The Regulation and Quality Improvement Authority

RQIA

Mental Health and Learning Disability

Unannounced Inspection

Muckamore Abbey Hospital
Cranfield ICU

Belfast HSC Trust

1 July 2013

national preventive mechanism

informing and improving health and social care
www.rqia.org.uk

Disclaimer

Inspectors would like to thank Cranfield ICU patients and staff for their cooperation and openness throughout the inspection process.

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1.0 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).

1.1 Purpose of the Inspection

The purpose of this inspection was to ensure that the service is compliant with relevant legislation and good practice indicators and to consider whether the service provided to patients was in accordance with their assessed needs and preferences.

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

- The Mental Health (Northern Ireland) Order 1986;
- 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.

1.2 Methods/Process

Specific methods/processes used in this inspection include the following:

- discussion with patients
- discussion with multi-disciplinary staff and hospital 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 inspectors in preparing for this inspection.

2.0 RQIA Compliance Scale Guidance

The inspectors rated the ward's Compliance Level against each recommendation made following the previous inspection.

The table below sets out the definitions that RQIA has used to categorise the ward's performance:

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.

3.0 Ward Profile

Trust	Belfast HSC Trust
Name of hospital/facility	Muckamore Abbey Hospital
Address	1 Abbey Road Muckamore Co. Antrim BT41 4SH
Telephone number	02895042066
Person-in-charge on day of inspection	Jennifer Geddis (Deputy Ward Sister)
Email address	Adrienne.creane@belfasttrust.hscni.net
Nature of service - MH/LD	Learning Disability
Name of ward/s	Cranfield ICU
Date of last inspection	29 June 2012

Cranfield ICU is a six bedded mixed gender ward on the Muckamore Abbey Hospital site. The purpose of the ward is to provide assessment and treatment to patients with a learning disability who need to be supported in an intensive care environment.

The ward is connected to the two acute admission wards in Muckamore Abbey Hospital – Cranfield Women's ward and Cranfield Men's ward. Access to the ward can be gained via a corridor linking all three Cranfield wards or via a separate entrance to the rear of Cranfield ICU.

Patients within Cranfield ICU receive input from a multidisciplinary team which incorporates psychiatry; nursing; psychology; behavioural support; and social work professionals. A patient advocacy service is also available. Carer advocacy services are not available.

4.0 Inspection Summary

An unannounced inspection of Cranfield ICU was undertaken on 1 July 2013.

The purpose of this inspection was to assess the Trust's progress and compliance in relation to the implementation of the recommendations made following the announced RQIA inspection of this facility on 29 June 2012.

Of the 23 recommendations made following the 29 June 2012 inspection, inspectors found compliance with 14 recommendations.

It was good to note that since the last inspection:

- vulnerable adults training had been undertaken by all staff working on the ward on the day of the inspection;
- mandatory training was up to date for all staff working on the ward on the day of the inspection;
- all care documentation reviewed by inspectors on the day of the inspection was legible;
- staff had recorded informing relatives of safeguarding vulnerable adults referrals;
- incidents reviewed by inspectors on the day of the inspection evidenced that relatives had been informed;
- a welcome pack for patients being admitted to Cranfield ICU had been developed and made available;
- staff working within Cranfield ICU were aware of the codes of professional conduct relating to their role and are familiar with how to access same;
- patient monies held on the ward was checked and countersigned by two staff members twice per day. In addition, weekly checks were carried out by the deputy ward manager and monthly checks were carried out by the operational manager for the unit;
- patients reported that the quality of food available on the ward had improved since June 2012 inspection.

Compliance could not be assessed with five of the recommendations as evidence was not available on the day of the inspection. Three recommendations have been restated as the Trust did not demonstrate sufficient compliance. A number of additional concerns in relation to care planning and documentation were identified by inspectors. Some information contained within care documentation reviewed lacked detail, was out of date, inaccurate and did not contain interventions or actions to address identified problems. Recommendations have been made in relation to these.

Verbal feedback was provided to the Service Manager and Clinical Director on the day of the inspection, and to the Operational Manager; Behaviour Nurse Specialist and Ward Sister following the inspection visit.

5.0 FOLLOW-UP ON PREVIOUS ISSUES

No.	Recommendation	Inspection Findings	Inspector's Validation of Compliance
1	It is recommended that a template is considered to evidence compliance with the fairness standards.	Although a specific template had not been developed, inspectors noted that a number of the standards from the fairness themed inspection had been implemented on the ward (e.g. advocacy services, information relating to patients right available in easy read format).	**Compliant**
2	It is recommended that all staff are trained in vulnerable adult processes by the end of 2012.	Inspectors found that vulnerable adults training had been undertaken by all staff working on the ward on the day of the inspection.	**Compliant**
3	It is recommended that vulnerable adults safeguarding procedure is included in all induction programmes.	The Muckamore Abbey Hospital Staff Induction Programme booklet was shared with inspectors. The Vulnerable adults safeguarding procedure was not referenced within this document however the deputy ward sister assured inspectors that this procedure is covered at induction. Inspectors were unable to assess compliance with this recommendation as completed induction booklets were not available on the day of the inspection. This recommendation will be carried forward to be evaluated fully on the next inspection.	**Carried forward to next inspection**
4	It is recommended that gaps in staff training are reviewed and resolved and that all training options are considered.	Inspectors found that mandatory training was up to date for all staff working on the ward on the day of the inspection.	**Compliant**

5	It is recommended that action plans following supervision are recorded, agreed and monitored.	Inspectors were unable to assess compliance with this recommendation as supervision records were not available on the day of the inspection. Inspectors were shown the template for recording supervision. This template includes an area for action planning. Inspectors were advised that present there is no arrangements in place at present to monitor action plans agreed at supervision.	**Carried forward to next inspection**
6	It is recommended that all reporting is legible.	All care documentation reviewed by inspectors on the day of the inspection was legible.	**Compliant**
7	It is recommended that the vulnerable adult's documentation has a field which evidences informing relatives.	The vulnerable adult's documentation in use at the time of the inspection did not include a field to prompt and record that relatives had been informed however inspectors noted that staff had recorded informing relatives on the care documentation reviewed. Inspectors were informed that new regional vulnerable adult's documentation was being introduced over the coming months. It is unknown if this documentation will include a field which will prompt and evidence recording relatives. A recommendation has been made in relation to this.	**Compliant**
8	It is recommended that the signing off and review of risk assessments are monitored.	Inspectors were unable to assess compliance with this recommendation as monitoring records were not available on the day of the inspection.	**Carried forward to next inspection**
9	It is recommended that there is consistency in informing relatives of incidents.	Incidents on the ward are recorded on the datix system. The incidents reviewed by inspectors on the day of the inspection evidenced that relatives had been informed.	**Compliant**

10	It is recommended to record capacity and/or checking out patient views post incident in relation to potential issues/ complaints.	Patient views and capacity are not recorded following incidents on the ward. At the time of the inspection, patients' financial capacity was assessed by medical staff. Inspectors were advised that a draft policy relating to capacity was being developed and was out for consultation at the time of the inspection. It is unknown if this policy included assessment of capacity post incident.	**Not Compliant**
11	It is recommended that leaflets are developed to inform patients and their relatives of their right to access information held about them.	A welcome pack for patients being admitted to Cranfield ICU has been developed. Information relating to patient's right to confidentiality and to how to access personal information held is outlined in an easy read format within this pack.	**Compliant**
12	It is recommended that the generic guidance on conduct is developed to reflect the arrangements in relation to behaviour within Cranfield ICU ward.	Staff working within Cranfield ICU were aware of the codes of professional conduct relating to their role and are familiar with how to access same.	**Compliant**
13	It is recommended that the need to implement DOLs interim guidance, DHSSPS, 2010 is considered in relation to certain restrictions.	Despite a number of practices in use on the ward at the time of the inspection, that could be viewed as being restrictive, inspectors were concerned to note that ward staff were not familiar with the Deprivation of Liberty Safeguards (DOLS) – Interim Guidance as outlined by the DHSSPSNI in October 2010. Many of the restrictive practices in use were not documented in the care documentation examined and were not under regular review. Senior trust representatives reported that training sessions in relation to Deprivation of Liberty Safeguards (DOLS) – Interim Guidance had recently taken place.	**Not compliant**

14	It is recommended that the role and function of patient forum meetings are clarified and that the advocate attends to enhance transparency.	Inspectors were unable to assess compliance with this recommendation as records relating to patient forums were not available on the day of the inspection. Inspectors were informed that responsibility for the patient forum had been allocated to a member of the ward team. Inspectors were advised that the patient forum takes place approx. every three months however advocates are generally unable to attend. Given that nature of the ward, it is anticipated that admissions should be for a short duration therefore more regular patient forums may be more appropriate to this setting. A recommendation has been made in relation to this.	**Carried forward to next inspection**
15	It is recommended that in order to fully meet their reconciliation process that small purchases, where there are no receipts, are recorded consistently and countersigned where possible.	Inspectors found that patient monies held on the ward is checked and countersigned by two staff members twice per day. In addition, weekly checks are carried out by the deputy ward manager and monthly checks are carried out by the operational manager for the unit.	**Compliant**
16	It is recommended that patients are asked at forum meetings to report potential missing items and this is monitored.	Inspectors were unable to assess compliance with this recommendation as records relating to patient forums were not available on the day of the inspection. Given the reported infrequent occurrence of patient forum meetings, inspectors were of the view that this may not be the best forum for reporting or monitoring patients missing items. This recommendation has therefore been amended for assessment at the next inspection.	**Recommendation amended and carried forward to next inspection**

17	It is recommended that a policy/ guidance document regarding bed management to the ward is required.	Inspectors were advised that bed allocation and availability is managed by the ward consultant working in partnership with the operational manager for the unit and the wider multidisciplinary team on a case by case basis. Outside of hours, the duty consultant and duty nursing officer assumes responsibility for bed management and availability. It was also reported that a working relationship has developed between hospital staff and the BHSCT home treatment team which is viewed as a positive step. At present, acute admission beds in learning disability hospitals do not fall under the regional bed management protocol for acute psychiatric admissions however local agreements are in place so that a patient with a learning disability presenting to services as requiring admission to hospital can be offered an admission to an acute bed within a psychiatric setting with a view to transfer to Muckamore Abbey Hospital when a bed becomes available.	**Compliant**
18	It is requested that the impact the of the issues relating to the mixed gender ward is monitored and assessed over the next six month and a report furnished to RQIA.	This recommendation was made following the announced RQIA on 29 June 2012. As part of the quality improvement plan for this facility, the BHSCT indicated that this report would be available by 31 March 2013. At the time of the inspection, RQIA were not in receipt of this report. Despite several assurances from senior representatives in the BHSCT that this report would be made available, the report remains outstanding. RQIA were advised by senior BHSCT representatives at feedback on the day of the inspection that there had been no issues relating to the gender mix on the ward during the time period from June 2012 – March 2013. RQIA requested that this be shared in the report as agreed.	**Not Compliant**

19	It is recommended that activities on the ward are kept under review at the patient forum meetings.	Inspectors were unable to assess compliance with this recommendation as records relating to patient forums were not available on the day of the inspection. A plan for daily activities was available on a notice board on the ward on the day of the inspection. Some patient's also had an individualised schedule of activities.	**Carried forward to next inspection**
20	It is recommended that efforts to improve the quality of food continues.	Inspectors where informed by patients that the quality of food available on the ward had improved. An improvement in the quality of food available on the ward was also highlighted to the RQIA inspector by a patient during the patient experience interviews in February 2013.	**Compliant**
21	It is recommended that the proactive input of advocacy services are monitored.	Inspectors were informed that all patients admitted to the ward are made aware of the availability of the patient advocacy service and offered a referral. Information relating to patient advocacy is also contained in the welcome pack for patients admitted to Cranfield ICU.	**Compliant**
22	It is requested that RQIA are kept informed of any future time delay in accessing funding for ECRs.	Inspectors were informed that there had been no applications made for an ECR since the June 2012 inspection.	**Compliant**
23	It is recommended that a MDT template is considered to fully evidence issues discussed, stakeholders present and actions planned and outcome updates.	A new MDT template is currently being devised. The draft version of this was shared with inspectors on the day of the inspection.	**Compliant** **A new recommendation relating to the implementation of this has been made**

6.0 Stakeholder Engagement

The following information is a summary of feedback received from those who met with inspectors during the inspection.

Patients: Inspectors met with a number of patient's on the day of the inspection. Patients reported satisfaction with their care and treatment in Cranfield ICU. One patient expressed frustration with the length of time it takes for patients to be discharged from hospital. Patients reported an improvement in the quality of food available on the ward.

Carers/ Relatives: The inspection was unannounced. Inspectors did not have the opportunity to meet with carers or relatives on the day of the inspection.

Visiting professionals: The inspection was unannounced. Inspectors did not have the opportunity to meet with visiting professionals on the day of the inspection.

Staff: Inspectors met with a number of staff on the day of the inspection. Staff reported that due to the nature and variety of needs patient's in Cranfield ICU present with, it can be a stressful environment to work in. Staff reported frustration with the delay in the discharge of patients to more appropriate community facilities and the impact that this has on bed availability for patients who require or may benefit for the type of supports available within ICU.

Advocates: The inspection was unannounced. Inspectors did not have the opportunity to meet with advocates on the day of the inspection.

7.0 Additional Concerns Noted by Inspectors (if applicable)

A number of additional concerns were also noted by inspectors on the day of the inspection. These concerns related to

- Care documentation
- Deprivation of Liberty Safeguards (DOLS) – Interim Guidance and Restrictive Practices
- Length of Patient stay/Delayed Discharge
- Patient profile
- Implementation of behavioural recommendations

Care Documentation
Inspectors reviewed care documentation relating to four of the six patients on the ward on the day of the inspection. Inspectors found that some information contained within care documentation reviewed lacked detail, was out of date, inaccurate and did not contain interventions or actions to address problems identified in the nursing assessment. A recommendation has been made in relation to this.

A number of inaccuracies were noted in care documentation relating to recommendations made by RQIA regarding one patient, and correspondence with RQIA regarding the care and treatment of another patient. The inaccuracies recorded in care documentation related to recommendations made by RQIA concerning a patient's care and treatment were outlined to senior trust representatives at feedback on the day of the inspection. The recommendations made by RQIA relating to that patients care and treatment are contained within the RQIA report of the unannounced inspection undertaken on 17 May 2013. A recommendation has been made in relation to this.

Inspectors were also concerned to note that nursing staff and hospital management were under the impression that a specific care plan relating to the care and treatment for a patient from October 2012 to February 2013 involving a large number of restrictive practices had been discussed and shared with RQIA. However, RQIA were not aware of, or familiar with, the care plan for this patient. The inaccuracy relating to the sharing of care and treatment plan for this patient with RQIA was discussed with the Operational Manager and Behavioural Nurse Specialist for the ward following the inspection. A representative from RQIA corresponded with the BHSCT in June 2013 in relation to an aspect of this patient's care however the use of restrictive practices or any specific care plan was not shared with RQIA.

Deprivation of Liberty Safeguards (DOLS) – Interim Guidance and Restrictive Practice

In addition to the concerns noted by inspectors in relation to care documentation, and despite a number of practices that could be viewed as restrictive in use on the ward at the time of the inspection, inspectors found an absence of care documentation relating to these practices. Many of the restrictive practices in use were not documented in the care documentation examined and were not under regular review. Inspectors were concerned that nursing staff were not aware of or familiar with Deprivation of Liberty Safeguards (DOLS) – Interim Guidance as outlined by the DHSSPSNI in October 2010. References to the completion of 'restriction checklists' had been made within the care documentation however completed restriction checklists were not available within the care documentation. A recommendation has been made in relation to this.

Length of Patient stay/Delayed Discharge

The ward was fully occupied on the day of the inspection with two female patients and four males. All of the patients on the ward were detained under the Mental Health (Northern Ireland) Order 1986. The length of admission ranged from 1 week – 3 years. One patient's discharge from hospital was described as delayed. There was clear evidence within the documentation that the Consultant Psychiatrist and wider multidisciplinary team had been advocating for the patient whose discharge from hospital was delayed and highlighting the impact that unnecessary time spent in hospital may have.

Patient Profile

Staff and patients highlighted the range of patient profile and needs on the ward on the day of the inspection and the impact that this has in terms of creating an appropriate therapeutic environment and promoting a recovery model. It was reported that this was further compounded by delays in timely discharge from hospital and the demand for acute beds. Senior trust representatives have highlighted the impact of delays in timely discharge from hospital.

Implementation of Behavioural Recommendations

Inspectors noted that care documentation relating to one patient contained a number of different behaviour support plans. Despite examining the care plan and behaviour support plan for this patient, inspectors could not establish what interventions had been recommended to meet the patient's current needs or address the patient's behavioural presentation. A recommendation has been made in relation to this.

Inspectors examined the recommended behavioural supports for another patient. This plan indicated that the patient requires the use of prompts in the form of photographs and a structured approach. However when inspectors asked ward staff about schedule of activity for this patient, staff indicated that this was not required describing the patient as being so autistic they schedule themselves. This practice is in contrast to the recommended intervention for this patient and evidence base for supporting individuals with autism. A recommendation has been made in relation to this.

Appendix 1 – Quality Improvement Plan

Quality Improvement Plan

Unannounced Inspection

Cranfield ICU, Muckamore Abbey Hospital

1 July 2013

The issue(s) identified during this inspection are detailed in the inspection report and the Quality Improvement Plan.

The details of the Quality Improvement Plan were discussed with Service Manager and Clinical Director on the day of the inspection, and with the Operational Manager; Behaviour Nurse Specialist and Ward Sister following the inspection visit. Please refer to Appendix 2 for specific reference documents. The timescales for completion commence from the date of the inspection.

1. Recommendations made following inspection

No.	Recommendation	MHLD Document No.	Reference	Number of times stated	Details of action to be taken by ward/trust	Timescale
1	It is recommended that vulnerable adults safeguarding procedure is included in all induction programmes.	19	PART 1 (1.2,1.3,1.4, 5.1, 6.1, 7.1, 7.2, 8.1)	1	The induction book was reviewed in August 2013 and includes induction of policies, procedures, guidance and training in safeguarding vulnerable adults for all new staff to the ward.	**Immediate and on-going**
2	It is recommended that action plans following supervision are recorded, agreed and monitored.	16 17	Section 6 (6.4, 6.5) Section 4 (4.3) (j, l, m) Section 5.3.3 (c, d, g)	1	Formal supervision is provided for all staff through the Personal Contribution Plans. A timetable was been developed in July 2013 with supervision dates for all staff. A template is completed following supervision which includes an agreed action plan, this is monitored.	**Immediate and on-going**
3	It is recommended that safeguarding vulnerable adults procedures incorporate informing relatives as part of the process.	18 19	Standard 6 PART 1 (1.2,1.3,1.4, 5.1, 6.1, 7.1, 7.2, 8.1)	1	Relatives are informed and a record of this is detailed in the patients care plan and on the ASP1 form, if the patient does not	**1 October 2013**

No.	Recommendation	MHLD Document No.	Reference	Number of times stated	Details of action to be taken by ward/trust	Timescale
					wish for their relative to be informed, this is also recorded.	
4	It is recommended that the signing off and review of risk assessments are monitored.	16	Section 4	1	There is a three monthly audit of the PQC risk assessment - this includes all patients admitted during the previous months. This is to be extended to include a random audit of all risk assessments on a three monthly basis. The signing off and review of all risk assessments will also be audited through the revised EQC audit tool.	**Immediate and on-going**
5	It is recommended that staff within Cranfield ICU receive awareness training on their role in relation to Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010	6		1	Ward Sisters and Charge Nurses received awareness training in May 2013 re. their role in relation to Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010 - Training slides following this have	**1 October 2013**

No.	Recommendation	MHLD Document No.	Reference	Number of times stated	Details of action to be taken by ward/trust	Timescale
					been forwarded to Ward Sisters and Charge Nurses to be shared with ward staff	
6	It is recommended that Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010, is implemented within Cranfield ICU.	6		2	Staff have started to implement the Deprivation of Liberty Safeguards (DOLS) – Interim Guidance, as outlined by the DHSSPSNI in October 2010.	**1 October 2013**
7	It is recommended that the role and function of patient forum meetings are clarified and that the advocate attends to enhance transparency.	17	Section 6.3.2	1	The role and function of patient forum meetings were added to the patients welcome pack in August 2013. The most recent agendas, minutes and actions are displayed on the notice board. Advocates are invited to meetings.	**1 October 2013**
8	It is recommended that the frequency of patient forum meetings is reviewed. Consideration should be given to the expected length of patient stay on the ward as part of this review.	17	Section 6.3.2	1	Patient forum meetings take place 3 monthly	**1 October 2013**

No.	Recommendation	MHLD Document No.	Reference	Number of times stated	Details of action to be taken by ward/trust	Timescale
9	It is recommended that a procedure for reporting and monitoring patient items that have gone missing is developed, implemented and communicated to patients.	4 11	ARTICLE 86 (2) (a)	1	Patients are encouraged to report missing items as soon as they are noted. All items are recorded on admission and on transfer between wards. If the patient is capable they will sign this documentation	**1 October 2013**
10	It is requested that the impact the of the issues relating to the mixed gender ward is monitored and assessed over the six month period until March 2013 and a report furnished to RQIA.			2	The SNM for the ward has completed a draft of this report - this is currently being circulated for consultation	**1 October 2013**
11	It is recommended that the multidisciplinary team template which fully evidences stakeholders present, issues discussed, actions planned and outcome is finalised and implemented.	11 12 16 20	ARTICLE 86 (2) (a) Statement 8 Section 4 Standard 20	1	A revised format for recording MDT meetings was developed in July 2013, this has been piloted in the hospital and is available for use in all wards. The format allows staff to record stakeholders present, issues discussed, actions planned and	**1 October 2013**

No.	Recommendation	MHLD Document No.	Reference	Number of times stated	Details of action to be taken by ward/trust	Timescale
					outcomes	
12	It is recommended that all care documentation is accurate, current and in keeping with relevant published professional guidance documents including NMC Record keeping guidance and DHSSPSNI 2010 Deprivation of Liberty Safeguards (DOLS) – Interim Guidance.	6 11 12 16 20	ARTICLE 86 (2) (a) Statement 8 Section 4 Standard 20	1	A new care plan has been developed. It is anticipated this will be completed and ready for implementation by the end of October 2013. Guidelines for completion are available. The review of the care plan will ensure care documentation is accurate, current, personalised and in keeping with relevant published professional guidance documents including NMC Record keeping guidance and DHSSPSNI 2010 Deprivation of Liberty Safeguards (DOLS) – Interim Guidance.	**Immediate and on-going**
13	It is recommended that care documentation is updated to ensure inaccuracies relating to RQIA	11 12 16	ARTICLE 86 (2) (a) Statement 8 Section 4	1	The care documentation referred to was updated in August 2013. Inaccuracies relating to RQIA	**1 September 2013**

No.	Recommendation	MHLD Document No.	Reference	Number of times stated	Details of action to be taken by ward/trust	Timescale
	recommendations are corrected.	20	Standard 20		were corrected	
14	It is recommended that information and correspondence relating to patient care and treatment is recorded clearly in the patient's care documentation to ensure accuracy.	11 12 16 20	ARTICLE 86 (2) (a) Statement 8 Section 4 Standard 20	1	Information and correspondence relating to patient care and treatment is recorded clearly and accurately in the patient's care documentation	**Immediate and on-going**
15	It is recommended that interventions developed by the multidisciplinary team are implemented as agreed.	11 12 16 20	ARTICLE 86 (2) (a) Statement 8 Section 4 Standard 20		A revised format for recording MDT meetings was developed in July 2013, this has been piloted in the hospital and is available for use in all wards. Interventions developed are implemented as agreed by the MDT	**Immediate and on-going**

The Quality Improvement Plan is to be signed by the Chief Executive and returned to:

Mental Health and Learning Disability Team
The Regulation and Quality Improvement Authority
9th Floor, Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Signed: _____

Name: _____colm donaghy_____ _____

Date: _____19 sept 2013_____

FOR OFFICE USE ONLY:

QIP viewed by inspector on:

Date: _____

Signed: _____

Name: _____

Appendix 2 – MHLD Reference Documents

MHLD Document Number	Legislation Title
1	AIMS -Older People(2009)
2	AIMS-Working Age Adults(2009)
3	AIMS-Learning Disabilities(2010)
4	Circular HSS(F)57/2009 – Residents' Monies
5	Complaints in HSC: Resolution & Learning (2009)
6	DHSSPS Interim Guidance - Deprivation of Liberty(2010)
7	DHSSPS Guidance - Restraint and Seclusion(2005)
8	Human Rights Act(1998)
9	Improving Dementia Services Reg Strategy(2011)
10	Learning Disability Service Framework(2012)
11	Mental Health(NI)Order(1986)
12	NICE Quality Standard 14-User experience(2011)
13	NICE Clinical Guideline 136 -User experience(2011)
14	OPCAT(2002)
15	Procedure for Reporting & Follow Up of SAIs(2010)
16	Promoting Quality Care(2009)
17	Quality Standards for HSC(2006)
18	Safeguarding VAs-Shared Responsibility(2010)

MHLD Document Number	Legislation Title
19	Safeguarding VAs-Protection Policy & Guidance(2006)
20	Service Framework for Mental Health & Well Being (2011)
21	UN Convention-Person with Disabilities(2006)
22	UN Convention-Rights of the Child(1989)
23	UTEC Guidance(2007)