Gillis Memory Centre

St Lukes Hospital

Southern Health & Social Care Trust

Unannounced Inspection Report

Date of inspection: 21 May 2015

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

Ward address: Gillis Memory Centre, St Lukes Hospital, Loughall Road, BT61 7NQ

Ward Manager: Sally Kennedy

Telephone No: 028 37412183

E-mail: team.mentalhealth@rqia.org.uk

RQIA Inspector: Audrey McLellan

Telephone No: 028 9051 7500

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.

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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 Purpose and Aim of this Inspection

To review the ward's progress in relation to recommendations made following previous inspections.

To meet with patients to discuss their views about their care, treatment and experiences.

To evaluate the type and quality of communication, interaction and care practice during a direct observation using a Quality of interaction Schedule (QUIS).

2.1 What happens on inspection

What did the inspector do:

- reviewed the quality improvement plan sent to RQIA by the Trust following the last inspection(s)
- talked to patients, carers and staff
- observed staff practice on the days of the inspection
- looked at different types of documentation

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 any necessary improvements

3.0 About the ward

Gillis Memory Centre is a 24 bedded mixed gender assessment and treatment ward on St Luke's hospital site for patients with dementia. The purpose of the ward is to provide assessment and treatment to patients over 65 years of age with memory problems who need to be assessed in an inpatient care environment.

On the day of the inspection there were 15 patients on the ward. There was one patient detained under the Mental Health (Northern Ireland) Order 1986. The multi-disciplinary team included three consultant psychiatrists, a doctor, nursing staff, an occupational therapist, an activity nurse and a pharmacist**.** A patient advocacy service is also available. The ward manager was in charge on the day of the inspection

4.0 Summary

Progress in implementing the recommendations made following the previous inspections carried out on 20 August 2013, 29 January 2014, and 6 and 7 January 2015 were assessed during this inspection. There were a total of 12 recommendations made following the last inspection.

Five recommendations had been implemented in full.

The inspector was pleased to note that the Trust was in the process of recruiting a psychologist to work as part of the multidisciplinary team. There was evidence that patients' capacity to consent to care and treatment was reviewed regularly. Discussions held with patients were recorded and the ward manager was completing regular audits of the multidisciplinary team template. All nursing assessments reviewed by the inspector were completed in full and deprivation of liberty care plans were in place which included a rationale to support the level of restriction in terms of proportionality and necessity.

Five recommendations had been partially met and two recommendations had not been met. These recommendations will be restated for a second time following this inspection.

Concerns were raised in relation to the availability of information in a format suitable to patients' individual needs. The updating of care plans when professionals had made recommendations in relation to patients' care and treatment. Risk assessments had not been completed in accordance with guidance, the multidisciplinary team template had been inconsistently signed by all in attendance and there were no individualised therapeutic and recreational activity plans in place.

A new recommendation has been made in relation to the ward manager reviewing the multidisciplinary team meeting (MDT) template to ensure that there is a record of patients' attendance at these meetings

A new recommendation has also been made in relation to the occupational therapist completing assessments and devising therapeutic/recreational activity plans from these assessments.

During the inspection the inspectors spoke to two patients. One of whom agreed to meet with the inspector to complete a patient experience questionnaire. This recorded the patient's experience in relation to the care and treatment they had received on the ward. Both of these patients made positive comments about how they had been treated on the ward.

4.1 Implementation of Recommendations

One recommendation which relates to the key question "**Is Care Safe**?" was made following the inspection undertaken on 6 and 7 January 2015

This recommendation concerned the completion of patient risk assessments in accordance to promoting quality care guidance. .

Despite assurances from the Trust, this recommendation had not been fully implemented. Risk screening tools in the four sets of care documentation reviewed were inconsistently completed. This recommendation will be restated for a **second time** in the quality improvement plan accompanying this report.

Nine recommendations which relate to the key question "**Is Care Effective**?" were made following the inspection undertaken on 6 and 7 January 2015. One of these recommendation had been made on the 20 August 2013 and restated on 29 January 2014 .

These recommendations were in relation to reviewing the composition of the multidisciplinary team (MDT) and the availability of psychologist psychotherapeutic interventions for patients on the ward, the inconsistent monitoring of patients' consent to care and treatment and poor record keeping in relation to MDT meetings. Meeting which had been held with patients had not always been recorded and concerns were raised in relation to the completion of nursing assessments. Recommendations were made in relation

to the updating of care plans from assessments completed by professionals and when information was received from relatives/carers. A recommendation was also made in relation to the absence of individualised therapeutic and recreational care plans

Four recommendations had been fully implemented.

- The Trust has reviewed the composition of the multidisciplinary team (MDT) and the availability of psychotherapeutic interventions for patients on the ward. Funding has been approved for a part-time psychologist to be part of the multidisciplinary team.
- Patients' capacity to consent to their care was monitored and reviewed regularly.
- Discussions/meetings held with patients were recorded in the patients' care documentation.
- Person centred nursing assessments reviewed by the inspector had been completed in full.

However, despite assurances from the Trust, five recommendations had not been fully implemented. All care plans reviewed had not been updated when professionals had made recommendations. The ward manager had not commenced audits of all care records, the multi-disciplinary team (MDT templates were not completed in full and patients did not have an individualised therapeutic and recreational activity plans in place. These recommendations will be restated for a **second time** in the quality improvement plan accompanying this report.

Two recommendations which relate to the key question "**Is Care Compassionate**?" were made following the inspection undertaken on 6 and 7 January 2015.

These recommendations concerned the availability of information in an easy ready format and the completion of deprivation of liberty care plans.

The inspector was pleased to note that one recommendation had been fully implemented.

- Individualised care plans were in place for each patient in relation to the deprivation of liberty they were experiencing on the ward.

However, despite assurances from the Trust, one recommendation had not been fully implemented. Easy read information was not available in relation to the detention process, the Mental Health Review Tribunal, the complaints procedure, consent and capacity and the advocacy service. However information was available in relation to the Human Rights Act. This recommendation will be restated for a **second time** following this inspection.

The detailed findings from the follow up of previous recommendations are included in Appendix 1.

5.0 Observation Session

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.

The inspector completed a direct observation 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.

Summary

The formal session involved observations of interactions between staff and patients/visitors. Four interactions were noted in this time period. The outcome of these interactions were as follows:

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

Overall the quality of interactions between staff and patients observed by the inspector were positive. Patients and nursing staff were observed sitting together in the communal areas. The atmosphere was relaxed and patients appeared to enjoy the tea party held in the afternoon. Staff were available and prompt in assisting patients throughout the day of the inspection

The detailed findings from the observation session are included in Appendix 3.

6.0 Patient Experience Interviews

One patient agreed to meet with the inspector to talk about their care, treatment and experience as a patient. One patient agreed to complete a questionnaire regarding their care, treatment and experience. None of the patients who met with the inspector had been detained in accordance with the Mental Health (Northern Ireland) Order 1986.

Responses to the questions asked were all positive.

The patient who spoke to the inspector stated that they had been well cared for on the ward and raised no concerns about their care and treatment.

The patient who completed the questionnaire stated the following

- Their admission to the ward was positive, staff introduced themselves and they were shown around the ward and were informed of their rights;
- Staff treated them with dignity and respect and they felt fully involved in their care and treatment. This included being updated regularly on how they were progressing;
- Staff listened to their views and they could refuse care and treatment. They advised that they refused to attend activities on the ward as "it's not their thing";
- They said they felt safe and secure on the ward;
- They felt being on the ward had helped them to recover.

Patients made the following comments:

"Great couldn't be better, it's a great place… it's like a 5 hotel, and the food is great";

"We had a tea party and I made the scones";

"Staff sit and talk to me when I'm worried";

"I had a bad back one morning and didn't want to get out of bed, the staff brought me my breakfast in bed….. in a tray";

The inspection was unannounced. No relatives or carers were available to meet with inspectors during the inspection.

The detailed findings are included in Appendix 2.

7.0 Other areas examined

During the course of the inspection the inspector met with :

Ward Staff	1
Other ward professionals	1
Advocates	1

A member of the ward staff told the inspector that:

They enjoyed working on the ward and had recently completed a six month dementia course which they found very enjoyable. They stated this course had given them a good insight into dementia care. They felt the staff team in Gillis worked well together and they stated that it had made a "huge difference" having a core team of nursing staff and not having to rely on bank staff.

The activity nurse told the inspector that :

They enjoyed working on the ward and felt part of the team. They advised they set up group activities and individual activities each day on the ward and are supported by the nursing staff. They stated the patients to not have an individualised therapeutic and recreational activity care plan in place. This recommendation has been restated

The advocate told the inspector that:

They attend the ward every Monday and Wednesday and hold an advocacy forum once a month with patients and relatives. They stated they have been involved in supporting a patient with discharge arrangements and have attended multidisciplinary team meetings with patients. They stated that they felt welcome on the ward by all staff.

8.0 Next Steps

A Quality Improvement Plan (QIP) which details the areas identified for improvement has been sent to the ward. The Trust, in conjunction with ward staff, must complete the QIP detailing the actions to be taken to address the areas identified and return the QIP to RQIA by 16 July 2015

The lead inspector will review the QIP. When the lead inspector is satisfied with actions detailed in the QIP it will be published alongside the inspection report on the RQIA website.

The progress made by the ward in implementing the agreed actions will be evaluated at a future inspection.

Appendix 1 – Follow up on Previous Recommendations

Appendix 2 – Patient Experience Interview

Appendix 3 – QUIS
(This document can be made available on request)

Follow-up on recommendations made following the unannounced inspection on 6 and 7 January 2015.

No.	Reference.	Recommendations	No of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	6.3.1 (a)	It is recommended that the Trust review the composition of the multidisciplinary team and availability of psychotherapeutic interventions to patients on the ward.	3	The inspector was informed by the ward manager and a senior trust representative that a review has taken place of the multidisciplinary team. Funding has been approved by the Trust for a part-time psychologist to be part of the multidisciplinary team within Gillis ward. They will provide psychotherapeutic interventions on the ward. The recruitment process has commenced for this post	Fully met
2	5.3.1 (f)	It is recommended that the ward manager ensures that the weekly ward round template is completed in full to record the patients' capacity to consent to their care and treatment and to evidence that this is monitored and re-evaluated regularly on the ward.	1	The multidisciplinary (MDT) template had been updated by the ward manager to include a record of the patients' capacity to consent to their care and treatment. In all four records reviewed there was evidence that patients' capacity to consent to their care was monitored and reviewed weekly. There was evidence that the ward manager had carried out regular audits to ensure that this document was completed in full.	Fully met
3	5.3.1 (f)	It is recommended that the ward manager ensures all discussions/meetings with patients are recording in the patients care documentation, which include meetings held with patients after each ward round.	1	The inspector reviewed four sets of patient care documentation. There was evidence that discussions/meetings held with patients were recorded in the patients' care documentation. This included meetings held with patients after each ward round if patients had not been in attendance to ensure they were updated on the outcome of these meetings.	Fully met

4	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, Good Management, Good Records, (DHSSPS) December 2014 guidelines.	1	There was evidence in the four sets of care records that the ward manager had completed regular audits to ensure that the MDT template was completed in full. The ward manager, senior trust representatives and the governance team were also devising an audit tool for all care documentation to ensure accurate up to date information was recorded for each patient. This recommendation will be restated for a second time	Partially met
5	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 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	1	The ward manager advised that they were working on documentation to ensure information was available in relation to the detention process, the Mental Health Review Tribunal, the complaints procedure, consent and capacity and the advocacy service. Easy read information was available on the Human Rights Act. This recommendation will be restated for a second time	Partially met
6	5.3.1 (f)	It is recommended that the ward manager ensures that all person centred nursing assessments are completed in full	1	The inspector reviewed four sets of care documentation and there was evidence that person centred nursing assessment had been completed in full.	Fully met

7	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	1	The inspector reviewed four sets of care documentation and there was evidence that when physiotherapy, speech and language and occupational therapy assessments had been completed with new recommendation that this was reflected in the patients' care plans. However there was one set of care documentation which had an assessment completed by the dietician with new recommendations in place however this was not reflected in the care plan for this particular patient. This was discussed with the ward manager who advised that these recommendations had been implemented and they would ensure the care plan is updated This recommendation will be restated for a second time	Partially met
8	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 and carers to ensure patients are proved with the appropriate care on the ward.	1	The inspector reviewed four sets of care documentation and there was evidence that all information received pertaining to the care and treatment of the four patients was reflected in the patients' care plans. This included updated information received from patient's relatives and carers. Care plans in the four sets of care documentation were completed with evidence that patients relative /carers had been involved in the implementation of these plans when appropriate. However there was one set of care documentation which had an assessment completed by the dietician with new recommendations in place. This was not reflected in the care plan for this particular patient. This was discussed with the ward manager who advised that these recommendations had been implemented and they would ensure the care plan is updated This recommendation will be restated for a second time	Partially met
9	5.3.1 (a)	It is recommended that the	1	The inspector reviewed four sets of care records which all	Not met

		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).		contained a risk screening tool. However each risk screening tool was inconsistently completed. There was no identification of the further action required in three of the assessments. However when this was discussed with the ward manager they advised that these risk screening tools were reviewed at the multidisciplinary team meeting and there was no requirement for a comprehensive assessment for all four patients. In all four assessments there was no record of patients or carers signatures and no reason recorded why these had not been signed when they had contributed to the assessment in two sets of records. In one set of care documentation all professionals who had contributed to the assessment had not signed this document. This recommendation will be restated for a second time	
10	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	1	Care documentation reviewed by the inspector evidenced that staff were recording a detailed account of the multi-disciplinary team (MDT) ward round meeting in the ward round template. However in all four records reviewed professionals, carers/relatives and patients who had attended the MDT meeting had not always signed the template and there was no record to explain the absence of these signatures. This recommendation will be restated for a second time It was not clear if patients had been invited to attend the MDT meetings as the template did not have a section to include the patients' name under the record of attendance. However there was a section for the patients to sign in	Partially met

		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.		relation to the decisions taken after the meeting but this was not consistently signed by patients and there was no record to explain the absence of the patients' signatures. A new recommendation has been made in relation to this	
11	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.	1	Patient care records reviewed by the inspector evidenced that patients were involved in therapeutic and recreational activities on the ward which were set up by nursing staff, the occupational therapist and the activity nurse. The inspector observed activities being carried with patients on the ward. There was also a timetable on the ward of the activities planned for the day. Records of patients' participation and progress in these activities were recorded in the patients' progress notes. However, each patient did not have an individualised therapeutic and recreational activity plan in place. There was no evidence of occupational therapy (OT) assessments having been completed which would assist in devising appropriate therapeutic/recreational activities and goals for patients to work towards. This recommendation will be restated for a second time and a new recommendation will be made.	Not met
12	5.3.1 (a)	It is recommended that the ward manager ensures that care plans in relation to perceived or actual deprivation of liberty include	1	There was evidence of individualised care plans in place for each of the four patients in relation to deprivation of liberty they were experiencing on the ward. These included the individual risk to the patient and a rationale to support the level of restriction in terms of proportionality	Fully met

		an outline of the individual risk to that patient and a rationale to support the level of restriction in terms of proportionality and necessity		and necessity	

Quality Improvement Plan

Unannounced Inspection

Gillis Memory Centre, St Luke's Hospital

21 May 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with the ward manager and the settlement officer on the day of the inspection visit.

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

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
Is Care Safe?					
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	Immediate and ongoing	The dementia risk screening tool format has been reviewed and updated. This will facilitate clearer recording of follow up actions required when completed at time of admission. The updated format will also provide opportunity to record explanations for absent signatures of patients/carers who have directly contributed information at the time of completing the report. The risk screening tool will be audited to ensure all areas 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). The Ward Sister has communicated to all nursing staff the requirement for the Dementia risk screening tool to be completed in full and signed by both the admitting Doctor and Nurse

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
Is Care Effective?					
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, Good Management, Good Records, (DHSSPS) December 2014 guidelines	2	Immediate and ongoing	Partially met at inspection on 21st May 2015 Monthly NIPEC audits are already completed on mandatory requirements for record keeping and this forms part of our nursing quality indicators. Ward based audit of the MDT template is also completed monthly. The ward documentation ie written records (medical & nursing), Patient admission assessments and personal details, Risk screening tool, Personalised care plans, MDT templates and discharge planning have been externally audited using the mental health audit tool developed for the Trust The ward sister has again communicated to all professionals in the MDT to ensure all areas of MDT template are fully completed and all present record their signature in full.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
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	Immediate and ongoing	The ward sister has reviewed and updated the MDT template to record an invitation to the patient to attend the meeting, their inability to attend or their desire not to be present.
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	Immediate and ongoing	Partially met at inspection on 21st May 2015 The ward sister has communicated with the specialist professionals associated with patient assessment & review, namely Speech & language therapist, Dietician, Physiotherapist, Diabetic nurse, Tissue viability nurse and Podiatrist and is endeavouring to implement the process whereby each professional will update the careplan at time of their review to reflect the recommendations madeat that time. This will ensure timely updating of the careplan by the professional making the recommendations.
5	5.3.1 (a)	It is recommended that the ward manager ensures that all information received pertaining to the care and	2	Immediate and	Partially met at inspection on 21st May 2015 The ward sister has reviewed the template of the careplan

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		treatment of the patients on the ward is reflected in the patients care plans and this includes updated information received from patient's relatives and carers to ensure patients are proved with the appropriate care on the ward.		ongoing	booklet to include a section that records discussions and up dates with relatives/carers regarding the care plans. This provides opportunity for relatives/ carers to provide additional information and is signed by the relative /carer.
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	Immediate and ongoing	Partially met at inspection on 21st May 2015 Ward sister has communicated to all members of the Multi-disciplinary team to ensure that all relatives / carers and patients present at the MDT meeting should be offered the opportunity to sign the MDT template or an explanation should be recorded if they decline this offer.
7	5.3.1 (a)	It is recommended that the ward manager ensures patients have an individualised therapeutic and recreational activity care plan in	2	31 August 2015	Currently all relatives are asked to complete the "This is me!" booklet for their relative. This contributes to the development of their individualised therapeutic and

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		place which has been developed from their 'personal profile assessment' and their 'person centred nursing assessment.			recreational care plan alongside the OT assessment now introduced for each patient on the ward to identify a programme of activities to meet the patients specific needs. Joint nursing / OT recording of level of participation and enjoyment by the patient influences the regular review of the careplan and the activities to be provided for the patient.
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	31 August 2015	The OT has introduced the Pool Activity Level (PAL) Assessment which is completed with each patient on admission. The outcome of this assessment along with their 'This is Me' forms the basis of the person's individualised therapeutic care plan and activity plan. The nursing and OT staff fill out the activity plans on a daily basis to give a clear record of activities that the patient has engaged in including their level of participation and enjoyment.
Is Care Compassionate?					

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
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 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	2	30 September 2015	Partially met at inspection on 21st May 2015 Easy read information is currently available for patients on -Human Rights -Capacity It is expected that work already underway to provide easy read versions of information on the Detention process & Mental Health Review Tribunal, the complaints procedure and the advocacy service will be completed within the time scale

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

NAME OF WARD MANAGER COMPLETING QIP	Sally Kennedy, Ward Sister
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Francis Rice

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable	x		Audrey McLellan	**23/7/15**
B.	Further information requested from provider				