The Regulation and Quality Improvement Authority

MENTAL HEALTH AND LEARNING DISABILITY

ANNOUNCED INSPECTION

GREENAN WARD, MUCKAMORE HOSPITAL

BELFAST HEALTH AND SOCIAL CARE TRUST

24 AND 25 JANUARY 2012

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

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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.

On 24 October 2011 RQIA informed the Belfast Health and Social Care Trust of the proposed inspection and forwarded the associated inspection documentation. RQIA adopted the approach of self-assessment, 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 included an analysis of the ward's self-assessment, other associated information, and discussions with ward staff, patients and relatives. A range of multidisciplinary records, policies and procedures were also examined as part of the inspection.

The recommendations made during the previous inspection on 18 and 19 November 2010 were also assessed during this inspection to determine the trust's progress towards compliance. The inspector found compliance in the following areas. It was noted that good progress was made in relation to: bed areas being personalised, meal times more enjoyable; enhanced information for patients and relatives; and improved multidisciplinary team review performance. While some progress has been made in relation to advocacy involvement on the ward, inspectors concluded that this remains in the early stages and recommended that the roles and responsibilities of advocacy services are defined and implemented. Recommendations were also restated regarding: improving ward-based activities for patients; implementation of communication care plans; and enhanced patients appropriate information material.

In spite of assurances from the trust, several recommendations remained outstanding from the previous inspection. Recommendations that were outstanding were added to the quality improvement plan for action (reference Appendix 1).

An overall summary of the ward's performance against the human rights theme of protection is in section 3 and full details of the inspection findings are outlined in Appendix 2.

Trust	Belfast Trust
Name of hospital/facility	Greenan Ward,Muckamore Abbey Hospital
Address	1 Abbey Road Antrim BT41 3SH
Telephone number	02894 463333
Person in charge on day of inspection	Mary Bogue
Nature of service - MH/LD	Learning Disability
Name of ward/s and category of care	Greenan Ward, adult continuing care.
Number of patients and occupancy level on days of inspection	24 beds, 20 patients during inspection
Number of detained patients on days of inspection	None
Date of last inspection	18 and 19 November 2010
Date of Inspection	24 and 25 January 2012
Name of Inspector	Margaret Cullen

2.0 Ward Profile

Greenan Ward is situated on the Muckamore Abbey Hospital site and provides continuing care to adults with learning disability and complex health care needs. The ward has 24 beds, four of which are in single rooms and the remainder in dormitory areas.

The ward has been open since 1981 and currently accommodates female patients, some of whom have been receiving care on the hospital site for over 50 years. The ward does not take direct admissions. Patients who come to the ward are most likely to have been transferred from other wards within the hospital site.

There are a number of bathroom and toilet areas on the ward; office accommodation; a dining room; and veranda area, two large sitting rooms; a visitor's area; interview room; clinical room and a number of areas for storage of equipment and consumables. The ward has tracking for overhead hoists in the dormitory and bathroom areas, and a number of portable hoists.

Patients have input from a variety of multidisciplinary professionals including medical, nursing, social work, podiatry, physiotherapy, speech and language therapy, dentistry and dietetics.

Approximately two thirds of the patients have ongoing family contact, and most patients have access to day care services on site. A minister of religion visits the ward regularly.

The patients range in age from mid 40s to late 70s and many of patients who have complex healthcare needs, most of them requiring assistance to mobilise. Two patients require supervision at meal times, one patient requires enteral feeding and the rest require feeding by a member of staff. The dependency levels of the patients on this ward are high.

3.0 Inspection Summary

An announced inspection to Greenan Ward was undertaken on the 24 and 25 January 2012. The purpose of this inspection was to assess the ward's procedures and arrangements for safeguarding vulnerable adults. Inspectors did this by speaking with patients, staff, an advocate and visiting professionals**.** A range of multidisciplinary records, policies and procedures were also examined.

The inspection was announced and took place on 23 and 24 January 2012**.** The ward manager had prepared some self-assessment information prior to the inspection, and distributed a number of questionnaires to patients, their relatives, staff and visiting professionals.

This inspection focused on the human rights theme of protection which included a focus on the safeguarding of vulnerable adults in Greenan Ward, Muckamore Abbey Hospital.

In relation to the ward's assessment on safeguarding vulnerable adults, inspectors concluded that while this process is evolving there was evidence to confirm that most staff are trained in this process. All staff participating in the inspection understood the criteria of abuse and the responsibility to protect the patient population. The safeguarding policy document was accessible along with an easy reference as well as other related and supporting policies and procedures. The responsibilities inherent in safeguarding are included in the trusts induction programme for new staff. A recommendation was made to incorporate this more fully into the ward induction programme.

Inspectors noted good practice in relation to the knowledge of the nursing staff regarding patient's choices and preferences. A number of templates were used which indicated good practice in relation to restrictive practices: Best interest document, protocol for unexplained scratches and bruising.

The procedure for vulnerable adults documentation examined was appropriate. The ward manager indicated the need for clarification on the threshold for referral and recommendations were made in relation to this.

Nursing staff had recrded the risk assessment for all patients and inspectors concluded that the document was useful in summarising identified risks. There was disagreement over the usefulness of the documentation for the patient profile on this ward from another professional and therefore the assessments were not signed off as required. A recommendation was made in relation to this.

There were significant measures to safeguard patients' monies and property but recommendations were made to improve the record of items purchased. Patients and relatives indicated no concerns regarding patients' possessions.

Appraisal were provided for all staff and training needs are identified and monitored. Supervision was provided for trained staff and a recommendation was made that formal supervision should be provided to all staff.

Overall, stakeholders were positive about the care, support and protection provided on the ward. Some patients indicated they would like more access/outings off the ward. Inspectors noted that staffing is stretched on a ward where dependency levels are high. Inspectors were advised that this impacts on activity provision for patients. Recommendations were made regarding these issues.

There was no evidence indicating that patients and relatives are informed of their rights to access information or about the children's visiting arrangements. There is no private area on the ward for visiting and recommendations have been made to address these areas.

This ward does not admit under 18 year olds.

Inspectors would like to thank the patients, staff, relatives and visiting professionals for their cooperation throughout the inspection process.

4.0 Stakeholder Engagement

Questionnaires were issued to staff, patients, relatives/ carers and visiting professionals in advance of the inspection. The responses from the questionnaires were used to inform the inspection process.

Questionnaires issued to	Number issued	Number returned
Patients	**4**	**2**
Carers/Relatives	**20**	**0**
Visiting Professional	**0**	**5**
Staff	**8**	**0**

During the inspection the inspector has the opportunity to meet with staff, patients, relatives/ carers, visiting professionals or advocates. Below are the details of the number of discussions held during the inspection.

Additional discussions during inspection	Number
Patients	**3**
Carers/Relatives	**0**
Visiting Professionals	**1**
Staff	**4**
Advocates	**1**

The following information is a summary of feedback received from those who returned a questionnaire or met with an inspector during the inspection.

Staff

Staff interviewed indicated satisfaction with the care provided. They indicated knowledge of the vulnerable adult's process but confidence reported in the use of the protocol varied. However, staff did confirm that patients on the ward were vulnerable and that they were committed to their protection and would raise any issues of poor practice immediately with the ward manager.

Relatives

The five relative questionnaires indicated satisfaction with the care provided. Not all relatives were aware of risk assessments or the vulnerable adult's policy but most indicated that they are kept informed of restrictive practices, incidents, progress and were aware of the complaints policy. While they were not all aware of their relative's financial situation none indicated concerns in relation to patients' money or property. Comments made included:

- "With the staffing levels provided the care is of good quality"

- "Staff in Greenan are excellent and are always available to listen to relatives if they have any concerns, like any place of work accidents do happen but they never happen twice."
- "The nursing staff deliver a great service …..it is a vocation. I have nothing but admiration for the care workers"

One improvement suggested:

- "More staff, improved décor"

Some of the relatives indicated their concerns regarding the future care of their loved ones stating clearly that as they had spent most of their lives in Muckamore it was their home and they did not feel they would get equal care in another environment.

Visiting professionals

Inspectors spoke with one visiting professional and it was apparent that there was a difference of opinion over the usefulness of the risk assessments for this patient population. This issue is discussed further in the report. This professional indicated that care on the ward was satisfactory, and no issues were raised.

Patients

The returned questionnaires and patient interviews indicated a good level of satisfaction with the care provided. Not all patients were aware of the vulnerable adult's policy, but they confirmed that they are treated well and that restrictions are explained to them. They also indicated that they knew they have a right to complain and would raise issues with the ward manager. One patient interviewed alleged they were not treated respectfully on one occasion and inspectors requested that this was processed as a vulnerable adult enquiry to ensure the safeguards were invoked.

Most patients indicated that they do not have concerns about their money or possessions. However one patient stated in their questionnaire that they were concerned about their property in case someone breaks it. Positive comments included:

- "It's a nice ward, I have good friends. All staff are very good to me, they treat me nice. I like ____(named nurse) to buy me things".
- "I like the other girls on the ward".

All issues and comments were discussed with the ward manager during the inspection.

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5.0 Additional Concerns Noted by Inspectors

5.1 Staffing

Inspectors noted the high dependency levels of patients on the ward and were informed by the ward manager that the ward has been working with one staff member down on a regular basis. It was noted that some patients were only getting up at 11.30 am and that activities on the ward were impacted as a result of staffing. It was clear during the inspection that staff on the ward are stretched. Inspectors recommended that an audit is undertaken of the work load on the ward, inclusive of patient therapeutic time, and a Telford assessment of need should be completed.

5.2 Access Off the Ward.

Inspectors were informed that patient's outings off the ward are limited. Patients interviewed raised this as an issue. Inspectors requested that this is reviewed.

5.3 Staff Support.

With the heavy demand on nursing staff for patient care it was recommended that the provision of laundry and clerical support is reviewed.

5.4 Environment.

One toilet area on the ward is in need of refurbishment and this matter has been raised for some time. It was recommended that the needs of the patient population are assessed and the use of this space is prioritised to enhance privacy for patients**.** Inspectors noted the lack of a private visiting area on the ward.

5.5 MDT reviews.

Inspectors referred to duplications and omissions on the templates of the MDT reviews in the notes examined. They were informed that a new template has been agreed by the MDT which is in use from January 2012 but was not in the notes examined. It was explained that the revised processes will include restrictive practices and evidence inclusivity more fully.

6.0 Compliance Scale

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.

NO	Question	Compliant	Substantially Compliant	Moving Towards Compliance	Not compliant	Not Applicable
1	How do you ensure that everyone involved with the ward is aware of and understands the safeguarding vulnerable adult policy?		.	✓		
2	List the additional procedures and guidelines that you use to support the safeguarding vulnerable adult policy.		✓			
3	List the additional procedures and guidelines, aimed at promoting safe and healthy working practices, which you use to support the safeguarding vulnerable adult policy.		✓			
4	Outline how the ward is involved in the review of the Trust's safeguarding vulnerable adult policy, the code of behaviour and the other associated procedures and guidelines.		✓			
5	Outline how new staff are appropriately inducted into the ward.		✓			
6	Describe how staff training needs, appropriate to the post/ role, are identified.		✓			
7	Outline the arrangements in place for: (i) the support and supervision of all staff (ii) the annual appraisal of staff and the review of volunteers.		✓			
8	Describe the arrangements in place for maintaining written records of: training completed; support and supervision; and annual appraisals and reviews.			✓		

9	Describe how the ward ensures staff and volunteers comply with the Safeguarding Vulnerable ults Standard 4.			✓		
10	Outline the steps the ward has taken to ensure that staff and volunteers are competent to recognise signs of abuse.			✓		
11	Describe how the ward identifies and manages risks for individual patients.		✓			
12	Outline the mechanisms used by the ward to ensure that vulnerable adults have the right to take risks in relation to their care.	✓				
13	Describe how the reporting, recording and reviewing accidents, incidents and near misses informs and influences ward practice and the risk assessment and management procedures.		✓			
14	Describe how the ward promotes and communicates the Trust's 'ethos of inclusion, transparency and openness' to vulnerable adults, carers, advocates, family members, staff and volunteers.		✓			
15	Describe the procedures in place for carers, advocates and vulnerable adults to share concerns they may have or to make complaints about the organisation.		✓			
16	Outline the steps the ward has taken to encourage carers, advocates and vulnerable adults to raise concerns or make a complaint following an incident.	✓				

17	Outline how the ward ensures that staff know and comply with the records management policy.	✓				
18	Outline the mechanisms the trust has in place to inform vulnerable adults about their right to access to information held about them.				✓	
19	Describe how the ward ensures that staff, volunteers and visitors know about and adhere to the Code of Behaviour.				✓	
20	outline how the ward safeguards patients' rights in relation to the use of: (i) restrictions on the ward (ii) isolation/ seclusion (iii) close observation (iv) restraint	✓				
21	Outline the mechanisms for the handling of vulnerable adults' money.		✓			
22	Outline how the ward ensures the safety of patients' property while on the ward.			✓		
23	Describe what arrangements the ward has in place for children visiting the ward.				✓	
24	Outline the safeguarding arrangements the ward has in place for the admission of an under 18 year old.					✓

APPENDIX 2 Unannounced visit to Greenan Ward Muckamore Abbey 9 March 2012

An unannounced visit was carried out to Greenan Ward Muckamore on 9 March 2012 in response to concerns raised by a whistle-blower.

RQIA's MHLD team received an anonymous telephone call from a bank member of staff from Greenan ward MAH who raised a concern about patients being woken out of their sleep to get dressed at 6am to "assist the day staff". She identified that it is a particular member of staff who has recently come to night duty from day duty who instigated this practice. She also indicated that this concern has been raised by other members of staff to the ward manager and nothing has been done. She prefers not to use the whistleblowing policy given that it has already been raised within the hospital.

Greenan was last inspected by MHLD inspectors on the 25 and 26 January and concerns were expressed about the lack of staff on the ward and the impact this had on patient care e.g. patients not getting up until 11.30am. Inspectors were told during Inspection that getting up at this time was the patient's choice and inspectors recommended the review of staffing levels regarding this.

An unannounced inspection took place to Greenan ward at 6.30am on Friday 9 March by Patrick Convery and Janet McCusker. Inspectors met with night staff and explained the reasons for their visit.

Following a tour of the ward it was observed that no patients were out of bed and staff nurse indicated that the practice did not happen while she was on duty.

Care plans were examined and there was no indication that patients were to be wakened out of their sleep nor was there any indication in care plans that patients should be taken out of bed as soon as they were awake.

MHLD staff met with ward manager when she commenced work who suggested that it may happen on occasions but only if patients were already awake. MHLD inspectors then met with the facility manager during the visit and sought assurances that the practice of wakening patients at 6am should not occur, and a reminder should be sent to night staff following our visit. The facility manager advised that the senior nurse on call for the hospital at night would provide an additional safeguard to ensuring that patients were not wakened from their sleep to get washed, and dressed and all those who are awake early were reported to them.

Staffing levels were then reviewed and while there has been concerns expressed around staffing levels during the announced inspection on the 25 and 26 January, there has been a recruitment drive since the last inspection. Assurances were given by facility manager that additional staff were being recruited and these would be allocated to Greenan Ward.

The issue of sick leave was discussed and while this is currently 5 - 5.5% inspectors were informed that this was average for the Muckamore site.

RQIA inspection staff were given assurances that an internal memorandum would be issued to all staff to remind them not to wake patients out of their sleep, and that any individual arrangements should be documented in care plans.

The visit concluded at 8.30am and managers were informed that this would be discussed further with senior management that day. RQIA MHLD staff would continue to monitor the situation.

Recommendations

It is recommended that the trust reissue to staff guidance in respect of patients awake before 7am.

It is recommended that the senior nurse on call for the site is informed of any patients awake and dressed prior to 7am.

It is recommended that the staffing levels for Greenan Ward are continually reviewed to ensure that they receive an appropriate number of staff from the recruitment trawl.

It is recommended that if a patient has a normal routine of waking early in the morning that this is clearly documented in the patients care plans.

Follow up
RQIA's Head of Programme for MHLD followed up with telephone call to the hospital services/resettlement manager on afternoon following visit.

The Director of MHLD also contacted the trust's Assistant Director for Learning Disability to apprise him of the visit and to explain the reasons for the unannounced inspection.

Following this report the MHLD team will continue to monitor staffing levels following this visit.

Appendix 1 – Quality Improvement Plan

The Regulation and Quality Improvement Authority

QUALITY IMPROVEMENT PLAN

ANNOUNCED INSPECTION

Greenan Ward, Muckamore Hospital

24 and 25 January 2012

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

The details of the Quality Improvement Plan were discussed with Ward Manager

RECOMMENDATIONS RESTATED FROM PREVIOUS INSPECTION

NO.	RECOMMENDATION	NUMBER OF TIMES STATED	DETAILS OF ACTION TO BE TAKEN	TIMESCALE (e.g. dd/mm/yy)
1	It is recommended that the hospital's advocacy service is developed to include an in-reaching service to patients in Greenan Ward on a consistent and proactive basis and those roles and responsibilities are defined.	2	Bryson House and Mencap are providing an advocacy service to the patients in Muckamore abbey Hospital. Advocates visit the ward monthly. A meeting has been set up to meet with advocates to define their roles and responsibilities. The hospital has set up an advocacy steering group which had representatives from each of the advocacy agencies	**Immediate and on-going**
	It is recommended that the ward continue to develop the 'welcome pack' and that this is accessible to all patients		The pack is completed	**Immediate and**

2	which includes information about patient's rights on the ward. While this work has progressed it requires further development.	2		**on-going**
3	It is recommended that patients who have specific communication needs have these assessed and an appropriate care plan developed	2	All patients requiring Speech & Language therapy have been referred regarding a communication pathway. Assessments underway.	**Immediate and o going**
4	It is recommended that the ward receive input from administrative staff to promote compliance with records management and filing guidelines. While the ward has currently three hours per week administrative support should be reviewed to ensure that it is adequate to meet the needs of the ward.	2	Ward staff have been advised that additional clerical support is available through the hospitals main secretariat	**Immediate and on-going**
5	It is recommended that all patients have an individualised programme of activities and that those patients who do not attend external day time activities have the opportunity to engage in meaningful ward based activities which reflect their personal preferences.	2	An activity timetable has been drawn up detailing activities available. Patients preferences and participation are recorded in their care plans	**Immediate and on-going**

2. RECOMMENDATIONS MADE FOLLOWING INSPECTION OF SAFEGUARDING VULNERABLE ADULTS AND CHILDREN – HUMAN RIGHTS THEME OF PROTECTION

NO	AREA FOR QUALITY IMPROVEMENT	RECOMMENDATION	DETAILS OF ACTION TO BE TAKEN	TIMESCALE
1	**Staff induction, training, supervision and appraisal.**	It is recommended that the ward induction programme includes the vulnerable adults procedure, the whistle blowing policy, and handling patients' monies guidance.	The induction booklet is currently under review for the hospital – identified areas will be included in the new document	**Immediate and on-going**
		It is recommended that formal supervision is provided for all staff.	Formal supervision is provided for all staff through the Peronal Contribution Plans. Professional supervision is provided as per Trust policy	**Immediate and on-going**
		It is recommended that alternate, efficient options for training staff on this site are considered.	The current processes are being reviewed with a number of options being considered	**Immediate and on-going**

2	**Awareness and implementation of procedures for the protection of vulnerable adults.**	It is recommended that all unexplained injuries are considered in relation to vulnerable adults' procedures. Check	In respect of all injuries sustained the NIC, SNM and Hospital Services Manager will make a decision regarding which process will be followed – i.e the vulnerable adults' process, SAI / untoward incident process or both	**Immediate and on going**
		It is recommended that the threshold for vulnerable adult referrals are discussed, agreed and monitored.	Discussion with Designated Officers are underway re establishing thresholds	**Immediate and on-going**
		It is recommended that staff access and appraisal of policy and guidance documentation is monitored.	This is a standing agenda item for ward staff meetings. The Service Directorate has a quarterly newssheet which highlights all new policies and procedures, this is available for all staff	**Immediate and on-going**
3	**Incident reporting, risk management.**	It is recommended that the matter of using the risk assessments on the ward is resolved and that agreed documentation for risk management is signed off by relevant staff.	Patients are individually assessed as to their need for a risk assessment under PQC guidance (LD)	**Immediate**

		It is recommended that the overview reports from Governance are resumed and that analysis of learning is included.	Monthly reports are sent to all wards / Consultants and Heads of Departments	**Immediate**
4	**Code of behaviour, patients' rights.**	It is recommended that a code of behaviour is developed for the ward. It is recommended that user friendly information in relation to rights to access information is developed and shared with patients and their relatives.	All professional staff groups have their own Code of Behaviour. All staff have a contract which includes a code of behaviour. Customer Care Standards are available in the ward. EQC monitors a number of standards in relation to behaviour. The Trust have existing guidelines for Volunteers working in the Trust. Leaflets are available in the ward	**Immediate** **Immediate**
5	**Patients' money and property**	It is recommended that the "best interest proforma" is used facilitate debits from patients accounts when they lack capacity. That the consultation of relatives and/or advocate is clearly referenced. It is recommended that the practice of using a sum of patients money to collectively purchase 'treats' for all the patients is stopped and that purchases	Best Interest Proforma is being used to facilitate debits from patients accounts when they lack capacity Staff are following the amended guidance detailed in the document	**September 2012** **Immediate**

		for patients are individually recorded and stored and that patients receive the items that they have purchased. It is recommended that the system for tracking patients' clothes/personal items is monitored more robustly.	Patient's/Client's Private Property – Written procedures for Long Stay Patients/Clients Staff have been reminded to follow the Patient Property Policy	**Immediate**
6	**Child Protection**	It is recommended that children's' visiting arrangements are included in the welcome pack and on the ward and that an appropriate area is designated which provides privacy and safeguards.	Guidance is provided in the Welcome pack	**September 2012**
7	**Other recommendations**	It is recommended that the additional recommendation in section 5 of the report; • Staffing • Access off the ward • Support • Environment • MDT template are fully actioned.	Detailed at 8 – 12 in the table below	**September 2012**

Recommendations from additional concerns highlighted in section 5

8	**Staffing**	Inspectors recommended that an audit is undertaken of the work load on the ward, inclusive of patient therapeutic time, and a Telford assessment of need should be completed.	This ward has been continually reviewed in relation to Staffing levels for the number of patients	**September 2012**

			and their dependency levels, however a Telford assessment of need will be completed in June 2012	
9	**Access off the ward**	Inspectors were informed that patient's outings off the ward are limited. Patients interviewed raised this as an issue. Inspectors asked that this is reviewed.	An activity timetable has being drawn up detailing activities available. Patients preferences and participation are recorded in their care plans. EQC provides a yearly audit on patient activities	**September 2012**
10	**Staffing support**	With the heavy demand on nursing staff for patient care it was recommended that the provision of laundry and clerical support is reviewed	Ward routines will be reviewed in relation to laundry duties to address capacity issue in relation to this task Ward staff have been advised that additional clerical support is available through the hospitals main secretariat	**September 2012** **September 2012**
11	**Environmental**	It was recommended that the needs of the patient population are assessed and the use of this space is prioritised to enhance privacy for patients. Inspectors noted the lack of a private visiting area on the ward.	The toilet area highlighted is to be refurbished to appropriate Infection Control standards	**September 2012**

			The Visiting area - options have been explored and the preferred option chosen – costs are currently being prepared	**November 2012**
12	**MDT Reviews**	Inspectors referred to duplications and omissions on the templates of the MDT reviews in the notes examined. They were informed that a new template has been agreed by the MDT which is in use from January 2012 but was not in the notes examined. It was explained that the revised processes will include restrictive practices and evidence inclusivity more fully	The new template has been fully implemented ✓	**September 2012**

Recommendations following Unannounced Inspection 9th March 2012

13	**Unannounced Visit**	It is recommended that the Trust re-issue to staff guidance in respect of patients awake before 7am	Each patients care plan reflects their assessed need in relation to early wakening ✓	**Immediate**
14	**Unannounced Visit**	It is recommended that the senior nurse on call for the site is informed of any patients awake and dressed prior to 7am	The night charge will be informed of any patients awake and dressed prior to 7am ✓	**Immediate and on-going**
15	**Unannounced Visit**	It is recommended that the staffing levels for Greenan are continually reviewed to ensure that they receive an appropriate number of staff from	Staffing levels in Greenan have remained under continual review and block	**Immediate and on-going**

		the recruitment trawl	staff contracts were obtained during this interim period while recruitment is underway	
16	**Unannounced Visit**	It is recommended that if a patient has a normal routine of waking early in the morning that this is clearly documented in the patients care plans	This has been entered in individual care plans where applicable	**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: C. McNicholl

DATE: 25/10/12

Margaret Cullen