Unannounced Follow up Inspection Report
5 – 7 June 2017

Gillis Memory Centre
Dementia Care
St. Luke's Hospital
Loughgall Road
Armagh
BT61 7NQ

Tel No: 028 37412183

Inspectors: Wendy McGregor, Audrey McLellan and Dr John Simpson

Lay assessor: Anne Simpson

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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

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. Patients may also present with associated complex behaviours that are challenging / distressing.

On the days of the inspection there were 16 patients on the ward. Two patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986. The multi-disciplinary team included psychiatry, medical, nursing, social work and psychology. A Pharmacist visited the ward every week. Patients had access to a Physiotherapist and a Speech and Language therapy service by referral. Referrals were also made to the community Occupational Therapy service when a patient is assessed ready for discharge. Patients with additional medical needs could also be referred to the Trust Acute Care at Home service. A patient advocacy service was also available.

3.0 Service details

Responsible person: Stephen McNally	**Ward Manager:** Sally Kennedy
Category of care: Dementia	**Number of beds:** 24
Person in charge at the time of inspection: Sally Kennedy	

4.0 Inspection summary

An unannounced follow-up inspection took place over three days on 5 – 7 June 2017.

The inspection sought to assess progress with findings for improvement identified from the - previous unannounced inspection completed on 2 – 6 November 2015. Inspectors also assessed if the Gillis Memory Centre was a well led service.

Inspectors noted that four areas for improvement made during the last inspection had been met. There was evidence that relatives were involved in their family member's risk screening and care assessments. The ward had implemented the Adult Safeguarding Prevention and Protection in Partnership policy (July 2015). Discharge processes had improved and the Ward Administrator was now receiving supervision from the Ward Manager,

Four areas for improvement were assessed as not met. The Clinical Supervision Policy and Complaints Policies were not up to date. The multidisciplinary ward round minutes did not identify the responsible person / team for completing agreed actions and a time frame for completing the actions had also not been identified. There was no Occupational Therapist working on the ward. The ward remains isolated on the St Luke's site.

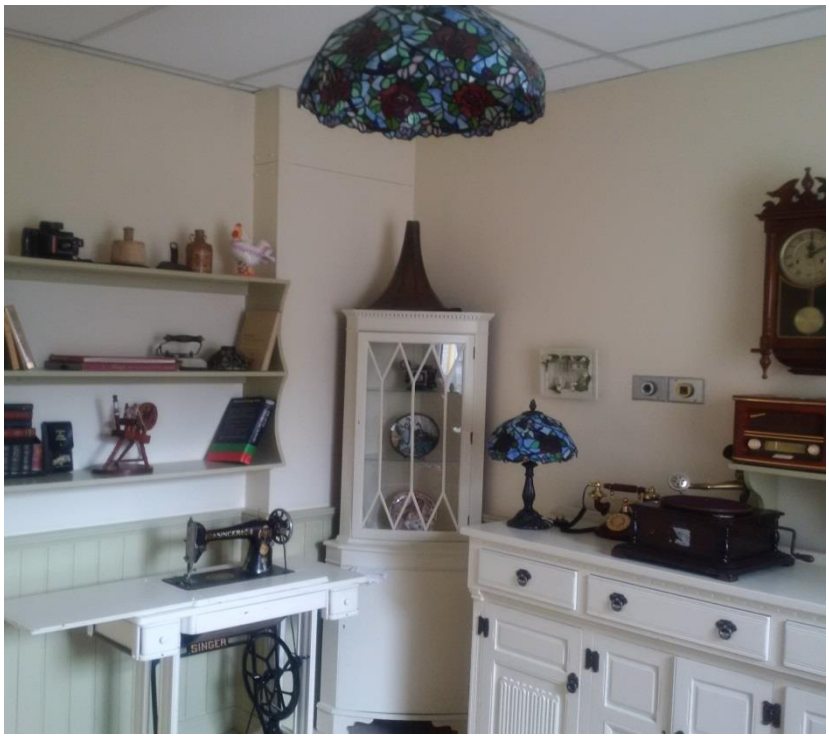
The Gillis Memory Centre multi-disciplinary team and Acute Care at Home Team have been nominated for the Southern trust Excellence Awards. Inspectors noted that the Trust's Acute Care at Home team were available to patients in the Gillis Memory Centre. This is a multi-disciplinary team that can provide additional medical care to patients and aims to reduce the need for a patient to be transferred to an acute general hospital. The team also supports nurses in the Gillis ward to provide end of life care. Staff on the ward stated that this team has enhanced patient care. Staff also commented that the two teams work well together, and share skills and knowledge.

There were governance mechanisms in place for the management of medication. Patients were prescribed the minimum effective dosage. This would indicate that standard practice was to prescribe the least amount of medication that is necessary and effective. However there was no Trust policy in place for the administration of covert medication. An area for improvement has been made in relation to this.

Staff mandatory training was up to date and practice development is actively encouraged. Staff were supported to participate in additional training relevant to dementia care.

The ward has a mechanism in place to gather the views of patients and their relatives and uses these views to develop quality improvement initiatives. The ward has committed to the John's Campaign "Stay with me" which welcomes visitors 24/7, offers tea and coffee making facilities and overnight stay if required.

There has been some improvements to the environment since the last inspection. The ward now has two sitting rooms and additional quiet areas for patients to retreat to. The location of the bedroom areas has also changed to enhance supervision. The ward has introduced a "parlour". This room was a particular favourite area for patients and their relatives.



The Parlour

An RQIA lay assessor spoke with three patients. Patients were complimentary about their care. One patient said that their admission to the ward had helped them. Patients said that they mostly felt safe; one patient said "I felt anxious when another patient was aggressive". However the patient said that staff would support and help them address this concern. Patients confirmed they knew who to speak to if they were unhappy and that staff were always available to talk to. Patients confirmed that they were well cared for and staff always explained care and treatment interventions to them.

Patients said:

"There is always a carer nearby and they are always ready to help".

"All the nurses look after you".

"Before discharge there was a meeting and she asked lots of questions. Everything was explained about discharge".

"Feel much better now. I am ready for home".

"Staff are helpful".

"My family can call anytime".

"I am being discharged today and I feel really well."

"I am very happy on this ward".

"Staff are brilliant".

"Staff are very kind".

"I am very happy, the staff are friendly and kind".

The lay assessor also commented that they noted there was a lack of structured activities on the ward. This was addressed with the Ward Manager. An Activities Co-ordinator will be taking up post in August 2017. The lay assessor also said that staff were attentive to patients and were observed to be engaging and supporting patients consistently.

Inspectors spoke to two relatives and received written correspondence from one relative during the inspection.

Relatives were complimentary about the staff on the ward. One relative stated that there were not enough staff working on the ward. This was addressed through the inspection process and findings are included in section 7.0 of the report.

One relative stated:

"Gillis ward is a warm, friendly, caring place and staff couldn't have done enough for my family member. My family member had many issues. The care and treatment on the ward could not

have been any better. My family member suffered from a delirium and staff handled the situation with great sensitivity. In fact they looked after the whole family. Relatives had to come over from England and they were well supported and facilitated. They had open access to visiting and were provided with all the information. The doctor was also very accessible. I also want to comment on my observations of the ward, and I have observed the approach of staff to other patients as second to none".

Inspectors interviewed six members of the multi-disciplinary team.
Staff confirmed that the team worked well together and that everyone's views were considered. Staff said that they felt listened to and were well supported by the deputy ward manager, ward manager and Head of Memory service. Staff said the ward was safe and that the care and treatment was effective. Staff indicated that they were positive about the role of the new Head of Memory service.

Staff confirmed that there has been a significant improvement with discharge processes with the introduction of a ward social worker. Staff also stated that the introduction of the psychologist will further enhance the care of patients who present with behaviours that are distressing.

Staff said:

"I am positive about the new Head of Memory service; it is good that they have a presence on the ward for support".

"I am well supported, the managers are very supportive".

"The Acute Care at Home team has been really beneficial for patients and staff working on the ward. It means we can care for patients here, when in the past patients may have transferred to an acute general hospital. This caused patients and their families to be very distressed. We work together very well and learn from each other. It is privilege to be able to provide end of life care with the support of this team".

"The team work well together".

"I am delighted that two management student nurses are returning to work on the ward as staff nurses".

"Everyone has an opinion or input as a member of the multi-disciplinary team".

"We all receive good support and a debrief after there has been an incident".

The findings of this report will provide the Trust 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	6

The total number of areas for improvement comprises:

- three areas restated for a second time.

- three new areas for improvement.

These are detailed in the Provider Compliance Plan (PCP).

Areas for improvement and details of the PCP were discussed with senior trust representatives, members of the multi-disciplinary team, the ward manager and ward staff as part of the inspection process. The timescales for completion commenced from the date of inspection.

5.0 How we inspect

The 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.

6.0 The inspection

The following areas were examined during the inspection:

- Care Documentation in relation to four patients
- Ward environment
- Advocacy service
- Minutes of staff meetings
- Records in relation to incidents and accidents
- Staff supervision and appraisal dates
- Staff training
- Staff rotas
- Medication prescription sheets
- Complaints and compliments
- Information in relation to safeguarding vulnerable adults
- Minutes from governance meetings

6.1 Review of areas for improvement from the last unannounced inspection 2 – 6 November 2015

The most recent inspection of the Gillis Memory Centre Ward was an unannounced inspection. The completed Provider Compliance Plan (PCP) was returned and approved by the responsible inspector. During this inspection we reviewed the areas for improvement made at the previous inspection and an assessment of compliance was recorded as met/partially met and not met. This PCP was validated by inspectors during this inspection.

Areas for Improvement		Validation of Compliance
Number/Area 1 **Ref**: Standard 5.3.3(b) **Stated:** First time	**Risk assessments** Promoting Quality Care risk screening tools had not been signed by carer and patient and the reason for this was not recorded.	**Met**
	Action taken as confirmed during the inspection: Four dementia risk screening tools were reviewed on the Patient Electronic Recording System (PARIS). There was evidence that all risk screening tools reviewed were discussed with the patient's next of kin and included the date of the discussion.	
Number/Area 2 **Ref**: : Standard Section 4.3 (i) **Stated:** First Time	**Staff Supervision** The administration staff had not received supervision since they commenced employment several years previously.	**Met**
	Action taken as confirmed during the inspection: Inspectors reviewed the supervision dates and also spoke to the ward administrative staff. Records reviewed evidenced that the ward administrative staff had received supervision from the ward manager every three months. The ward administrative staff stated they found the	

	supervision beneficial. The ward administrative staff confirmed they also received supervision and appraisal from their line manager.	
Number/Area 3 **Ref**: Standard Section 5.3.1 (c) **Stated:** First Time	**Safeguarding Vulnerable Adults** The ward manager was the investigating officer (IO) in a safeguarding vulnerable adult investigation on their ward.	**Met**
	Action taken as confirmed during the inspection: Inspectors reviewed information in relation to safeguarding vulnerable adults from May 2016 to June 2017. There were six referrals made. All referrals were made and reviewed by the Designated Adult Protection Officer in accordance with the Adult Safeguarding Prevention and Protection in Partnership policy (July 2015).	
Number/Area 4 **Ref**: Standard Section 5.3.1 (a) **Stated:** First Time	**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 resulted 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.	**Met**
	Action taken as confirmed during the inspection: Inspectors spoke with the Head of Memory services. Inspectors noted that there were developments in relation to the structure of the multi-disciplinary team on the ward since the last inspection. The Head of Memory services was responsible for both the community memory services and inpatients services. A full time social worker was now in place for the ward and at the time of the inspection there was one consultant psychiatrist.	

	The Psychologist also works in both inpatient and community services. These developments enhanced the transition from inpatient services to community services. Pre discharge meetings were held and evidenced input from community staff and family involvement. Patients were referred to the community Occupational Therapist prior to discharge. Where required the ward Psychologist also continued to provide a service to the patient following discharge. The ward Social Worker was responsible for the co-ordination of pre-discharge meetings and liaised between inpatient and community services. A post discharge meeting was held two weeks after the patients discharge and occurs in the community. All relevant information was shared with the community services, and included the "This is me" booklet.	
Number/Area 5 **Ref**: Standard Section 6.3.1 (a) **Stated:** First Time	**Medical Cover** 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.	**Not met**
	Action taken as confirmed during the inspection: RQIA escalated this area for improvement following the last inspection of the Gillis Memory Service about this area for improvement. The Trust responded and stated that a "Proposal which was subject to public consultation confirmed that Gillis would be incorporated into service provision at Craigavon Area Hospital as part of the hospital site development plan, which has been submitted to Department of Health as a business case for approval". Inspectors confirmed the following was in place in the Gillis Memory Service. The staff grade doctor is available from 9am to 5pm Monday to Friday. When the staff grade doctor is on leave the duty doctor covers and remains on the ward from 9am to 5 pm Monday to Friday. Out of hours (which included weekends) medical	

	cover is provided by a duty doctor. All band 5 nursing staff have received up to date training in Immediate Life Support (ILS) which means they are trained to manage all medical emergencies until emergency services arrives. The ward has access to the immediate response team available by dialling 6666. The Trust Acute Care at home team are now available. This service is to prevent unnecessary admissions to acute general hospital. The service provides support with medical issues and palliative care. The Trust has placed the isolation risk on the Trust corporate risk register. The Head of the Memory Service stated that there are plans for the service to move to the Craigavon Area Hospital site in the next five to eight years. The Trust stated they will continue to review the situation. Although we have assessed this area for improvement as not met as the ward remains isolated, it will be not be included in the provider compliance plan, as the Trust have assumed the risk and have the above measures in place.	
Number/Area 6 **Ref**: Standard Section 5.3.1 (f) **Stated:** First Time	**Policies and procedure** Clinical supervision policy and complaints policy. **Action taken as confirmed during the inspection**: Inspectors reviewed both policies and noted the following: The trust complaints policy was reviewed in July 2015 however the policy remains in a working draft format. The nursing supervision policy has not been updated. This area for improvement will be restated for a second time.	**Not met**
Number/Area 7 **Ref**: Standard Section 5.3.1 (a)	**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	

Stated: First Time	**Action taken as confirmed during the inspection**: Inspectors reviewed the ward round minutes completed for four patients. The ward round template is completed on the PARIS system. None of the ward round templates included the responsible person / team for completing the actions or a time frame. Inspectors noted that there is provision on the PARIS system for the above to the documented. Inspectors acknowledge that Gillis Memory Service has been moving patient care records to the PARIS system on a phased basis since January 2017 and the process is still at its early stage. It was noted that the Northern Ireland Single Assessment Tool (NISAT) is available on the PARIS system. Plans are in place to move care plans to the system. This area for improvement will be restated for a second time.	**Not met**
Number/Area 8 **Ref**: Standard Section 5.3.1 (a) **Stated:** First Time	**Occupational Therapy (OT) Assessment Records** 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.	**Not Met**
	Action taken as confirmed during the inspection: Inspectors reviewed care documentation in relation to four patients and noted that none of the patients had an OT assessment or an individualised therapeutic/recreational activity plan completed. The ward OT went on a period of extended leave in September 2016. Staff stated there were difficulties recruiting and although an OT was recruited to cover the leave they did not take up the post. Although it was evident that activities were happening on the ward there was no structured group activity schedule.	

	However inspectors noted that on 30 May 2017 contact was made with a locum OT to enquire about their availability. The locum OT can provide cover three days per week. Documentation for approval for this cover was completed on 5 June 2017 and staff confirmed that the locum OT will start in the next 2 weeks. This area for improvement will be restated for a second time.	

6.1 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

Governance arrangements were in place in relation to medicines management. A pharmacist attends the ward every week. Senior nursing staff complete a daily audit of medicines. A yearly audit for delayed and omitted medicines is completed by the bed flow co-ordinator.
Patients were prescribed the minimum effective dosage. This would indicate that standard practice was to prescribe the least amount of medication that is effective.

A new policy and procedure is currently being developed for the use of restrictive practices.
A procedure for continuous engagement and supportive interventions including continuous observations in Gillis Memory centre is being developed.

There was governance oversight of timely discharge, average length of stay and delayed discharges. The length of stay has been reduced by 20 days.

All staff interviewed confirmed they knew the policy and procedure for reporting incidents and accidents.

All incidents were reviewed on the incident recording system (DATIX) and reviewed by senior nursing staff and the Head of Memory service. The Trust clinical and social care governance co-ordinator reviews the incidents on the DATIX system. The incidents were broken down into categories e.g. slips, trips and falls. This information was collated and available to the ward manager and discussed at the staff meetings.

Monthly audits were completed for nurse revalidation, staff supervision, Safeguarding Vulnerable Adults training, falls, medication, Malnutrition Universal Screening Tool (MUST), National Early Warning Score (NEWS) and any restrictive interventions used during the day and

night shift. It was recorded on the audit that there were no restrictive interventions used during the May 2017.

Staff meetings were held every month and sometimes twice a month to ensure that all staff had the opportunity to attend. The staff meeting minutes were clear and organised. The Deputy Ward Manager ensured that all staff had access to the minutes including night staff. Minutes are also emailed to staff.

All staff interviewed stated there were good working relationships between the multi-disciplinary team.

Nursing staff meet every Monday to discuss all patients and prepare for the multi-disciplinary ward round.

All staff stated they were well supported by the ward manager, deputy ward manager and the Head of Memory service. All staff working on the ward had received up to date supervision and appraisal.

The Head of Memory service attended the ward every week.

Ward staff and ward management monitor overall patient experience. There were systems in place to collect and analyse patient and relative views regarding their care and treatment. Complaints and compliments were reviewed and outcomes were displayed on entry to the ward. Patient and relative forum meetings were held every month and attended by the patient advocate. Surveys of relatives' experiences were completed and reviewed quarterly and outcomes were displayed. The outcomes from audits about falls and pressure sores were displayed. The independent advocate worked closely with staff and patients and ensured that all patients were aware of the service by introducing themselves to patients on admission. The advocate stated that staff responded positively to any issues or suggestions that they had raised with staff in the past.

There were a number of quality improvement initiatives. Staff were encouraged and supported to participate in relevant practice development and share their learning with other staff to improve the service. The ward has developed a new information pack for patients and relatives.

The ward has responded positively to complaints. Complaints were managed through the trust complaints policy and procedures.

There was a defined organisational and management structure that identified the lines of responsibility and accountability.

The ward had a good system in place to monitor the uptake of mandatory training. Records reviewed evidenced that all staff had received up to date mandatory training. Practice development was actively encouraged and managed well and takes into account of availability and skill mix of staff. Staff on the ward were supported to attend appropriate training in relation to dementia care which included training to enhance their knowledge and understanding of people whose behaviour challenges / distresses. Two staff had completed the dementia championing training

A psychologist commenced working on the ward in August 2016. The psychologist works with patients and their families and supports staff to understand and care for people whose behaviour distresses /challenges.

Areas for improvement

It was recorded in three medication prescription records that medication could be administered covertly. There was no trust policy or procedure in place to govern the use of covert medication.

There was no carers advocate on the Gillis Memory Centre.

7.0 Other areas examined

RQIA received correspondence from relatives that stated a number of concerns about care and practice. The Trust was also managing these concerns through their complaints policy and procedure.

In response to the concerns raised by relatives, inspectors reviewed care documentation in place in relation to the care and support of patients who present with behaviours that are challenging / distressing. Inspectors also reviewed the processes in place in relation to the use of restrictive practices, staffing levels and maintenance of the garden area.

Findings in relation to the use of restraint.

There was evidence of family involvement in the risk screening tools and care plans in relation to restrictive practices. Relatives had signed the care plans.

There was no evidence of a formalised record that evidenced a MDT agreement for the use of the restrictive practices or an agreed MDT management plan.

Restrictive practices were not consistently reviewed every week by the MDT. Where it was recorded that the restrictive practice was reviewed, the review was not comprehensive or robust enough and did not detail the frequency and times on the day when the restrictive practice was used (for thematic review) or the reasons for the restrictive practice.

Nursing care plans were completed for the use of the restrictive practices. However the rationale for the use of the restrictive practices was unclear. Care plans included some diversionary techniques; however these could have been more detailed. Care plans stated that the restrictive practices were only to be used as a last resort and for the shortest time possible.

Staff did not consistently record what and when diversionary methods were tried. (If diversionary techniques were clearly detailed in the care plans, staff could have made reference to these in the progress notes).

The restrictive practice monitoring documentation was unclear, and in some instances incorrectly completed. The documentation did not clearly identify the length of time the restrictive practice was used.

The incident report (DATIX) number was not consistently recorded in the progress notes therefore it was unclear if an incident report was completed every time a restrictive practice was used.

Staff were now attending training on supporting and caring for patients who present with behaviours that are distressing /challenging.

The trust has reviewed its procedures for the use of restrictive practices and is currently developing a new policy and procedure in relation to this.

An area for improvement has been made in relation to these findings and included in the ward PCP.

Findings in relation to staffing levels

Inspectors reviewed the duty rota from January 2017 – June 2017. Staffing levels ranged from 10 – 13 staff for day duty and 7 – 9 staff for night duty. Shortfall in numbers of staff was provided by bank staff. Currently there are four band 5 vacancies on the ward, however inspectors were informed that there were two final year student nurses on the ward who were progressing toward the completion of their training. Both students have secured posts on the ward and will commence employment as health care assistants while waiting on their NMC pin number. Staff stated in order to maintain the safety of patients on the ward, patients is supervised in central areas at times to allow for staff breaks.

Garden area

There were areas in the garden that were overgrown and required pruning. This was addressed during the inspection.

8.0 Provider Compliance Plan

Areas for improvement identified during this inspection are detailed in the provider compliance plan (PCP). Details of the PCP were discussed with senior trust representatives, members of the multi-disciplinary team, ward manager and ward staff as part of the inspection process. The timescales commence from the date of inspection.

The responsible person must ensure that all areas for improvement identified within the PCP are addressed within the specified timescales. The responsible person should note that failure to comply with the findings of this inspection may lead to escalation action being taken.

8.1 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 to Team.MentalHealth@rqia.org.uk for assessment by the inspector by 17 July 2017.

Provider Compliance Plan	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** Quality Standard Section 5.3.1 (f) **Stated:** Second time **To be completed by**: 6 December 2017	<u>Policies and procedure</u> The Clinical Supervision policy and Complaints policy was not up to date.
	Response by responsible individual detailing the actions taken: Clinical Supervision Policy, CNO has requested a review to be facilitated by NIPEC with a view to concluding work in Spring 2017**.** Complaints policy was updated in 2015 but is still in draft form. CGO will update with input from directorate governance offices. Nurse Governance Lead to lead.
Area for Improvement No. 2 **Ref:** Quality Standard Section 5.3.1 (a) **Stated:** Second time **To be completed by:** 6 August 2017	<u>Personal Well-Being Plans</u> The ward round template was not always completed with the responsible person / team for completing the actions or a time frame.
	Response by responsible individual detailing the actions taken: As PARIS is still being embedded into Gillis unit an audit tool has been devised to facilitate a two weekly audit which is carried out by the ward manager to ensure that the responsible person/team and actions and time frames are being recorded. Update sessions have been provided for staff by senior staff to embed this practise
Area for Improvement No. 3 **Ref:** Quality Standard Section 5.3.1 (a) **Stated:** Second time **To be completed by:** 6 September 2017	<u>Occupational Therapy (OT) Assessment Records</u> There were no OT assessments completed in relation therapeutic/recreational activities.
	Response by responsible individual detailing the actions taken: OT commenced post on 21st June 17 and completes assessment in relation to therapeutic/ recreational activities (PALS) in collaboration with the MDT. OT currently on maternity leave due to return on 17th August 2017
Area for Improvement No. 4 **Ref:** Quality Standard 5.3.1 (f)	<u>The use of covert medication</u> There was no trust policy to govern the use of covert medication.
	Response by responsible individual detailing the actions taken: Links have been made with pharmacy and governance colleagues to

Stated: First time **To be completed by:** 6 September 2017	develop a standard operating procedure for the use of covert administration of medication in Gillis unit. First meeting scheduled for 22 August 2017. Those who need to be involved have been proposed. Gillis MDT are following current processes for administration of covert administration of medication as previously agreed with pharmacy. Ward Manager will lead on this.
Area for Improvement No. 5 **Ref:** Quality Standard 5.3.1 (a) **Stated:** First time **To be completed by:** 6 August 2017	<u>Restrictive Practice</u> The use of restrictive practices was not completed in accordance with Trust policy and procedures.
	Response by responsible individual detailing the actions taken: Following discussion with RQIA inspector it was agreed to implement in Gillis the use of the monitoring form from the draft guidance on the use of restrictive interventions and restrictive practises. Ward manager will monitor its use.
Area for Improvement No. 6 **Ref:** Quality Standard 6.3.2 (g) **Stated:** First time **To be completed by:** 6 September 2017	<u>Carers advocate</u> There was no carers advocate in the centre.
	Response by responsible individual detailing the actions taken: Ward manager and HOS met with CAUSE on 30th June to agree a strategy to implement carers advocacy within Gillis unit. CAUSE have been asked to return a proposal to achieve this. It was agreed that a carers advocate would be made available to a carer if requested.

Name of person (s) completing the PCP	Siobhan Donaghy		
Signature of person (s) completing the PCP	Siobhan Donaghy	**Date completed**	19.07.17
Name of responsible person approving the PCP	Bryce McMurray		
Signature of responsible person approving the PCP	Bryce McMurray	**Date approved**	21.07.17
Name of RQIA inspector assessing response	Wendy McGregor		
Signature of RQIA inspector assessing response	Wendy McGregor	**Date approved**	26 July 2017

Please ensure this document is completed in full and returned to MHLD.DutyRota@RQIA.org.uk from the authorised email address

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