The Regulation and Quality Improvement Authority

Elm

Tyrone and Fermanagh Hospital

Western Health and Social Care Trust

Unannounced Inspection Report

12 – 16 October 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 Inspection Outcomes

This inspection focussed on the theme of Person Centred Care

Person Centred Care

This means that patients are treated as individuals, with the care and treatment provided to them based around their specific needs and choices.

On this occasion Elm Ward has achieved the following levels of compliance:

Is Care Safe?	**Partially Met**
Is Care Effective?	**Partially Met**
Is Care Compassionate?	**Met**

3.0 What happens on Inspection

What did the inspector do:

- reviewed information sent to RQIA before the inspection
- talked to patients, carers and staff
- observed staff practice on the days of the inspection
- reviewed other documentation on the days of the inspection
- checked on what the ward had done to improve since the last inspection

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 the necessary improvements
- send regular update reports to RQIA for the inspector to review

4.0 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 care for patients with a psychiatric illness who require assessment and treatment in an inpatient care environment.

On the day of the inspection there were three 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. Referrals can also be made to the following teams within the community for support with patient care and treatment:

- Community addiction team
- Community personality disorder team
- Community forensic team
- Eating disorder team
- Psychosexual team

The acting ward manager was in charge of the ward on the day of the inspection.

5.0 Summary

5.1 What patients, carers and staff told inspectors

During the inspection the inspector was able to meet with:

7 patients
2 carers
5 staff
1 ward advocate

Patients told the lay assessor that:

They were given all the information they needed to understand their care and treatment. Two patients stated they were involved in some parts of their care and treatment plans and two patients stated they were just told how it was going to be. Inspectors reviewed these two patient's care records and noted that there was evidence that staff had engaged with the patients to updated them on their care can treatment.

Three of the seven patients who met with the lay assessor stated they were offered activities to take part in every day. Three patients stated they had not been involved in any activities on the ward and one patient stated that they had been involved in activities but sometimes they do not always take place.

Five patients interviewed stated that staff actively inform them how they are progressing and two patients stated that staff do not tell them how they are progressing.

Five patients felt that being on the ward was helping them recovery. One patient stated they were unsure of being on the ward was helping them recover and one patient stated that they felt they were not recovering on the ward. Patients made the following comments:

"I don't think I would have lasted as long here if it wasn't for the other patients……I think it would be of benefit if I had a copy of my care and treatment plans"

"Staff are very approachable and very kind they boost your morale"

"Nurses are great and the doctors"

"The rooms are nice…….they have a gym facility which is good…..there is good camaraderie amongst the patients…. Property can go wandering…a lockable cupboard in the room would be good"

"It's good, it's clean…..they're very gentle with you, doctors, cleaners and all".

“Staff and doctors are friendly enough”

Carers told the inspector that:

They felt their relatives’ health had improved since being admitted onto the ward. They stated that they were involved in their relatives’ care and treatment and had been informed of their diagnosis/condition.

One relative stated that they felt communication between staff on the ward could be improved as they have had to repeat information to a number of staff members.

One of the patient’s relatives who met with the inspector stated that they felt there were not enough activities on the ward for patients to participate in each day and that their relative was “bored”.

Relatives made the following comments:

“On the whole the care is very good…..empathy towards my daughter’s condition is very good”

“Staff are always friendly and approachable”

Staff told the inspector that:

The inspector spoke to the ward OT, two nursing staff, a health care worker and the ward social worker. All staff felt that the team worked well together and raised no concerns regarding the care and treatment of patients on the ward.

The staff who met with the inspector appeared to be very experienced in their role and had a good understanding of the needs of the patients on the ward.

The advocate told the inspector that:

They visit the ward once a week with another member of the team. They advised that they meet all new patients on the ward. They advised that their main role is to listen to any issues patients may have. They have been involved in supporting patients at MDT meetings and in helping to apply for benefits.

Patient experiences of the ward are reported in Appendix 2.

5.2 What inspectors saw during the inspection

The ward environment appeared clean, clutter free and odours were neutral. The furnishings throughout the ward were well maintained. Patients slept in four bedded bay areas and each area had a curtain for patients’ privacy. The bedroom areas were available to patients throughout the day. There were a number of rooms available for patients to retreat to and patients were observed

coming and going from the ward. The ward had a small garden area to the back of the ward which was not well maintained and did not provide a therapeutic environment for patients. The ward had access to a therapy room and a small gym.

There was a visitor's room at the entrance to the ward and visitors could also come onto the ward to visit patients. Patients had access to their mobile phones.

All staff on duty was wearing their name badges and information about the nursing staff and the MDT team was displayed. It was good to note the ward had an information booklet which was up to date. Information was displayed in relation to Human Rights, the Mental Health Order and the MHRT. There was information displayed regarding the days of the ward round and when the advocate visits the ward.

There were metal frame/profiling beds on the ward and risk assessments had been completed for patients with an associated care plan. The trust were in the process of replacing all metal frame/profiling beds. The ward had an up to date ligature risk assessment and action plan completed. It was good to note that all ligature work in relation to the environment had been completed

The inspector observed positive interactions between staff and patients over the days of the inspection. Staff showed empathy and warmth towards patients and were prompt in responding to patients' requests. Staff were present in the communal areas and actively engaging with patients throughout the day. Staff appeared skilled at de-escalating situations when patients had become distressed and anxious.

The inspector observed the ward OT facilitate an arts and craft session with patients. The inspector observed positive interaction between the OT and the patients who all seemed to enjoy this activity.

The detailed findings are included in Appendix 3 and 4

5.3 Key outcomes

5.3.1 Is Care Safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them

Compliance Level	Partially Met

What the ward did well

✓ Personal safety plans were individualised and were used to inform personal wellbeing plans.

✓The ward was clean and tidy and in a good state of repair.

✓The ward had a range of facilities available which were accessible to patients

✓Patients could access an outside space as there was a small garden area off from the main ward and a larger garden area at the front of the ward.

✓The ward had an up to date ligature risk assessment and action plan completed which evidenced that all ligature work in relation to the environment had been completed

✓A separate visitor's room was located just off the main ward and was used by children to visit family members. Visitors could also come onto the ward to visit relatives.

✓Staff had up to date appraisals in place and all nursing staff had a received regular supervision meetings with their line manager.

✓Patients were informed on how to make a complaint

✓ Staff attended to patients needs promptly when required

✓ There were enough staff available during the inspection to meet the needs of the patients on the ward.

✓ Patients said that staff had taken time to inform them of their rights and ensured they understood this process

Areas for improvement

- **Environmental safety**

X This garden area at the back of the ward was very small and was not well maintained. Cigarette debris was lying on the ground with bins overflowing. In both the back and front garden areas there were no plants or flowers and both gardens did not provide patients with a therapeutic environment. *Quality Standard 6.3.1 (c)*

- **Patient care**

X There was no evidence of patient/family/carer involvement in the patients' personal safety plans and no record of who contributed to the assessment. In

each personal safety plan reviewed there was no management plan or contingency plans completed and two out of the three personal safety plans contained very limited information and did not focus on patients' strengths. Personal safety plans were reviewed however they did not record an update on the current risks. Therefore they were not completed in accordance with the Promoting Quality Care - Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. *Quality Standard 5.3.1 (a)*

- **Staffing**

X There was no record of health care assistants having received supervision. *Quality standards 4.3 (i)*

X The average number of banking shifts per week was 17 shifts. *Quality Standard 4.3.(n)*

See attached Appendix 5 for detail.

5.3.2 Is Care Effective?

The right care, at the right time in the right place with the best outcome

Compliance Level	Partially Met

What the ward did well

✓ There was evidence in patients' care records that assessments were completed and interventions were based on each patient's assessed need.

✓ Patients attended their MDT meetings each week and were involved in their care and treatment plans.

✓ Patients were provided with 1:1 therapeutic time each day and there was evidence that their care and treatment was discussed at these sessions

✓ Personal wellbeing plans had been completed with patients' involvement and were reviewed regularly

✓ There was evidence that well-being plans included treatment goals, safety goals, family and social goals and health and lifestyle goals

✓ There was evidence of a number of low intensity psychological interventions and recreational activities being carried out with patients by nursing staff

✓ There was evidence that patients attended their MDT meetings each week and records were maintained of the decisions agreed, the person responsible for implementing the agreed actions and the timeframe for implementation.

✓ There was evidence of personal well-being plans being reviewed each week and updated when necessary

✓ There was evidence that patients were actively involved in their discharge plans and appropriate community support mechanisms had been put in place prior patients' discharge.

✓ The ward was an open ward and patients were observed coming and going from the ward throughout the inspection

✓ There was evidence that the MDT reviewed patients detention regularly to ensure patients were experiencing the least restrictive option when being cared for on the ward

✓The staff members who met with the inspector all appeared to have a good understanding of the needs of patients who were admitted onto the ward

✓There was evidence that staff had engaged with patients to updated them on their care can treatment

✓An advocate from Foyle Advocates attended the ward each week

Areas for improvement

- **Personal well-being plans**

X There was no evidence of assessments completed by the occupational therapist and therefore there was no individualised therapeutic/recreational activity plans set up with goals for each patient to work towards to support recovery. An action plan in relation to this area of improvement is to be forwarded to RQIA by 1st December 2015. *Quality Standard 5.3.1(a)*

X There was evidence of the implementation of low level psychological therapeutic interventions by staff on the ward. However these interventions were not referenced in the patients' personal well-being plans with regard to how they would assist in the patients' recovery. *Quality Standard 5.3.1(a)*

X Patient meetings were held however there was no clear evidence that the individual views and choices of patients had been considered.

See attached Appendix 6 for detail.

5.3.3 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

Compliance Level	Met

What the ward did well

✓ There was evidenced in patient care records and through observations on the days of the inspection that staff gained consent from patients prior to providing any intervention/care and treatment.

✓ Patients had been provided with one to one therapeutic time from nursing staff each day to discuss their care and treatment

✓ Patients attended their MDT meetings each week and were fully involved in their care and treatment

✓ An advocate from the Foyle advocacy service visits the ward each week and when requested by patients they attended meetings to support the patient

✓ Family members advised that staff are approachable and listen to their views and respected their opinion. They also felt that their relatives were treated with dignity and respect

✓ Patients were involved in developing their care and treatment plans

✓ Patients were observed sitting with staff discussing their care and treatment plans

✓ This is an open ward and patients were observed coming and going from the ward. There was evidence that the MDT team reviewed patients status at each ward round to ensure that the least restrictive measures are in place

✓ There was evidence in the patients' care records that they could refuse their care and treatment and these decisions were respected

✓ A number of patients interviewed by the lay assessor stated that staff had time to talk to them and they were offered reassurance when they were unhappy or feeling distressed

✓ Patients had their own mobile phones and there was evidence in the care records that staff ensured patients had access to the ward phone if they did not have a mobile phone

Areas for improvement

X A number of patients advised that they would like access to a locked cupboard for some of their belongings. *Quality Standard 6.3.2 (a)*

X Patients and relatives stated that the garden areas could be improved as there was nowhere pleasant for them to sit and relax. *Quality Standard 6.3.1 (c)*

X Patients stated that therapeutic activities on the ward were very limited *Quality Standard 5.3.1(a)*

X Patients did not have access to tea and coffee facilitates throughout the day. *Quality Standard 5.3.1 (f)*

See attached Appendix 7 for detail.

6.0 Follow up on Previous Inspection Recommendations

Nine recommendations were made following the last inspection on 18 May 2015. The inspector was pleased to note that five recommendations had been implemented in full. Two recommendations were not met and two were partially met. Two will be restated for a second time and two will be restated for a third time. These recommendations were in relation to the limited therapeutic and recreational activities on the ward as well as the availability of tea and coffee facilities for patients.

See attached Appendix 1 for detail.

7.0 Other Areas Examined

7.1 Serious concerns

RQIA wrote to the trust following this inspection as there were a number of concerns that required to be address as priority one. A response is due by 12 November 2015

- Lack of progress in implementing RQIA recommendations

RQIA have also requested an action plan by the 1 December 2015 in relation to the role of the occupational therapist (OT) on the ward and the plans in place in

relation to developing individualised therapeutic/recreational activity plans for paitent.

8.0 Next steps

Areas for improvement are summarised below. The Trust, in conjunction with ward staff, should provide an improvement plan to RQIA detailing the actions to be taken to address the areas identified.

	Area for Improvement	Timescale for implementation in full
Priority 1 recommendations		
1	Patients did not have the opportunity to be involved in developing and agreeing their individual therapeutic and recreational activity programme. *Quality Standard 6.3.2 (b,d)*	12/11/2015
2	The range of therapeutic and recreational activities planned throughout the day including evenings and weekends did not incorporate the individual views and choices of patients on the ward. *Quality Standard 6.3.2 (b,d)*	12/11/2105
Priority 2 recommendations		
3	There was no evidence of assessments completed by the occupational therapist and therefore there was no individualised therapeutic/recreational activity plans with goals set for each patient to work towards to support recovery. There was no record of the patients' participation and progress in meeting set goals. An action plan in relation to this area of improvement is to be forwarded to RQIA by 1st December 2015. Quality Standard 5.3.1 (a)	01/12/2015
4	This garden area at the back of the ward was very small and was not well maintained. Cigarette debris was lying on the ground with bins overflowing. In both the back and front garden areas. There were no plants or flowers and both gardens did not provide patients with a therapeutic environment. QualityStandard 6.3.1 (c)	15/01/16
5	There was no evidence of patient/family/carers involvement in the patients' personal safety plans and no record of who contributed to the assessments. In each personal safety plan reviewed there was no management plan or contingency plans completed and two out of the three personal safety plans contained very limited information and did not focus on patients strengths. Personal safety plans were reviewed	15/12/15

	however they did not record an update on the current risks. Therefore they were not completed in accordance with the Promoting Quality Care - Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. Quality Standard 5.3.1 (a)	
6	There was no record of health care assistants having received supervision. *Quality standards 4.3 (i)*	15/01/16
7	There was evidence of low level psychological therapeutic interventions facilitied by staff on the ward. However these interventions were not referenced in the patients' personal well-being plans with regard to how they would assist in the patients' recovery. *Quality Standard 5.3.1(a)*	15/12/15
8	A number of patients advised that they would like access to a locked cupboard for some of their belongings. Quality Standard 6.3.2 (a)	15/01/16
9	Patient meeting were held however there was no clear evidence that the individual views and choices of patients had been considered. *Quality Standard 5.3.3 (b)*	15/01/16
10	Patients did not have access to tea and coffee facilitates throughout the day. *Quality Standard 5.3.1 (f)*	15/01/16
Priority 3 recommendations		
11	The average number of bank shifts per week on the ward was 17 shifts. *Quality standard 4.3 (n)*	15/04/16

Definitions for prority recommendations

PRIORTY	TIMESCALE FOR IMPLEMENTATION IN FULL
1	This can be anywhere from **24 hours to 4 weeks from the date of the inspection** – the specific date for implementation in full will be specified
2	Up to **3 months** from the date of the inspection
3	Up to **6 months** from the date of the inspection

Appendix 1 – Previous Recommendations

Appendix 2 – PEI Questionnaires
This document can be made available on request

Appendix 3 – Ward Environmental Observation Tool
This document can be made available on request

Appendix 4 – Quality of Interaction Schedule
This document can be made available on request

Appendix 5 – Is Care Safe?
This document can be made available on request

Appendix 6 - Is Care Effective?
This document can be made available on request

Appendix 7 - Is Care Compassionate?
This document can be made available on request

Appendix 1

Follow-up on recommendations made following the unannounced inspection on 18 May 2015

No.	Reference.	Recommendations	No of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
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	The inspector reviewed three sets of care records and there was evidence that a risk assessment and care plan had been completed for all three patients in relation to the use of profiling beds/exposed metal frame beds on the ward. There was evidence that these assessments were reviewed regularly.	Met
2	4.3 (l)	It is recommended that the Ward Manager ensures that all nursing staff receive an annual appraisal.	3	The inspector reviewed the records of appraisals completed on the ward and there was evidence that all nursing staff including the health care assistants had received their annual appraisal.	Met
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	The inspector reviewed three sets of care records and there was evidence that care plans had been developed in response to the individual needs of patients**.**	Met

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	The inspector reviewed three sets of care records and there was evidence that patients were attending activities on the ward and if they had refused this was also recorded. Patient meetings were also held and activities for the forthcoming week were discussed and agreed. However each patient had not been given the opportunity to be involved in developing and agreeing their own individual therapeutic and recreational activity programme.	Partially Met
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	In the three sets of care records reviewed by the inspector there was no evidence of assessments completed by the OT. There were no individualised therapeutic/recreational activity plans in place with set goals for patients to work towards	Not Met
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	1	In the three sets of care records reviewed there was evidence that patients had signed their MDT template to indicate they had agreed with the actions from the meeting. When patients refused to sign this was also recorded with the reason why.	Met

		explain the absence of the signature.			
7	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.	2	The inspector reviewed three sets of care records and there was evidence that the range of therapeutic and recreational activities had been reviewed and were available to patients throughout the day including weekends. However this review did not incorporate the individual views of patients. Patient meeting were held however there was no clear evidence that the individual views and choices of patients had been considered.	Partially Met
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	The inspector reviewed three sets of care records and there was evidence that patients had been given the opportunity to meet with their nurse on a daily basis and that this was reflected in each patient's care documentation.	Met
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 these facilities throughout the day	1	The inspector was advised by senior trust representatives that they were planning to install a machine on the ward for patients to access tea and coffee during the day. However negotiations are still ongoing in relation to this.	Not Met

Western Health
and Social Care Trust

Chairman
Gerard Guckian

Chief Executive
Elaine Way

Ref EW.00882/JMcM

7th December 2015

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

Dear Sir/Madam

Please find enclosed completed HSC Trust Improvement Plan in relation to the inspection of Elm Ward which was undertaken on the 12 – 16 October 2015.

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

Yours sincerely

Elaine Way

ELAINE WAY CBE
CHIEF EXECUTIVE

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HSC Trust Improvement Plan

WARD NAME	Elm Ward	ACTING WARD MANAGER	Jackie McCutcheon	DATE OF INSPECTION	12-16 October 2015
NAME(S) OF PERSON(S) COMPLETING THE IMPROVEMENT PLAN	Jackie McCutcheon Gene Gillease	NAME(S) OF PERSON(S) AUTHORISING THE IMPROVEMENT PLAN	Claire Hay 8.12.15		

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

The areas where improvement is required, as identified during this inspection visit, are detailed in the inspection report and improvement plan.

The completed improvement plan should be completed and returned to team.mentalhealth@rqia.org.uk from the HSC Trust approved e-mail address, by 4 December 2015

Please password protect or redact information where required.

PRIORTY	TIMESCALE FOR IMPLEMENTATION IN FULL
1	This can be anywhere from **24 hours to 4 weeks from the date of the inspection** – the specific date for implementation in full will be specified
2	Up to **3 months** from the date of the inspection
3	Up to **6 months** from the date of the inspection

Part A

Priority 1: Please provide details of the actions taken by the Ward/Trust in the timeframe **immediately** after the inspection to address the areas identified as **Priority 1**.

Area identified for improvement	Timescale for full implementation	Actions taken by Ward/Trust	Attached Supporting Evidence	Date completed
Key Outcome Area – Is Care Safe? There were no areas of improvement identified as a result of this inspection within this priority				
Key Outcome Area – Is Care Effective? There were no areas of improvement identified as a result of this inspection within this priority				
Key Outcome Area – Is Care Compassionate? There were no areas of improvement identified as a result of this inspection within this priority				

Part B

Priority 2: Please provide details of the actions proposed by the Ward/Trust to address the areas identified for improvement. The timescale within which the improvement must be made has been set by RQIA.

Area identified for improvement	Timescale for improvement	Actions to be taken by Ward	Responsibility for implementation
Key Outcome Area – Is Care Safe? The garden area at the back of the ward was very small and was not well maintained. Cigarette debris was lying on the ground with bins overflowing. In both the back and front garden areas there were no plants or flowers and both gardens did not provide patients with a therapeutic environment. **Minimum Standard 6.3.1 (c)** This area has been identified for improvement for the **first** time	15/01/16	The outdoor patio area at the rear of Elm is limited in size due to topography and the site boundry. Since inspection the area has been powerwashed and cleaned. The seasonal nature of this makes a January 2016 timescale difficult. Planters and shrubs will be procured in spring 2016 to enhance the areas.	
Key Outcome Area – Is Care Safe? There was no evidence of patient/family/carer involvement in the patients' personal safety plans and no record of who contributed to the assessments. In each personal safety plan reviewed there was no management plan or contingency plans completed and two out of the three personal safety plans contained very limited information and did not focus on patients' strengths. Personal safety plans were reviewed however they	15/12/15	Comprehensive risk assessment and management plans are being completed for all patients on admission in accordance with the Promoting Quality Care-Good Practic Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. Deficits have been addressed since the time of inspection and the process now includes evidence of patient/family/carer involvement and a record of who contibuted to assessment. The Comprehensive Risk assessment and Management plan is reviewed and updated on an ongoing basis in the context of Mutidisciplinary Zoning meetings	

did not detail an update on the current risks. Therefore they were not completed in accordance with the Promoting Quality Care - Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. **Quality Standard 5.3.1 (a)** This area has been identified for improvement for the **first** time			
Key Outcome Area – Is Care Safe? There was no record of health care assistants having received supervision. **Quality standards 4.3 (i)** This area has been identified for improvement for the **first** time	15/01/16	Ward has put arrangements in place for supervision of nursing assistants. Supervisors have been identified and received appropriate training. Consultation is taking place in the process and content of supervision. All available nursing assistants will receive a first supervision session before timescale date. Supervision records will be maintained.	
Key Outcome Area – Is Care Effective? There was evidence of low level psychological therapeutic interventions being carried out on the ward by nursing staff. However these interventions were not referenced in the patients' personal well-being plans with regard to how they would assist in patients' recovery. **Minimum Standard 5.3.1(a)**	15/12/15	The Ward Sister has engaged with staff to assure that all nursing interventions occur in the context of a nursing assessment and related care plan that is subject to regular review based on individual needs, and set in terms of recovery principles. The Ward Sister will monitor nursing records in relation to this	

This area has been identified for improvement for the **first** time			
Key Outcome Area – Is Care Effective? Patient meetings were held however there was no clear evidence that the individual views and choices of patients had been considered **Minimum Standard 5.3.3 (b)** This area has been identified for improvement for the **first** time	15/01/16	Since inspection the Ward Sister has ensured that patient meetings are clearly minuted and include evidence that individual views and choices of patients have been considered and any related actions have been taken.	
Key Outcome Area – Is Care Compassionate? A number of patients advised that they would like access to a locked cupboard for some of their belongings. **Minimum Standard 6.3.2 (a)** This area has been identified for improvement for the **first** time	15/01/16	Patients currently have access to a central locked property store on the ward to store their belongings. Patients also have access if they wish to a secure cupboard for valuables. The Head of Service will explore procurement of individual lockers for patients on Elm Ward.	

Part C

Priority 3: Please provide details of the actions proposed by the Ward/Trust to address the areas identified for improvement. The timescale within which the improvement must be made has been set by RQIA.

Area identified for improvement	Timescale for improvement	Actions to be taken by Ward	Responsibility for implementation
Key Outcome Area – Is Care Safe? The average number of banking shifts per week was 17 shifts. **Minimum Standard 4.3.(n)** This area has been identified for improvement for the **first** time	15/04/15	All funded nursing posts within Elm Ward are currently filled. The nurse bank is used to cover absences including: Sickness Training Other unscheduled absences Attendance at work is managed through the WHSCT Attendance at Work Protocol Use of bank is necessary to assure safe and effective services and adequate staff to patient ratios at times when absences occur. Bank is also used on occasions to elevate staffing levels to meet patient needs. The ward sister keeps use of bank under review daily and verfies all bank use. She submits a monthly bank use report that is scrutinised through WHSCT Qulaity Improvement & Cost Reduction Projects (QICR). The Lead Nurse for Adult Mental Health and the Crisis Services Manager will meet with the Assistant Director for Nursing Workforce and Education to consider use of bank in Elm. Bank staff who work in Elm come from an established cohort	

		of internal staff who are familiar with the ward, its systems and routines which lends to consistency and continuity of patient experience.	
Key Outcome Area – Is Care Effective? There were no areas of improvement identified as a result of this inspection within this priority			
Key Outcome Area – Is Care Compassionate? There were no areas of improvement identified as a result of this inspection within this priority			

Part D

Outstanding Recommendations: Please provide details of the actions proposed by the Ward/Trust to address outstanding recommendations, identified at previous inspections. The timescale within which the improvement must be made has been set by RQIA.

Recommendation	Timescale for improvement	Actions to be taken by Ward	Responsibility for implementation
Key Outcome Area – Is Care Safe? There were no areas of improvement			

identified as a result of this inspection within this priority			
Key Outcome Area – Is Care Effective? Patients did not have the opportunity to be involved in developing and agreeing their individual therapeutic and recreational activity programme. **Minimum Standard 6.3.2 (b,d)** This area has been identified for improvement for the **third** time	12/11/2015	As per correspondence with the RQIA on 12.11.15. Patients are now involved in developing and agreeing their individual therapeutic and recreational activity programme. Following review by the Head Occupational Therapist with effect from 9th November 2015 dedicated OT staff are providing input into Elm Ward. All patients are screened and prioritised by the multidisciplinary team for specific OT assesment and therapeutic interventions, and are engaged in the development of their individual plan based on assessed needs. The plan includes individual/group OT and ward based nursing therapeutic activities spanning a 7 day period. The plan is discussed and developed at a weekly staff-patient meeting where patients contribute to the type and range of activity to be delivered. Patients meet nursing staff to discuss and agree individual activity plans based on their needs.	
Key Outcome Area – Is Care Effective? The range of therapeutic and recreational activities throughout the day including evenings and weekends did not incorporate the individual views and choices of patients on the ward. **Minimum Standard 6.3.2 (b,d)** This area has been identified for improvement for the **third** time	12/11/2015	The programme of therapeutic and recreational activities is now reviewed at the weekly staff-patient meeting and is developed based on individual views and choices.	

Key Outcome Area – Is Care Effective? There was no evidence of assessments completed by the occupational therapist and therefore there was no individualised therapeutic/recreational activity plans set up with goals set for each patient to work towards to support recovery. There was no record of the patients' participation and progress in meeting set goals. An action plan in relation to this area of improvement is to be forwarded to RQIA by 1st December 2015. **Minimum Standard 5.3.1 (a)** This area has been identified for improvement for the **second** time	01/12/15	Following review the Crisis Service OT Care Pathway has been implemented. This process includes individual screening and assessment set against a service priority check list, and includes individual OT care planning that sets individual activity plans and goals to support recovery, and includes individual person-centred OT review. OT record-keeping practice in relation to this now includes evidence of patient involvement.	
Key Outcome Area – Is Care Compassionate? Patients did not have access to tea and coffee facilitates throughout the day. **Minimum Standard 5.3.1 (f)** This area has been identified for improvement for the **second** time	15/01/16	The Ward Sister and Crisis Service Manager have been engaging with Support Services in relation to providing tea and coffee facilities in the form of vending machines on Elm Ward. Preparatory estates plumbing and installation work is complete. A six month trial of a vending machine has been agreed and we are awaiting confirmation date for installation of the machine.	

TO BE COMPLETED BY RQIA

I have reviewed the Trust Improvement Plan and I am satisfied with the proposed actions or I have reviewed the Trust Improvement Plan and I have requested further information	A McLellan	14/12/15.
I have reviewed additional information from the Trust and I am satisfied with the proposed actions		