The Regulation and Quality Improvement Authority

RQIA

Mental Health & Learning Disability

Announced Inspection

Cranfield Male Ward

Muckamore Abbey Hospital

Belfast Health & Social Care Trust

18 & 19 November 2013

npm national preventive mechanism

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. 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 service users was in accordance with their assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

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

Committed to a culture of learning, RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the Inspection Standards.

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

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

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

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

The recommendations made during the previous inspection on **15 February 2011 and 8 March 2011** were also assessed during this inspection to determine the Trust's progress towards compliance. The inspector found compliance in the following areas,

- staff have ensured that the statutory duty with regard to informing patients of their rights is documented
- staff have routinely documented that patients induction to the ward has been completed
- the practice of maintaining a treats box has been reviewed
- all risk assessments have been signed appropriately
- staff have specified one to one interactions with patients and reviewed the frequency of these
- loose pages in medical notes have been secured
- patients views were discussed at ward meetings

In spite of assurances from the Trust, two recommendations remained outstanding from the previous inspection. The previously stated recommendations that were outstanding have been 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 1.

2.0 Ward Profile

Trust	Belfast HSC Trust
Name of hospital/facility	Muckamore Abbey Hospital, Cranfield Male Ward
Address	1 Abbey Road ANTRIM BT41 4SH
Telephone number	028 94463333
Person-in-charge on day of inspection	Bert Lewis
Email address	bert.lewis@belfasttrust.hscni.net
Nature of service - MH/LD	Learning Disability
Name of ward/s and category of care	Cranfield Male Admissions
Number of patients and occupancy level on days of inspection	14 beds 14 patients on the day of inspection
Number of detained patients on day of inspection	10
Date of last inspection	15 February 2011 and 8 March 2011
Name of inspector	Siobhan Rogan & Wendy McGregor

Cranfield men's is a fourteen bedded ward on the Muckamore Abbey Hospital site. The purpose of the ward is to provide assessment and treatment to male patients with a learning disability who need to be supported in an acute psychiatric care environment.
On the day of inspection there were 10 patients on the ward who were detained under the Mental Health (Northern Ireland) Order 1986. There were three 'delayed discharge' patients on the ward at the time of the inspection.

Patients within Cranfield men's 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

3.0 Inspection Summary

An announced inspection of **Cranfield Male Ward, Muckamore Abbey Hospital** was undertaken on **18 & 19 November 2013**. The purpose of this inspection was to assess the ward's arrangements and procedures for safeguarding vulnerable adults.

The following is a summary of the inspection findings of the arrangements for safeguarding vulnerable adults on this ward and represents the position on the ward on the day of the inspection.

Information relating to adult safeguarding that included the Regional Adult Protection Policy and Procedure (2006) and other guidance documents were available on the ward. There was also a flow chart for staff reference displayed in the ward office.
A review of training records available indicated that all the staff working on the ward on the day of the inspection had undertaken training in safeguarding of vulnerable adults.

Records available on the day of the inspection demonstrated that guidance on safeguarding of vulnerable adults procedures was included in the induction programme for new staff.

Care documentation in relation to safeguarding of vulnerable adults referrals reviewed by inspectors evidenced that referrals had been made, forwarded to the safeguarding vulnerable adults designated officer and reviewed. Protection plans were completed, on the safeguarding vulnerable adult documentation and recorded in the patients care documentation. Inspectors met with the safeguarding vulnerable adults designated officer on the day of inspection. A template has been completed to assist staff to complete referrals. The designated officer confirmed he discussed multiple referrals at the multi-disciplinary team. The wards easy read welcome / information booklet for patients detailed vulnerable adult processes.

Care documentation in relation to four patients was reviewed on the day of the inspection. Staff were in the process of transferring care documentation onto the new care plan format. Care and treatment was documented in both medical and nursing files. Records from other members of the multi-disciplinary team were not available on the ward. There was evidence that patient needs were assessed however not all needs have a related intervention plan completed e.g. a patient with incontinence needs or requiring support with their personal care did not have an intervention plan.

In the four sets of care documentation inspectors reviewed there was evidence of patient's signatures both in care plans and risk assessments.

Records of the multi-disciplinary meeting were contained in the file and included evidence of discussions with the patients both prior to and after the meetings.

Inspectors noted a number of practices on the ward on the day of the inspection that could be viewed as restrictive. Individual Deprivation of Liberty care plans had been completed by nursing staff and agreed by multi-disciplinary team, however the rationale or therapeutic aim for these practices was not clearly documented and did not always justify the level of restrictive intervention used with each individual.

All staff present on the ward on the day of inspection had received up to date physical intervention training. Inspectors noted physical intervention forms had been completed appropriately. Information in relation to managing behaviour that is challenging was included in the ward welcome/information booklet in easy read format.
Patients who were detained under the Mental Health (Northern Ireland) Order 1986 had specific care plans completed in relation to their detention. There was evidence in the care documentation that patients had been informed of their rights.
There were also discharge plans in place in the care documentation reviewed by inspectors.

Patient valuables and small amounts of cash were stored in individual lockable drawers in the ward office. All transactions were countersigned. In addition, cash drawer balances were checked and signed for by two staff twice daily. Cash drawer balances were also audited on a weekly basis.

Inspectors reviewed a risk assessment in relation to mobile phone use for one patient. The risk assessment was comprehensive and proportionate to the restrictions put in place.

Ten out of the fourteen patients attended onsite day care. There was no evidence of a ward base schedule for therapeutic activities for patients not attending day care or for activities available to patients outside day-care hours.
Access to occupational therapy, speech and language therapy and behaviour therapy is available via referral to these services. Patients have access through referral to music therapy and aromatherapy. There was no evidence in the care documentation to link therapeutic activities to assessed needs. Evidence of a multi-disciplinary team assessment for the most appropriate and therapeutic use of activities was not available on the day of the inspection.

Induction, supervision and Knowledge Skills and Framework (KSF) records were available to inspectors on the day of the inspection. Records demonstrated that all staff had received supervision and KSF appraisals. Two induction booklets were reviewed for new staff these were comprehensive and included Safe Guarding Vulnerable Adults. Inspectors noted that there had only been one ward meeting for staff within the last year.

The organisational structure for the ward and staff on duty was not on display in any of the patient areas on the days of the inspection.

Inspectors reviewed care documentation relating to four patients on the day of the inspection. There was evidence of the use of pre-printed care plans in one of the four sets of care documentation reviewed during the inspection. At present nursing documentation on the ward is being transferred to a new care plan format. The care documentation completed in the revised format was individualised and reflected person centred care. It was noted that errors had not been corrected appropriately as correction fluid was evident in all four patients' notes. The care plans had been reviewed by the named nurses frequently however, the ward manager does not formally audit the care documentation.

Inspectors were shown the computerised reporting system (Datix) for recording and reporting accident, incidents and near misses. Referral to other members of the multi-disciplinary team had been made were necessary, including the Vulnerable Adults Safeguarding team.

There had been three patient forum ward meetings within the past year, minutes were reviewed by inspectors and demonstrated service user involvement, the patient advocate was present at the patient ward meetings.

There had been one formal complaint and two local resolution complaints within the year. Inspectors reviewed the outcome and noted the complaints were investigated fully and included in patients care documentation.
On this occasion **Cranfield Male Ward** has achieved an overall compliance level of **substantially compliant** in relation to the human rights inspection theme "Protection".

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

4.0 FOLLOW-UP ON PREVIOUS ISSUES

No.	Expectation Statement	Recommendations	Action Taken (confirmed during this inspection)	Inspector's Validation of Compliance
1	Each patient who is detained is informed of the process and the implications for them.	It is recommended that staff consistently ensure that the statutory duty with regard to informing patients of their rights and powers is documented.	Inspectors noted it was clearly recorded on the patients admission notes that they had been informed of their rights and each patient who is detained has a specific care plan.	Compliant
2	Patients are informed and familiarised with the ward environment and routines in an on-going patient focused manner.	It is recommended that staff routinely document that induction has been completed. It is recommended that the practice of maintaining a treats box is reviewed and individual patients are allowed to keep their own property where this not deemed to be a significant risk.	On admission patients are orientated and familiarise with the ward, this is evident in the admission checklist. The ward also has an information booklet. Patients are encouraged to keep treats in their own room; however some patients have chosen to keep their treats locked in the store, to resist eating them all within a short period of time.	Compliant
3	All patients are informed of and involved in a person centred assessment	It is recommended that all risk assessments are signed appropriately.	In the four sets of care documentation completed, patients have signed the risk assessments.	Compliant

	and care planning process.			
4	Patients will be given the opportunity to meet and discuss in private any issues with their primary nurse or in their absence an allocated nurse on a daily basis.	It is recommended that staff specify one to one interactions with patients and review the frequency of these.	In the four sets of notes reviewed, it is recorded when patients have had the opportunity to meet with their primary nurse or in their absence an allocated nurse on a daily basis. This is also documented in the records for the multi-disciplinary meetings.	Compliant
5	Patients have the opportunity to meet and discuss in private their care and treatment, with any health or social care	It is recommended that visiting professionals document a summary of their intervention in ward records.	There was no evidence of visiting professionals documenting their intervention in the ward. This recommendation has been restated	Not compliant

	professional involved in their care.			
6	Clear documented systems are in place for the management and filing of records in accordance with professional and legislative requirements	It is recommended that loose pages in medical notes are secured.	Four sets of notes were reviewed by inspectors on the day of inspection; all pages were secure within the notes.	Compliant
Additional	Activities	It is recommended that staff record any instance when planned activity is cancelled due to low staffing levels or ward disturbances. It is further recommended that patient's views are discussed at a patients meeting.	Records of any instance when planned activity is cancelled were not available to Inspectors on the day of inspection. There have been three patient meetings in the past year.	Not compliant

5.0 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
Staff	26	26

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

Additional discussions during inspection	Number
Patients	**1**
Carers/Relatives	**2**
Staff	**10**
Advocates	**0**

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

Patients: Inspectors met with one patient on the day of the inspection. Feedback was generally positive. The patient raised some issues in relation to restrictions not being fully explained to him. Inspectors reviewed the patient's notes. There was evidence that restrictions were recorded and that an explanation had been provided to the patient.

Carers/ Relatives: Inspectors met with the relatives of two of the patients during the inspection. All of the relatives reported a very positive experience regarding the care and treatment available on the ward. One area for potential improvement highlighted related to the information on the BHSCT website relating to Muckamore Abbey Hospital. This family reported a lack of information relating

to location, services offered, contact details – information that would have been useful to help prepare the patient for admission to hospital a recommendation had been made in relation to this.

Inspectors also received a letter was from the relatives of another patient. Feedback was positive from all relatives.

Staff: Inspectors met with ten members of staff from a number of professional backgrounds during the inspection. Staff reported positive working relations on the ward and indicated that they felt appropriately supported. Inspectors reviewed 26 questionnaires returned by staff. Feedback on the questionnaires was positive.

Advocates: Inspectors did not meet with any advocates on the day of inspection.

6.0 Additional Concerns Noted by Inspectors (if applicable)

There were no additional concerns noted during the two day inspection.

7.0 RQIA Compliance Scale Guidance

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable	Compliance with this criterion does not apply to this ward.	A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant	Compliance will not be demonstrated by the date of the inspection.	A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the inspection year.	In most situations this will result in a recommendation being made within the inspection report

4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a recommendation, being made within the Inspection Report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and being made within the inspection report.

8.0 Summary of Compliance – RQIA Assessment

No.	Question	Compliant	Substantially Compliant	Moving Towards Compliance	Not Compliant	Unlikely to become compliant	Not Applicable
1	The ward has robust arrangements in place that ensure the safety and well-being of patients that are consistent with legislative and best practice guidance documents.	✓					
2	Patients' needs are accurately assessed, risks identified and responded to appropriately.		✓				
3	The ward safeguards patient rights in relation to the use of: (i) restrictive practice; (ii) isolation/seclusion; (iii) close observation; (iv) use of restraint		✓				
4	The ward provides patients with an appropriate range of therapeutic individualised and group activities.		✓				
5	The ward has robust processes in place to ensure the safety of patients' monies and property.	✓					

6	There are procedures in place for the effective management, support, supervision and training of staff.		✓				
7	There is an appropriate organisational structure for the ward that defines staff and management roles, responsibilities and the accountability arrangements.		✓				
8	Patients and their family/carers have access to appropriate information in relation to their rights, including information on how to make a complaint.	✓					
9	Care plans are written in an individualised and person-centred manner that is consistent with professional and legislative requirements.		✓				
10	Staff report accidents, incidents and serious adverse incidents in accordance with policies and procedures and regional guidance and follow these up appropriately.	✓					

Inspection Standards – The organisation has appropriately trained staff and robust procedures to support and meet the needs of patients **Ward Self-Assessment**	
Statement 1. – **The ward has robust arrangements in place that ensure the safety and well-being of patients that are consistent with legislative and best practice guidance documents;** **The ward monitors these arrangements to ensure that they are appropriately and consistently applied;** **Staff ensure that vulnerable adult procedures are followed and all vulnerable adult issues are addressed promptly, appropriately and in accordance with local and regional policies and procedures.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Cranfield Men's ward staff duty rota's are completed on a 4 weekly basis in line with the Trust Roster Policy, these are also reviewed weekly by Charge Nurse and Senior Nurse Manager, staffing requirements may vary dependent on patients' needs within the ward; as Cranfield is an admission unit and hence this can change on a daily basis. All staff deficits/requirements are referred to Senior Nurse Manager for action. Each patient on admission has a risk screening tool completed, this is discussed by the multidisciplinary team and a decision is made as to whether the individual requires a comprehensive risk assessment, patients who already have a comprehensive risk assessment in place have it updated whilst in hospital to reflect significant events that lead to hospital admission. All risk assessments follow promoting quality care guidance. If a patient is in Cranfield for longer than 6 months CRA's are reviewed 6 monthly in keeping with Department of Health guidance. Each patient has a person centred care plan in place and a named nurse, these plans of care reflect current needs and are linked to Safeguarding Vulnerable adult processes. All Vulnerable Adult issues are referred to the designated officer for the ward (Michael Creaney), ASP1 forms are completed and appropriate documentation is sent to the designated officer for further screening. A protection plan is implemented immediately following a vulnerable adult issue and this plan is reflected in the	Compliant

patient's care plan. Staff and patients are aware of the Designated Vulnerable Adults Officer and liaise freely re: sharing of information and safeguarding measures. If a Vulnerable Adult issue has been raised the Designated Officer will visit the ward to speak with identified persons and will also partake in multidisciplinary team meetings if required. Staff members have completed Safeguarding Vulnerable Adults Level 1 training; newly appointed staff members have been booked on this training. Staff are aware of policies in relation to safeguarding, incident reporting, whistleblowing, levels of observation, restrictive practise, physical intervention, Zero Tolerance and complaints policy. Staff are also aware of mental health and learning disability policies available at ward level in addition to corporate policies and procedures available on the intranet, all staff have access to IT facilities. All staff including relief/bank staff receive an induction to the ward, all induction reflects adult safeguarding. Patient forums are held regularly and advocates are invited to attend, minutes are recorded and action points documented and completed accordingly, any points of concern noted at forums are passed on to Charge Nurse. Patients have weekly 1:1's with their named nurse, following MDT conference patients also have 1:1 with Charge Nurse/Deputy Ward Sister and outcomes of meeting are discussed, patient's views are also recorded prior to MDT meetings.	
Inspection Findings: FOR RQIA INSPECTORS USE Only	
Information relating to adult safeguarding that included the Regional Adult Protection Policy and Procedure (2006) and other guidance documents were available on the ward. There was also a flow chart for staff reference displayed in the ward office. Staff interviewed by inspectors confirmed that they had undertaken training and were able to detail actions to be taken in the event of a safeguarding concern. Review of training records available indicated that all the staff working on the ward on the day of the inspection had undertaken training in safeguarding of vulnerable adults. Inspectors spoke to the designated officer, and a template for assisting staff to complete a vulnerable adult referral had been developed. Care documentation relating to three vulnerable adult referrals was reviewed by inspectors. Inspectors found that the vulnerable adult referrals had been completed appropriately and forwarded to the designated officer	Compliant

for screening, the vulnerable adult process had been followed and the documentation relating to outcomes had been returned. Inspectors met with the designated officer on the day of the inspection who confirmed that all multiple vulnerable adult referrals are detected by the designated officer and discussed by the multi-disciplinary team. Safeguarding Vulnerable adults is included in the new staff induction books. Vulnerable Adult processes are explained in the patients welcome book.	

Inspection Standards – Assessment of need and risk **Ward Self-Assessment**	
Statement 2. – **Patients' needs are accurately assessed, risks identified and responded to appropriately.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
All patients have a named nurse identified at the point of admission who has responsibility to devise a detailed Person Centred Care Plan, needs are identified and planned interventions are recorded. Care Plans are reviewed at a minimum of 6 monthly by named nurse or sooner if the need indicates. Care plans are audited frequently by both Charge Nurse and Deputy ward Sister and frequently form the basis of clinical supervision sessions with first level nurses and any outcomes actioned by named Nurses. All Care Plans reflect the vulnerable adult's process and patients are actively encouraged to participate in the care planning process. The vulnerable adult process is adhered to; ASP1 forms are completed for all safeguarding incidents. Incidents are discussed with Designated Vulnerable Adults Officer and were deemed necessary the designated officer attends the MDT to discuss safeguarding measures. If there are multiple referrals due to the same alleged perpetrator the DVAO will arrange a MDT strategy meeting to develop a more detailed protection plan. Patients are aware of the vulnerable adult process and informed at the time of any incidents. NOK are	Compliant

informed of all vulnerable adult incidents with the patient's consent. All vulnerable adult incidents are reported via DATIX system and incidents are approved by charge Nurse / Deputy Ward Sister Care plans are updated as required to reflect vulnerable adult incidents. A flow chart is available to assist staff with the link between adult protection procedures and patient care plans. Post incident reviews/de briefings take place when required. Care plans adhere to the NMC guidelines on record keeping. All Nurses have received training on Promoting Quality Care. The assessing of risk is an integral part of the process of supporting patients and maintaining their safety. All patients have a screening tool or were indicated a comprehensive risk assessment is completed. Screening tools & risk assessments are reviewed according to promoting quality care guidelines. All changes in risk are discussed at MDT meetings and agreed action plan is implemented. Cranfield Men's ward operates within Service improvement project which was undertaken in 2006 when the new service was developed; all patients have a post admission meeting/ discharge planning meeting and discharge meetings. Patients, relatives and involved community professionals are invited to these meetings. Also where indicated 'Progress' meetings are held to keep everyone informed and refocus attention to cases of delayed discharge. All patients have access to independent advocacy services and admission to hospital triggers an automatic referral. Advocates are invited to attend the various meetings were the patient requests their support or are active in their case.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Care documentation in relation to four patients was reviewed on the day of the inspection. A comprehensive risk assessment had been completed and signed for the four patients. The care plans were person centred and had been reviewed. A MUST screening tool and Braden assessment was completed for each patient and	Substantially compliant

follow up care plans were completed. There was evidence of patient's signatures in the care documentation. There was evidence of family involvement in the care documentation. There was evidence that care plans have been reviewed by the named nurse. Inspectors noted that all assessed needs did not have an associated care intervention completed e.g. a patient with incontinence did not have a care intervention completed in relation to this**. A recommendation has been completed in relation to this.** At present, the ward manager does not routinely audit the care documentation. **A recommendation has been completed in relation to this.**	

Inspection Standards – Awareness and application of safeguarding procedures Ward Self-Assessment	
Statement 3 . –The ward safeguards patient rights in relation to the use of: **(i) Restrictive Practice;** **(ii) Isolation/Seclusion;** **(iii) Close Observation;** **(iv) Use of Restraint.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
All patients Care plans address restrictive practice and the rationale for utilising same. Currently Named Nurses are using the new care plan format for all new admissions to the ward and our mapping over existing patient care plans into the new format. Within this document there is a section for restrictive practice. **(1) Restrictive Practice** The Cranfield Multi-disciplinary team meet every Tuesday afternoon and in preparation for the meeting, nursing staff record on The MDT proforma, any restrictive Practice in use for each patient, hence all MDT members and Senior nurse manager are aware of any restriction and have opportunity to discuss and then decide outcomes. The initiative of using MDT templates was introduced in September 2013 and has been adapted for use in Cranfield Men's Ward. **(2) Seclusion** Patients in Cranfield Men's ward have access to the seclusion suite in The Intensive Care Unit and is only used when all prescribed interventions have been exhausted and the risk of harm to the patient or others is seen as unacceptable or if requested by the patient. The decision to use seclusion will always be based on the immediate presenting risks, professional judgement and knowledge of the patient. A seclusion care plan is implemented for all episodes of seclusion and continuous observation is provided. Duty officer and medical officer are consulted for all episodes. During the period from May – July 2013, there were a total of 8 periods of seclusion of patients from Cranfield	Compliant

Men's ward. The current seclusion policy is under review. **(3) Close observation** There are currently 4 patients who require supervision levels above Level 1. Level of observation of a patient is assessed and discussed at the point of admission and prescribed by the admitting medical officer; Responsible consultant and duty officer are updated. Levels of observations are only reduced after discussion with the consultant psychiatrist and are reviewed at the weekly MDT meeting. Enhanced observations are prescribed to protect the patient and ensure the safety of themselves or others. Nursing staff responsible for carrying out observation utilise the 1:1 time with patients to engage the patient in activity. Patients are fully aware of the Level of Observations prescribed to them.- N.O.K. are also informed aware of any level of observations placed upon a family member and would be aware of the reasons for same. There is a statement in the ward admission booklet highlighting what special observations are. **(4) Use of Restraint** All care staff have received a 5 day MAPA course and an annual 2 day refresher training. Physical interventions is used as a last resort as per trust policy. Audit forms are completed after physical intervention has been used and are audited by the MAPA co-ordinator for the hospital. Body charts are completed as soon as possible after incidents of physical intervention. The trust has governance arrangements in place to monitor and review the use of MAPA and identify trends. This report is shared with staff and available on the ward. During the period of May to July 2013; MAPA was used on 16 separate occasions with 6 individual patients within Cranfield Men's Ward. The use of Physical intervention fluctuates from month to month as it is an ever changing patient occupancy of the unit.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Restriction, seclusion, close observation and restraint are used on the ward. Care documentation in relation to four patients was reviewed on the day of the inspection. The nursing staff were responsible for completing the care documentation in relation to restrictive interventions after agreement from the multi-disciplinary team. The care documentation was individualised and had been completed for the use of restrictive practices, seclusion, close observation and restraint. However, the rationale did not appear to justify the level of restrictions used. **A recommendation has been completed in relation to this.** The impact on the patients' human rights had been documented in the restrictive care plans. All staff had completed up to date training in the management of challenging behaviours.	Substantially compliant

Inspectors reviewed one physical intervention form, this had been completed appropriately.	

Inspection Standards – Provision of and access to therapeutic activity **Ward Self-Assessment**	
Statement 4. – **The ward provides patients with an appropriate range of therapeutic individualised and group activities;** **The daily programme with details of professionals involved is available and accessible;** **Clear and accurate documentation is maintained.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Dependent on reason for admission and length of stay in hospital, most patients are referred to the most suitable onsite day-care department which can cater for their needs and interests. Decision to refer is indicated at weekly MDT meetings and following a process of assessment including Pen Picture and induction, a person centred timetable is produced. The attendance at day-care not only provides daytime activity, but performs an important part of the assessment process, where the patient's mental health can be monitored in a less structured environment. Those patients who are in hospital for longer periods benefit from on-site education resources. Nursing staff currently support 4 individual patients at day-care providing supervision and encouragement to engage in activity. Nursing staff at times support and supervise individuals in community daytime opportunities and education to achieve the best possible discharge package. The decision of patients not to attend day-care is respected and alternative activities are sourced and provided by nursing staff.	Compliant

Ward based activities are offered to those patients who wish to participate and include, board games , card games, pool table, Multi-sensory sessions and access to exercise equipment. Patients avail of shopping trips both as small group or individual basis as indicated in care plans and after assessment. Psychology and Adult Behaviour Services take referrals from members of MDT and action with Assessment of Need,1:1 sessions and Dialectical Behaviour Therapy As part of individual assessments, patients can avail of the following therapies: Artist in residence, Music therapy, Occupational Therapy and Aromatherapy 2 patients in Cranfield represent the ward on The Patient's Council and one has recently sat on Interview panel for 'Lost for Words' project.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Ten out of the fourteen patients attended onsite day care. There was no evidence of a ward base schedule for therapeutic activities for patients not attending day care. **A recommendation has been completed in relation to this.** Access to occupational therapy, speech and language therapy and behaviour therapy is completed through referral to these services. There was no evidence in the care documentation to link therapeutic activities to assessed needs. There was no evidence of a multi-disciplinary team assessment for the most appropriate and therapeutic use of activities for each patient. **A recommendation has been completed in relation to this.** Patients have access through referral to music therapy and aromatherapy.	Substantially compliant

Inspection Standards – The organisation operates effective procedures for managing patients' finances and property Ward Self-Assessment	
Statement 5. – **The ward has robust processes in place to ensure the safety of patients' monies and property.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
On admission all patients have access to a locked drawer for personal money and a locked drawer for small valuable items such as jewellery, passports etc. On admission a written record of patient property is made, a copy of which is filed in the care plan. All staff adheres to Patients/ Clients Private Property Guidance for long story Patients/Clients. This document is currently under review. All patients have an assessment of financial capability and this is documented on the financial control form which is filed in individual careplan. All transactions from the individual cash drawer are entered on a cash ledger form and in case of patient deemed incapable are signed by 2 members of staff and receipts provided for purchases. In the case of a patient deemed capable, this is signed by one staff member and patient making the withdrawal. Cash drawers are checked weekly by two staff, one of which is trained. Weekly audits are also completed by charge nurse or deputy ward sister and monthly audits are completed by the senior nurse manager. Patients who are deemed capable are facilitated in visiting ATM machines to withdraw money; recently a request by Hospital Services Manager to have an ATM on site was declined. Withdrawals from patients account are monitored weekly by Charge nurse / Deputy Ward sister and a monthly statement of withdrawal from patient accounts is provided by finance. All staff have attended safeguarding training at which financial abuse is discussed and areas of concern are highlighted to ensure staff are aware of 'any signs or changes in a patient's presentation that may indicate that there is something wrong. Patients are encouraged to not bring high valued goods into the ward. Patients are risk-assessed for suitability of been given a bedroom key and hence those deemed capable can	Compliant

chose to store valuables in their bedroom.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Care documentation in relation to four patients was reviewed. All four patients had a financial capacity assessment completed and a written record of patient's property had been completed. All patients had an individual cash drawer. Withdrawals from the cash drawer had been signed by two staff and the patient where appropriate. Weekly audits had been completed by the ward manager and deputy ward manager.	Compliant

Inspection Standards – There are procedures in place for the effective management, support, supervision and training of staff. **Ward Self-Assessment**	
Statement 6. – **The ward has an appropriate training and development plan in place to address the training needs of all staff ;** **Records of training evidence that all staff have attended mandatory training in accordance with policies, and training plans;** **Staff have the necessary skills knowledge and competence for the role they undertake;** **All staff have formally recorded supervision meetings in accordance with policies and procedures;** **All staff have formally recorded annual performance appraisal meetings;** **Additional support is provided for staff through various mechanisms, such as regular ward meetings.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
There is a high level of support within the team in Cranfield Men's Ward – the Senior Nurse Manager makes himself available to all members of the staff and helps to promote a professional working environment. Senior Nurse Manager meets regularly with Charge Nurse to discuss all aspects of developing the unit as a whole. Also the Multi-Disciplinary Team is readily available to offer support and guidance to all the staff. Clinical Supervision is completed twice annually coupled with the annual Personal Contributions plan – following that Charge Nurse can identify any outstanding or new training needs and will link in with the N.D.L. to identify specific courses/study days or Conferences relevant to the area of Practice. All staff have received training in Knowledge and Skills Framework resulting in a Personal Development Plan and are aware of their job descriptions. Training records are maintained and checked to ensure Mandatory training is adhered to. Most courses are booked through the Trust T.A.S. and the Clinical Education Centre (formally known as Beeches)	Substantially Compliant

Staff also avail of commissioned courses at University of Ulster at Jordanstown and Queens University Belfast One member of staff has recently progressed from HCW to Band 5 nurse via 4 year part-time diploma at Queens University, which the Trust offered full time secondment. Psychology department offer staff support through training initiatives on topics such as dealing with self-harm and Personality disorder. Currently 3 staff are undertaking DRAM's training facilitated by Psychology staff. Health Care Workers have been offered the opportunity of attending Introduction to Forensic Course in conjunction with the team from Sixmile Forensic Unit and facilitated by Clinical Education Centre. Staff have opportunity of 1:1 with Charge nurse during any shift of his duty Ward Meetings are held when indicated but the priority is to have information cascaded to staff in the shortest timescales possible.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Two induction booklets for new staff members were reviewed by inspectors on the day of the inspection; these had been comprehensively completed. Inspectors reviewed one preceptor ship portfolio; this had been comprehensively completed. Supervision, induction and training records for nursing staff working on the ward were available. The records for twenty seven staff reviewed by inspectors evidenced that there was one outstanding supervision, all KSF appraisals were up to date, one staff member had not received up to date training in child protection, three staff had not received up to date training in fire safety and twelve staff had not received up to date training in infection control. **A recommendation has been completed in relation to this.** There has been one ward meeting in the past year. **A recommendation has been completed in relation to this.** It was noted that bank staff work on the ward on a regular basis. The ward manager confirmed bank staffing was provided by existing ward staff therefore they had access to training records for bank staff.	Substantially compliant

Inspection Standards – There is an appropriate organisational structure for the ward that defines staff and management roles, responsibilities and the accountability arrangements **Ward Self-Assessment**	
Statement 7. – **Patients and staff are aware of the organisational structure and accountability arrangements;** **Staff can describe their reporting procedures;** **Senior staff can describe their role in the accountability framework for the ward, and how/if this works in practice.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
The ward supports the trusts core value of accountability. Personal & professional accountability are encouraged for the provision of high quality care by competent staff in a safe environment. The most experienced staff member is the nurse in charge on shift. Staff and patients are aware at all times who the nurse in charge is. The unit was designed so that patients have access to staff at all times, the ward office is located behind the staff base with an un-obscured view. Qualified staff are accountable to their professional body, The NMC and adhere to the code of conduct, they also maintain their own professional portfolios. Newly qualified staff complete perceptorship as identified by the BHSCT and there is a responsibility for this to be completed within 6 months of employment. The unit has 7 mentors for student nurses and has an annual education audit, the ward ethos values student nurses and can accept up to 3 students at any given time. Senior staff nurse on the ward has areas of responsibility to include management of staff records and	Compliant

overseeing perceptorship. Roles and responsibilities of staff are outlined in contracts of employment all staff are aware of their job descriptions, copies of which are retained at ward level. Post outlines are referred to at annual appraisals. Staff have received training in KSF delivered by deputy ward sister. Charge Nurse/ Deputy ward sister attend Service mangers monthly meeting and cascade information to all staff team. Charge Nurse/ Deputy ward sister attend Senior Nurse Manager Core Hospital Unit Meeting and cascade information to staff team. Information to staff is relayed in a timely fashion via staff handovers, electronically and ward meetings. Staff adhere to trust policy and procedures in relation to reporting. Induction booklet includes reporting procedures.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
There was an organisational structure for the ward on display in the ward office at the time of the inspection. This information has also been outlined in the patient welcome pack for the ward. The patient who met with inspectors on the day of the inspection was aware of the organisational structure for the ward. Information relating to organisational structure, accountability arrangements and staff on duty was not available in patient areas. **A recommendation has been completed in relation to this.**	Substantially compliant

Inspection Standards – Information for patients and carers Ward Self-Assessment	
Statement 8. – **Patients and their family/carers have access to appropriate information in relation to their rights;** **There is a defined complaints procedure in place in a format appropriate to the needs of patients and their carers;** **The ward maintains appropriate records of complaints, concerns, suggestions and compliments.** **There is evidence of feedback from the Governance leads in relation to complaints and concerns raised.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Leaflets are available on the ward for families and relatives. Each patient receives a welcome pack in easy read format. In addition to ward information, the following documents are included in the booklet: '' Your Rights when you are in Muckamore Abbey Hospital'' '' Keeping it Confidential'' '' Complaints information leaflet and easy read booklet'' '' Vulnerable Adults Process'' '' RQIA Leaflet'' ''Advocacy Leaflets from Bryson House and MENCAP'' ''Keep me safe, treat me with respect'' MAPA approach Staff are aware of how to recognise the signs of abuse and are aware of the procedures (a copy of the Adult Protection Policy and procedure 2013 is available on the ward). Patients are aware of the Adult Protection process within the hospital. Detained patients receive statement of rights which are read and explained to them by nursing staff. Patients	Compliant

are offered the opportunity for copies to be sent to Next of Kin. When a patient is being assessed in regards to detention, the Consultant psychiatrist has a responsibility to explain reasons for detention. The Trust Complaints procedure is adhered to and leaflets are available on the ward. Induction book includes Complaints procedure. All patients have access to Advocacy service – Admission to hospital triggers an automatic referral to relevant advocacy service and leaflets are in the admission booklets. Advocates are invited to Patient Forums and attend were possible. Patients also have the opportunity to attend Post Admission/ progress / discharge planning meetings. Patient regularly meet with Social Worker, Psychology and Consultant and have weekly 1:1 with Named Nurse. Patients are actively encouraged to be involved in the decision making process. Patients requests for discussion are recorded on a Monday evening for discussion at Multi-Disciplinary Team the next day. Feedback is given to each patient following the Multi-Disciplinary Team meeting by Nurse In Charge and if indicated Next of Kin are updated also. The procedure for dealing with complaints is displayed in the office The Complaints policy is retained at ward level. An information screen located in the foyer for patients/family and visitors that displays required information. A file of compliments is held on ward and copies of which are forwarded to Co-Director with responsibility for Learning Disability Services	

Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Information and guidance on how to make a complaint was on display in patient and visitor areas on the ward on the day of the inspection. This information had also been included in the ward welcome pack in an easy to read format. The care notes reviewed by inspectors evidenced that patients detained under the Mental Health (Northern Ireland) Order 1986 had been made aware of their rights. This information was also available to patients on the ward in an easy to read format. The ward welcome pack included easy to read information for patients including 'Your Rights when you are in Muckamore Abbey Hospital"; 'Your Right to Confidentiality'; Keep me safe, treat me with respect'; and 'If you have a complaint, let's talk about it'. There have been three patient forums the past year. **A recommendation has been completed in relation to this.** The minutes of the patient ward meetings were reviewed by inspector and demonstrated patient involvement and advocate support. A policy for dealing with complaints was in place for staff to follow which included the availability of a 'local resolution complaints policy' A record of complaints was reviewed by inspectors. There was a record of one formal complaint that was fully investigated and resolved. There were two local resolution complaints. The detail of these was recorded in the patients' files. There was clear evidence of discussions and agreement with the family and the patient on strategies to resolve the complaint. A record of compliments was reviewed by inspectors.	Compliant

Inspection Standards – The organisation has a clear policy for documentation and management of records, confidentiality and sharing of information. **Ward Self-Assessment**	
Statement 9 – **Care plans are written in an individualised and person-centred manner that is consistent with professional and legislative requirements.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
All patients are allocated a named nurse at the point of admission to the ward. Care plans are a nursing record of care and other professional staff maintains their own records. Currently Named Nurses are using the new careplan format for all new admissions to the ward and our mapping over existing patient care plans into the new format. All patients have a Person Centred Care Plan which reflect current treatment and planned interventions. Care Plans are under continuous review by Charge Nurse, who oversees implementation of any amendments to the care plans. E.Q.C. audit Care Plans annually. All staff adhere to Records Management and confidentiality Policy. Trained staff adhere to N.M.C. guidelines and Code of Conduct regarding record keeping. Daily entries are made into all Care Plans. All patient care is discussed at the Multi Disciplinary Team meeting each week, Nursing staff prepare an MDT Template in advance of meeting involving patient and relative views where possible. These are then updated and information shared with patients and comments documented.	Compliant

All Care plans are individual and consideration is given in regards to restrictive practice on an individual basis depending on Risk – same is discussed with individual patients and is shared and agreed by Multi Disciplinary Team and reviewed weekly. All Care Plans include any Vulnerable Adults referrals and relevant interventions and protection plans. .Multi Disciplinary Team reviews weekly Human Rights consideration and restrictive practice.	
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Care documentation in relation to four patients was reviewed by inspectors on the day of inspection. All four records contained a comprehensive pen picture of the patient and all records had been signed by the patients. One out of the four care plans did not reflect a person centred approach as it was completed on a pre-printed care plan; however inspectors were informed staff were in the process of transferring all the notes using the new care planning format. **A recommendation has been completed in relation to this.** It was good to note that there was evidence of patients and their families' involvement in the care planning. Inspectors met with two carers on the days of the inspection who stated they were consulted about care planning. It was good to note that those patients whose discharge is delayed had a specific care plan in place. It was also good to note that those patients who were detained had a specific care plan in place. There was evidence that errors in the care documentation had not been corrected in accordance with NMC report writing and record keeping. **A recommendation has been completed in relation to this.**	Substantially compliant

Inspection Standards – The organisation has a clear policy for the reporting of accidents, incidents and serious adverse incidents **Ward Self-Assessment**	
Statement 10. – **Staff report accidents, incidents and serious adverse incidents in accordance with policies and procedures and regional guidance and follow up these up appropriately.**	**COMPLIANCE LEVEL**
Ward Self-Assessment:	
Staff adhere to BHSCT Policy in relation to reporting all accidents/incidents and all Serious Adverse Incidents. All incidents are reported using the Datix System All incidents require approval by Charge Nurse / Deputy Ward Sister and are actioned typically within 48 hours following the incident. In the absence of ward management, process is in place to alert Senior Nurse Manager for the unit, who will act as handler for incidents to ensure timely review and action if required. All incidents are recorded in Patient's Care Plan and discussed at the Multi Disciplinary Team meeting. Serious adverse incidents are reported immediately to Senior Nurse Manager, Hospital Consultant and R.Q.I.A. All incident reports are audited by Hospital Management Team and Risk Governance office and monthly reports are provided not just for the ward but all other wards in the hospital. Monthly Incident reports are held at Ward Level for future Learning and improvement.	Compliant

Inspection Findings: FOR RQIA INSPECTORS USE ONLY	
Inspectors were shown the computerised reporting system (Datix) for recording and reporting accident, incidents and near misses. Referral to other members of the multi-disciplinary team had been made were necessary, including the Vulnerable Adults Safeguarding team. Inspectors reviewed one Datix entry; this had been completed appropriately.	Compliant

Ward Manager's overall assessment of the ward's compliance level against the statements assessed	**COMPLIANCE LEVEL**
	Bert Lewis

Inspector's overall assessment of the ward's compliance level against the statements assessed	**COMPLIANCE LEVEL**
	Substantially compliant

SUPPLEMENTARY INFORMATION

For information or incidents within the last 12 months, this is interpreted as being from the date of the inspection.

Within the last 12 months, please confirm the number of Under 18 admissions to the ward and the age, gender and length of stay for each placement.							
Admission number	Age	Gender	Length of Stay (days)	Admission number	Age	Gender	Length of Stay (days)
1	15	Male	4	8			
2				9			
3				10			
4				11			
5				12			
6				13			
7				14			

Within the last 12 months, please confirm the number of investigations undertaken on the ward and their outcomes.			
Adult Protection Investigations		**Child Protection Investigations**	
Substantiated Allegations	19	Substantiated Allegations	0
Unsubstantiated Allegations	11	Unsubstantiated Allegations	0
On-going Allegations	1	On-going Allegations	0
Total	31	Total	0

Please confirm the names of the following contacts for safeguarding children and vulnerable adults.	
The wards Nominated Manager for Safeguarding Vulnerable Adults	Mr Michael Creaney

Quality Improvement Plan

Announced Inspection

Cranfield Male Ward, Muckamore Abbey Hospital

18 & 19 November 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 the ward manager, service manager and operations manager either during or after the inspection visit. Please refer to Appendix 1 for specific reference documents. The timescales for completion commence from the date of the inspection.

1. Recommendations restated from previous inspection

No.	Recommendation	Number of times stated	Details of action to be taken by ward/trust	Timescale
1	It is recommended that visiting professionals document a summary of their intervention in ward records.	2	Visiting professionals document a summary of their intervention in the clinical file (apart from Social work and daycare) – input to the care plan by visiting professionals is on the agenda for the next care plan review group in jan 2014	**Immediate and on-going**
2	It is recommended that staff record any instance when planned activity is cancelled due to low staffing levels or ward disturbances.	2	A process for recording any instance when planned activity is cancelled due to low staffing levels or ward disturbances is in place.	**Immediate and on-going**

2. Recommendations made following inspection of safeguarding vulnerable adults and children – human rights theme of protection

No.	Recommendations	Number of times stated	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	The organisation has appropriately trained staff and robust procedures to support and meet the needs of patients					
	Assessment of need and risk					
1	It is recommended the ward manager ensures that all individually patient assessed needs have a care intervention completed.	1	17	5.3.1	All identified needs have an individualised plan of care	**18 February 2014**
2	It is recommended the ward manager routinely formally audits patients care documentation.	1	17	5.3.1	Charge Nurse and deputy ward sister formally audit one care plan each per month, outcomes are discussed with named nurses and record of audit is retained	**18 February 2014**
3	It is recommended the ward manager ensures that all patients care documentation are individualised and person centred.	1	17	5.3.1	All patients care plans are individualised and person centred	**18 February 2014**

No.	Recommendations	Number of times stated	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	Awareness and application of safeguarding Procedures					
4	It is recommended the ward manager ensures that care plans in relation to actual or perceived deprivation of liberty are reviewed to ensure that there is clear rationale for the deprivation of liberty.	1	6		There is clear documentation in individual care plans in relation to the rational for actual or perceived deprivation of Liberty. These are reviewed as required through the MDT	**18 February 2014**
	Provision and access to therapeutic activity					
5	It is recommended the ward manager ensures all patients are assessed by the multi-disciplinary team for the most appropriate therapeutic activity.	1	17	5.3.1	The need for therapeutic activity is assessed by the MDT, following this a referral is submitted to day services.	**18 February 2014**
6	It is recommended the ward manager ensures that there is provision and access to therapeutic activity for all patients on the ward	1	17	5.3.1	All patients have access to therapeutic activity through day services in the hospital	**18 February 2014**

No.	Recommendations	Number of times stated	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	There are procedures in place for the effective management, support, supervision and training of staff.					
7	Is it recommended the ward manager ensures all staff attend mandatory training.	1	17	4.3	Staff will receive Mandatory training within timescales identified	**18 March 2014**
8	It is recommended the ward manager reviews the frequency of staff ward meetings.	1	17	8.3	Ward meetings are scheduled to be held on the first Sunday of each month with times alternating between 12:45 and 19:30 to accommodate both day duty and Night duty staff	**18 March 2014**
	There is an appropriate organisational structure for the ward that defines staff and management roles, responsibilities and the accountability arrangements					
9	It is recommended the ward manager ensures that Information relating to organisational structure,	1	17	6.3.2	Information on the organisational structure, accountability arrangements and staff on duty is	**18 March 2014**

No.	Recommendations	Number of times stated	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	accountability arrangements and staff on duty is available in patient areas.				available on a patient accessible notice board	
	Information for patients and carers					
10	It is recommended the ward manager reviews the frequency of patient forums and ensures it is documented when patients do not attend.	1	17	6.3.2	Patient forums are held on 1st Friday of Each Month. Attendees will be recorded in the minutes of the meeting	**18 March 2014**
11	It is recommended the BHSCT provide information on the trust web site on the location, services offered and contact details of Muckamore Abbey Hospital.	1	17	8.3	The trust website provides information on the location, services offered and contact details for Muckamore Abbey Hospital.	**18 March 2014**
	The organisation has a clear policy on the documentation and management of records, confidentiality and sharing of information.					
12	It is recommended the ward manager ensures that errors in care documentation are corrected in accordance with NMC record keeping	1	17	5.3	This information has been shared with all members of the nursing team and compliance with NMC Record Keeping ' Guidance	**18 March 2014**

No.	Recommendations	Number of times stated	Document Number	Reference	Details of action to be taken by ward/trust	Timescale
	guidance.				for Nurses and Midwives' July 2009 is adhered to	

NAME OF WARD MANAGER COMPLETING QIP	Bert Lewis
NAME OF CHIEF EXECUTIVE / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Colm donaghy

Inspector assessment of returned QIP		**Yes**	**No**	**Inspector**	**Date**
A.	Quality Improvement Plan response assessed by inspector as acceptable	✓		Siobhan Rogan	**14 January 2014**
B.	Further information requested from provider				

Appendix 1 – 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)