The Regulation and Quality Improvement Authority

Ash

Tyrone and Fermanagh Hospital

Western Health and Social Care Trust

Unannounced Inspection Report

Date of inspection: 22 July 2015

npm national preventive mechanism

informing and improving health and social care

www.rqia.org.uk

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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 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 assess that the ward physical environment is fit for purpose and delivers a relaxed, comfortable, safe and predictable environment.

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

Ash Ward is a ten bedded mixed gender ward set on the Tyrone and Fermanagh Hospital site. The ward provides assessment, care and treatment to patients with dementia who may present with behaviours that are distressing. There were ten patients on the day of the inspection; two patients were detained in accordance with the Mental Health (NI) Order 1986.

The multidisciplinary team consists of nursing, psychiatry, occupational therapy, psychology and social work. The ward also has an activities co-ordinator. The trust were in the process of recruiting a ward manager.

The ward sister was in charge on the day of the inspection.

4.0 Summary

Patients on Ash ward had previously been cared for in Oak B ward. The ward sister and staff had also worked in Oak B. Oak B ward closed and both patients and staff moved to Ash ward. The recommendations made following the previous inspection carried out in Oak B on 11 & 12 November 2014 were assessed.

There were a total of 20 recommendations made following this inspection.

It was good to note that eighteen recommendations had been implemented.

One recommendation had been partially met and one recommendation had not been met. These recommendations will be restated for a second time following this inspection.

The lay assessor met with three patients and one relative. Both patients and the relative made positive comments about their experience of the ward and were complimentary about the staff.

The ward atmosphere was calm and relaxed. Patients on the ward required support with their daily activities of living and their communication. Staff were observed to engage positively with patients. Staff were attentive and attended to patients when they required support with ther care needs. Staff encouraged patients to join in with appropriate recreational activities.

The ward environment was observed to be fit for purpose and delivered a relaxed and safe environment. Interior décor of the ward created a homely type environment. The ward was spacious and open. Signage around the ward was of a good size and easily seen.

4.1 Implementation of Recommendations

Five recommendations which relate to the key question "**Is Care Safe**?" were made following the inspection undertaken on 11 & 12 November 2014.

These recommendations concerned assessments and care plans in relation to restrictive practices, the implementation of the Trust's restrictive intervention policy and staff training in the management of behaviours that challenge.

The inspector was pleased to note that three of the recommendations had been implemented.

Each patient had an individualised assessment and care plan in place in relation to restrictive practices with patient and family involvement. Staff had implemented the restrictive intervention policy. The majority of staff had received up to date training in the management of behaviours that challenge with a plan in place for the remaining staff to complete their training in August 2015.

However, despite assurances from the Trust, one recommendation had not been implemented. All staff on the ward had not received up to date mandatory training.

Four recommendations which relate to the key question "**Is Care Effective**?" were made following the inspection undertaken on 11 & 12 November 2014.

These recommendations concerned the availablility of therapeutic / recreational activities for patients, the completion of discharge pathways and the Person Centred Integrated Care Pathway for Dementia Assessment.

The inspector was pleased to note that three recommendations had been implemented. Patients had a therapeutic / recreational activity plan in place. Staff had recorded patients' participation in therapeutic and recreational a activities. Although there were no patients assessed as ready for discharge, staff were aware of the discharge pathway.

However, despite assurances from the Trust, one recommendation had not been fully implemented. Medical staff were not completing the relevant section in the Person Centred Integrated Care Pathway for Dementia Assessment.

Eleven recommendations which relate to the key question "**Is Care Compassionate**?" were made following the inspection undertaken on 11 & 12 November 2014.

These recommendations concerned the Trust's Locked Door policy, patient and family involvement in care plans, risk assessments and multi-disciplinary reviews. Recommendations were also made in relation to how patients' capacity to consent was assesessed, monitored and reviewed. . Recommendations were made in relation to information about advocacy services, the ward information book, and ensuring the ward curtains in patients sleeping areas had been returned.

The inspector was pleased to note that all recommendations had been implemented. The Trust had reviewed the locked door policy. There was evidence of patient and relative involvement in care plans, risk assessments and the weekly multi-disciplinary reviews. The ward information book was available for relatives and there was information displayed in relation to advocacy services. Patients capacity to consent was assessed, monitored, and reviewed weekly and care plans were updated following any changes in capacity to consent.

5.0 Ward Environment

"A physical environment that is fit for purpose delivering a relaxed, comfortable, safe and predictable environment is essential to patient recovery and can be fostered through physical surroundings." Do the right thing: How to judge a good ward. (Ten standards for adult-in-patient mental health care RCPSYCH June 2011)

The inspector assessed the the ward's physical environment using a ward observational tool and check list.

Summary

Information about the ward was included in the ward information book. The ward environment was clean, tidy and well maintained. There was ample lighting and neutral odours. Signage was clear and in both written and pictorial format.
There was information displayed in relation to each patient's named nurse and community key worker. Patient sleeping bays were single sex.

Patients had access to their bedrooms and an outside space.
The ward door was locked; information explaining the reason for this was included in the ward information book. Each patient had a restrictive practice care plan in place.
The ward décor was designed to create a homely feel. The dining room was spacious. There was open access throughout the ward, patients could choose to sit in the company of others or retreat to a quiet space.
Staff were available in the communal areas. There was enough staff to meet the support needs of the patients. Supervision and enhanced observations were carried out discreetly and with dignity and respect.
The ward had a ligature risk assessment and each patient had self harm risk assessments completed in relation to the risks associated with profiling beds.

The inspector noted that the curtains had been removed from the four bedded sleeping area. A recommendation has been made in relation to this.

The inspector identified other areas which should be reviewed by the ward manager to improve standards on the ward in accordance with good practice guidance. These include;

- The development of a patient / relative feedback mechanism
- The development of a patient / carer forum
- Displaying information about the date of the ward round.
- Including other members of the multi-disciplinary team on the staff display board.
- Staff name badges in a format that meets the communication needs of the patients.
- The trust considering distraction screens and etched glass coverings on windows and doors.

A lay assessor participated in the inspection and reported they observed the ward environment was pleasant, bright and airy. The lay assessor also observed that the layout was confusing although there was clear easy to read signage for the bathrooms and other facilities.

The outdoor garden area was clean and bright and colourfully furnished.

The detailed findings from the ward environment observation are included in Appendix 2.

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

Positive social (PS) - care and interaction over and beyond the basic care task demonstrating patient centred empathy, support, explanation and socialisation

Basic Care (BC) – care task carried out adequately but without elements of psychological support. It is the conversation necessary to get the job done.

Neutral – brief indifferent interactions

Negative – communication which is disregarding the patient's dignity and respect.

Summary

On the day of the inspection the inspector observed interactions between staff and patients. Ten interactions were noted in this time period. The outcomes of these interactions were as follows:

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

All interactions were observed as positive. Staff were kind and compassionate and treated patients with dignity and respect. Staff were also empathetic when communicating with the patients. Staff demonstrated their knowledge and skills in supporting patients who presented with behaviours that challenge, and are confused and distressed. Staff were observed to be actively engaging with patients and encouraged patients to participate in activities.
The detailed findings from the observation session are included in Appendix 3.

7.0 Patient Experience Interviews

A lay assessor participated in the inspection of the ward. Three patients and one relative agreed to meet with the lay assessor to talk about their care, treatment and experience as a patient.
The lay assessor reported the following;
They observed that seven of the nine patients were in the TV lounge. The general feedback from patients was that the staff were “good” and patients were well cared for. The lay assessor observed three staff in the lounge interacting positively with patients.
The lay assessor spoke to one relative. The relative stated their family member was safe, well cared for and treated with compassion. The relative indicated that staff had recognised their needs as a relative and carer and responded accordingly. In particular they spoke highly of the ward Sister.

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 September 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 – Ward Environment Observation
This document can be made available on request

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

Appendix 1

Follow-up on recommendations made following the announced inspection on 11 & 12 November 2014

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	5.3.1 (f)	It is recommended the Trust review the locked door policy and procedure within this ward	2	There was evidence that the Management of Locked Doors, and Egress policy had been reviewed by the trust. The policy is currently in draft form version three. The assistant director stated the following; • Staff from Acute and Woman and Children's directorate were consulted with and invited to provide comments. This took some time to make sure all divisions/programmes of care contributed. I made the necessary changes to the policy based on their comments. • Draft policy has been sent to the 3 advocacy groups Alzheimer's Society, Cause, Mind yourself. Closing date has passed, reminder was sent out but still no response. • As per advised by our Equality team I have been trying to contact the NI human rights commission to invite them to review policy and provide comments. Contact person has not returned any of my calls. Draft policy sent on 20th July via email to NI commission asking to review • Equality screening form has been completed. • Timescale of full completion and sign off of policy will likely be end of November, as the policy has to be approved in draft form through our Directorate Governance meeting, Trust CMT	Met

				meeting and then Trust Board for final sign off prior to being issued to staff.	
2	5.3.1 (a)	It is recommended that procedural safeguards and robust care-plans regarding restrictions on patients be implemented to protect against actual or perceived deprivation of liberty in accordance with DHSSPS Interim Guidance - 2010 (DOLS).	2	Inspectors reviewed care documentation in relation to four patients. Each patient had an individualised care plan in place that addressed each restriction. The care plans identified the restriction, the rationale for the restriction, how this may have impacted on the patient's human rights, and made reference to Deprivation of Liberty. The care plans demonstrated that the restrictions were proportionate to each patient's risk. The care plans also detailed how to manage the restriction. There was evidence of patient and family involvement.	Met
3	4.3 (m)	It is recommended that all staff receive training in relation to the application of the Trusts Restrictive Intervention policy.	2	Inspectors reviewed The Policy For The Use of Restrictive Interventions With Adult Patients. The policy was up to date and due to be reviewed in August 2016. Inspectors noted that the policy was available on the ward for staff. The inspectors reviewed two sets of documentation were staff had documented that they used a restrictive intervention and noted that staff had implemented the policy and procedure in full. Inspectors also noted that were a patient required a physical intervention to maintain their health and wellbeing e.g. assistance with personal care; staff had documented that the multi-disciplinary team along with the patients family had agreed that a physical intervention was required in the patient's best interest.	Met
4	5.3.1 (f)	It is recommended that the	2	Inspectors reviewed care documentation in relation to	Met

		ward manager ensures that all activities are documented in the patient's current up to date care records so that patients progress in this area can be monitored.		four patients. Activities were incorporated in the integrated care pathway. There was evidence of family and patient involvement. Patient participation or otherwise was recorded in the progress notes. A list of available activities was displayed on the ward. Inspectors observed patients participating in a number of activities on the day of the inspection.	
5	4.3 (m)	It is recommended that the ward manager ensures that all staff are trained in management of aggression.	2	Inspectors reviewed the training records for twenty five nursing staff working on the ward. Eight out of the twenty five staff had not received up to date training in the management of aggression. However, five staff were attending Management of Actual or Potential Aggression (MAPA) on the day of the inspection and a further three staff were booked to attend the training in August 2015.	Met
6	5.3.1 (f)	It is recommended that where patients are unable or unwilling to sign care plans and reviews with their nurse that the reasons are clearly recorded with an indication of their ability to understand the process.	2	In the four sets of care documentation reviewed there was evidence of patient and where appropriate relative involvement. Patients had signed an overarching care plan sheet detailing the care plans in place. Where a patient had not signed a reason was recorded on these occasions, and there was evidence that patients' relatives had signed the documentation.	Met
7	6.3.2 (c)	It is recommended that the ward manager ensures that information is available on the ward in relation to the advocate service in an easy	1	Inspectors noted that information in relation to advocacy services was displayed in the ward. This information was provided by the Alzheimer's Society and was in a format that met the communication needs of the patients on the ward.	Met

		read format so that it can be understood by patients with dementia			
8	8.3 (j)	It is recommended that the ward manager ensures that patients capacity to consent to care and treatment is monitored and re-evaluated regularly by the multi-disciplinary team throughout patients admission and this is documented clearly in the patients care documentation	1	Inspectors reviewed care documentation in relation to four patients. Inspectors noted that patient's capacity to consent was assessed and recorded on admission. There was evidence that patient's capacity was monitored and evaluated daily and at the weekly multi-disciplinary team (MDT) meetings. Staff had recorded that they had sought consent prior to care delivery.	Met
9	8.3 (j)	It is recommended that the ward manager ensures that patients and or/ their relatives are involved in any formal assessments in relation to capacity to consent, and that this involvement or otherwise is recorded in the patients care documentation.	1	In the four sets of care documentation reviewed there was evidence of patient and where appropriate relative involvement in the assessment process following admission. Capacity to consent was assessed on admission and recorded.	Met
10	5.3.1 (f)	It is recommended that the ward manager ensures that patients who have been assessed as lacking capacity to make decisions	1	Inspector reviewed care documentation in relation to four patients. Inspectors noted that where a patient was assessed as lacking capacity in making decisions about their care and treatment the multi-disciplinary team along	Met

		regarding there care and treatment, have a multidisciplinary discussion regarding best interest decisions, as outlined in the March 2003 References Guide to Consent for Examination, Treatment or Care.		with family involvement had decided what was in the best interest of the patient. Inspectors noted that best interest decisions were made in accordance with the March 2003 Guide to Consent for Examination, Treatment or Care.	
11	5. 3.1 (f)	It is recommended the ward manager ensures that care plans are updated when patients have been assessed as lacking capacity to consent to their care and treatment	1	In the four sets of care records reviewed inspectors noted that patient's capacity to consent was monitored daily and evaluated daily and at the weekly MDT meeting. Care plans were reviewed and updated where there were changes in patients' capacity to consent.	Met
12	5.3.3 (b)	It is recommended that the ward manager ensures that patients and relatives/carers views are sought prior to multi-disciplinary case conference meetings. Relative should be informed that these meeting take place each week. If patient/relatives do not attend these meetings a record of the reason for this should be recorded in the patients notes and they should be updated on the	1	The four sets of care documentation reviewed reflected that patients and their relatives were informed of the weekly MDT meetings. There was evidence that both patients and their relative's views were sought prior to and during the meeting and documented. Staff had recorded patient and relative attendance or otherwise at the MDT meetings. Outcomes from the meeting were noted to have been discussed with the patient and their relative where either had not attended. One relative confirmed on the day of the inspection that they were involved in decisions and about their family members care and were offered the opportunity to attend the weekly MDT meetings.	Met

		outcome of the meeting			
13	5.3.3 (b)	It is recommended that the ward manager ensures that when staff complete risk assessments and care plans they ensure that patients and relatives (when acting on behalf of the patient) have the opportunity to be involved in these assessments. There should be a clear identification of who contributed to the assessment/care plan and that this involvement or otherwise is recorded in the patients care documentation	1	Inspectors reviewed risk assessments completed in relation to four patients. Risk assessments are completed electronically on the Epex system. There was evidence that on admission and during the patients stay on the ward that risks identified were discussed with the patient and where appropriate their relative. Risk assessments were reviewed and updated weekly at the MDT meeting. The names of the people involved and / or consulted in the risk assessments were recorded on all four of the risk assessments reviewed by the inspectors.	Met
14	5.3.1 (a)	It is recommended that the ward manager ensures that patients care and treatment on the ward is documented in the patients 'Person Centred Integrated Care Pathway for Dementia Assessment Unit' and that all staff have training it in	1	Inspectors were informed by the ward sister that all staff except for two new staff members had received training in the use of the 'Person Centred Integrated Care Pathway for Dementia Assessment Unit'. In the four sets of care documentation reviewed inspectors noted that nursing staff had completed in full their relevant section in the 'Person Centred Integrated Care Pathway for Dementia Assessment	Partially met

		relation to using this pathway.		Unit'. However, it was noted that in two files the medical section to be completed by medical staff was not completed and in another two files this section had not been completed in full. This needs to be reviewed by the trust as the ward sister is not responsible for the completion of the medical notes. This recommendation will be reworded and restated for a second time.	
15	5.3.3. (b)	It is recommended that the ward manager ensures that all patients have a therapeutic/recreational activity care plan in place and ensured that this is monitored and reviewed on a regularly basis.	1	Inspectors noted that therapeutic and recreational activities are in incorporated in the patients Person Centred Integrated Care Pathway for Dementia Assessment Unit'. Inspectors noted staff had documented therapeutic and recreational activities in the four sets of care documentation reviewed. These were monitored and reviewed regularly.	Met
16	6.3.2 (b)	It is recommended the ward manager ensures that all patients and their relatives/carers are given a copy of the wards handbook	1	Inspectors reviewed the ward information booklet. The inspectors were informed that all patients are given a copy of the booklet and a copy is available for carers on request. There was evidence that staff had recorded in the care documentation when a copy of the book had been issued to patients.	Met
17	7.3 (c)	It is recommended the ward manager ensures that all patients who have restrictions in place have an assessment completed and robust care-plans in place	1	Inspectors reviewed care documentation in relation to four patients. Each patient had an individualised risk assessment (completed on epex) and a care plan in place that identified the restriction required to manage each risk. There was evidence of patient and relative	Met

		regarding the restrictions. The ward manager should ensure that relative/carers and patients are involved from the onset in the decision making processes in relation to the implementation of restrictive practices. Care plans should reference how staff have considered the potential impact of the restrictive practices on patient's human rights in relation to articles 3 and 14 and that this is implemented in accordance with DHSSPS Interim Guidance – 2010 (DOLS).		involvement. The risk assessment and care plan demonstrated that the restriction was necessary and proportionate to the risk. Care plans referenced the potential impact on the patient's relevant human rights articles and evidenced that staff had implemented the DOLS guidance (2010).	
18	5 .3. 3 (b)	It is recommended that the ward manager ensures each patients discharge pathway is completed in the 'Person Centred Integrated Care Pathway for Dementia Assessment Unit' which details a discharge checklist, multi-disciplinary discharge plan, trial leave planning and transfer of patients to nursing homes. There should be an action	1	The inspectors were informed that there were no patients on the ward assessed as ready for discharge. The 'Person Centred Integrated Care Pathway for Dementia Assessment Unit' section for discharge planning is completed once a patient has been assessed as ready for discharge and following the discharge planning meeting. Once a patient has been assessed as fit for trial leave the relevant section is completed. There was one patient assessed as ready for trial leave on the day of the inspection. The ward manager stated that the trial leave section of the	Met

		plan with clear timescales in place and an identified responsible person to take the lead. Patients and/or their relatives/carers should have the opportunity to participate in and contribute to the discharge planning process. Their attendance or otherwise should be documented.		pathway will be completed following further consultation with the patient's family as their input was necessary to complete the pathway i.e. agreement to support the patient on trial leave and the care and support the patient will require.	
19	4.3 (m)	It is recommended that the ward manager ensures that all staff have up to date mandatory training completed which includes fire training, vulnerable adult safeguard training and moving and handling training	1	Inspectors reviewed the mandatory training records for twenty five nursing staff on the ward. The findings were as follows; Fourteen staff had not received up to date Fire training; Eight staff had not received up to date Safeguarding Vulnerable Adult training; Twelve staff had not received up to date training in Moving and Handling Ten out of twelve qualified staff had not received up to date training in Immediate Life Support (ILS). This recommendation will be amended to include ILS training and restated a second time.	Not met
20	6.3.2 (a)	It is recommended that the ward manager ensures that the wards curtains in the four bedded bay areas are cleaned and returned to the unit to ensure patients are	1	Inspectors reviewed the ward environment. On the morning of the inspection it was noted that the curtains in one of the four bedded bay areas had been removed. The inspectors were informed that these had been removed the day before due to heavy soiling and had been sent for cleaning.	Met

		provided with privacy and dignity.		The inspector noted that the curtains had been returned and replaced in the four bedded bay area before the end of the inspection. The inspector was informed by the ward sister that on occasions due to the needs of the patients there is a requirement for curtains to be removed and sent for washing due to heavy soiling. There was no evidence of a surplus supply of curtains to replace them immediately once removed and sent for washing. A new recommendation will be made to ensure that patients' privacy and dignity is maintained at all times.	

R3

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Inspection

Ash, Tyrone and Fermanagh Hospital

22 July 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 ward sister on the day of the inspection visit and followed up with a phone call to the assistant director on 23 July 2015.

It is the responsibility of the Trust to ensure that all 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	4.3 (m)	It is recommended that the ward sister ensures that all staff have up to date mandatory training completed which includes fire training, vulnerable adult safeguard training, moving and handling training and immediate life support (ILS).	2	19 November 2015	The ward sister will ensure that all staff have up to date mandatory training completed which includes fire training, vulnerable adult safeguard training, moving and handling training and immediate life support (ILS). The Trust requires an extension on this timescale to January 2016 due to restricted places available on manually handling and ILS.
Is Care Effective?					
2	5.3.1 (a)	It is recommended that the trust ensures that medical staff complete the relevant medical section in the patients 'Person Centred Integrated Care Pathway for Dementia Assessment Unit'.	2	19 November 2015	The Trust will ensure that medical staff will complete the relevant medical section in the patients Person Centered Care Pathway for the Dementia Assessment Unit.
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
3	6.3.2 (a)	It is recommended that the ward sister ensures that there is a surplus supply of curtains available on the ward. This is to ensure that once curtains are removed for washing or routinely cleaned that they are replaced from the supply immediately to maintain patient privacy and dignity.	1	Immediate and on-going	The ward sister ensures that there is a surplus supply of curtains available on the ward. This is to ensure that once curtains are removed for washing or routinely cleaned that they are replaced from the supply immediately to maintain patient privacy and dignity – completed.

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	Nuala Burke
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Elaine Hay

Inspector assessment of returned QIP		Yes	No	Inspector	Date
A.	Quality Improvement Plan response assessed by inspector as acceptable	✓		Wendy M'Gregor	7 October 2015
B.	Further information requested from provider				

Extension granted, letter sent: agreeing to extension 31 January 2015. letter saved on iConnect

Wendy