The Regulation and Quality Improvement Authority

# Inspection Report

11- 29 June 2024

# Loane House
# South Tyrone Hospital

Type of service: HSC Hospital
Address: Carland Road, Dungannon, BT71 4AU
Telephone number: 028 8772 2821

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

## 1.0 Service information

| **Organisation:**<br>Southern Health and Social Care Trust<br><br>**Responsible individual:**<br>Dr Maria O Kane |
|---|
| **Person in charge at time of inspection:**<br>Ms Sinead Morrow |
| **Brief description of the accommodation/how the service operates:**<br>South Tyrone Hospital is a non-acute hospital in the Southern Health and Social Care Trust which provides a range of inpatient and outpatient care services, including day surgery. Rehabilitation services are provided on-site in a dedicated unit called Loane House; which affords eighteen commissioned beds in each of its two wards. |

## 2.0 Inspection summary

An unannounced inspection was conducted to wards 1 and 2 of Loane House, from 11 to 29 June 2024. The multidisciplinary inspection team was comprised of care inspectors (including senior inspector), RQIA's clinical lead, a pharmacy inspector, and associated administrative support.

The inspection was carried out as a result of intelligence received by RQIA which raised concerns in relation to: governance and leadership; medicines management; management of the deteriorating patient; and the management of patients living with diabetes. In response to this intelligence, RQIA engaged with the Trust to seek assurances regarding the aforementioned concerns, which the Trust subsequently then provided. Following a review of this information RQIA determined that an unannounced inspection of Loane House inpatient wards was indicated.

The inspection focused on governance; incident management; safeguarding; medicines management; the management of deteriorating patients; and diabetes.

During the inspection, the RQIA team engaged with a range of staff, including managers, nursing, medical, allied health professionals (AHP) and pharmacy staff.

Trust staff were observed to deliver care compassionately at Loane House. They were helpful and engaging throughout the inspection.

The findings of this inspection determined that further improvement was needed in relation to the matters raised with RQIA and for some additional issues that were identified during the inspection.

Six areas for improvement (AFIs) were made as a result of this inspection. The AFIs related to: medical governance arrangements; audit action plans; Mental Capacity Act 2016 (MCA) training; equipment controller training for ward managers for fridge monitoring; training surrounding a new resource tool for managing deteriorating patients and the accessibility of contemporaneous policies & procedures on diabetes management.

## 3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

This inspection was underpinned by the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and the DHSSPSNI Quality Standards for Health and Social Care (March 2006).

In advance of this inspection a range of relevant information was reviewed, including*;*

- Previous inspection reports
- Information on concerns
- Care opinion website

This inspection included discussion with staff, observation of practice, and review of relevant documentation. Records examined during the inspection included nursing care records; medical records; senior management and governance reports; minutes of meetings; and training records.

## 4.0 What people told us about the service

Posters were displayed to inform patients, staff and visitors that the inspection was being conducted. Both staff and patients were invited to complete a questionnaire about their experiences during the inspection. No completed questionnaires were received from staff; and in a follow up discussion with the senior lead nurse, a further questionnaire was subsequently issued. The responses in the returned questionnaires were analysed and a synopsis is outlined below.

**Patient and relative feedback**

We received three patient/relative questionnaires, all of which were complimentary about the services provided at Loane House.

**Staff engagement**

Nine staff questionnaires were returned. All of which indicated that staff were either satisfied or very satisfied that patient safety was maintained; patients were treated with compassion; care was effective; and that the two wards were well led. Staff described good morale and team working across the multi-disciplinary team, and reported that they would have no issues with raising concerns. This was corroborated by staff who spoke directly with the inspection team.

## 5.0 The inspection

## 5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The previous inspection to Loane House was undertaken on 27 June 2013. That inspection focussed upon hygiene and infection, prevention and control (IPC), with 24 areas for improvement identified. The Trust subsequently submitted a quality improvement action plan to RQIA with assurances that all actions required for improvement would be taken within the specified timescales.

## 5.2 Inspection findings

### 5.2.1 Profile of the service

In January 2024, the Trust reviewed the profile of the service for Loane House. Changes were made to the provision of arrangements for medical cover, as the previous arrangements relied heavily on the use of locums and lacked consistency and reliability. Medical cover has now transferred to a local general medical practice with general practitioners (GPs) conducting two ward rounds per day [one in the morning and one in the afternoon]. A communication diary is available for the GPs to use during their ward rounds; and nursing staff state that GPs are very responsive to urgent enquiries about patient care. Outside of the twice daily ward rounds, nursing staff can ring the practice and speak to a GP. Staff commented on their initial anxieties regarding the new profile of the service; however, after a few months of implementation they feel that it is working effectively.

Since the re-profiling, the criteria for admission to Loane House has changed. Whilst this has been communicated to those who refer patients to Loane House for admission, the Trust has not revised the information available to the public informing them of these changes. It is the Trust's responsibility to provide contemporary information on any notable service changes to ensure that all stakeholders are aware.

Processes are in place to ensure that patients referred for admission to Loane House meet the admission criteria. The GP has access to contact the Acute Care at Home (ACH) team, on a case-by-case basis to support patient care.

### 5.2.2 Governance

The Trust's organisational structure and governance arrangements were reviewed to establish if there were appropriate oversight mechanisms capable of assuring that the hospital was delivering safe, effective and compassionate care.

As part of the assessment of governance, the inspection team reviewed a number of documents, and minutes of internal meetings. It was clear that there were structures and processes in place to facilitate effective communication.

The minutes evidenced discussions across a range of issues; and verified that the process for the dissemination of new policies and procedures [including new National Institute for Health and Care Excellence (NICE) NI endorsed guidance] was functioning appropriately. Documentation also evidenced that a collective leadership model for the implementation of best practice and shared governance oversight was in place.

A copy of the service risk register was reviewed. The risks identified were relevant and appropriate however there were a number of risks that required updating to reflect ongoing work to mitigate and reduce risks.

The medical governance arrangements had not been updated to reflect the change of medical cover in Loane House. Although GPs reported there was good communication via email on relevant policies, procedures and guidance, there was no formal medical governance structure in place. This matter was escalated during the inspection and senior Trust staff gave a commitment that the Trust would ensure an appropriate formal medical governance structure would be put in place.

RQIA's clinical lead met with two GPs from the local GP practice that provides medical support to Loane House. The GPs reported that the new re-profiling of the service and current arrangements was working well. They reported that many of the patients in Loane House were registered to their practice which was of benefit to patients, as the GPs can provide continuity of care prior, during and post discharge. Whilst the Trust GP out of hours' arrangements also apply to Loane House, the GPs reported that they are willing to offer an out-of-hours phone consultation as they are familiar with their patients' needs and are happy to accommodate requests, whenever possible.

The senior lead nurse provides operational support and oversight to the ward managers and shares their time between South Tyrone and Lurgan Hospitals. Supporting the senior lead nurse are two lead nurses who also provide support to the wards across the two sites. It was evident that there were good working relationships between ward managers and the service lead nurse who also reported there were good relationships with the assistant director, consultant geriatrician and allied health professional (AHPs) leads. Agreeable working relationships was a common theme during consultation with all staff; and assurance was provided that this extends across all grades of staff and disciplines.

**Ward Governance**

Ward governance arrangements were reviewed to ensure there was good support and oversight for the nursing team; and good delivery of care. Observations from inspectors and reports from nursing staff indicated that ward managers were visible and accessible to staff. There were a number of deputy ward managers across both wards to ensure seven-day senior nurse cover on the wards. Effective channels of communication were in place and no concerns were highlighted by staff in respect of escalating information or concerns.

Staff supervision and appraisals were being conducted, with good compliance evidenced. As this was a focused inspection, only the training records of the areas outlined in the intelligence received were reviewed. These related to safeguarding, medicines management, managing the deteriorating patient and diabetes management; these specific areas are all noted below in the relevant sections of this report.

The senior lead nurse advised that they had devised a three-year training plan. This included training a number of staff as nurse prescribers and advanced nurse practitioners.

It was noted that the induction programme required updating to reflect the re- profiling of the service. The programme should also outline any additional training requirements identified as a result of this change. This is the responsibility of the Trust to review.

Information leaflets were available to patients and relatives. However, these require updating to reflect the new profile of the service and the role of the GP. This will ensure patients and their families will understand the new model.

Staff knew how to refer and access specialist teams such as the diabetic specialist, dietetic team, and Speech and Language team (SALT) and staff reported good relationships with the range of specialist input.

Ward managers and lead nurses were visible in the wards and also undertook audits across a range of areas. The associated audit action plans were not always robust and require review and strengthening in line with specific, measurable, achievable, realistic and time bound (SMART) principles.

Ward meetings are not held regularly. Both ward managers confirmed that they are progressing plans to hold these meetings on a more regular basis. Staff were updated and communicated with via daily safety briefs and through staff email.

It was noted that appropriate action was taken in response to a change in the environmental risk assessment.

Two governance AFIs have been made; to develop a new medical governance structure to reflect the changes in medical cover arrangements; and, to ensure action plans are in keeping with SMART principles.

### 5.2.3 Incident Management

Incident management processes were reviewed to ensure that incidents were managed appropriately. Staff understood their responsibility in relation to raising concerns and in reporting incidents and near misses.

Governance and oversight arrangements are in place ensuring that the service is collating, analysing and learning from incidents/near misses, and sharing the knowledge to prevent reoccurrence.

### 5.2.4 Safeguarding

Safeguarding policy and procedures were available alongside ward resources that provided relevant contacts and aide memoire pathways to assist staff dealing with concerns.

Staff demonstrated they were aware of types and indicators of potential abuse and the actions to be taken should a safeguarding issue be identified. Additionally, staff reported good access to advice and support from the social work team regarding any safeguarding matters, should this be required.

Review of the staff training matrix evidenced that one ward had a deficit in training compliance in relation to safeguarding. Management were aware of this deficit and were addressing the compliance rate.

**Deprivation of Liberty Safeguards (DoLS)**

Aspects of the management of DoLS was reviewed during this inspection. DoLS is the procedure prescribed in law when it is necessary to deprive a patient of their liberty, and/or a patient who lacks capacity to consent to their care in order to keep them safe from harm. The procedure aims to ensure that any such deprivation of liberty only happens when it is necessary, proportionate and in the persons' best interests. The Mental Capacity Act 2016 (MCA) protects people who cannot make their own decisions about care and treatment and DoLs is part of this legislation.

MCA information was displayed on notice boards in the wards; yet there was a varying degree of staff confidence regarding their role within the MCA processes. The social worker for the wards had good knowledge of MCA and the role of the MCA team; and regularly liaised with them.

There are a number of forms which require completion at all stages of the DoLs process. The social worker provides support to staff responsible for completing the required capacity assessment forms.

Following review of patient notes its was noted that all the relevant DoLs documentation was not easily accessible, although there was evidence of care planning relating to DoLS throughout the patient records. Both wards should agree a system for filing and storage of these forms to ensure ease and timely access. Clinical notes were found to be bulky and difficult to navigate and there was no evidence of clinical note auditing.

Under the previous service model the consultant was responsible for completing the DoLs medical assessment form; however, this role is not currently fulfilled by the aligned GP's. Staff reported that this arrangement has the potential to lead to delays in referring cases to tribunals, and this issue has been escalated to senior managers. The Trust should consider training GPs in relation to completing the assessment and related documentation to prevent any potential delays.

MCA training compliance for nursing staff was low. It is the Trust's responsibility to take the appropriate action to ensure compliance is achieved.

An AFI has been identified in relation to training compliance with MCA.

### 5.2.5 Medicines Management

An assessment of how medicines are managed in the wards formed part of this inspection.

A critical medicine is one where the timeliness of administration is crucial to minimise harm for patients. Every effort should be made to avoid omitted and delayed doses of medicines. Staff confirmed that if time critical medication is omitted or administered late, or there have been drug errors that these are reported via the Trust's incident reporting arrangements. Ward medicine incidents were subject to audit, with actions identified to prevent recurrence; any consequent learning was also shared.

A pharmacist and pharmacy technician was accessible from 9am to 5pm, five days a week. Nursing staff described the pharmacy team as 'invaluable'. The pharmacy team support nurses and GPs in a number of areas including; medicines reconciliation, preparing discharge medication, and obtaining supplies of medicines.

Drugs were stored within a secure room, which was only accessible through the use of a keypad. However, the key code was visible to staff, patients and the public. This breach in the access control system was brought to the attention of the ward manager and remedial action was taken.

The wards endeavoured to ensure that all patients had medication prescribed in a timely manner. When GPs are not readily available and as there were no nurses trained as prescribers, the Trust has taken steps to seek to mitigate the risk of potential delays in prescribing medication. The ward pharmacist, who was available Monday to Friday, was a trained prescriber; and the SMT were considering training nursing staff to administer medicines under Patient Group Directives (PGDs) [PGDs are written instructions to help staff supply or administer medicines to patients, usually in planned circumstances].

The *'Medicines Fridge Temperature Monitoring, Standard Operating Procedure* (SOP) was provided to RQIA by the Trust ahead of the onsite inspection; and was also available in the staff resource/guidance folder dated 2015. An updated version, dated August 2022 was presented when requested during the inspection. This version included detailed guidance for staff and identified training requirements; including the need for ward managers to undergo Equipment Controller training; which to-date has not been completed. Additionally, ward staff were not familiar with the 2022 guidance.

Medicines which require cold storage must be stored between 2℃ and 8℃ to maintain their stability and efficacy. In order to ensure that this temperature range is maintained it is necessary to monitor the maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. The temperatures of the medicine refrigerators were monitored; however, there were numerous gaps noted in the records of the required checks. It was noted that staff had recorded temperatures which were outside the specified acceptable range and that no appropriate action had been taken in accordance with the Trust's policy. These deviations were not identified through audits or ward manager walkabouts.

The records viewed did not provide assurances that the refrigerator temperature was maintained within the required range at all times.

An AFI was identified in relation to the compliance with required Equipment Controller training; staff access to and knowledge of *Medicines Fridge Temperature Monitoring SOP (August 2022)*; and in relation to the lack of adherence to the actions required to be taken in accordance with the SOP.

### 5.2.6 Managing the deteriorating patient and Diabetes Management

**Deteriorating Patients**

Inspectors reviewed staff training and National Early Warning Score (NEWS2) recording charts, NEWS2 guidance for staff, and associated assurance mechanisms regarding the completion of NEWS2 charts.

Following the re-profiling of the service the Trust senior management team identified the need for the delivery of bespoke staff training for recognising the deteriorating patient. The bespoke training is certificated and there is a rolling programme in place so that all nurses may avail of the training.

The National Early Warning Score (NEWS2) is a system for scoring physiological measurements normally taken at the patient bedside and includes the recording of respiration; oxygen saturation; blood pressure; pulse rate; temperature; and level of consciousness [or new-onset of confusion]. Its purpose within the acute hospital setting is to identify acutely ill patients whose condition may be deteriorating, and to ensure that the appropriate clinical response is taken.

The technology | National Early Warning Score systems that alert to deteriorating adult patients in hospital | Advice | NICE

Both wards adopted the RESTORE2 tool (Recognise Early Soft Signs, Take Observations, Respond, Escalate), during January 2024 when the profile of the service changed. RESTORE2 makes National Early Warning Scores (NEWS2) accessible to care and nursing homes through the use of soft signs of deterioration. It includes a communication and escalation protocol developed with GP's, ambulance providers and deterioration experts specifically for care/nursing homes to support them to raise concerns and a structured communication tool (SBARD) to ensure residents get the support they need.

Even though the NEWS2 scoring system forms part of this tool, the suggested escalation actions and observation frequency based on scoring, differ from the NEWS2 algorithm, because the care settings are different. Staff must be trained in the NEWS2 system and receive additional further training to use the RESTORE2 tool safely. It is also important to note regardless of which tool is used, or the care setting, clinical judgement should always be applied with reference to individual patient care/escalation plans and any agreed limits of care.

RESTORE2™ official :: NHS Hampshire and Isle of Wight (icb.nhs.uk)

Review of staff training records evidenced good compliance for NEWS2. Staff had not received additional training on the use of RESTORE2 prior its implementation and relevant guidance for staff had not been reviewed and updated to include reference to the RESTORE2 tool.

Whilst there was good evidence that a deteriorating patient had been appropriately escalated during the on-site element of the inspection, a sample of patient charts were reviewed across both wards and inconsistencies were noted in the documentation. Completion of the field entitled; ‘what was normal for this resident’ within charts was not always completed; and the oxygen saturation scale in use was not always clearly stipulated, signed or dated. These discrepancies have the potential to prevent the escalation of a deteriorating patient, or conversely may contribute to inappropriate escalation. This was brought to the attention of relevant staff during the on-site phase of the inspection.

It was noted that adopted assurance mechanisms did not ably manage the consistent application of the RESTORE2 tool; and audit findings repeatedly identified trending discrepancies within patient charts. Associated action plans to address findings were also found to be insufficiently detailed, and similar issues continued to be identified over a number of months. Refer to section 5.2.2 for further information regarding governance oversight associated with audit action plans.

An AFI has been made in relation to the safe implementation and use of RESTORE2.

**Diabetic Management**

A resource folder was available in both wards to guide staff in the management of patients with diabetes. The folder included the Trust’s Diabetic Ketoacidosis Protocol; Guidelines for Patient Involvement; Guidelines for provision of an Insulin Passport; and Medicines Fridge Temperature Monitoring. It was noted some of this guidance had not been reviewed and updated.

The ward managers were advised to engage with the diabetic nurse specialist to ensure that the resource folder contained contemporary information/guidance; and that staff were able to access the up-to-date versions on the Trust intranet. There should be mechanisms in place to ensure hard copy version control is maintained in the resource folders of each ward.

Staff had received ‘6 Steps to Insulin’ training and compliance levels in both wards was good. Some staff had also received bespoke training provided by the diabetic nurse specialist. As outlined in the Trust’s response [relating to a previous RQIA request for assurances] diabetic awareness training for health care assistants was to be completed. This training had not been progressed at the time of the inspection.

Staff were able to outline the process of referring a patient to the diabetic nurse for specialist advice/guidance and support. They also reported that the diabetic nurse specialist was visible and attended the ward twice weekly. One ward had a number of nurses identified as 'diabetic link nurses' and the other ward confirmed that they were currently identifying nurses who could fulfil this role.

Issues relating to medicine refrigerator temperatures [and by extension to the stability and efficacy of the drugs, including insulin] were identified during the inspection. The wards had conducted monthly checks of insulin storage, which included checking if the refrigerator had been out of range; however, these audits had failed to identify that the refrigerators indeed had been out of range (see section 5.2.5).

Blood glucose monitoring chart/subcutaneous insulin prescription and administration charts were reviewed for two patients; with both records being correctly recorded and included target capillary blood glucose range, and clear guidelines for insulin adjustment.

An AFI was identified in relation to ensuring that the resources available to guide staff in the management of diabetes provides up-to-date information and that the completion of related audits are strengthened.

## 6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with the *DHSSPSNI Quality Standards for Health and Social Care (March 2006)*

| | Standards |
|---|---|
| **Total number of Areas for Improvement** | 6 |

Areas for improvement and details of the Quality Improvement Plan were discussed with members of the SMT, as part of the inspection process. The timescales for completion commence from the date of inspection.

| **Quality Improvement Plan** | |
|---|---|
| **Action required to ensure compliance with the DHSSPSNI Quality Standards for Health and Social Care ( March 2006)** | |
| **Area for improvement 1**<br><br>**Ref:** Standard 4<br>Criteria 4.3 (b, i)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>11 October 2024 | The Trust should review the medical governance arrangements for Loane House wards to ensure that there is a robust formal medical governance structure in place.<br><br>Ref: 5.2.2 |
| | **Response by registered person detailing the actions taken:**<br>The medical governance arrangements for Loane House were reviewed and Medical Goverance Meetings have been held on 17 July 2024 and 3 October 2024. These meetings are to continue on a 3 monthly basis to ensure robust formal medical |

<table>
<tr><td></td><td>governance structures are in place. Standing agenda for meetings include: audit, complaints/compliments, incidents, learning from incidents/learning letters, risks/review of risk registers, standards & guidelines, training, policies & procedures and safety, quality and patient experience.</td></tr>
<tr><td rowspan="2">Area for improvement 2<br><br>Ref: Standard 5<br>Criteria 5.3.3 (g, h)<br><br>Stated: First time<br><br>To be completed by:<br>11 October 2024</td><td>The Trust should strengthen audit action plans to ensure they are in keeping with SMART principles.<br><br>Ref: 5.2.2</td></tr>
<tr><td>Response by registered person detailing the actions taken:<br>Standing agendas for all professional governance meetings have been amended to strengthen audit action plans to ensure they are in keeping with SMART (Specific, Measurable, Achievable, Realistic and Time-bound) principles.<br>Clinical lead staff will raise awareness of the SMART principles through information sessions during team meetings.</td></tr>
<tr><td rowspan="2">Area for improvement 3<br><br>Ref: Standard 5.1<br>Criteria 5.3.3 (d)<br><br>Stated: First time<br><br>To be completed by:<br>11 October 2024</td><td>The Trust should ensure that all relevant staff receive mandatory training in respect of DoLs.<br><br>The Trust should develop an agreed protocol for storing and ease of access to DoLs forms in patient notes.<br><br>The Trust should ensure there is a mechanism to provide assurance that DoLs guidelines are adhered to.<br><br>Ref:5.2.4</td></tr>
<tr><td>Response by registered person detailing the actions taken:<br>A review of mandatory training records in respect of DoLs was completed for all relevant staff. A timescale for completion of training has been agreed with the relevant groups of staff.<br><br>A standard operating procedure is being developed and implemented in Loane House with regards to access and storage of DoLs forms in patient records.<br><br>Once implemented an audit process will be commenced to monitor compliance against guidelines.</td></tr>
<tr><td>Area for improvement 4<br><br>Ref: Standard 5<br>Criteria 5.3.1 (m)<br><br>Stated: First time</td><td>The Trust should ensure that staff have familiarisation training and easy access to the Medicines Fridge Temperature Monitoring SOP (August 2022); and that robust oversight mechanisms are in place to ensure compliance with this SOP.<br><br>Ref: 5.2.5</td></tr>
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| **To be completed by:**<br>11 October 2024 | **Response by registered person detailing the actions taken:**<br>The Medicines Fridge Temperature Monitoring SOP (August 2022) was discussed and shared with all ward sisters for dissemination and discussion at ward level on 11 June 2024.<br>Drug fridge monitoring audit has been added to the ward sister and nurse managers walkabout review.<br>The Medicines Fridge Temperature Monitoring SOP (August 2022) and training presentation was shared via email to all registered nurses and Pharmacy staff working in Loane House on 11 June 2024. A hard copy of this SOP is available in ward 1 and 2 treatment rooms at all times.<br>All registered nursing and pharmacy staff to complete or update their training on the management of drug fridge temperatures by 11 October 2024 and training compliance will be added to the staffs training record. |
| **Area for improvement 5**<br><br>**Ref:** Standard 5<br>Criteria 5.3.1(f)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>11 October 2024 | The Trust should ensure that there is a policy and procedure in place to support the full implementation of RESTORE2.<br><br>The Trust should ensure that staff are trained in the use of the RESTORE2 tool and its associated escalation processes and update auditing mechanisms to provide assurance on the appropriate application of RESTORE2.<br><br>Ref: 5.2.6 |
| **Area for improvement 6**<br><br>**Ref:** Standard 5<br>Criteria 5.3.1 (f)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>11 October 2024 | The Trust should ensure that staff are able to access up-to-date ‘condition management’ policies and procedures, so that care is delivered in accordance with best practice and strengthen its assurance mechanisms in relation to the accurate completion of audit tools.<br><br>Ref: 5.2.6 |
| | **Response by registered person detailing the actions taken:**<br>The current diabetes resource files on ward 1 and ward 2 Loane House were reviewed and updated to reflect current policies and procedures on 11 June 2024.<br>All other condition management policies and procedures are available on trust intranet or from clinical guideline websites e.g. NICE.<br>All professional leads and ward sisters are to discuss with each staff group how to access sharepoint at their next team meeting before 11 October 2024.<br><br>Audit processes have been reviewed and outlined in areas of improvement points 2 and 4 within this Quality Improvement Plan. |

***Please ensure this document is completed in full and returned via the Web Portal**

The **Regulation** and **Quality Improvement Authority**


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