The Regulation and Quality Improvement Authority

Waterside 1

Waterside Hospital

Western Health and Social Care Trust

Unannounced Inspection Report

9 – 13 November 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 ward 1 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:

- looked at information sent to RQIA before the inspection
- talked to patients, carers and staff
- observed staff practice on the days of the inspection
- looked at 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

Ward 1 is a ten bedded ward. The purpose of the ward is to provide assessment and treatment to male and female patients over 65 years. The multidisciplinary team consists of a consultant psychiatrist, junior medical staff, nursing staff, a psychologist, an occupational therapist, a pharmacist and health care assistants. Patients also have access to speech and language therapy and physiotherapy through a referral system.

On the day of the inspection there were nine patients on the ward. There were no patients detained in accordance with the Mental Health (Northern Ireland) Order 1986. The ward manager was in charge on the day of the inspection.

5.0 Summary

5.1 What patients, carers and staff told inspectors

During the inspection patient representatives were asked to complete questionnaires. Four relatives completed questionnaires with the lay assessor.

During the inspection the inspector was able to meet with:

Four carers/relatives
Five patients
Five staff

Relatives told the lay assessor that:

All four relatives stated that staff were available and approachable. They all stated they were involved in decisions regarding their relatives' care and treatment. All four relatives stated they knew which professionals were involved in their family member's care and treatment. Three of the relatives stated they had been informed of their family member's diagnosis and had also been informed on how to help their family member regarding their illness. One relative stated that their family member was only on the ward a week and had not received a diagnosis yet. Three relatives stated they felt their family members were getting better. All four relatives stated they felt their relatives' privacy and dignity was respected. The following comments were made.

"My wife has been treated very well in ward 1"

"All the staff are excellent"

"I am very happy with the care my brother has been given"

Patients told the lay assessor that:

Patients' overall comments regarding their care and treatment on the ward were positive. Patients stated they felt safe on the ward and if at any time they had concerns regarding their safety they could speak to staff to receive reassurance. Four patients confirmed that they were fully involved in their care and one patient stated they were involved in some parts of their care.

Two patients stated that they were always informed of the results of assessments and investigations, one patient said they had to ask for results and two patients told the lay assessor that staff mostly inform them of the results of investigation but not always.

Three of the five patients interviewed said that staff regularly informed them on how they were progressing and two patients stated staff sometimes discuss their progress with them. Four patients stated they were offered the opportunity to attend activities every day and one patient said that activities do not always happen. Four patients felt being on the ward was helping them recover and one patient was unsure if being on the ward was helping them recover. All five patients felt that staff treated them with dignity and respect and four patients stated they felt staff listened to their views. One patient felt staff listened to their views but they were unsure if their views were always considered. Patients made the following comments:

"I feel very relaxed"

"Staff are very encouraging"

"This is a safe environment. Sometimes I have been in despair but the staff are very attentive, caring and encouraging. I have felt reassured"

"Staff are kind"

"Staff are first class... couldn't be better"

Staff told inspectors that:

The inspectors spoke to five members of the ward team and the community team leader who attended the MDT meeting each week.

The health care assistant (HCA) talked about their role on the ward and how since the OT had left the ward they had tried to continue with the activities the OT had set up. The HCA advised that since the OT resigned from their post there are now less activities being run on the ward. The HCA was looking forward to the new team of staff being recruited to work in the therapeutic hub as they felt this would benefit the patients on the ward. The HCA spoke about how the ward is being flexible with routines to ensure that patients were cared for in a person centred manner.

The deputy ward manager spoke about their role on the ward and advised that they will be acting up as ward manager when the ward manager retires at the end of the month. The deputy advised that they had been involved in piloting the integrated care pathway and they felt this this was a good format to provide patients with continuity in their care.

The clinical psychologist advised that they were on the ward for two sessions each week and one of these sessions involves attending the ward round. The psychologist has set up a weekly 'feelings group' and is also involved in one to one work with patients. The psychologist discussed their involvement in completing psychometric assessments, CBT work, cognitive assessments and family therapy work. The psychologist worked closely with the ward OT in the therapeutic hub and was looking forward to this facility being set up with a full team of staff. The psychologist advised that with this new facility patients who

have been involved in group work as inpatients will be able to continue this work when they are discharged.

The consultant psychiatrist advised that having an occupation therapist on the ward had been a great asset as they were able to feedback to the multidisciplinary team on how patients were progressing. The consultant psychiatrist works on the ward and also has a community caseload. The consultant advised that the junior doctor on the ward is involved in covering duty on the hospital site and also works in ward 2. The consultant informed the inspector that they had been involved in developing the new integrated care pathway which was piloted on the ward. They stated they felt that this new pathway would be more appropriate to the needs of patients in ward 1.

The inspectors spoke to the community team manager who advised that there were good relationship between the ward and community staff. The manager advised that they attended the multidisciplinary team meeting each week to ensure that information is reported to the patient's keyworker in the community. When the patient is ready for discharge the keyworker attends the discharge meeting and will make a follow up appointment with the patient within seven days.

5.2 What inspectors saw during the inspection

The ward appeared homely and welcoming on first impression. This theme continued throughout the whole ward. There were soft furnishings throughout the ward, TV units, display cabinets with ornaments and pictures. Patients slept in bay areas and there were also 4 single rooms two of which had an ensuite.

The ward was spacious and there were several areas for patients to sit and relax. Visitors were able to visit the ward throughout the day and during the inspection the inspectors observed visitors coming and going from the ward. The outside spaces were clean, well maintained and accessible during the day.

Information was displayed in relation to complaints and compliments. The ward also had an easy read information booklet which detailed information in relation to human rights, the locked door on the ward and the advocacy service. There was information available in relation to the Mental Health Order the Mental Health Review Tribunal and patients' right to access information held about them.

The ward had an up to date ligature risk assessment completed on 23 February 2015. The inspectors were advised that plans were in place to remove all environmental ligature points and this would be completed by March 2016.

Patients were aware of their named nurse and their associated nurse as this was displayed in their bedroom areas and was recorded in the patients' ward information booklet. Patients' named nurse and associated nurse worked

opposite shifts so patients knew each day who was allocated therapeutic time with them.

On the days of the inspection there was enough staff on duty to meet the needs of the patients. Inspectors observed positive interactions between patients and all staff. Staff were attentive and responded promptly when patients sought reassurance. The ward environment appeared relaxed throughout the days of the inspection.

Further detail is contained in the ward physical environment observational tool / checklist and the Quality of Interaction Schedule (QUIS).

See attached Appendices 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.
- ✓ There was a staff presence in the communal rooms during the inspection
- ✓ Patients could access three outside spaces.
- ✓Nursing staff had attended regular supervision meetings with their line manager in the last year.
- ✓There were enough staff available during the inspection to meet the needs of the patients in the ward.
- ✓ Staff were observed responding promptly to patients' needs
- ✓Information was available to patients in relation to their rights

✓Regular governance meeting were held with senior managers. There was evidence that information was cascaded to staff on the ward.

✓The ward had completed an environmental ligature risk assessment and action plan. The action plan was still outstanding however funding had been secured for this work to be completed by March 2016 and plans were underway.

Areas for improvement

- **Environmental safety**

X The ward had 7 profiling beds for patients who had a clinical need for this type of bed. Patients had a risk assessment completed in relation to the use of these beds. However there was no risk management plan in place for each patient as detailed in the safety alert issued on 23/12/13 by the Northern Ireland Adverse Incident Centre (NIAC) Estates Facilities Alert /2010/006 associated with profiling beds. *Quality Standard 4.3 (i)*

X A generic health and safety assessment had been completed on 2 March 2015 with an action plan. However there were a number of areas in the action plan which needed to be completed/updated. *Quality Standard 5.3.1 (f)*

- **Staff**

X Mandatory training was up to date. However three staff required up to date training in manual handling. Dates had been set on 17/11/15 and 10/12/15 for these staff member to attend training. *Quality Standard 4.3 (m)*

- **Patients**

X Personal safety plans/risk assessments 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)*

X The call system in the bathrooms and in the patients' bedded areas/bedrooms had been disconnected and therefore patients were unable to call for assistance if required. *Quality Standards 5.3.1 (a)*

- **Policy and procedures**

X A number of policies and procedures had not been reviewed and updated for staff. These included the:
Disciplinary procedure September 2007;
Trip, slips and falls 2010;
The procedure for recording fluid balance charts 2010;
The integrated admission and discharge policy 2008;
The policy on the referral to NMC 2011.
The ward's operational policy. *Quality Standard 5.3.1 (f)*

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

✓ Assessments were completed on admission by nursing and medical staff and interventions were based on each patient's individual assessed need.

✓Referrals were made to other professionals when this was identified as a need.

✓Wellbeing plans were person centred and had been reviewed regularly

✓ Patients were involved in their care and treatment planning

✓ The Trust were in the process of recruiting an OT, staff nurse and health care assistant to work in the 'therapeutic hub' adjacent to the ward.

✓ The community team leader attended each MDT meeting to ensure that the patients' keyworker in the community was kept up to date on each patient's progress.

✓Discharge planning had commenced on admission and was discussed each week at the MDT meeting.

✓ The MDT reviewed patients' detention regularly to ensure patients were experiencing the least restrictive option within their care and treatment.

✓ Deprivation of liberty (DOLS) plans were in place which explained the rationale in relation to the locked door on the ward and the individual details around each person's access to the keypad code when appropriate.

✓ Human rights were embedded in the ward culture.

✓ Patients had met with all disciplines involved in their care and treatment.

✓Overall patients and their relatives felt the care on the ward was good

Areas for improvement

- **Personal well-being plans**

X The integrated care pathway (ICP) was not fully completed. *Quality Standard 5.3.1 (a)*

X The signature of the doctor on a number of care records was unclear and did not detail the designation of the doctor. The medical staff had not completed the signature sheet in the ICP. *Quality Standard 5.3.1 (f)*

X There was no evidence of assessments completed by occupational therapy (OT) as the OT had resigned from their post. *Quality Standard 5.3.1 (a)*

X There were limited therapeutic/recreational activities being carried out on the ward. *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. *Quality Standard 5.3.3 (b)*

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

✓ Staff were observed gaining consent from patients before assisting them with care interventions.

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

✓ Patients' relatives stated that staff were approachable and listened to their views. They advised that they knew who was involved in their relatives care and treatment and they confirmed that they were involved in decisions that were made.

✓ Patients could request for their relative/carer or advocate to attend meetings.

✓ Patients' relatives stated that they felt staff listened to their views and respected their opinion. They also felt that their relatives were treated with dignity and respect.

✓Staff were observed engaging positively with patients.

✓Patients could refuse their care and treatment and these decisions were respected

✓Individualised plans were in place in relation to the locked door.

✓ Staff responding promptly to patients' needs.

✓ Patients made positive comments about the care and treatment they were receiving.

Areas for improvement

Inspectors noted no areas for improvement in relation to compassionate care.

6.0 Follow up on Previous Inspection Recommendations

Six recommendations were made following the last inspection on 19 February 2015. The inspector was pleased to note that all six recommendations had been implemented in full.

7.0 Other Areas Examined

There were no other areas examined

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		
	No recommendations were identified as priority one	
Priority 2 recommendations		
1	The ward had 7 profiling beds for patients who had a clinical need for this type of bed. Patients had a risk assessment completed in relation to the use of these beds. However there was no risk management plan in place for each patient as detailed in the safety alert issued on 23/12/13 by the Northern Ireland Adverse Incident Centre (NIAC) Estates Facilities Alert /2010/006 associated with profiling beds. *Quality Standard 4.3 (i)*	15 December 2015
2	A generic health and safety assessment had been completed on 2 March 2015 with an action plan. However there were a number of areas in the action plan which needed to be completed/updated. *Quality Standard 5.3.1 (f)*	8 January 2016
3	Mandatory training was up to date. However three staff required up to date training in manual handling. Dates had been set on 17/11/15 and 10/12/15 for these staff member to attend training. *Quality Standard 4.3 (m)*	15 December 2015
4	Personal safety plans/risk assessments 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)*	22 January 2016
5	The integrated care pathway (ICP) was not fully completed. *Quality Standard 5.3.1 (a)*	1 January 2016
6	The signature of the doctor on a number of care	I January 2016

	records was unclear and did not detail the designation of the doctor. The medical staff had not completed the signature sheet in the ICP. *Quality Standard 5.3.1(f)*	
7	There was no evidence of assessments completed by the occupational therapist (OT) as the OT had resigned from their post. *Quality Standard 5.3.1 (a)*	5 February 2016
8	There were limited therapeutic/recreational activities being carried out on the ward. *Quality Standard 5.3.1 (a)*	5 February 2016
9	Patient meetings 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 December 2015
10	A number of policies and procedures had not been reviewed and updated for staff. These included the: Disciplinary procedure September 2007; Trip, slips and falls 2010;The procedure for recording fluid balance charts 2010; The integrated admission and discharge policy 2008; The policy on the referral to NMC 2011 and The ward's operational policy. *Quality Standard 5.3.1 (f)*	5 February 2015
Priority 3 recommendations		
11	The call system in the bathrooms and in the patients' bedded areas/bedrooms had been disconnected and therefore patients were unable to call for assistance if required. *Quality Standards 5.3.1 (a)*	30 May 2016

Definitions for priority 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 and 19 February 2015

No.	Reference.	Recommendations	No of times stated	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
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	The inspector reviewed three sets of care records and there was evidence that care plans were reviewed on a regular basis and when there were changes to patients' needs.	Met
2	4.3. (i)	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	There was evidence that an environmental ligature risk assessment had been completed on 23 February 2015 with and action plan. The ward manager and a senior trust representative informed the inspector that all ligature points identified in the risk assessment will be removed by March 2016. Plans are in place to move patients to another ward for this work to commence.	Met
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	See above	Met
4	5.3.1 (a)	It is recommended that the ward manager ensures that when patients are using a profiling bed that a risk assessment is completed for each individual patient	1	There was evidence in the three sets of care records reviewed by the inspector that when patients were using a profiling bed a risk assessment had been completed and was reviewed regularly. This assessment identified if there were any risks with the patient sleeping this type of bed. However a risk management plan was not in place for each patient. This will	Met

		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.		be recorded in the Trust's improvement plan as an area for improvement with a timeframe for completion	
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	The inspector reviewed three sets of care records and there was evident that patients' participation and progress was recorded in the patients' progress notes	Met
6	5.3.1 (a)	It is recommended that the ward manager ensures that patients have an individualised therapeutic activity plan.	1	Each patient had an individualised therapeutic activity care plan in place which detailed the therapies on offer which could potentially benefit patient recovery.	Met

HSC Trust Improvement Plan

	Waterside 1		Winifred O'Kane		9 – 13 November 2015
	Jacqueline O Dorherty		ELAINE WAY CHIEF EXECUTIVE Elaine Way		

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 1 January 2016.

Please password protect or redact information where required.

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**.

Key Outcome Area – Is Care Safe? No areas for improvement were identified in this priority				
Key Outcome Area – Is Care Effective? No areas for improvement were identified in this priority				
Key Outcome Area – Is Care Compassionate? No areas for improvement were identified in 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.

Key Outcome Area – Is Care Safe? 1: The ward had 7 profiling beds for patients who had a clinical need for this type of bed. Patients had a risk assessment completed in relation to the use of these beds. However there was no risk management plan in place for each patient as detailed in the safety alert issued on 23/12/13 by the Northern Ireland Adverse Incident Centre (NIAC) Estates Facilities Alert /2010/006 associated with profiling beds. **Minimum Standard *4.3 (i)*** This area has been identified for improvement for the **first** time	15 December 2015	Risk Management plan has now been completed for each patient that require a profiling bed as outlined in the recommendation .	Jackie O'Doherty
2: A generic health and safety assessment had been completed on 2 March 2015 with an action plan. However there were a number of areas in the action plan which needed to be completed/updated.	8 January 2016	There were two recommendations from the health and safety assessment, one was completed in that it was recommended that a copy of the risk assessment was to be retained at ward level . The second recommendation was reference to a fire door that required upgrading to ensure that when fire alarm is activated the fire door will automatically close. Minor capital works was completed on the 13/11/15 to address this	Jackie O'Doherty

Minimum Standard *5.3.1 (f)* This area has been identified for improvement for the **first** time		recommendation.	
3: Mandatory training was up to date. However three staff required up to date training in manual handling. Dates had been set on 17/11/15 and 10/12/15 for these staff members to attend training. **Minimum Standard** 4.3 (m) This area has been identified for improvement for the **first** time	15 December 2015	Recommendation accepted. Training dates have been organised for staff to attend.	Jackie O'Doherty
4: Personal safety plans/risk assessments 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 **Minimum Standard** 5.3.1 (a) This area has been identified for improvement for the **first** time	22 January 2016	This applied to Out of Hours medical cover and has been addressed with the consultant to raise at the consultant forum to ensure avoidance of reoccurrence.	Leo Tumelty Consultant Psychiatrist

5: A number of policies and procedures had not been reviewed and updated for staff. These included the: Disciplinary procedure September 2007; Trip, slips and falls 2010; The procedure for recording fluid balance charts 2010; The integrated admission and discharge policy 2008; The policy on the referral to NMC 2011. The ward's operational policy. **Minimum Standard 5.3.1 (f)** This area has been identified for improvement for the **first** time	5 February 2015	Regional policies are being developed in relation to 1. Disciplinary procedure - This is a Regional development which will need to go for consultation with a proposal to finalise by March 2016. 2. A Regional Fluid Balance Tool - A Regional Fluid balance chart is being developed and awaiting final approval. The Trust is awaiting finalisation of these policies to adopt same. 3. Slips, Trips and Falls - Ward specific algorithm for the management of falls has been developed and approved Older Peoples Mental Health wards in November 2015. - Trust Trips and Falls Policy approved at CMT on 14/01/16 and tabled for Trust Board on 04/02/16 for final approval. 4. Policy on referral to NMC - Revised and with Director of Nursing for approval prior to going to CMT / Trust Board Integrated Admission and Discharge policy - this has been escalated to Director of Adult Mental Health for review. The Ward Operational procedure finalised and approved by PCOP Governance November 2015	Pauline Casey
6: The call system in the bathrooms and in the patients' bedded areas/bedrooms had been disconnected and therefore patients were unable to call for assistance if required. **Minimum Standard 5.3.1 (a)** This area has been identified for improvement for the **first** time	5 February 2016	This was considered but provides a ligature point for patient access and therefore deemed of high risk. Patients while in the bedded areas are in view of nurses station and intentional ward rounds in place on a regular basis during the night. Consideration also given in consultation with Estates Services regarding WI Fi device as identified by Inspector; it has been confirmed that these are personal alarms and not a nurse call system. A revised Business Plan is currently being considered by the Trust, this includes the installation of a patient call system for Ward 1. It is proposed this Business Case will be finalised by the end of April 2016. This contract will then be tendered and proposed work would commence in June 2016.	Jackie O'Doherty

Key Outcome Area – Is Care Effective? 7: The psychiatric medical section of the integrated care pathway (ICP) was not fully completed Minimum Standard 5.3.1(a) This area has been identified for improvement for the **first** time	1 January 2016	This has been addressed with the medical staff. Any medical omissions noted while carrying out the nursing NIPEC audit will be brought to the attention of the responsible consultant.	Jackie O'Doherty and Pauline Casey
8: The signature of the doctor on a number of care records was unclear and did not detail the designation of the doctor. The medical staff had not completed the signature sheet in the ICP. **Minimum Standard 5.3.1(f)** This area has been identified for improvement for the **first** time	1 January 2016	This has been addressed with the medical staff. Any medical omissions noted while carrying out the nursing NIPEC audit will be brought to the attention of the responsible consultant.	Jackie O'Doherty and Pauline Casey
9: There was no evidence of assessments completed by occupational therapy (OT) as the OT had resigned from their post. **Minimum Standard 5.3.1 (a)** This area has been identified for improvement for the **first** time	5 February 2016	Recruitment is in process post advertised, shortlisted and interviews taking place on 8th January.	Jackie O'Doherty and Pauline Casey
10: There were limited therapeutic/recreational activities being carried out on the ward.	5 February 2016	There was recreational and therapeutic interventions ongoing due to the resignation of OT this had reduced in frequency. It is planned that the OT post will be appointed on 8th January and	Jackie O'Doherty

Minimum Standard 5.3.1 (a) This area has been identified for improvement for the **first** time		therapeutic nurse post is being interviewed on Monday 21st December.	
11: 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 December 2015	Addressed and actioned. More detailed minutes of patient meetings will be maintained to reflect individual patient views and choices.	Jackie O'Doherty
Key Outcome Area – Is Care Compassionate? No areas for improvement were identified in this priority			

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.

Key Outcome Area – Is Care Safe? No areas for improvement were identified in this priority			
Key Outcome Area – Is Care Effective? No areas for improvement were identified in this priority			
Key Outcome Area – Is Care Compassionate? No areas for improvement were identified in 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.

Key Outcome Area – Is Care Safe? No areas for improvement were identified in this priority			
Key Outcome Area – Is Care Effective? No areas for improvement were identified in this priority			
Key Outcome Area – Is Care Compassionate? No areas for improvement were identified in this priority			

TO BE COMPLETED BY RQIA

I have reviewed the Trust Improvement Plan and any attached evidence and I am satisfied with the proposed actions Or I have reviewed the Trust Improvement Plan and any attached evidence and I have requested further information.	A McMahon	15/4/16.
I have reviewed additional information from the Trust and I am satisfied with the proposed actions		