relation to activities in their care documentation. The ward manager stated an OT has been identified to cover maternity leave and should commence as soon as their employment checks have been completed. This recommendation will be restated for a second time in the Trust Improvement Plan accompanying the report.	Partially met
9	6.3.2 (c)	It is recommended that the ward manager ensures that information relating to the detention process, the Mental Health Review Tribunal, the	2	The inspector noted that information relating to the detention process, the Mental Health Review Tribunal, the complaints procedure, consent and capacity, human rights and the advocacy service was	Met

		complaints procedure, consent and capacity, human rights and the advocacy service is made available on the ward in a format suitable to patients individual needs so that they are able to understand the implication of their care and treatment		made available on the ward in a format suitable topatient's individual needs so that they are able to understand the implications of their care and treatment.	

HSC Trust Improvement Plan

WARD NAME	Gillis Memory Centre	WARD MANAGER	Sally Kennedy	DATE OF INSPECTION	2-6 November 2015
NAME(S) OF PERSON(S) COMPLETING THE IMPROVEMENT PLAN	Sally Kennedy & Rebecca Cullen		NAME(S) OF PERSON(S) AUTHORISING THE IMPROVEMENT PLAN	Miceal Crilly	

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 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 24 December 2015.

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? There were no priority one areas for improvement identified.				
Key Outcome Area – Is Care Effective? There were no priority one areas for improvement identified.				
Key Outcome Area – Is Care Compassionate? There were no priority one areas for improvement identified.				

Part B

Priority 2: Please provide details of the actions proposed by the Ward/Trust to address the areas identified for improvement. The timescale within which the improvement must be made has been set by RQIA.

Area identified for improvement	Timescale for improvement	Actions to be taken by Ward	Responsibility for implementation
Key Outcome Area – Is Care Safe? Risk assessments **Minimum Standard 5.3.3(b)** This area has been identified for improvement for the **first** time	2 February 2016	The risk assessment form has now been reviewed and amended to indicate the persons who have contributed to the completion of the risk assessment. Signatures record all those who contributed information at the time of admission. An added section is now in place to record that the family have been informed of the risks and allows for them to contribute any additional information in relation to risks. Signatures are obtained.	Ward Manager
Staff supervision **Minimum Standard 4.3 (i)** This area has been identified for improvement for the **first** time	2 February 2016	The ward manager will provide ongoing supervision for ward manager support staff . Administration manager will continue to provide support with KSF for this member of staff.	Ward Manager
Safeguarding vulnerable adults ***Minimum Standard 5.3.1 (c)*** This area has been identified for improvement for the **first** time	2 February 2016	Safeguarding Vulnerable adults Regional Policy 2015 is presently being revised. We will be following the new policy and procedures in relation to Designated and Investigating officers on receipt of new policy. Until this is available we will continue to liaise with the Trust Safeguarding team.	Ward Manager & Safeguarding team

Patient discharge **Minimum Standard 5.3.1 (a)** This area has been identified for improvement for the **first** time.	2 February 2016	Recruitment is at an advanced stage for Full time Social Worker for the ward. Confirmation of commencement date is 01/02/2016. Their role will include Liaising with the various teams to inform and ensure effective, timely discharges. This will aid effective communication between community and the ward multidisciplinary teams, in line with the Dementia Strategy **<u>Interface with Community Teams for discharge planning</u>** The introduction of PARIS information system to Gillis will improve the level of information available to them in relation to community involvement and will identify if the patient has a key worker. Paris will enable the ward staff to interrogate all information available including assessments, reviews, case notes, safeguarding issues ect. This will facilitate a mores seamless discharge process by involving the key people who are involved with a patient in the community. As of 14th December 2015 ICS are now facilitating discharges for placement, this will support a harmonised approach across the three localities. It is recognised that systems need to be refreshed with Gillis staff due to this change. A meeting will be set up with ICS, Memory Services, ICT and Gillis staff. Transfer from hospital protocol to be shared which is the agreed process across all hospitals regardless of which team in the community is involved. Currently if patients are known to the community Memory team, it is normal practise that the key worker shares relevant information and assessments on admission with Gillis staff. The key worker will also attend a discharge planning meeting when requested to do so.	Ward Manager & Dementia Services Co-ordinator
Key Outcome Area – Is Care Compassionate?			

There were no priority two areas for improvement identified.			

Part C

Priority 3: Please provide details of the actions proposed by the Ward/Trust to address the areas identified for improvement. The timescale within which the improvement must be made has been set by RQIA.

Area identified for improvement	Timescale for improvement	Actions to be taken by Ward	Responsibility for implementation
Key Outcome Area – Is Care Safe? Medical cover **Minimum Standard 6.3.1 (a)** This area has been identified for improvement for the **first** time	2 May 2016	Please see letter sent to Ms Nixon from Mr Francis Rice	Francis Rice
Policies and procedures **Minimum Standard 5.3.1 (f)** This area has been identified for improvement for the **first** time.	2 May 2016	**Complaints policy** Senior staff in Gillis Memory Centre raised this issue with the Clinical and Social Care Governance Department Mental Health Directorate on 16th December 2015 and who escalated it to the authors of the Trust Complaints Policy (ie Corporate Complaints Office and Assistant Director for Governance) that same day. The coporate Governance / Corporate Complaints Department have responsibility for reviewing this policy and issuing same throughout the Trust. **Supervision policy**	Corporate Governance /Corporate Complaints Office and Assistant Director for Governance. Coporate

		Senior staff in Gillis Memory Centre raised the issue with Nurse Governance, Coporate governance have responsibility for reviewing this policy and issuing same throuthout the Trust. It has been confirmed that there has been a regional discussion with the CNO and NIPEC have been asked to review nursing supervision in the context of Nursing Revalidation. NIPEC will facilitate the review and Trust staff will be invited to contribute to it.	Governance.
Key Outcome Area – Is Care Effective? Personal well-being plans **Minimum Standard 5.3.1 (a)** This area has been identified for improvement for the **first** time.	2 May 2016	The ward round template has been revised to indicate th name of the person/persons responsible to follow up on each action identified. These actions are then reviewed weekly at the Multidisciplinary team meetings. The regular audit of care documentation will ensure compliance.	Ward Manager
Key Outcome Area – Is Care Compassionate? There were no priority three areas for improvement identified.			

Part D

Outstanding Recommendations: Please provide details of the actions proposed by the Ward/Trust to address outstanding recommendations, identified at previous inspections. The timescale within which the improvement must be made has been set by RQIA.

Recommendation	Timescale for improvement	Actions to be taken by Ward	Responsibility for implementation
Key Outcome Area – Is Care Safe? There were no restated recommendations			
Key Outcome Area – Is Care Effective? It is recommended that the occupational therapist (OT) ensures that patients have assessments completed and from these assessments, individualised therapeutic/recreational activity plans should be devised with goals for patients to work towards. A record should be maintained of the patients' participation and progress in toward these goals **Minimum Standard 5.3.1 (a)** This area has been identified for improvement for the **second** time	2 May 2016	The band 6 OT backfill for maternity leave has commenced post on 30/11/15. All patients will have the necessary Manual handling and therapeutic activity assessments completed. Each patient will have an activity plan informed by these assessments which is reviewed weekly. A record is maintained of the patients participation in activities. .	O.T and Ward Manager
Key Outcome Area – Is Care Compassionate? There were no restated recommendations			

TO BE COMPLETED BY RQIA

Inspector comment (delete as appropriate)	**Inspector Name**	**Date**
I have reviewed the Trust Improvement Plan and any attached evidence and I am satisfied with the proposed actions Or I have reviewed the Trust Improvement Plan and any attached evidence and I have requested further information.		
I have reviewed additional information from the Trust and I am satisfied with the proposed actions		