The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Beech Ward, Tyrone and Fermanagh Hospital

Western Health and Social Care Trust

25 and 26 February 2015

npm national preventive mechanism

informing and improving health and social care

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Contents

1.0 General Information

Ward Name	Beech Ward
Trust	Western Health and Social Care Trust
Hospital Address	Tyrone and Fermanagh Hospital 1 Donaghanie Road Omagh BT79 0NS
Ward Telephone number	028 82835371
Ward Manager	Jim Duffy (Acting)
Email address	Jim.duffy@westerntrust.hscni.net
Person in charge on day of inspection	Day 1 – Nuala Kerr, Staff Nurse Day 2 – Jim Duffy, Acting Ward Manager
Category of Care	Male, Mental health continuing care and rehabilitation
Date of last inspection and inspection type	PEI – 24 July 2014
Name of inspector(s)	Kieran McCormick Dr Oscar Daly

2.0 Ward profile

Beech is a twenty bedded male ward on the grounds of the Tyrone & Fermanagh Hospital site. The purpose of the ward is to provide rehabilitation and continuing care to patients' who require on-going support to manage their mental health needs. The ward has a rehab/recovery care ethos. There were 12 patients on the ward on the day of the inspection none of these patients' were detained under the Mental Health (NI) Order 1986.

The multidisciplinary team consists of a team of nursing staff and health care assistants, a medical registrar, consultant psychiatrist and a resettlement social worker. Patients' have access to psychology services through a referral system.

The main entrance to the ward was unlocked; on the days of inspection patients' were observed independently exiting the ward.

The inspector noted the ward was welcoming. The internal ward area was well lit, well maintained, clean and fresh smelling. There were separate day spaces and dining areas for patients'.

3.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Northern Ireland's health and social care services. RQIA was established under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to drive improvements for everyone using health and social care services. Additionally, RQIA is designated as one of the four Northern Ireland bodies that form part of the UK's National Preventive Mechanism (NPM). RQIA undertake a programme of regular visits to places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment, upholding the organisation's commitment to the United Nations Optional Protocol to the Convention Against Torture (OPCAT)**.**

3.1 Purpose and Aim of the Inspection

The purpose of the inspection was to ensure that the service was compliant with relevant legislation, minimum standards and good practice indicators and to consider whether the service provided was in accordance with the patients' assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

The aim of the inspection was to examine the policies, procedures, practices and monitoring arrangements for the provision of care and treatment, and to determine the ward's compliance with the following:

- 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.

Other published standards which guide best practice may also be referenced during the inspection process.

3.2 Methodology

RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the inspection standards.

Prior to the inspection RQIA forwarded the associated inspection documentation to the Trust, which allowed the ward the opportunity to demonstrate its ability to deliver a service against best practice indicators. This included the assessment of the Trust's performance against an RQIA Compliance Scale, as outlined in Section 6.

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.
Specific methods/processes used in this inspection include the following:

- analysis of pre-inspection information;
- discussion with patients and/or representatives;
- discussion with multi-disciplinary staff and managers;
- examination of records;
- consultation with stakeholders;
- file audit; and
- evaluation and feedback.

Any other information received by RQIA about this service and the service delivery has also been considered by the inspector in preparing for this inspection.

The recommendations made during previous inspections were also assessed during this inspection to determine the Trust's progress towards compliance. A summary of these findings are included in section 4.0, and full details of these findings are included in Appendix 1.

An overall summary of the ward's performance against the human rights theme of Autonomy is in Section 5.0 and full details of the inspection findings are included in Appendix 2.

The inspector would like to thank the patients, staff and relatives for their cooperation throughout the inspection process.

4.0 Review of action plans/progress

An unannounced inspection of Beech was undertaken on 25 and 26 February 2015**.**

4.1 Review of action plans/progress to address outcomes from the previous announced inspection

The recommendations made following the last announced inspection on 18 September 2013 were evaluated. The inspector noted that three of 12 recommendations had been fully met. However, despite assurances from the Trust, nine recommendations had not been fully implemented. Two recommendations have been combined and will be restated for a third time. Seven recommendations will require to be restated for a second time, in the Quality Improvement Plan (QIP) accompanying this report.

4.2 Review of action plans/progress to address outcomes from the patient experience interview inspection

The recommendations made following the patient experience interview inspection on 24 July 2014 were evaluated. The inspector was pleased to note that all three recommendations had been fully met.

4.3 Review of action plans/progress to address outcomes from the previous finance inspection

The recommendations made following the finance inspection on 7 January 2014 were evaluated. The inspector noted that two of seven recommendations had been fully met. However, despite assurances from the Trust, four recommendations had not been fully implemented and will require to be restated for a second time in the Quality Improvement Plan (QIP) accompanying this report. One recommendation has been removed as it is no longer applicable.

5.0 Inspection Summary

Since the last inspection it was positive to note a more structured approach to supporting patients to be resettled to the community. There was a more proactive multi-disciplinary approach to identifying appropriate community living arrangements for each patient.

The following is a summary of the inspection findings in relation to the Human Rights indicator of Autonomy and represents the position on the ward on the days of the inspection.

The inspector noted there was minimal information available or displayed for staff and patients in relation to Capacity, Consent and Human Rights.

Staff who met with the inspector on the days of inspection explained the steps they took to ensure patients consented to care and treatment. Care plans in

two of the three patients files reviewed were individualised and person centred. In one of the three care files reviewed, the inspector noted that there were no nursing care plans or risk assessments completed for a patient admitted to the ward five days prior to the inspection. A recommendation has been made in relation to this.

Care plans in the other two patients' files had not consistently been signed by the patient or where they had not been signed an explanation inserted. The inspector was not provided with any evidence that care plans not signed or where a patient was unable to sign, that an opportunity at a later date was provided for them to sign their care plans. A recommendation has been made in relation to this.

The inspector observed an example of a registered nurse having recorded that consent was obtained prior to venepuncture. However in each of the patients' files reviewed, the care plans did not provide guidance to staff on how to obtain or assess consent or the actions to take if consent was not obtained. Patients' daily progress notes made no reference that patients were consenting or not to care and treatment. A recommendation has been made in relation to this.

In one of the three patients' care files reviewed the inspector noted a Human Rights care plan. The care plan had been signed by the patient and made reference to the consideration of respective articles of the Human Rights Act.

In two of the patient care files reviewed the patient had a completed nursing history and initial assessment completed. However this was not in place for the other patient who had been recently admitted to the ward. In this case there were no nursing care plans or assessments completed for the patient despite being admitted five days previously. A recommendation has been made in relation to this. Care plans and assessments reviewed for the other patients identified the individuals physical and mental health needs. However risk assessments and care plans were not consistently reviewed and evaluated throughout each patient's admission. A recommendation has been made in relation to this.

The inspector noted contracts developed and agreed with the patient to help maintain safety, independence and promote rehabilitation and recovery in the files reviewed. In each case this had been signed by the patient and the named nurse.

The inspector reviewed the Promoting Quality Care (PQC) documentation for three patients. The inspector could not be reassured that PQC documentation was completed and regularly reviewed in accordance with the PQC Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. A recommendation has been made in relation to this.

The inspector was supported by a Senior Professional Officer(Consultant Psychiatrist) from RQIA on the second day of the unannounced inspection.

This inspector spoke with the junior doctor who confirmed that he visited the ward a few times per week. He advised that he had carried out annual medical reviews and indicated that he had a good support from the registrar and consultant. The doctor also reported good relationships with the nursing staff. The inspector reviewed four sets of medical records. One patient had been admitted in the past week, transferred from another ward. There was a clearly documented medical history, and both mental state and physical examinations with a treatment plan. The patient also had been reviewed by the registrar within a few days of admission. There was reference to multidisciplinary team discussion. In each of the other records there was evidence of annual review being carried out by the junior doctor. The inspector noted concerns regarding errors in the dating of entries. A recommendation in relation to this has been made.

There were references to multidisciplinary team working with input, as appropriate, from clinical psychology, learning disability services and optometry. There was a recent case summary in one of the patient's files. Case summaries were not available in the files relating to the other two patients which were both noted to be volume six. A recommendation has been made in relation to this.

The inspector reviewed the nursing records relating to these patients. They referenced regular involvement with patients and there were several references to multidisciplinary working and resettlement meetings.

The legibility of entries in medical records was reasonable overall however some were poor and it was not possible to work out the writer or the writer's designation. A recommendation has been made in relation to this.

The 24 hour nursing progress notes in three of the patients' files were reviewed. In each case staff had not recorded a contemporaneous entry of the care delivered to the patient during the course of the 24 hour period. In one of the patients files reviewed, on three consecutive nights, no entry or record was made of the care delivered to the patient during the night. A recommendation has been made in relation to this.

Staff were familiar with individual patient needs, likes, dislikes and choices. Three ward staff who met with the inspector demonstrated their knowledge of patients' communication needs. The inspector reviewed the care file for a patient with a sensory impairment. A review of the patient's care plans clearly evidenced the patient's alternative communication needs and provided advice to staff on how to communicate with the patient. The patient's care records also evidenced the use of an interpreting service to help promote patient participation in their care and treatment.

The inspector met with the nursing sister of the nearby Rowan Day Centre. The nursing sister explained that patients who consent to accessing the Rowan Centre are referred. Following this the nursing sister will meet with the patient to establish activities suitable to individual need. The needs and capabilities of the patient are assessed to establish level of ability. The nursing sister advised that some patients choose not to attend the Rowan Centre. Whilst in the Rowan Centre patients have access to Occupational

Therapists (OT) who undertake functional assessment work with the patient, if required. In addition to a morning and afternoon session, Monday – Friday, patients who attend the Rowan Centre also have access to evening and weekend outings. The day centre sister confirmed that day centre staff will attend multi-disciplinary team (MDT) meetings and reviews if required.

The inspector spoke with a number of patients who confirmed their attendance at the Rowan Centre and who expressed positive comments in relation to their time spent there.

A review of one of the patients' files evidenced that appropriate assessments had been completed by the OT. Recommendations and outcomes were clearly documented within the individual patient's care file.

Patients who do not avail or engage with the Rowan Centre received activity input from the ward. The inspector requested to review the ward based activity records. The acting ward manage explained that there were no ward activity records maintained and that any activities carried out with patients were recorded in individual progress notes. In each of the three patients' files reviewed the inspector seen little evidence of recreational or therapeutic activities carried out with patients by ward staff. A recommendation has been made in relation to this.

The inspector observed nursing staff engagement, communication and interactions with patients to be positive. However, over the course of the two day inspection the inspector did not observe any ward based activities taking place, although it was noted that a patient had been taken out shopping. In addition there was no display or communication with patients in relation to who their named nurse was for the day. A ward activity timetable was displayed however observations during the inspection did not reflect that it was in operation. A recommendation has been made in relation to this.

Ward information leaflets were accessible for patients. Leaflets detailed information in relation to patients' rights, what a patient should expect regarding their care and treatment and the responsibilities of the ward staff. Information on how to make a complaint and the patient advocacy service was displayed on the ward.

Patient meetings were previously held every three months. A review of the minutes from the last meeting, held in December 2014 evidenced an agenda, those in attendance and matters arising, however there was no evidence that agreed actions had been implemented. A recommendation has been made in relation to this.

In two of the three patients' files reviewed, patients had been risk assessed as requiring individualised restrictive practices the third file had no risk assessments in place. Restrictions included the use of physical interventions, use of as and when required medication and locked environment (on occasions). The acting ward manager explained that the main entrance door may require locking on occasions. This is assessed on the needs of an individual patient and following input and discussion with medical staff.

Arrangements are in place for all other patients to be able to exit the ward during such times. In each circumstance an individualised risk assessment had been completed with a supporting care plan that had been signed by the patient. In one of the patient's files, a personalised deprivation of liberty care plan had been created this had been signed by the patient but not by the named nurse. A recommendation has been made in relation to this.

Care documentation reviewed demonstrated that the use of individualised restrictions had been discussed with the patient and recorded in each individual patient's care file. Care documentation in one of the patient's files made reference to the consideration of patients Human Rights Article 3, rights to be free from torture, inhuman or degrading treatment or punishment, Article 5; rights to liberty and security of person, Article 8, to respect the right to family, private life and Article 14, the right to be free from discrimination. However this was not available in the other two care files reviewed. A recommendation has been made in relation to this.

Three of the six questionnaires which were completed by ward staff prior to the inspection indicated that not all staff had received training in relation to restrictive practices. A recommendation has been made in relation to this. Training records examined did not provide full reassurances that all staff working on Beech ward had received up to date training in physical interventions. A recommendation has been made in relation to this.

The inspector met with the acting ward manager and spoke with the consultant psychiatrist who provided an explanation of the discharge process. The inspector was advised that resettlement meetings are held every other month. This provided an opportunity to review each patient's case and to progress and plan for discharge from hospital. The inspector reviewed the minutes of the previous resettlement meeting. A review of the minutes evidenced the actions required to progress each patient's discharge from hospital. A review of the minutes did not provide a timescale for actions to be completed so that they could be tracked and monitored. A recommendation has been made in relation to this.

The inspector was advised that the ward had an allocated social worker who worked on the ward one day per week and who takes the lead in co-ordinating the discharge and resettlement for patients to the community.

The inspector was not provided with any evidence of a formalised discharge pathway. In one of the three patients' files reviewed there was evidence of a resettlement care plan to guide the patient's preparation for discharge. There was evidence in the same patient's file of a referral to supported living, outings with the community social worker to visit potential new living facilities and input from family members. The other two patients' files did not provide evidence of a discharge or resettlement care plan to guide staff on preparing the patient for discharge or to monitor the patient's progress towards discharge. A recommendation has been made in relation to this.

The acting ward manager advised that patients whose discharge is delayed are escalated and reported accordingly to the hospital senior management.

From this, they are escalated to hospital directors and the Health and Social Care Board. The acting ward manager advised that there were currently a number of patients who were not deemed medically fit for discharge, patients who had been in hospital for many years and those who were delayed in their discharge from hospital because they require a bespoke community placement.

The inspector met with four patients during the course of the inspection; none of the patients' expressed any concerns in relation to involvement in their care and treatment whilst on Beech ward.

Details of the above findings are included in Appendix 2.

On this occasion Beech has achieved an overall compliance level of **Moving Towards Compliance** in relation to the Human Rights inspection theme of "Autonomy".

6.0 Consultation processes

During the course of the inspection, the inspector was able to meet with:

Patients	**4**
Ward Staff	**4 and 2 student nurses**
Relatives	**0**
Other Ward Professionals	**3**
Advocates	**0**

Patients

The inspector met with four patients'. Patients who met with the inspector spoke positively regarding time spent on the ward and also spoke positively about the ward staff. One patient stated that it can be a long day as they are woken by staff at 06.30am. This was discussed with the acting ward manager who reassured that no patients who are still sleeping, are woken before 08.15am.
Patients' stated:

"all staff are very good to me"

"I get on the very best in Beech"

"I really like it here"

"it is peaceful and relaxing"

Relatives/Carers

There were no relatives available to meet with the inspector on the days of the unannounced inspection.

Ward Staff

The inspector met with four members of nursing staff and two student nurses. All staff stated they felt well supported and that there was a harmonious staff team. The staff stated that they felt the ward had a good working team. Staff who met with the inspector expressed concerns regarding accessing training due to prioritising the staffing requirements of the ward. The student nurses who met with the inspector stated that the ward was brilliant and that the staff were supportive. Nursing staff and students stated that patients were well cared for.

Other Ward Professionals

The inspector spoke with three visiting ward professionals over the course of the two day inspection. All professionals spoke highly of the care delivered on the ward.

Advocates

There were no advocates available to meet with the inspector on the days of the unannounced inspection.

Questionnaires

Questionnaires were issued to staff, relatives/carers and other ward professionals in advance of the inspection. The responses from the questionnaires were used to inform the inspection process, and are included in inspection findings.

Questionnaires issued to	Number issued	Number returned
Ward Staff	13	6
Other Ward Professionals	5	0
Relatives/carers	13	0

Ward Staff

Six questionnaires were returned by ward staff

The inspector noted that information contained within the staff questionnaires demonstrated that all six staff were aware of the Deprivation of Liberty Safeguards (DoLS) – Interim Guidance. Three staff members indicated that they had received restrictive practice training and were aware of restrictive practices on the ward. Examples of restrictive practices as reported by staff included “locked main door on occasions”, “use of MAPA” and “as and when required medication”. Four of the six staff members indicated they had received training in the areas of Human Rights. One of the six members of staff indicated they had received training in relation to capacity and consent.

One of the six staff members, who returned their questionnaires prior to the inspection, stated they had received training on meeting the needs of patients who require support with communication. All staff questionnaires indicated that patients’ communication needs are recorded in their assessment and care plan. All six staff members reported that patients’ had access to therapeutic and recreational activities and that these programmes meet the individual patients’ needs.

Other Ward Professionals

The inspector did not receive any completed visiting professional questionnaires.

Relatives/carers

The inspector did not receive any completed relative questionnaires.

7.0 Additional matters examined/additional concerns noted

Complaints

Prior to the inspection RQIA received a record of the number of complaints made between 1 April 2013 and 31 March 2014. The inspector reviewed the record of complaints held on the ward and in discussion with the acting ward manager clarified the details. The acting ward manager advised that all complaints had been fully investigated in accordance with policy and procedure; this was confirmed on review of the complaint records. The inspector noted that the complaints policy and procedure was created May 2011 and was due review May 2015 however this had not been completed. A recommendation has been made in relation to this.

Adult Protection Investigations

The inspector discussed with the acting ward manager the safeguarding activity on the ward. The acting ward manager advised that staff were familiar with the Safeguarding Vulnerable Adult policy and procedure and were making appropriate referrals in accordance with policy and procedure. The acting ward manager advised that referrals for safeguarding investigations by ward staff were promptly completed to the safeguarding team and that protection plans were put in place.

The acting ward manager advised that there were currently no new or ongoing investigations.

The inspector noted that the safeguarding vulnerable adults policy and procedure created March 2010 was due review March 2011; there was a current draft from October 2014 but has not been officially implemented. A recommendation has been made in relation to this.

Additional concerns noted

Staff training

The inspector requested the staff training records for the ward. The inspector was informed that the ward does not have a staff training matrix. Staff training is recorded on individual staff record sheets. This did not provide a clear, accurate and robust mechanism for governing and monitoring staff training. The inspector reviewed the individual staff training record sheets for the 15 staff currently work on the ward and noted gaps in mandatory training across the staff team and across a number of different subjects. A recommendation has been made in relation to this.

Management of Actual or Potential Aggression (MAPA) – of the 15 staff currently working on the ward there are 4 (27%) staff with no record of having attended MAPA training.

Safeguarding Vulnerable Adults – Of the 15 staff currently working on the ward there are 11 (73%) staff with no record of having attended SVA training.

Fire safety – Of the 15 staff currently working on the ward there are 7 (47%) staff with an expired fire safety training record or no record at all.

Infection control – Of the 15 staff currently working on the ward there are 9 (60%) staff with an expired infection control training record or no record at all.

In addition to this the inspector reviewed evidence of only two staff having attended human rights and restrictive practice training. There was no evidence of the remaining staff having attended training on restrictive practices, deprivation of liberty, capacity, consent and Human Rights. A recommendation has been made in relation to this.

The inspector was advised that the acting ward manager had no access to the bank staff training records. The acting ward manager advised the inspector that it wasn't until staff are on the ward that their knowledge, skills and training can be confirmed. This has resulted in staff attending for bank shifts that do not have the necessary skills and training to work on the ward. A recommendation has been restated in relation to this.

Transfer of patients from other wards

The inspector was advised by the acting ward manager that Beech ward is used as an 'overflow facility' for the acute admission ward, Lime. This therefore resulted in Beech ward receiving patients who do not have a bed on Lime. If this situation arises the patient from Lime is transported to Beech before 11pm at night, will sleep over and then will be woken the next morning at 7.20am and transported back to Lime. The patient will then wait in Lime for a bed to become available; if this is not secured the patient is transported back to Beech ward to sleep over again. The most recent example of this happening was on 7 January 2015, involving one patient.

A review of ward records indicated that a patient had been transported back and forth from Lime and Beech ward on nine separate occasions between 13/08/14 – 27/08/14.

The inspector reviewed the sleeping facility in which acutely unwell patients slept whilst on Beech. On initial assessment of the environment the three bed area presented as a significant environmental risk due to the large quantity of unused items, disorganisation and clutter. The inspector advised the acting ward manager that this would need to be cleared before the end of the inspection; this was achieved. In addition to this the environment was concerning in terms of a number ligature points. This included the suspended ceiling, loose wires protruding from the walls, curtain rails, three manually operated metal profiling beds and the hanger rail which was accessible in the patients' wardrobes.

The acting ward manager advised that when Beech receives patients from Lime, the ward is not provided with additional staff to meet those patients' needs. On review of the ward records it was apparent that the ward had cared for up to three acutely unwell patients in addition to the patient profile

already on Beech. A review of records evidenced that this had occurred on the 15,16,17, 21, 22 August 2014.

A recommendation in relation to this area of concern has been made.

Sleeping on night duty

In the male changing area the inspector observed a two seat settee made up as a bed, with sheets and pillows. In an empty unused dorm area the inspector also observed an arm chair draped with bed sheets and a profiling bed also made up.

The inspector discussed this matter with the acting ward manager who advised that he believed that staff sleep whilst on their allocated break on night duty. He also advised that the WHSCT had not issued any guidance or authorisation in relation to this matter.

There was no evidence of systems or procedures in place to govern this matter and provide assurances regarding patient safety during the night.

A recommendation has been made.

Policies and procedures

The inspector reviewed a number of key policies and procedures and noted that they had not been updated or reviewed:

Poilcy and procedure	**Date created**	**Date due review**
Complaints policy and procedure	May 2011	May 2014 – not complete
Safeguarding vulnerable adults policy and procedure	March 2010	March 2011 - latest draft issued October 2014 however not officially implemented.
Patients property procedure	March 2012	No evidence of when next due review and no evidence that it has been updated in response to the 2014 finance inspection.
Cash handling procedure	September 2011	No evidence of review or update since originally created.

Profiling beds

A serious adverse incident resulting in a fatality concerning the use of a profiling bed as a ligature point occurred in 2013. In December 2013 The

Health and Social Care Board requested that all HSC Trusts take appropriate actions in accordance with The Northern Ireland Adverse Incident Centre Estates and Facilities Alert EFA/2010/006. The exposed bed frame on the beds on Beech presents the same level of risk associated with ligature points as was the case when the fatality occurred.

During the course of the inspection the inspector noted a variety of beds that present as a ligature risk located within individual side rooms and dorms. This included those beds used by acutely unwell patients transferred from Lime

The inspector reviewed care files for three patients who were currently occupying these beds. The inspector noted that in each care file there was no rationale, care plan or risk assessment for the use of the bed. The matter was brought to the attention of the acting ward manager.

A recommendation has been made.

8.0 RQIA Compliance Scale Guidance

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable	Compliance with this criterion does not apply to this ward.	A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant	Compliance will not be demonstrated by the date of the inspection.	A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the inspection year.	In most situations this will result in a recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a recommendation, being made within the Inspection Report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and being made within the inspection report.

Appendix 1 – Follow up on Previous Recommendations

The details of follow up on previously made recommendations contained within this report are an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Appendix 2 – Inspection Findings

The Inspection Findings contained within this report is an electronic copy. If you require a hard copy of this information please contact the RQIA Mental Health and Learning Disability Team:

Contact Details
Telephone: 028 90517500
Email: Team.MentalHealth@rqia.org.uk

Follow-up on recommendations made following the announced inspection on 18 September 2013

No.	Reference.	Recommendations	Number of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1		It is recommended that all files are regularly audited.	2	The inspector met with the ward manager who advised that there was currently no regular auditing of files. The ward manager provided the inspector with a copy of the Trust auditing tool. The ward manager advised that they were not using the tool in full in accordance with instructions issued by the nursing services manager.	**Not met**
2	Document number:18 Section 3	It is recommended that in line with regional guidance 'Safeguarding Vulnerable Adults – A Shared Responsibility' (2010), the charge nurse ensures that all staff undertake training in relation to responding to, recording and reporting concerns about actual or suspected adult abuse	1	Staff training records for 11 of the 15 staff (73%) currently working on the ward had no record that they had attended safeguarding vulnerable adult training.	**Not met**
3	Document number:17 Section 5.3	It is recommended that the charge nurse introduces a formalised system to audit care records and record keeping.	1	The inspector met with the ward manager who advised that there was currently no regular auditing of files. The ward manager provided the inspector with a copy of the Trust auditing tool. The ward manager advised that they were not using the tool in full in accordance with instructions issued by the nursing services manager.	**Not met**
4	Document number:7 Section 3	It is recommended that the trust ensures that all staff working on the ward undertake training in restraint appropriate to their role and responsibility.	1	The WHSCT use MAPA as their preferred tool for physical interventions. Training records evidenced that of the 15 staff currently working on the ward there were four (27%) staff with no record of having attended MAPA training. The inspector was advised that the ward manager has no access to the bank	**Not met**

				staff records and no way of knowing bank staff training. The ward manager advised the inspector that it wasn't until staff were on the ward that their skill and training in relation to MAPA could be confirmed.	
5	Document number:17 Section 4.3	It is recommended that the charge nurse ensures that all staff working on the ward undertake all mandatory training appropriate to their role	1	The ward did not have a training matrix that clearly evidenced those staff that had completed mandatory training. The inspector identified that there were gaps in mandatory training across the staff team, in a variety of mandatory subjects.	**Not met**
6	Document number:17 Section 4.3	It is recommended that the charge nurse ensures that all staff working on the ward receive an annual appraisal.	1	The inspector reviewed the appraisal records and could confirm that 11 (73%) of the 15 staff working on the ward had received their annual appraisal. The remaining four staff were due their appraisal before April 2015. Staff who met with the inspector confirmed they had received their appraisal.	**Not met**
7	Document number:18 Section 2	It is recommended that the Trust ensure that a system is put in place so that the charge nurse/nurse in charge can ensure that bank staff have the appropriate training skills and knowledge to work on the ward.	1	The inspector was advised that the ward manager had no access to the bank staff training records. The ward manager advised the inspector that it wasn't until staff are on the ward that their skill and training can be confirmed. This had resulted in staff attending for bank shifts who did not have the necessary skills, knowledge and training to work on the ward.	**Not met**
8	Document number:17 Section 4.3	It is recommended that the charge nurse ensures that ward meetings are held regularly.	1	The ward manager advised that staff meetings do not currently take place on the ward.	**Not met**
9	Document number:17 Section 8.1	It is recommended that the charge nurse develops a procedure to ensure that compliments are recorded and captured.	1	A review of the complaints and compliments records evidenced a procedure in place to document and record compliments received.	**Fully met**
10	Document	It is recommended that the charge nurse	1	A review of the complaints and compliments records	**Fully met**

	number:17 Section 8.1	develops a procedure to document locally resolved complaints.		evidenced a procedure in place to document and record locally resolved complaints. A review of the records evidenced local complaints received by the ward, the actions taken and the outcome.	
11	Document number:12 Statements 3;8;11	It is recommended that risk assessments and care plans are discussed with the patient and if appropriate their carer. This should be evidenced within the care documentation.	1	A review of three patients' care files evidenced that risk assessments and care plans were not consistently discussed and signed by the patients or their representatives.	**Not met**
12	Document number: 15 Section 5	It is recommended that the trust review the frequency of multidisciplinary team meetings for all patients on the ward to ensure safe and effective care.	1	The weekly ward round is now held weekly on a Monday by the medical registrar. The consultant psychiatrist also visits the ward weekly on a Tuesday. In addition to this, the resettlement meetings are held bi-monthly.	**Fully met**

Appendix 1

Follow-up on recommendations made following the patient experience interview inspection on 24 July 2014

No.	Reference.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	5.3.1 (a)	It is recommended that the Trust ensures that multidisciplinary team meetings to progress patients' resettlement from hospital are held on a regular basis. These meetings should especially address the planned move for each patient from the hospital to community based care and support. A record of these meetings should be maintained on the ward. Patients should participate in and be kept fully informed of this process.	The inspector was informed that resettlement meetings are held bi-monthly, the inspector was provided with a schedule of these meetings for 2015. The inspector reviewed the records of the most recent resettlement meeting which was centrally recorded for all patients. The minutes of the meetings evidenced those in attendance, matters arising, the progress and actions to be taken were relevant for each patient's discharge. Information from the resettlement meetings had not been captured in the individual patients' records; a new recommendation has been in relation to this.	**Fully met**
2	5.3.1 (a)	It is recommended that the Trust ensures that the person responsible for co-ordinating the planned move from the hospital to community based care and support are identified, attend resettlement meetings and keep patients informed of progress.	A social worker responsible for leading the patient resettlement programme is allocated to the ward one day per week. The inspector was informed that resettlement meetings were held bi-monthly, the inspector was provided with a schedule of these meetings for 2015.	**Fully met**
3	6.3.2 (b)	It is recommended that the Trust ensures that advocates (where involved) are invited to participate in the resettlement and discharge process for individual patients.	Information regarding the independent advocacy service was displayed throughout the ward. A review of patients' records evidenced advocacy input. Staff who met with the inspector were familiar with the referral process and advised that advocates were invited to attend meetings were necessary.	**Fully met**

Appendix 1

Follow-up on recommendations made at the finance inspection on 7 January 2014

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensures that two members of staff authorise the withdrawal of patients' money from the cash office, and that different staff collect and record receipt of the money on the ward.	A review of the ward finance records evidenced two members of staff authorising withdrawal and a different member of staff collecting the money. The records evidence signatures in place for those staff involved in the process.	**Fully met**
2	It is recommended that the ward manager ensures that receipts are obtained for all expenditure, clearly identified and kept with the individual patient's records.	A review of individual patients' expenditure evidenced receipts had been obtained and retained for all expenditure; receipts had been signed by two members of staff.	**Fully met**
3	It is recommended that the Trust reviews the current practice for authorisation of larger purchases, including eliminating the practice of the same staff authorising the purchase and verifying the receipt. A policy and procedure should be developed and implemented.	The purchase of larger items was signed by three different members of staff; however a policy and procedure had not been developed or implemented to reflect the current practice. The current policies and procedures pertaining to patients' property and finances had not been reviewed or updated since 2011/2012.	**Not met**
4	It is recommended that the Trust develops and implements a policy and procedure in relation to group purchases.	This recommendation has been removed by the inspector. There was no evidence that the practice of group purchasing is ongoing and as a result the policy has not been developed.	**N/A**
5.	It is recommended that the ward manager trust introduces a weekly audit of receipts against expenditure on this ward.	The inspector was advised by the ward manager that they do not complete a weekly audit of receipts.	**Not met**
6.	It is recommended that the Trust introduces a secondary check of expenditure records on this ward.	The inspector was provided with no evidence of secondary checks; there was also no evidence that expenditure was being audited or reviewed by the ward manager.	**Not met**
7.	It is recommended that the ward manager ensures that a record of all staff who obtain the key to the safe where patients' money is stored is maintained including the reason for access.	A review of ward records indicated that staff were not recording staff who obtain the key to the safe and/or a reason for access to the safe in relation to monies.	**Not met**

Appendix 1

Follow up on the implementation of any recommendations made following the investigation of a Serious Adverse Incident

No.	SAI No	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1		N/A		

Quality Improvement Plan

Unannounced Inspection

Beech, Tyrone and Fermanagh Hospital

25 and 26 February 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 acting ward manager 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
1	5.3.3 (h)	It is recommended that the nurse in charge introduces a formalised system for auditing and ensures that all care files are regularly audited.	3	5 June 2015	At the time of inspection the Acting Ward Manager had been using the WHSCT record keeping Audit Tool to audit patient files. Evidence that the mandatory section of this audit tool was being completed by the Acting Ward Manager is recorded on the Trust Dashboard. Not all sections of this audit tool were relevant to the clients in Beech villa. The Head of Service had also completed a record keeping audit which is now due to be repeated by June 2015. Results will be available on the ward.
2	4.3 (m)	It is recommended that in line with regional guidance 'Safeguarding Vulnerable Adults – A Shared Responsibility' (2010), the nurse in charge ensures that all staff undertake training in relation to responding to, recording and reporting concerns about actual or suspected adult abuse.	2	5 June 2015	All staff are aware of relevant policies and protocols in relation to making a referral to the Safeguarding Team. The designated officer held a training session on the ward in September 2014 which 5 staff attended.(this was not recorded as formal training) In the event of any incidents on the ward referral to Adult Safeguarding is discussed with the Head of Service Staff have been booked for Vulnerable Adults

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					Safeguarding training. 28/4/15 – 2 staff 29/4/15 -3 staff 7/5/15 – 2 staff 15/6/15 – 2 staff 5 staff remain to be allocated training slots. It is not possible to complete within the given timescale due to availability of training.
3	4.3 (m)	It is recommended that the Trust ensures that all staff working on the ward complete training in restraint appropriate to their role and responsibility.	2	5 June 2015	6 staff out of a staff compliment of 18 in Beech Villa require training in MAPA. It has not been possible to complete within the given timeframe. A further 4 staff have been booked in for MAPA training 15/6/15 A time table for the remainder of staff will be booked when dates become available and will be

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					co-ordinated by the Acting Ward Manager. MAPA refresher - staff booked 2/6/15 – 3 staff 26/8/15 – 3 staff This is part of the training schedule available on the ward.
4	4.3 (m)	It is recommended that the nurse in charge ensures that all staff working on the ward undertake all mandatory training appropriate to their role.	2	3 July 2015	A training matrix has been drawn up in Beech Villa. This clarifies to staff what mandatory training is required by the Trust and identify timescales for updates. This will be monitored by the Acting Ward Manager. Combination Day training which covers – infection control, effective record keeping, complaints, COSHH health and safety, medicines administration and lone worker. 4 registrants have recently attended

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					3 registrants booked for 20/4/15 2 nursing assistants booked for 14/4/15.
5	4.3 (m)	It is recommended that the Trust ensure that a system is put in place so that the nurse in charge can ensure that bank staff have the appropriate training skills and knowledge to work on the ward.	2	5 June 2015	This is being taken forward as a corporate agenda item, led by Assistant Director for Nursing Workforce and Development. A project has been established to improve professional governance arrangements around Bank nursing staff across all POCS. The Lead Nurse for AMH will be working with all nurse managers to progress this work locally. The Acting Ward Manager will seek assurance that any Bank Nurse working in Beech is equipped and competent to carry out their duties by reviewing training records and encouraging attendance at local induction. Bank staff to attend training appropriate to the role needed.
6	5.3.3 (a)	It is recommended that the nurse in charge ensures that ward meetings are held regularly.	2	Immediate and ongoing	Acting Ward Manager had one ward meeting April 14 which was poorly attended by staff. A system of team brief was adopted by the Acting Ward Manager in Beech Villa to inform staff of issues relevant to their practice and the patient care on

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					the ward and give staff an opportunity to voice any concerns. On the basis of this recommendation there has been a further ward meeting held on 23/3/15. There will now be a bi-monthly meeting in Beech Villa. The meeting will be minuted and the minutes will be available for all staff to review and comment.
7	5.3.1 (a)	It is recommended that the nurse in charge ensures that risk assessments and care plans are discussed with the patient and if appropriate their carer. This should be evidenced within the care documentation.	2	Immediate and ongoing	Risk assessments and care plans are completed collaboratively with each individual in Beech Villa. Comprehensive risk assessments are completed electronically and are updated regularly on the basis of a multi-disciplinary review. Any identified issues are discussed with the patient. Staff are aware that patient care plans will be subject to audit. It is expected that the named nurse review patient care plans at least monthly. Emerging needs must also be reflected and updated with care plans. Any amendment will be

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					discussed with the patient and carer if appropriate. Patients are encouraged to sign their care plans. Where an individual declines to do so, this will be clearly documented in the patient notes.
8	5.3.1 (c)	It is recommended that the Trust reviews the current practice for authorisation of larger purchases, including eliminating the practice of the same staff authorising the purchase and verifying the receipt. A policy and procedure should be developed and implemented.	2	3 July 2015	Since the RQIA financial inspection in January 2014 there have been 46 transactions of larger purchases requiring three signatures -1 person to authorise, 1 person to purchase and 1 to reconcile goods purchased against receipts. Of the 46 transactions 2 had only two signatures the other 44 had 3 signatures. All staff have been reminded of the requirement to ensure that there are 3 signatures. When ordering monies from patient's accounts 3 people are involved as signatures are required. There is a Trust Policy exists to support financial management at ward level 'Patients' Property Procedures March 2012'.

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					The requirement to update the existing policy has been raised with the Finance Department by the Head of Service. This will be taken forward as a corporate issue.
9	5.3.1 (c)	It is recommended that the nurse in charge introduces a weekly audit of receipts against expenditure on this ward.	2	Immediate and ongoing	The Acting Ward Manager explained to the inspector that receipts were being reconciled against the patient ledger; evidence was available in patient cash files. This practice had lapsed in the few weeks prior to the inspection due to staff leave and clinical prioritisation. From the date of inspection the Acting Ward Manager has reconciled all cash receipts on a weekly basis and signs the patient cash ledger verifying the action. Acting Ward Manager will sign the documentation and verify receipts in future.

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
10	5.3.1 (c)	It is recommended that the Trust introduces a secondary check of expenditure records on this ward.	2	Immediate and ongoing	Financial transactions are subject to internal Trust audit. This recommendation has been shared with the finance department.
11	5.3.1 (c)	It is recommended that the nurse in charge ensures that a record of all staff who obtain the key to the safe where patients' money is stored is maintained including the reason for access.	2	Immediate and ongoing	Since the date of inspection this is now current practice in Beech Villa. This is evidenced via a 'safe key register'.
12	4.3 (l)	It is recommended that the charge nurse ensures that all staff working on the ward receive an annual appraisal.	2	31 July 2015	All staff will have had their appraisal by 31st July 2015. The inspector confirmed that 11 of the 15 staff had received their annual appraisal and that the remaining 4 were due to have theirs completed by April 2015.
13	4.3 (i)	It is recommended that the Trust urgently review the continued use of the current beds on the ward. The outcome of the review should be clearly reflected in the	1	Immediate and on-going	The Acting Ward Manager has ensured that all patients in Beech Villa have a care plan in their files for using profiling and metal framed beds. All patients have current risk assessment. None of

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		environmental and ligature risk assessment. Patients who continue to use the beds should have a clear rationale in their care file supported by a risk assessment and care plan.			the patients in Beech are deemed to be at risk of suicide / self harm. This follows the Estates and Facilities Alert ref: EFA/2010/006 The Trust is currently undergoing a review of profiling and metal framed beds and plans to replace these once a suitable replacement is sourced. Replacements are being prioritised based on the clinical need/risk.
14	5.3.3 (b)	It is recommended that the acting ward manager ensures that risk screening tools and comprehensive risk assessments are completed in full. As outlined in the Promoting Quality Care Guidance Document – Good Practice on the Assessment and Management of Risk in Mental Health and Learning Disability Services- May 2010.	1	Immediate and ongoing	On the day of inspection, one comprehensive risk assessment could not be located on the EPEX records. All comprehensive risk assessments are fully up to date in Beech Villa. Evidence available as this information is held electronically. These assessments are updated following patient reviews and whenever a patient's risk profiles changes.

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
15	8.3 (j)	It is recommended that the nurse in charge ensures that staff assess patients' consent to daily care and treatment, this should be recorded in the patients' individual care plans and continuous nursing notes.	1	Immediate and ongoing	All patients in Beech Villa have a care plan detailing consent. The Acting Ward Manager has reinforced to staff the requirement to obtain and document patient's consent when carrying out any nursing/clinical procedure. Where consent is not given this must be discussed at the MDT and a best interest decision in conjunction with capacity assessment will apply. This will be documented in the patient's notes and legal advice sought where appropriate.
16	5.3.1 (a)	It is recommended that the acting ward manager ensures that all patients' care plans are reviewed as prescribed. Reviews of care plans should ensure that care plans are measurable and that the outcome of goals is reviewed.	1	Immediate and ongoing	The Acting Ward Manager has indicated to all trained staff that patient care plans will be subject to audit. Care plans are expected to be reviewed on a regular basis. Guidance on formulating measurable goals will be provided via CEC. The Head of Service will carry out random checks on care plans to ensure use of smart objectives. NIPEC Guidance has been issued to ward staff.
17	5.3.1 (a)	It is recommended that the nurse in charge ensures that all patients	1	30 April	On the day of inspection, 5 out of 12 patients did not have a discharge/resettlement care plan. Since

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		have a person centred discharge care plan that indicates the actions to support and prepare patients for discharge.		2015	inspection all but 2 patients in Beech now have a resettlement care plan. These patients are not subject to discharge planning at present having been in hospital for many years and presenting with complex needs.
18	5.3.1 (a)	It is recommended that the nurse in charge ensures that each patient has an individualised care plan that reflects the rationale and assessment of any individual or blanket restrictions. The care plan should incorporate the Deprivation of Liberty Safeguards.	1	30 April 2015	All patients in Beech Villa have been individually assessed and care plans collaboratively drawn up. These cover restrictive practices and incorporate Deprivation of Liberty safeguards. These include locked door, use of PRN medication and management of aggression.
19	6.3.2 (b)	It is recommended that the nurse in charge ensures that patient signatures are available on all relevant assessment and care documentation. Staff should record evidence of patient involvement.	1	Immediate and ongoing	The Acting Ward Manager has informed staff that patient files will be subject to audit and that this is an area that will be closely scrutinised. If for any reason an individual refuses or is unable to sign any document, this must be clearly detailed in the relevant assessment and care documentation.
20	5.3.1 (a)	It is recommended that the nurse in charge ensures that	1	Immediate	The Acting Ward Manager has spoken to staff in relation to this recommendation and reinforced that

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		individualised and person centred care plans are created for all new admissions and that whilst an assessment of the individual is ongoing an interim care plan should be agreed and put in place by the multi-disciplinary team (MDT).		an ongoing	all new patient transfers into Beech Villa should have an initial assessment of their needs established and relevant care plans collaboratively drawn up. All patients in Beech are transferred from admission wards and existing care plans may be used in the interim whilst assessment is ongoing.
21	5.3.1 (f)	It is recommended that the nurse in charge ensures that a detailed record of care delivered is contemporaneously documented per shift in accordance with the Nursing and Midwifery Council standards on record keeping.	1	Immediate and ongoing	The Acting Ward Manager has informed all staff that it is a requirement that at least 2 entries are recorded in patient's progress notes in a 24 hr period. This practice will be subject to audit.
22	6.3.2 (g)	It is recommended that the nurse in charge provides an opportunity for structured and meaningful recreational activity for those patients who do not avail of external day care services; this should consider the individual needs and views of the patients.	1	31 July 2015	Out of the 12 patients on the ward, 3 individuals choose not to engage with any activities offered by both recreational dept. and the staff on the ward. Staff in Beech Villa encourage participation however, respect the individual's choice not to engage in recreational activity. Since date of inspection a ward activity book is

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
					maintained where staff detail activities they have provided for patients outside of their daily programme in Rowan Villa.
23	5.3.1 (f)	It is recommended that the Trust ensures all policies and procedures are subject to a systematic and comprehensive three yearly review.	1	31 July 2015	This issue will be addressed via the Trust Quality and Safety committee. The Governance Lead will coordinate Mental Health input to Trust response
24	4.3 (m)	It is recommended that the Trust urgently review the current system and process for the collation, recording and maintenance of staff training records.	1	30 April 2015	A staff training matrix has been introduced to Beech Villa. This will be monitored by the Head of Service.
25	5.3.1 (f)	It is recommended that the Trust ensures that timescales are agreed against any actions carried forward following an MDT meeting so that progress can be monitored and tracked.	1	Immediate and ongoing	Timescales will be determined at MDT reviews and recorded in relevant documentation. Format for recording MDT meetings will be amended to include section for Action and timescale.
26	4.3 (m)	It is recommended that the Trust ensures that all ward based staff are provided with training in:	1	3 July 2015	3 staff have received training on restrictive interventions, 3 more staff have been booked for

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		Human Rights, restrictive practice, capacity, consent and Deprivation of Liberty safeguards.			16/4/15. The Head of Service will liaise with staff in acute sector to ensure that this awareness and training is provided on site. All staff will be made aware of the pertinent guidelines.
27	6.3.1 (a)	It is recommended that the Trust urgently review the current practice of transferring acutely unwell patients from Lime ward to Beech ward. If this practice is to continue an urgent review of the sleeping area and safe staffing arrangements must be completed.	1	31 March 2015	Last patient sleepover was in January 2015. The unused dormitory area would have been screened off to provide privacy in the event of the bed being used. Patients are only transferred following an updated MD risk assessment and agreement of the clinical team. The assessment will consider the support required by the patient to ensure safety and good practice. The Trust will follow the Regional Bed Management Protocol.
28	4.3 (i)	It is recommended that the Trust	1	31 March	The Head of Service will engage with HR

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
		confirms if staff are authorised to sleep in specified areas on the ward during their allocated breaks. If so authorised, it is recommended that the Trust provides guidance for staff in relation to sleeping on authorised breaks, including specifying the arrangements for the governance of this practice to ensure optimum patient safety and supervision at all times.		2015	Department and review guidance in relation to this practice to ensure optimum patient safety.
29	5.3.1 (f)	It is recommended that all members of the MDT ensure that documents such as the most recent case summaries are held in the current volume of records.	1	3 July 2015	All members of the MDT will be reminded to ensure that documents such as the most recent case summaries are held in the current volume of records.
30	5.3.1 (f)	It is recommended that all members of the MDT must ensure that the correct date and time is recorded in patients' care records. An audit of records should be undertaken to ensure accuracy.	1	3 July 2015	Ward Manager will emphasis this to staff and include in regular audit of care records.

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No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
31	5.3.1 (f)	It is recommended that the Trust review the current arrangements for the hand written recording of MDT records so to ensure information is clearly legible and that the writer and designation of the writer can be established.	1	3 July 2015	Staff will be reminded to write neatly and record their designation on all care records.
32	6.3.2 (g)	It is recommended that the nurse in charge ensures that agreed actions following patients' meetings are implemented and followed up at the next meeting.	1	31 July 2015	This is now current practice in Beech Villa. Patient meeting held 22/3/15 details of actions available with minutes. Patient forum meetings to be 3 monthly

NAME OF WARD MANAGER COMPLETING QIP	JIM DUFFY

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 CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	TREVOR MILLAR

Inspector assessment of returned QIP				**Inspector**	**Date**
		Yes	**No**		
A.	Quality Improvement Plan response assessed by inspector as acceptable		x	Kieran McCormick	**17/4/15**
B.	Further information requested from provider	x		Kieran McCormick	**17/4/15**