The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Waterside 1, Waterside Hospital

Western Health and Social Care Trust

18 and 19 February 2015

npm national preventive mechanism

informing and improving health and social care
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Contents

1.0 General Information

Ward Name	Waterside 1
Trust	Western Trust
Hospital Address	Waterside 1 Waterside Hospital Gransha Park Clooney Road BT47 6WH
Ward Telephone number	028 71860007
Ward Manager	Winifred O'Kane
Email address	winifred.okane@westerntrust.hscni.net
Person in charge on day of inspection	Winifred O'Kane
Category of Care	Functional mental health over 65 years.
Date of last inspection and inspection type	14 April 2014, Announced patient experience interview inspections
Name of inspectors	Audrey McLellan Marie Crothers

2.0 Ward profile

Ward 1 is a ten bedded ward in the waterside hospital on the Gransha hospital site. The purpose of the ward is to provide acute mental assessment and treatment to male and female patients over 65 years.

The multidisciplinary team consists of two consultant psychiatrists, a senior house officer, nursing staff, a psychologist, an occupational therapist, a pharmacist and health care assistants. Patients also have access to speech and language and physiotherapy through a referral system.

On the day of the inspection there were ten patients on the ward, five of who were male and five female. There was one patient who was detained in accordance with the Mental Health (Northern Order) 1986. None of the patients were on leave on the days of the inspection.

The ward is locked and is accessed via a key code system. The ward had moved from ward 3 to ward 1 in October 2014. On the days of the inspection the atmosphere on the ward was calm and welcoming.

Information leaflets were display in the foyer and on the notice boards in relation to the advocacy service and how to make a complaint. The ward had four single rooms which all had en-suites. There was also a four bedded bay and a two bedded bay, both had a bathroom.

There were two communal areas which were homely with soft furnishings and ornaments on the shelves. There was also a dining room, kitchen and a relaxation room. The ward led out to two separate garden areas and the doors were open during the day.

3.0 Introduction

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

3.1 Purpose and Aim of the Inspection

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

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

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

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

3.2 Methodology

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

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

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

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

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

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

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

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

4.0 Review of action plans/progress

An unannounced inspection of Waterside 1 was undertaken on 18 and 19 February 2015.

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

The recommendations made following the last unannounced inspection on 27 November 2013 were evaluated. Inspectors were pleased to note that four recommendations had been fully met and compliance had been achieved in the following areas:

- An occupational therapist is now working on the ward and divides their time equally between ward 1 and ward 2. They monitor the patients' participation in therapeutic activities and attend the weekly multi-disciplinary team meetings;
- Patients' capacity is monitoring throughout their admission and this is documented;
- All staff have attended training in relation to safeguarding vulnerable adults;
- All staff have appraisals completed in accordance with Trust and professional guidance.

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

There were no recommendations made following the patient experience interview inspection on 14 April 2014.

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

The recommendations made following the finance inspection on 8 January 2014 were evaluated. Inspectors were pleased to note that two recommendations had been fully met and compliance had been achieved in the following areas:

- The nurse in charge of the ward holds the safe key. A record is kept of the balance of the safe on each handover shift and is signed by two members of staff. The reason for access to the safe is recorded by two members of staff;
- A receipt book is held on the ward which details purchases made by staff on behalf of patients including receipts. Records of patients' money stored in the safe are maintained. Any deposits or withdrawals are recorded in the safe book. Two staff sign for every transaction that occurs.

Details of the above findings are included in Appendix 1.

5.0 Inspection Summary

Since the last inspection the ward has recruited an occupational therapist to work with patients on the ward. The ward manager advised that the ward is working on producing easy read information for patient use.

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

The inspectors reviewed three sets of care documentation. There was evidence that patients' capacity had been assessed on admission by the nursing staff. In all three sets of care documentation there was evidence of ongoing monitoring of the patients' capacity and ability to consent to care and treatment. This was evidenced in the multi-disciplinary team records and the patients' progress notes.

Care documentation reviewed by the inspectors evidenced that patients' views had been sought prior to the multi-disciplinary team (MDT) meetings. A record of the patient's views had been recorded on each MDT template. Patients attended the MDT meetings and relatives were also in attendance when agreed by patients. If relatives/carers or patients did not attend the MDT meeting this was recorded on the template with the reasons why they did not attend. There was evidence that patients had been allowed time to understand their care and treatment. This was evidenced in the progress notes reviewed by the inspectors as nurses had recorded the 1:1 time they had spent with patients and all care plans had been signed by patients indicating they agreed with the care and treatment planned.

Policies, procedures and guidance in relation to capacity and consent and human rights legislation were available on the ward. Staff who spoke to the inspectors demonstrated knowledge of the importance of assessing a patient's capacity to consent.

There was evidence in care documentation that patients' Article 8 rights to respect for private and family life and Article14 rights to be free from discrimination had been considered. Patients' progress notes and multidisciplinary templates that were reviewed showed that families/carers were involved in patients care and treatment when appropriate. The ward also had flexible visiting times in place for visitors.

Care documentation reviewed by inspectors evidenced that patients had an individualised assessment of their needs completed by the medical and nursing staff. All three sets of care documentation had a risk screening tool completed which had been reviewed at the multi-disciplinary team meetings. These had been completed in accordance with Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services May 2010. Patient care plans had been completed from identified assessed need which reflected a person centred approach.

The ward manager advised that if concerns are raised in the assessment regarding patients' communication needs appropriate referrals are made. This can be to the interpreting service if it is in relation to language issues. If there are concerns in relation to the patients' physical health i.e. swallowing difficulties then referrals can be made to the speech and language department. Patients are also seen by the consultant if there were issues in relation to the patients' capacity to understand the assessment process.

Inspectors noted there were a number of profiling beds being used on the ward by patients who did not have a physical health care need requiring this type of bed. The ward manager assured inspectors that none of the patients on the ward had any suicidal ideation. However, there were no individual risk assessments in place for each patient using these beds. A recommendation has been made

There was evidence that care plans were reviewed regularly in two out of the three sets of care documentation. In one set of care documentation five of the seven patients care plans had not been reviewed since 6/11/14. A recommendation has been made.

Inspectors met with six patients on the ward all of whom advised that they had been involved in their care and treatment. One patient who had been detained in accordance with the Mental Health (Northern Ireland) order 1986 raised concerns related to their detention on the ward. The patient had spoken to the advocate and had made an application to the mental health review tribunal.

An occupational therapist was working part-time on the ward. They advised that additional day-care opportunities will be provided when the Hub/Day Care Unit attached to both ward 1 and 2 is opened. There was evidence that patients were receiving therapeutic and recreational activities and the patients' participation in and progress was monitored. The ward had a 'ward activity plan' which nurses and patients completed together. On the days of the inspection there were two sessions of activities arranged for patients on the ward each day. A wide range of therapeutic activities were available which included: relaxation sessions- hand/foot massages, exercises, nostalgia sessions, domestic skills and baking.

The inspectors spoke to a health care assistant (HCA) who advised that they carry out activities when the occupational therapist was not on the ward. They advised that they complete various activities with patients and they use the ward's relaxation room as it has a bed, fibro optic lights and sensory equipment. The HCA informed inspectors that they record this information in a separate book and not in the patients' care documentation. The inspectors were concerned that this information was not used to inform the multi-disciplinary team of the patients' progress in this area and when patients leave the ward the information was lost. This was discussed with the ward manager. They advised that they will ensure the health care worker records this information in the patients' care documentation, so that there is a detailed record of the patients' participation in therapeutic activities, along with the occupational therapist record. A recommendation has been made

Individualised assessments had been completed by the nursing staff for therapeutic activities which had included information in relation to patients' hobbies and interests, past occupation, socially active/interests, and specific talents, prefers groups/individual activities or both. However, only one patient had an individualised therapeutic/recreational care plan in place from this assessment. A recommendation has been made in relation to this.

In one set of patient care documentation there was evidence that this patient was receiving ongoing support from psychological. The intervention related to the patient's diagnosis. The patient's progress notes indicated that the patient had participated well in the session and had benefited from this work.

All staff interviewed were aware of the advocacy service and stated that patients had spoken with the advocate on various occasions. There was adequate signage on the ward's notice boards regarding advocacy and also regarding complaints. Staff advised that all patients who are detained in accordance with the Mental Health (Northern Ireland) Order 1986 were given information in relation to their rights. Staff made sure that patients understood this process by discussing the leaflet with each patient. However this leaflet is not available in easy read format. The ward manager advised that they were in the process of completing a number of easy read information booklets for patients. They had contacted another ward who had this information in place and were in the process of changing sections of this to suit ward 1.

The ward had an information booklet which was given to each patient on arrival. The booklet contained information regarding the patients stay on the hospital.

Inspectors reviewed one set of care documentation where the patient had been detained in accordance with the Mental Health (Northern Ireland) Order 1986. There was evidence that this patient had been informed of their rights in relation to the detention process. This included detail regarding the patient's right to apply to the Mental Health Review Tribunal. Inspectors spoke to the patient. The patient advised that they had been informed of their rights when they were detained. They had also spoken to the advocate and made an application to the mental health review tribunal.

There was evidence in the patients' care documentation that their Article 5 rights to liberty and security of person had been considered. This was a locked ward but five out of the six patients were aware of the code to the door. Patients who met with the inspectors stated they sometimes forgot the code and had to ask the nurses when they wanted to go out. The patient who was detained in accordance with the Mental Health (Northern Ireland) Order1986 did not have access to the code however their care plan detailed the rationale around this restriction.

The door to the ward was locked and there was evidence in the care documentation reviewed that patients could leave the ward alone or accompanied by family/carers as they were aware of the key code. The inspectors spoke to five patients on the ward in relation to their time off the

ward and four said that they had been out with their relatives. The Patients talked about how they had gone to the local café on the hospital site and how they could access a taxi to take them into town.

Inspectors spoke to staff in relation to restrictive practices. Staff advised they work towards using the least restrictive practice. They advised that they very rarely use physical intervention and they demonstrated a good understanding of how to dis-escalate a situation and how to work with patients using diversion techniques

There was evidence of good liaison with community teams in relation to discharge. Inspectors spoke to the community social work team manager and one of the social workers. Inspectors were advised that the team had a system in place which involved one member of staff attending the multidisciplinary team meeting each week and then providing feedback to the keyworker in the team. When patients are ready for discharge the keyworker in the community will attend the discharge meeting to ensure all supports are in place in the community so patients can be discharged without any delays. Both highlighted the good communication between the community and the hospital and how both aspects of the service worked together. There was evidence that discharge was discussed on admission and at the multi-disciplinary team meetings each week. There were two patients whose discharge was delayed. Both patients were being reviewed by the multidisciplinary team each week. The patients' delayed discharge had been reported to the Health and Social Care Board. The social work manager stated that if a patient is medically fit for discharge, and requires residential care, the patient is offered a choice of three or four residential places. If none of the chosen places are available, they can be moved to a different residential place until a suitable one becomes available. Care managers set up appointments to see discharged patients within seven days of discharge. Where a patient with behaviours that challenge is discharged to a nursing or residential setting, a follow-up appointment is arranged by the psychologist for a further six-eight week period if required.

Care documentation reviewed by inspectors evidenced that there was one patient who was ready for discharge. Discharge planning meetings had been held with the multi- disciplinary team and the patient. There was evidence that the patient had been to view their new accommodation with the social worker and nurses had spent 1:1 time with the patient discussing the process.

There was evidence that patients' Article 8 rights to respect for private and family life had been considered as relatives/carers were involved in discharge planning meetings and were kept informed of the progress made. Inspectors spoke to six patients on the ward who all advised that their relative had been involved in their care and treatment.

Details of the above findings are included in Appendix 2.

On this occasion ward 1 has achieved an overall compliance level of Compliant in relation to the Human Rights inspection theme of "Autonomy".

6.0 Consultation processes

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

Patients	**6**
Ward Staff	**3**
Relatives	**0**
Professionals	**5**
Advocates	**0**

Patients

The inspectors spoke to six patients. All patients advised that they knew why they were in hospital and had been involved in their care and treatment. They stated that their relatives/carers had been involved in their care and treatment. They were all complimentary about the staff on the ward and advised that they felt the overall care on the ward was very good. They reported that they enjoyed the activities offered on the ward and they stated they could leave the ward any time as they had been told the keypad code.

One patient had been detained in accordance with Mental Health (Northern Ireland) Order 1986 and advised that they had been given information regarding appeal to the MHRT and stated that the advocacy service had been in contact with them. They were unsure at what stage their appeal was at or if their application was made. The inspector spoke to the staff who advised they would update the patient.

Relatives/Carers

There were no relatives/carers available to speak to the inspectors on the days of the inspection.

Ward Staff

The inspectors spoke to a health care worker, staff nurse and a student nurse who all advised that they enjoyed working on the ward. All three staff demonstrated a good understanding of how important it was to uphold patients' human rights. They talked about gaining consent prior to carrying out any care and treatment and how they would always work at encouraging patients to attend activities on the ward to help them in the recovery process. They spoke about how they would be flexible with routines to ensure that patients were cared for in a person centred manner. They advised that they would let patients stay in bed in the mornings if they requested this and would bring their breakfast down to them or give them breakfast at a later part in the

day. They also talked about implementing activities on the ward that the patients had chosen. They advised that they would spend one to one time with patients each day developing trusting relationships so patients could talk about their fears and worries.

Other Ward Professionals

The inspectors spoke to the consultant, the senior house officer and the occupational therapist on the days of the inspection.

The consultant advised that having an occupation therapist on the ward has been a great asset to the ward. They stated that they are able to feedback to the multidisciplinary team on how patients were progressing. They also advised that the psychologist carries out areas of work with patients which include psychometric assessments, CBT work, cognitive assessments and family therapy work. They also continue working in the community when this has been recommended by the multidisciplinary team.

The occupational therapist on the ward advised that they were new in their post and were looking forward to the HUB/day care unit opening when staff have been recruited. They stated they felt their contribution to the team had been welcomed and respected.

The senior house officer was new to the ward as they had taken up post the previous week. They advised that they had been given an induction to the ward and had received copies of policies, procedures and protocols to read and sign off. They stated that they were enjoying working on the ward and were supported by the consultants.

Other Professionals

The inspectors spoke to the community team manager and a community social worker on the days of the inspection. Both professionals advised that there were good relationship between the ward and community staff. They advised that a member of the community team attends the multidisciplinary ward round each week to feedback to the patient's keyworker. When the patient is ready for discharge the keyworker attends the discharge meeting and will make a follow up appointment with the patients after seven days.

Advocates

The advocate was not available on the days of the inspection.

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

Questionnaires issued to	Number issued	Number returned
Ward Staff	10	3

Other Ward Professionals	5	0
Relatives/carers	10	2

Ward Staff

Three questionnaires were returned by ward staff in advance of the inspection. Information contained within the staff questionnaires demonstrated that all staff were aware of the Deprivation of Liberty Safeguards (DOLS) – interim guidance. All staff members indicated that they had received training in the area of capacity to consent, human rights and restrictive practices.

Staff indicated they had received training on meeting the needs of patients who need support with communication. All three staff stated they were aware of alternative methods of communication and that these were used in the care setting and they confirmed that the ward has processes in place to meet patients' individual communication needs on the ward. The three staff reported that patients had access to therapeutic and recreational activities and that these programmes meet the patient's needs.

Other Ward Professionals

There were no questionnaires returned from ward professionals

Relatives/carers

Two questionnaires were returned by relatives/carers in advance of the inspection. These relatives/carers stated that the care on the ward was excellent. They both stated that they had been offered the opportunity to be involved in the decision regarding their relatives care and treatment in the ward. One relative/carer made the following statement:

"I have been really content with the care my X has received. The staff are all doing their best and the Unit is very inviting"

7.0 Additional matters examined/additional concerns noted

Complaints

There were no complaints received in relation to the ward.

Additional concerns

The inspectors were concerned to note that there were a number of places throughout the ward which could potentially be used as a ligature point. A discussion with a senior Trust representative confirmed that the ligature risk assessment for this ward had not been updated since the purpose of the ward

and the profile of the patients in the ward had changed in October 2014. The inspectors were concerned to note that the Trust representative was unable to provide a timeline to the inspectors on when the risk assessment and ensuing actions to minimise risks to patients' safety would be completed. RQIA have written to the Trust to seek assurance that this work will be carried out to ensure patients' needs will be appropriately and safely met. A response is due from the Trust by 23 March 2014. A recommendation has been made in relation to this.

8.0 RQIA Compliance Scale Guidance

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

Appendix 1 – Follow up on Previous Recommendations

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

Appendix 2 – Inspection Findings

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

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

Appendix 1

Follow-up on recommendations made following the unannounced inspection on 27 November 2013

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the Trust review the range and availability of Occupational Therapy input to ward 3 in order to provide a full multidisciplinary approach to care and treatment.	Ward 3 has relocated to ward 1. An occupational therapist is now working on the ward and divides their time equally between ward 1 and ward 2. They monitor the patients' participation in therapeutic activities and attend the weekly multi-disciplinary team meetings.	Fully met
2	It is recommended that the ward manager ensures that capacity and consent issues are clearly and consistently documented.	There was evidence in the Integrated Care Pathway that patients' capacity had been assessed on admission by the nursing staff. In the care documentation reviewed by the inspectors there was evidence of ongoing monitoring of the patients' capacity and ability to consent to care and treatment. There also evidence in the care documentation of ongoing monitoring of patients capacity to consent.	Fully met
3	It is recommended that the ward manager ensures that all staff have attended training in safeguarding vulnerable adults..	The inspector reviewed training records and all staff had received up to date training in safeguarding vulnerable adults.	Fully met
4	It is recommended that all staff have appraisal in accordance with policies and procedures.	The inspector reviewed appraisal records and all staff had received appraisals in accordance to Trust policy and procedures. Staff who met with the inspectors reported no concerns regarding their appraisal. This included new staff that had moved to the ward from Slievemore ward	Fully met

Appendix 1

Follow-up on recommendations made at the finance inspection on 8 January 2014.

No.	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	It is recommended that the ward manager ensures that a record is kept of the staff member who obtains the master key to the patients' safes is maintained, including the reason for access.	The nurse in charge of the ward holds the key to the safe where the patients' money is held. A record is kept of the balance of the safe on each handover shift and is signed by two members of staff. The reason for access to the safe at any other point is recorded by two members of staff.	Fully met
2	It is recommended that the ward manager ensures that appropriate systems are put in place to record purchases made by staff on behalf of patients with related receipts. Appropriate, detailed and verified records of transactions must be maintained	A receipt book is held on the ward which details purchases made by staff on behalf of patients. The book records details of purchases and provides receipts. The majority of patients on the ward request small amounts of their money to spend themselves and when this is withdrawn a record is kept and signed by two members of staff and the patient.	Fully met

R3

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Unannounced Inspection

Waterside 1, Waterside Hospital

18 and 19 February 2015

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

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

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

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

No.	Reference	Recommendation	Number of times stated	Timescale	Details of action to be taken by ward/trust
1	5.3.3 (b)	It is recommended that the ward manager ensures that all care plans are reviewed in accordance to Trust and best practice guidelines.	1	Immediate and ongoing	NIPEC Audit completed monthly by Ward Manager and validated 6 monthly by Head of Service. Staff has attended record keeping training and abide by NMC record keeping guidelines.
2	4.3. (l)	It is recommended that the Trust completes a ligature risk assessment of the ward. This should include a subsequent action plan to address any identified risks. Details of this action plan should be forwarded to RQIA by 23/3/15	1	23 March 2015	Ligature assessment completed in 2014 and in Feb 2015. Ligature points remain on the Directorate Risk Register including suspended ceilings and window'door handles and minor capital works completed and awaiting approval, requires capital funding source. Risk assessments carried out on patients on admission. Care Plan put in place to minimise risks. Unlikely work will be completed within timescale but will be prioritised.
3	4.4 (i)	It is recommended that the Trust ensures that the areas of work identified in the ligature risk assessment are completed to ensure that patients' needs are appropriately and safely met.	1	19 April 2015	Minor Capital works request completed and approved. Requires capital funding may not be completed within timescale, but will be prioritised as above.
4	5.3.1 (a)	It is recommended that the ward	1	Immediate	Draft Risk assessment and care plan in place will be

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
		manager ensures that when patients are using a profiling bed that a risk assessment is completed for each individual patient and reviewed regularly in accordance with the safety alert raised on 23/12/13 by the Northern Ireland Adverse Incident Centre (NIAC) Estates Facilities Alert /2010/006 associated with profiling beds.		and ongoing	reviewed at Governance meeting.
5	5.3.1 (f)	It is recommended the ward manager ensures patients participation and progress in therapeutic activities is recorded in the patients care documentation.	1	Immediate and ongoing	Completed
6	5.3.1 (a)	It is recommended that the ward manager ensures that patients have an individualised therapeutic activity plan.	1	30 April 2015	Completed

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

NAME OF WARD MANAGER COMPLETING QIP	Winifred O'Kane.
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	

Inspector assessment of returned QIP		Yes	No	Inspector	Date
A.	Quality Improvement Plan response assessed by inspector as acceptable	X		AM'Cullen.	19/5/15
B.	Further information requested from provider	X		AM'Cullen	19/5/15.

I/N formation requested in relation to recommendation 2+3. Response received 8/5/15. AMcC.
Work will be completed by Dec 2015. Trust to ensure rec 2+3 is implemented V. Care Plans + Risk Assessments for Individual Pt's.