The Regulation and Quality Improvement Authority

Elm

Tyrone and Fermanagh Hospital

Western Health and Social Care Trust

Unannounced Inspection Report

Date of inspection: 18 May 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.

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

Elm is a 13 bedded female acute admission ward on the Tyrone & Fermanagh Hospital site. There is an integrated psychiatric intensive care unit (PICU) attached to the ward. The purpose of the unit is to provide assessment and treatment for patients with a psychiatric illness who require assessment and treatment in an inpatient care environment. On the day of the inspection there were five patients on the ward who had been detained under the Mental Health (Northern Ireland) Order 1986. The multidisciplinary team on the ward included input from nursing, psychiatry, social work and occupational therapy. The ward manager was in charge of the ward on the day of the inspection.

4.0 Summary

Progress in implementing the recommendations made following the previous inspections carried out on 13 September 2013 and 8 and 9 December 2014 were assessed during this inspection. There were a total of 12 recommendations made following the last inspection.

Six recommendations had been implemented in full. A plan was in place for all staff to have completed mandatory training, governance arrangements were in place to ensure vulnerable adult referrals were completed, safety alerts were shared with all nursing staff and remedial works to address risks identified in the environmental ligature risk assessment had been actioned.

Two recommendations had been partially met and four recommendations had not been met. It was concerning to note that one recommendation will be restated for a third time and four recommendations will be restated for a second time following this inspection.

Concerns were raised in relation to the absence of completed appraisals for nursing staff, and patients continuing to be nursed in metal frame beds without a risk assessment completed and subsequent risk management plan in place. Staff were not aware that the safety alert in relation to profiling beds included exposed metal frame beds.

There was limited information available in relation to activities that had been completed with patients by the occupational therapist and nursing staff. Patients did not have an individualised therapeutic activity plan in place. Records indicated that patients had received one to one support from their named nurse; however this was not on a daily basis as agreed within patients' care plans.

New recommendations have been made in relation to the occupational therapist completing assessments and devising therapeutic/recreational activity plans from these assessments. It has also been recommended that the occupational therapist records the patients' participation and progress in relation to these activities. A new recommendation has also been made in

relation to patients signing their multidisciplinary team template to ensure that they understand the agreed outcomes/actions of these meetings.

One patient who was interviewed by the inspector expressed concerns that that they had not received one to one individual time with their named nurse on a daily basis. One patient interviewed stated they would like to have access to tea and coffee facilities throughout the day. A recommendation will be restated in relation to these concerns and a new recommendation will be made.

The above concerns were discussed at the conclusion of the inspection with the ward manager and senior trust representatives. Assurances were given the these recommendations would be implemented.

4.1 Implementation of Recommendations

Seven recommendations which relate to the key question "**Is Care Safe**?" were made following the inspections undertaken on 13 September 2013 and 8 and 9 December 2014.

These recommendations were in relation to the low numbers of staff who had received mandatory training, governance arrangements in relation to adult safeguarding and the process of staff and managers receiving safety alerts. Concerns had also been raised in relation to environmental ligature risks that had been identified on the ward but had not been addressed to minimise the risk. The absence of risk assessments and subsequent care plans in relation to the risks associated with patients being nursing in metal frame beds were not completed.

The inspector was pleased to note that six recommendations had been fully implemented, and improvements had been made in relation to:

- A plan was in place for all staff to have up to date mandatory traning.
- All staff had received up to date vulnerable adult training.
- Governance arrangements were in place to ensure appropriate application of adult safeguarding procedures.
- Ligature work was being carried out on the ward during the inspection and since this date the Trust have confirmed that this work is now complete
- All safety alerts were sent to the ward manager. If relevant to the ward this was discuss with senior managers and action plans were devised.

However, despite assurances from the Trust, one recommendation had not been fully implemented. This recommendation will be restated for a **second time** following this inspection.

- The ward did not have individual risk assessments, care plans or a detailed rationale for the use of mental frames beds.

Four recommendations which relate to the key question "**Is Care Effective**?" were made following the inspection undertaken on 13 September 2013 and 8 and 9 December 2014

These recommendations concerned annual appraisals for nursing staff, the development of person centred care plans from assessed need which comply with published guidance and standards, and the involvement of patients in recreational and therapeutic activities on the ward. It was recommended that these activities are continued throughout the day including evening and weekends

However, despite assurances from the Trust, none of these recommendations had been fully implemented. Three recommendations were not met and one recommendation was only partially met.

One recommendation will be restated for a **third** time and three recommendations will be restated for a **second time** following this inspection.

- Nursing staff did not have an up to date appraisal in place

- A number of care plans had not been developed in response to individual assessed needs and did not comply with published guidance and standards

- There were no record of activities that had been carried out with patients on the ward by nursing staff

- There was no record to evidence that the ward was providing activities in the evenings and weekends.

One recommendation which relate to the key question "**Is Care Compassionate**?" was made following the inspections undertaken on 8 and 9 December 2014.

This recommendation concerned patients having the opportunity to meet with their named nurse on a daily basis.

However, despite assurances from the Trust, this recommendation had not been fully implemented. This recommendation will be restated for a **second time** following this inspection.

- Patients were not given the opportunity to meet with their name nurse on a daily basis

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

5.0 Patient Experience Interviews

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

Responses to the questions asked were mostly positive.

Two of the three patients felt that staff were supportive and helpful on admission to the ward. One patient said they were very unwell on admission and could not remember this period of time.

All three patients stated that they had been informed of their rights and that they were treated with dignity and respect all the time.

Two of the three patients felt fully involved in their care and treatment. One patient stated that they did not feel fully involved. This patient also stated that they would like some time spend with them after the multi-disciplinary meeting to explain the outcome of these meetings as they were never "quite sure what plan of care was going to be in place". The inspector reviewed three sets of care documentation and there was no evidence that patients had signed and agreed with the outcome of their MDT meetings. A recommendation has been made in relation to this.

All three patients stated they could refuse treatment and they all confirmed that staff listen to them. One patient stated that staff are sometimes too busy and they don't always get their one to one daily time with their named nurse. A recommendation has been made in relation to this.

All three patients said that staff provide an explanation before supporting them with care and treatment. Two out of the three patients said that they are informed of the outcome of assessments and investigations. One patient stated that they are never informed of any results. This patient advised that if the outcome of the multidisciplinary meeting was discussed with them this would help them to understand.

Two out of the three patients said that staff inform them on how they are progressing. One patient stated that they are not always informed. Two out of the three patients said they felt safe and secure on the ward. One patient stated that they did not like it when other patients were verbally abusive. However they stated they felt reassured by staff during these times.

All three patients said that they can attend activities each day. One patient said they had refused to attend activities on the ward. Two patients said that the activities were helpful and two patients said that being on the ward was helping them to recover. One patient said they did not feel that they were

recovering but stated: “I don’t think it’s the fault of the ward it’s just me……although I’m on new medication now which might help”

Patients made the following comments:

“I get on well with the staff, they are very sweet”

“The advocate spoke to me…I found them very helpful”

“I would like a detailed account of the multi-disciplinary meeting … the outcomes, so I can agree or disagree”

“The staff are brilliant, they take a lot of hassle from us patients”

“I attend the multi-disciplinary meeting and I’m on new medication and its working”

“Staff encourage me to do things …but I can refuse, I don’t go to activities, I don’t want to, but I did go to the shop with the occupational therapist once”

The detailed findings are included in Appendix 2

6.0 Other areas examined

During the course of the inspection the inspector met with:

Ward Staff	2
Other ward professionals	0
Advocates	0

The inspector spoke with two nursing staff working on the day of inspection. Staff who met with the inspector did not express any concerns regarding the ward or patients’ care and treatment.

The inspection was unannounced. Advocates were not available to meet with the inspector during the inspection.

7.0 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 13 July 2015

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

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

Appendix 1 – Follow up on Previous Recommendations

Appendix 2 – Patient Experience Interview

Appendix 1

Follow-up on recommendations made following the unannounced inspection on 8 and 9 December 2014.

No.	Reference.	Recommendations	No of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	4.3 (l,m)	It is recommended that the Ward Manager ensures that ward staff have undertaken mandatory training relevant to their role and that staff training records are complete and up to date.	2	The inspector reviewed the mandatory training records for nursing staff on the ward. In relation to fire training, 10 out of the 22 staff members did not have up to date training in place. However dates had been set up on 19th, 28th May and 4th June 2015 for all staff to be trained. It was confirmed by the ward on 12 June that all staff now have this training in place. There were 6 staff members who also required up to date training in Intermediate Life Support. The ward manager confirmed that this training will be completed by these 6 members of staff on 11th June. It was confirmed by the ward on 12 June that all staff now have this in place. In relation to manual handling training, 16 staff members required up to date training. The ward manager confirmed that dates had been set up in June and 11 members of staff will be trained by this date and a further five staff will be trained in August 2015. In relation to MAPA training (Management of Actual or Potential Aggression) the ward manager confirmed that all staff will have up to date training completed by 20th May.	Fully met

				No other concerns were noted in relation to mandatory training on the ward.	
2	4.3 (l)	It is recommended that the Ward Manager ensures that all nursing staff receive an annual appraisal.	2	The inspector discussed this with the ward manager who advised that to date no staff members on the ward had an appraisal. This recommendation will be restarted for a second time	Not met
3	5.3.1 (c)	It is recommended that the Trust ensures that staff receive training appropriate to their role in relation to safeguarding vulnerable adults procedures.	1	The inspector reviewed training records of the nursing staff on the ward and there was evidence that they all had received up to date vulnerable adult training.	Fully met
4	5.3.1 (c)	It is recommended that the Trust ensures that governance arrangements are in place at to ensure that appropriate application of adult safeguarding procedures.	1	The inspector discussed this procedure with the ward manager and two members of the nursing team. All staff demonstrated a good understanding of the vulnerable adult process. Referrals are discussed with the ward manager or deputy ward manager who then contacts the safeguarding team directly to make the appropriate referral.	Fully met
5	5.3.1	It is recommended that the Trust ensures that all priority actions to be taken to address risks identified following ligature risk assessments on the ward in June 2014 and November 2014 are actioned.	1	When the inspector carried out an observation of the ward environment they observed ligature work being carried out and senior managers within the Trust assured them that this work would be completed by 22 May 2015. The inspector subsequently received confirmation from the ward on 22 May which stated that this work had been completed.	Fully met
6	5.3.1 (a)	It is recommended that the	1	Works to address the risk of ligature in Elm ward was in	Fully met

		Trust ensures that the findings of the current ligature risk assessment is updated to ensure that all potential ligature points on the ward are identified and appropriate actions are taken.		progress on the day of the inspection. Senior managers within the Trust assured the inspector that this work would be completed by 22 May 2015. The inspector subsequently received confirmation from the ward on 22 May 2015 which stated that this work had been completed.	
7	5.3.1 (c, f)	It is recommended that where the use of a profiling/exposed metal frame bed on the ward is unavoidable, the Trust develops and implements a risk assessment as outlined by the Northern Ireland Adverse Incident Centre (NIAIC) – EFA/2010/006 safety alert self-harm associated with profiling beds reissued on 23 December 2013 and in the letter issued to Trust Chief Executives jointly from the Public Health Agency and Health and Social Care Board on 28 February 2014.	1	The inspector was informed that all patients on the ward were either nursed in a profiling bed or an exposed metal frame bed. The ward had one profiling bed and staff had completed a risk assessment and related care plan for this patient. However for the patients who were being nursed in a metal frame bed there was no evidence that risk assessments had been completed, and related care plans which detailed the rationale for the use of metal frames beds were not in place. This recommendation will be restated for a second time	Not met
8	8.3.1 (d)	It is recommended that the	1	The inspector discussed this process with the ward	Fully met

		Trust ensures that safety alerts are shared with all ward managers and relevant staff.		manager and the deputy ward manager who both confirmed that all safety alerts are sent to the ward manager. If relevant to the ward this is discussed with senior managers and action plans are devised. The ward manager advised that this is also discussed at governance meetings which are held every quarter.	
9	5.3.1 (a)	It is recommended that the ward manager ensures that patient care plans are developed in response to individual assessed needs, are patient centred and comply with published guidance and standards.	1	The inspector reviewed three sets of care documentation and there was evidence that care plans had been developed from assessed need. However in one care plan there was a description of the patient's needs and a detail of the objectives however the actual plan of care was not in place. In another patient's care documentation it was identified that the patient had a physical health care need which required treatment whilst they were on the ward. The care plan reviewed in relation to this area of care was not of an acceptable standard. It did not include a detailed account of the care the patient should be receiving on the ward and therefore did not safely direct this patient's care. This recommendation will be restated for a second time	Not met
10	6.3.2 (b,d)	It is recommended that the ward manager ensures that each patient has the opportunity to be involved in developing and agreeing their individual therapeutic	1	The inspector reviewed three sets of care documentation and there was no evidence that patients had had the opportunity to be involved in developing and agreeing an individual therapeutic/recreational activity programme. The inspector observed activities being carried out by	Not met

		and recreational activity programme and that this is reflected in the patients care documentation.		nursing staff with patients on the ward. There was also a timetable on the ward of the activities planned for the day. However, there were no records in the three sets of care documentation of activities that had been carried out with patients on the ward There was no evidence of occupational therapy (OT) assessments having been completed which would assist in devising appropriate therapeutic/recreational activities and goals for patients to work towards. There was evidence that one patient had attended therapeutic/recreational activities with the OT. However there was only a record of the activity recorded. There was no record of the patients' participation and progress in these areas. In two sets of records reviewed by the inspection there was no record of occupational therapy involvement and no record of the reasons why This recommendation will be restated for a second time and a new recommendation will be made.	
11	6.3.2 (b)	It is recommended that the ward manager ensures that each patient has the opportunity to meet with their nurse or a daily basis and that this is reflected in the patients care	1	In the three sets of care records reviewed there was evidence that each patient had a care plan in place which detailed that they would meet with their named nurse each day. In the three sets of care documentation there was evidence that patients had met with their named nurse however this was not on a daily basis. The inspector interviewed three patients and one of these	Partially met

		documentation.		patients advised that they did not have the opportunity to speak to their named nurse every day and stated they did not know if and when this would happen This recommendation will be restated for a second time .	
12	6.3.2 (b,d)	It is recommended that the range of therapeutic and recreational activities throughout the day including evenings and weekends is reviewed. This review should incorporate the views and choices of patients on the ward.	1	The inspector observed that the ward staff had displayed the activities that would take place on the day of the inspection. The inspector spoke to the deputy ward manager who advised that these activities change each day after they have a discussion with the patients in the morning as the patients choose what they want to do. They advised that each day they have three activities arranged. The deputy ward manager advised that patients can also attend the occupational therapy room to complete activities with the OT. In the three sets of care records reviewed by the inspector there was no evidence that patients were involved in therapeutic and recreational activities throughout the day including evenings and weekends as this was not recorded in the patients care documentation. There was no record of the patients' progress and participation in these activities. This recommendation will be restated for a second time	Partially met

Appendix 1

Western Health
and Social Care Trust

Ref EW.00829/JMcM

17th July 2015

The Regulation & Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Dear Sir/Madam

Please find enclosed completed quality improvement plan in relation to the unannounced inspection of Elm Ward, Tyrone & Fermanagh Hospital, which was undertaken on the 18th May 2015.

Should you require any further information, please do not hesitate to contact me.

Yours sincerely

ELAINE WAY CBE
CHIEF EXECUTIVE

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The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Inspection

Elm Ward, Tyrone and Fermanagh Hospital

18 May 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with the ward manager, the crisis service manager and the head of service on the day of the inspection visit.

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

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
Is Care Safe?					
1	5.3.1 (c, f)	It is recommended that where the use of a profiling/exposed metal frame bed on the ward is unavoidable, the Trust develops and implements a risk assessment as outlined by the Northern Ireland Adverse Incident Centre (NIAIC) – EFA/2010/006 safety alert self-harm associated with profiling beds reissued on 23 December 2013 and in the letter issued to Trust Chief Executives jointly from the Public Health Agency and Health and Social Care Board on 28 February 2014.	2	Immediate and ongoing	The Trust is in the process of procuring replacement beds of suitable specification to comply with HBN 35 - Accommodation for people with mental illness, Part 1, The Acute Unit (1999). The Estates and Facilities Alert EFA-2010-006 and associated considerations are known to all staff and shared at staff meetings and copies left on the ward. I can confirm that an individual risk screening tool has developed and taken through directorate governance processes for approval and implementation. A risk screening is completed for all patients admitted to the ward and an individual risk management plan is developed and reviewed where individual risks have been identified.

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
Is Care Effective?					
2	4.3 (l)	It is recommended that the Ward Manager ensures that all nursing staff receive an annual appraisal.	3	28 May 2015	All nursing staff have received an annual appraisal for 2015/2016 as per WHSCT appraisal and development review policy and procedure.
3	5.3.1 (a)	It is recommended that the ward manager ensures that patient care plans are developed in response to individual assessed needs, are patient centred and comply with published guidance and standards.	2	31 July 2015	The Ward Manager will review our current audit process to identify why it is not picking up issues in relation to patient's care plans. The Ward Manager will work with the Service Improvement Manager to take forward a practice improvement project relating to assessment, and care planning in-line with NIPEC standards for person centred record keeping practice.
4	6.3.2 (b,d)	It is recommended that the ward manager ensures that each patient has the opportunity to be involved in developing and agreeing their individual therapeutic and recreational activity programme and that this is reflected in the patients care documentation.	2	31 August 2015	Through the assessment and care planning practice improvement initiative above the Ward Manager and Service Improvement Manager will review patient involvement in the development of individualised programmes of therapeutic and recreational activity.

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
5	5.3.1 (a)	It is recommended that the occupational therapist (OT) ensures that patients have assessments completed and from these assessments an individualised therapeutic/recreational activity plans should be devised with goals for patients to work towards. A record should be maintained of the patients' participation and progress in toward these goals	1	31 August 2015	The Head Occupational Therapist will review why assessments / treatment plans / progress towards objectives were not recorded. A Crisis OT Treatment pathway (attached) will be implemented in August 2015.This incorporates Prioritisation for OT, Initial Standardised Assessment, OT plan, Treatment sessions and Pre-discharge Standardised Assessment. An audit of OT notes and records is planned for September 2015
6	5.3.3 (b)	It is recommended that the multi-disciplinary team (MDT) ensures patients review and sign the MDT template. Should a patient refuse to sign or is unable to do so this should be recorded on the document to explain the absence of the signature.	1	Immediate and ongoing	The Ward Manager will ensure that patients review and sign their Multidisciplinary Care Plan at or following the ward conference. If they refuse to sign or are unable to do so, this will be recorded on the document to explain the absence of the signature. The Ward Manager will also review our current audit process to identify why it is not picking up the lack of signature.
7	6.3.2 (b,d)	It is recommended that the range of therapeutic and recreational	2	31 July	The Head OT will facilitate a series of workshops with MDT staff in September2015, to develop a therapeutic activity

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
		activities throughout the day including evenings and weekends is reviewed. This review should incorporate the views and choices of patients on the ward.		2015	culture in Elm, with integrated OT and ward activity programmes, both group and individual. Service user involvement in the choice of therapeutic activities will be prioritised. This item has been placed on the weekly patient meetings Agenda and the views and choices of patients considered. The Ward Manager is also procuring additional activity resources.
Is Care Compassionate?					
8	6.3.2 (b)	It is recommended that the ward manager ensures that each patient has the opportunity to meet with their nurse or a daily basis and that this is reflected in the patients care documentation.	2	Immediate and ongoing	The ward has an established standard of daily 1:2:1 time between patients and their named nurses, which is subject to monthly audit. The audit takes its evidence from notes and records. The Ward Manager will keep this under review.
9	5.3.1 (f)	It is recommended that the trust reviews patients' access to tea and coffee facilitates on the ward to ensure patients have access to	1	31 July 2015	The Ward Manager has engaged with Trust Support Services to explore procurement of a hot and cold drinks vending machine for the ward.

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
		these facilities throughout the day			

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	Gloria Shaw
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	X		A McLellan	27/7/15
B.	Further information requested from provider				