Unannounced Follow up Inspection Report
28 - 29 November 2017

Oak A Ward

Acute Psychiatric Admission
Tyrone and Fermanagh Hospital
Omagh

Tel No: 028 8283 3100

Inspector: Alan Guthrie

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Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Oak A is a ten bedded mixed gender ward set on the Tyrone and Fermanagh Hospital site. The ward provides assessment and care and treatment to patients over the age of 65 with a mental health illness. On the days of the inspection there were ten patients admitted to the ward. This included two patients who had been detained in accordance with the Mental Health (NI) Order 1986. The ward was also providing continuous support to one patient. The patient was being supported by one staff at all times.

The multidisciplinary team (MDT) consists of nursing, psychiatry, occupational therapy, and psychology. The ward sister was in charge on the days of the inspection.

3.0 Service details

Responsible person: Anne Kilgallen	**Ward Manager:** Nicola Hayes
Category of care: Functional mental health 65+	**Number of beds:** 10
Person in charge at the time of inspection: Nicola Hayes	

4.0 Inspection summary

An unannounced follow-up inspection took place over two days on 28 – 29 November 2017.

The purpose of the inspection was to meet with patients and staff and to review twenty areas for improvement identified from the previous unannounced inspection completed on 7 - 9 June 2016. Findings from the inspection were positive and the inspector evidenced that on the day of the inspection patients were receiving a good standard of care.

On the days of the inspection the inspector evidenced that the ward was appropriately staffed and the atmosphere was relaxed. Patients presented as being at ease in their surroundings and staff were patient focussed and attentive. The ward was clean, fresh smelling and well presented. Patients who met with the inspector were complimentary about the care and treatment they were receiving. Each of the patients reflected positively on their relationships with staff. It was positive to note that each of the five patients who met with the inspector stated that they were getting better since their admission to the ward. Staff who met with the inspector stated that the ward was managed appropriately and the care and treatment interventions provided to patients were effective.

The inspector reviewed each of the twenty areas for improvement and evidenced that the Trust had made significant progress in addressing each of the areas identified. Seventeen of these areas had been met. Three areas had not been met. Although the ward's environment had remained largely unchanged and there were a significant number of ligature points, the Trust was in the process of moving Oak A to an adjacent ward. The inspector reviewed the adjoining ward and noted that its environment had been refurbished to a high standard. New anti-ligature

fittings were evident and the new ward provided more communal areas for patients. The inspector was informed by the ward's senior management team that Oak A would be moving to the adjoining ward within the next three weeks. The inspector wrote to the Trust asking that confirmation of the move be forwarded to RQIA in writing.

Areas for improvement in relation to profiling beds, patient risk assessments, 1 to 1 contact between patients and staff, care planning, medical review, MDT minutes, clinical management and supervision, patient meetings, patient access to psychology, care pathways and Trust policies had all been met. The evidence verifying the inspector's findings for each of these areas for improvement is discussed below.

Three areas for improvement had not been met. The inspector reviewed the Velux window which was located in the lounge within Oak B (ward adjoining Oak A and the ward to which Oak A will be moving to in the near future). The window remained broken. The inspector met with a member of the Trust's estate services staff. The estates officer informed the inspector that the window would be reviewed in the near future.

The inspector reviewed records of the patient forum meetings completed during the previous year. It was positive to note that from the 24/10/17 meetings commenced being held on a weekly basis. However, prior to this there were significant gaps between meetings. The inspector also noted that records of meetings completed from the 24 October 2017 did not include action points.

The consultant psychiatrist continued to work as a locum. It is important to note that the Trust had attempted to recruit a permanent consultant since the last inspection. Each of these three areas for improvement has not been met and will be restated for a second time.

The inspector identified two new areas for improvement. The Trust should ensure that the ward's weekly meeting is attended by a community team representative. Secondly a procedure for the completion of comprehensive risk assessments (CRA's), (in accordance to PQC guidance) should be agreed between acute care services and relevant community teams. The procedure should define whose responsibility it is to complete a CRA when patients are already known to the Trust. It should also state who is responsible for the completion of a CRA as a result of an emergency admission where the patient is not known.

The inspector reviewed three sets of patient care records. Generally, records were noted to be comprehensive, up to date and easy to follow. Each patient had a comprehensive assessment, risk assessment and care plan based on their assessed needs. The ward had introduced a new MDT template and patient care pathway documentation. Nursing continuous care records were noted to be appropriately detailed, patient centred and linked to the patient's care plan.

The inspector reviewed the ward's clinical room and emergency medical equipment. The clinical room was bright, clean and appropriately maintained. The ward's emergency equipment had been well maintained and regularly reviewed. The ward's dining and kitchen area was clean and welcoming. The ward's reception and lounge areas were being maintained to a good standard and there was appropriate information relevant to patients and carers was posted on notice boards throughout the ward. The inspector was concerned to note that clean linen was being stored on a trolley at the end of the ward's entrance corridor. The inspector discussed this with the ward manager. The inspector was given assurances that his issue would be addressed with staff and linen would be stored appropriately. The inspector was informed that

a store room on the ward would be made available to store linen. Subsequently, an area for improvement has not been made.

Patients stated

The inspector met with five patients. Patients presented as being content and at ease in their surroundings and with staff. Patients were very positive about the ward and the support they received from nursing staff. Patients stated that they felt safe on the ward and that they were treated with dignity and respect. It was positive to note that each patient stated they had felt better since their admission. The inspector observed patient and staff interactions on both days of the inspection. Staff were evidenced as being supportive, attentive, patient centred and caring. The inspector observed staff to be available throughout the ward. Patients moved freely and patient requests were dealt with promptly and appropriately. Patients who met with the inspector reported that they knew who to talk to if they had a concern or were not happy. Patients stated they had no concerns when requesting support from staff.

Patient comments included:

"Staff are very nice and courteous".

"Staff are very helpful".

"I have no complaints".

"Staff are very good to me".

"Very content with the ward".

"I feel safe".

"I wouldn't change anything".

Relatives stated

No relatives were available to meet with the inspector on the days of the inspection. One relative's questionnaire was returned. The relative recorded that they were very satisfied with the care patients received on the ward. The relative also commented that they felt the ward was well managed.

Staff stated

The inspector met with ten members of ward staff.

Staff who met with the inspector reported that they felt the ward was effective and patient centred. Staff stated that they felt the ward was generally a positive place to work and that their views and opinions were sought and considered. Staff reported that they felt the MDT was effective. Nursing staff who spoke with the inspector recorded that they believed the care provided to patients admitted to the ward was safe, effective and compassionate. Staff also felt that the ward was well led and appropriately managed.

Staff reported no concerns regarding the levels of nursing staff available. Staff informed the inspector that they had no difficulties regarding their ability to access training and supervision.

Staff comments included:

"I have no concerns regarding my clinical supervision or the managerial support I receive".

"The garden in the new ward needs a refurb."

"Access to podiatry can be difficult at times".

The inspector discussed patient access to podiatry services with the ward manager. The ward manager assured the inspector that accessing podiatry services for patients was not an issue. The ward manager stated that patients on the ward could be fast tracked into services as required. The garden within the ward where Oak A will be moving to is to be refurbished prior to the move.

The findings of this report will provide the Trust with the necessary information to assist them to fulfil their responsibilities, enhance practice and service user experience.

4.1 Inspection outcome

Total number of areas for improvement	Five

The total number of areas for improvement comprise of three areas being restated for a second time. Two new areas for improvement were also identified as a result of this inspection. These relate to the completion of comprehensive risk assessments for patients admitted to the ward and community team representation at the ward's MDT meeting.

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

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

5.0 How we inspect

The inspection was underpinned by:

- The Mental Health (Northern Ireland) Order 1986
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006
- The Human Rights Act 1998
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- Optional Protocol to the Convention Against Torture (OPCAT) 2002

6.0 The inspection

The following areas were examined during the inspection:

- Care documentation in relation to four patients
- Ward environment
- Patient discharge/transfer arrangements
- Minutes of staff meetings
- Records in relation to incidents and accidents
- Staff supervision and appraisal dates
- Staff training
- Staff duty rotas
- Complaints and compliments
- Information in relation to safeguarding vulnerable adults
- Minutes from governance meetings

6.1 Review of areas for improvement from the last unannounced inspection

The most recent inspection of Oak A ward was an unannounced inspection. The completed Provider Compliance Plan (PCP) was returned and approved by the responsible inspector. During this inspection the inspector reviewed the areas for improvement made at the previous inspection and an assessment of compliance was recorded as met, partially met or not met. This PCP was validated by the inspector during this inspection.

Follow-up on recommendations made following the unannounced inspection on 7 – 9 June 2016

Areas for Improvement		Validation of Compliance
Number/Area 1 **Ref**: 5.3.1(f) **Stated:** First Time	The wards' environmental ligature risk assessment and action plan had not been updated to detail when this work would be completed.	**Met**
	Action taken as confirmed during the inspection: The inspector evidenced that the ward's ligature risk assessment and action plan had not been updated and anti-ligature work within the ward had not been completed. However, the inspector was informed that patients from Oak A would be moving to the ward next door (formerly Oak B) in the next two weeks. Oak B had been renovated and significant anti-ligature works had been completed. The inspector reviewed Oak B and noted that it had been updated to a good standard. Doors, blinds and toilet areas had been fitted with anti-ligature fixtures. The ward manager informed the inspector that Oak B's environmental assessment would be updated to include assessment and review of any remaining ligature points. The ward manager was confident that any outstanding ligature concerns would be locally managed by the ward staff team.	
Number/Area 2 **Ref**: 5.3.1(f) **Stated:** First time	A patient who required a profiling bed did not have a risk assessment/management plan in place.	**Met**
	Action taken as confirmed during the inspection: On the days of the inspection three patients were being nursed and cared for using a profiling bed. The inspector reviewed each patient's risk assessment and noted that each patient's *Person centred integrated care pathway* (risk assessment section 4) had been updated to include a profiling bed risk assessment. Patient care plans also reflected the need and use of a profiling bed. The inspector noted no concerns regarding the MDT's ability to manage associated risks and the use of profiling beds. It was positive to note that each of the profiling beds had been placed close to the nursing station.	

Number/Area 3 **Ref**: 5.3.1(a) **Stated:** First Time	A number of vacant profiling beds were on the ward which created extra ligature points and therefore needed to be removed.	**Met**
	Action taken as confirmed during the inspection: The inspector evidenced that there were three profiling beds available on the ward. Each bed was being used. The remaining seven beds were fixed divan beds.	
Number/Area 4 **Ref**: 5.3.1(a) **Stated:** First Time	Patients' risk assessments were not completed in accordance with the Promoting Quality Care – Good Practice Guidance on the Assessment of Risk Management of Risk in Mental Health and Learning Disability Services, May 2010.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed three sets of patient care records and risk assessments. The inspector evidenced that each patient had a comprehensive risk assessment (CRA) completed. The ward's practice was to ensure that a CRA is completed upon admission if one has not been completed prior to admission (for example if the patient was previously unknown to services and did not have a community keyworker). Patient's CRA's were evidenced as being up to date, patient centred and continually reviewed. CRA's were retained on electronic format on the Trust's PARIS (electronic patient information system). The inspector noted that not all patients admitted to the ward had a CRA completed prior to their admission. The inspector evidenced that two patients did not have a CRA completed in the community despite this being indicated as necessary in accordance to Promoting Quality Care (PQC) Regional Guidance 2011. The inspector noted that ward staff completed CRA's for patients admitted to the ward despite staff not being best placed or having previous knowledge of the patient. The inspector has detailed two new areas for improvement. Firstly, the Trust should ensure that the ward's weekly meeting is attended by a community team representative. Secondly a procedure for the completion of CRA's, (in accordance to PQC guidance) should be agreed	

	between acute care and relevant community teams. The procedure should define whose responsibility it is to complete a CRA when patients are already known to the Trust vs. the completion of a CRA as a result of an emergency admission where the patient is not known.	
Number/Area 5 **Ref**: 5.3.1(a) **Stated:** First Time	Patients' individual environmental risk assessments were not person centred. **Action taken as confirmed during the inspection**: The inspector reviewed three sets of patient person centred integrated care pathways (ICP's), associated risk assessments, CRA's and care plans. The ICP risk assessments were completed on prepopulated booklets and the information provided was in a tick box format. However, when cross referenced with patients individualised falls risk assessments, CRA's and care plans the inspector was able to evidence a comprehensive risk assessment was in place for each patient. When reviewed together these records evidenced that each patient's risk assessment was individualised, patient centred and specific to the presenting needs of the patient. The inspector also evidenced that each patient had an individual assessment in relation to the ward's locked door. Those patients' deemed as having capacity could leave the ward as required and they were provided with the four digit security code. This procedure was in line with the Trust's locked door policy. The inspector noted that none of the patients he met with had accessed the four digit code. Patient involvement in assessment, risk assessment and care planning was evidenced in each of the care plans reviewed.	**Met**
Number/Area 6 **Ref**: 5.3.1(a) **Stated:** First Time	Patients did not always receive daily 1:1 therapeutic time. **Action taken as confirmed during the inspection**: The inspector met with five patients. Patients reported no concerns regarding their ability to meet and speak with nursing and ward staff. Care records	**Met**

	reviewed by the inspector evidenced that patients were engaging in daily therapeutic interactions with nursing staff, ward staff and fellow patients. The inspector noted that nursing continuing care records were completed to a high standard and evidenced that nursing staff remained patient centred, attentive and engaged with patients. These findings were supported by the inspector's observations during the two day inspection. The inspector observed six staff/patient interactions and noted these to be positive and supportive. Patients presented as being relaxed and at ease and comfortable with staff.	
Number/Area 7 **Ref**: 5.3.1(a) **Stated:** First Time	Care plans were inconsistently reviewed in the progress notes. **Action taken as confirmed during the inspection**: The inspector assessed three patient care plans and progress notes. Care plans detailed that staff reviewed these on a weekly basis and as required. Care plans were also reviewed each Tuesday by the ward's MDT. Care plans were goal orientated and nursing staff continually assessed each patient's progress against the patient's care plan goals. The continuing care records evidenced the care plan interventions. The inspector also noted that patients could access medical support as and when required. This included review by the ward's consultant.	**Met**
Number/Area 8 **Ref**: 5.3.3(b) **Stated:** First Time	Patients did not appear to be routinely reviewed again during the week by the consultant psychiatrist. **Action taken as confirmed during the inspection**: Patients were reviewed by the ward's MDT and the consultant psychiatrist each Tuesday morning. The consultant psychiatrist also attended the ward on Friday afternoons to complete any further follow up assessments/consultations with patients.	**Met**
Number/Area 9 **Ref**: 5.3.1(a) **Stated:** First Time	The MDT template was not completed in full. **Action taken as confirmed during the inspection**: The ward had updated its MDT template. Templates reviewed by the inspector had been completed	**Met**

	comprehensively and in full. It was positive to note that the MDT record provided a detailed review of each patient's progress. The MDT record had been signed by a nurse. The inspector was informed that the consultant had also commenced signing the record and this was evident in two sets of the patient records.	
Number/Area 10 **Ref**: 6.3.2(a) **Stated:** First Time	The ward environment was very small with limited room in the communal rooms. **Action taken as confirmed during the inspection**: Oak A's layout remained unchanged and the inspector noted that patients and staff had limited space within communal rooms due to the ward's design. The Trust had completed renovation work on Oak B ward (located next door to Oak A through interconnected corridors) and the inspector was informed that patients would be moving from Oak A into Oak B within the next two weeks. Oak B's layout included three communal rooms as compared to Oak A's two. The inspector noted that due to the ward's structural design space for a large communal room was limited. The inspector wrote to the Trust requesting that the Trust inform RQIA when patients move to Oak B.	**Met**
Number/Area 11 **Ref**: 6.3.2(a) **Stated:** First Time	In an adjoining room to the ward which was used as an activity room the Velux window was broken (it would not open). **Action taken as confirmed during the inspection**: The inspector reviewed the Velux window which was located in the lounge within Oak B (adjoining Oak A). The window remained broken. The inspector met with a member of the Trust's estate services staff. The staff member informed the inspector that the window would be reviewed in the near future.	**Not Met**
Number/Area 12 **Ref**: 4.3(l) **Stated:** First Time	The consultant psychiatrist (locum) was not aware of their clinical lead. **Action taken as confirmed during the inspection**: The inspector met with the ward's consultant psychiatrist. The consultant confirmed that they continued to have clinical supervision, on a quarterly basis, with the Trust's clinical lead for older people's	**Met**

	services.	
Number/Area 13 **Ref**: 6.3.2(g) **Stated:** First Time	Minutes of the patient forum meetings did not evidence that action had been taken to address issues raised at the previous monthly meeting. Patients' average stay on the ward was 51 days however the patient forum meetings were held on a monthly basis.	**Not Met**
	Action taken as confirmed during the inspection: The inspector reviewed records of the patient forum meetings completed during the previous year. It was positive to note that from the 24/10/17 meetings commenced being held on a weekly basis. However, prior to this there were significant gaps between meetings. Meetings had been held on the following dates during the previous year: • 01-07-16 • 25-07-16 • 26-01-17 • 10-05-17 • 04-08-17 • 07-09-17 The inspector also noted that records of meetings completed from the 24 October 2017 did not include required action points.	
Number/Area 14 **Ref**: 4.3(n) **Stated:** First Time	The clinical psychologist was unclear regarding their allocated time on the ward to provide patients with psychological interventions.	**Met**
	Action taken as confirmed during the inspection: The inspector was informed that the clinical psychologist had 1 day per week of protected time in Oak A to provide support to patients. At the time of the inspection the psychologist was on long term leave. Unfortunately the Trust had been unable to recruit a temporary psychologist in the interim. Despite this it was positive to note that a psychologist was available to support patients as required. This service was limited as the psychologist was providing support to two wards and the community teams. The ward's senior management team confirmed that the psychologist had a set time of one day per week to support patients in Oak A.	

Number/Area 15 **Ref**: 4.3(l) **Stated:** First Time	The consultant psychiatrist and clinical psychologist had not received any information in relation to clinical governance meetings from their clinical leads.	**Met**
	Action taken as confirmed during the inspection: The inspector was unable to meet with the ward's consultant psychologist as they were on long term leave. The ward's consultant psychiatrist stated that they were invited to clinical governance meetings. The consultant also explained that clinical governance arrangements and reviews were completed as part of their clinical supervision. The inspector was satisfied that the consultant psychologist did receive governance information as they were routinely invited to attend governance meetings.	
Number/Area 16 **Ref**: 4.3(l) **Stated:** First Time	Nursing staff appeared to have limited understanding with regard to defined care pathways, evidence based practice and the process of formulation.	**Met**
	Action taken as confirmed during the inspection: Staff who met with the inspector understood the needs of the patient group and demonstrated an understanding of the ethos and purpose of the ward. Each member of staff had completed formulation training since the last inspection. The inspector noted that patient risk assessments, care plans and continuing care records evidenced the background to each patient's admission, the patient's proposed care and treatment pathway and the interventions being used to support the patient.	
Number/Area 17 **Ref**: 5.3.1(a), 5.3(f) **Stated:** First Time	Not all care plans were recovery focused, evidence based with defined care pathways.	**Met**
	Action taken as confirmed during the inspection: Care plans reviewed by the inspector (three of the ten patients) evidenced that plans were based on patient's presenting needs, were patient centred and regularly reviewed. Interventions such as medication regimes, ECT and psycho social interventions were detailed and evidence supporting the use of the intervention was recorded. Care and treatment pathways for each patient had been clearly defined. Continuing care records evidenced that the presentation of each patient had improved since their	

	admission. It was positive to note that each of the five patients who met the inspector stated that they had felt better since being admitted to the ward.	
Number/Area 18 **Ref**: 4.3(j) **Stated:** First Time	The consultant psychiatrist was working on the ward as a locum. There was no permanent consultant on the ward for some time. **Action taken as confirmed during the inspection**: The consultant psychiatrist continued to work as a locum. It is important to note that the Trust had attempted to recruit a permanent consultant since the last inspection. The inspector noted that the consultant attended the ward on Tuesdays from 10am to 4pm and on Friday afternoons from 2pm to 4pm. Whilst recognising that the Trust has made significant efforts to recruit a permanent consultant this area for improvement has not been met and will be restated for a second time.	**Not Met**
Number/Area 19 **Ref**: 5.3.1(f) **Stated:** First Time	Two policies were out of date. • Records Management Policy November 2013. • Learning, Education and Development Strategy, December 2013. **Action taken as confirmed during the inspection**: The inspector reviewed both these policies. Both policies had been reviewed and updated. The Learning, Education and Development Strategy was in the process of being further developed.	**Met**
Number/Area 20 **Ref**: 5.3.1(a) **Stated:** Second Time	It is recommended that the ward manager ensures that when decisions have been made at the MDCC meetings in relation to the rationale around restrictive practices this is clearly documented in the patients' deprivation of liberty (DOLS) care plans. **Action taken as confirmed during the inspection**: Each set of the patient care records reviewed by the inspector evidenced that a DOLS checklist had been completed upon admission. The checklist included review of the patient's capacity, ability to consent and the required restrictive interventions to ensure the patient's safety.	**Met**

	Two of the three files reviewed in relation to DOLS evidenced that both patients had a DOLS care plan completed. These plans were reviewed on a weekly basis by the MDT and as required by the patient's named nurse. Patient CRA's were also updated weekly and provided clear evidence of the patient's presenting risks and any changes required when managing same. One patient record did not contain a DOLS care plan. The patient's progress, their care pathway, risk assessment and continuing care records evidenced the interventions being used and the rationale behind these. The inspector was assured that a DOLS care plan for this patient would be formalised at the next MDT meeting.	

7.0 Other areas examined

The inspector identified two new areas for improvement as a result of this inspection. The Trust should ensure that the ward's weekly meeting is attended by a community team representative and a procedure for the completion of comprehensive risk assessments (CRA's), (in accordance to PQC guidance) should be agreed between acute care services and relevant community teams.

8.0 Provider Compliance Plan

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

8.1 Actions to be taken by the service

The Provider Compliance Plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed Provider Compliance Plan via the Web Portal for assessment by the inspector by 18 January 2018.

Provider Compliance Plan	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** Quality Standard 6.3.2 (a) **Stated:** Second time **To be completed by:** 29 May 2018	In an adjoining room to the ward which was used as an activity room the Velux window was broken (it would not open).
	Response by responsible person detailing the actions taken: Estates Services reviewed the Velux window. The motor is currently damaged beyond repair. Estates Services are currently researching the manufacturers and part number for replacement motor. If this fails, Estates Services will attempt to obtain a new unit.
Area for Improvement No. 2 **Ref:** Quality Standard 6.3.2(g) **Stated:** Second time **To be completed by**: 29 December 2017	Minutes of the patient forum meetings did not evidence that action had been taken to address issues raised at the previous monthly meeting. Patients' average stay on the ward was 51 days however the patient forum meetings were held on a monthly basis.
	Response by responsible person detailing the actions taken: Recording documentation for weekly patient forum meetings has been changed to include: outstanding issues from previous meeting; issues raised during the meeting and the action required along with responsible person for same. The Ward Manager signs off these minutes on a weekly basis and will also escalate any issues not addressed.
Area for Improvement No. 3 **Ref:** Quality Standard 4.3(j) **Stated:** Second time **To be completed by**: 29 May 2018	The consultant psychiatrist was working on the ward as a locum. There was no permanent consultant on the ward for some time.
	Response by responsible person detailing the actions taken: The Trust continues in the recruitment process for permanent Consultants.
Area for Improvement No. 4 **Ref:** Quality Standard 5.3.1(a) **Stated:** First time **To be completed by**: 29 February 2018	A procedure for the completion of comphrensive risk assessments for patients admitted to the ward was not available. The procedure should identify if the accute care team or a community team is responsible.
	Response by responsible person detailing the actions taken: The ward has introduced new documentation for new admissions 'verbal handover for admissions'. This includes a section in relation to risk assessment and the completion/updating of risk screening and comprehensive assessments. In collaboration with the CMHTOP primarily; new admissions will be accompanied with a comprehensive

	risk assessment tool at time of admission, given the clinical need for admission and the stepped care model of care.
Area for Improvement No. 5 **Ref:** Quality Standard 5.3.1(a) **Stated:** First time **To be completed by**: 28 February 2018	A staff member from older peoples community care team(s) did not attend the ward's weekly multi-disciplinary meeting. **Response by responsible person detailing the actions taken:** A member of the CMHTOP will attend the weekly Multi-disciplinary team meeting; taking into account demands from the community services.

Name of person (s) completing the PCP	Mrs Nicola Hayes		
Signature of person (s) completing the PCP	Nicola Hayes	**Date completed**	12.01.2018
Name of responsible person approving the PCP	Dr Robert Brown		
Signature of responsible person approving the PCP		**Date approved**	18.01.2018
Name of RQIA inspector assessing response	Alan Guthrie		
Signature of RQIA inspector assessing response	Alan Guthrie	**Date approved**	19.01.2018

Please ensure this document is completed in full and returned via the Web Portal.

The Regulation and Quality Improvement Authority

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