Unannounced Care Inspection Report
16 September 2019

Ambassador

Type of Service: Nursing Home
Address: 462-464 Antrim Road, Belfast BT15 5GE
Tel No: 02890771384
Inspector: Michael Lavelle

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 48 persons.

3.0 Service details

Organisation/Registered Provider: Amstecos Ltd **Responsible Individual:** Emer Bevan	**Registered Manager and date registered:** Amelia Noach – 1 April 2005
Person in charge at the time of inspection: Amelia Noach	**Number of registered places:** 48 A maximum of 2 patients in category NH-A
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. A – Past or present alcohol dependence. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 46

4.0 Inspection summary

An unannounced inspection took place on 16 September 2019 from 12.10 hours to 21.05 hours.

This inspection was undertaken by a care inspector.

The inspection assessed progress with areas for improvement identified in the home since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to adult safeguarding, infection prevention and control, the home's environment, communication at shift handover, teamwork, culture and ethos of the home, dignity and privacy, listening to and valuing patients, management of incidents and maintaining good working relationships.

Areas requiring improvement were identified in relation to staff training, staff supervision and appraisal, developing care plans in a timely manner, wound management, patient centred evaluation of care, care record audits and governance arrangements.

Patients described living in the home as being a good experience. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with staff.

Comments received from patients and relatives during the inspection, are included in the main body of this report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

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4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	5	2

Details of the Quality Improvement Plan (QIP) were discussed with Amelia Noach, registered manager, as part of the inspection process and with Emer Bevan, responsible person, during a phone call on 17 September 2019. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent inspection dated 21 November 2018

The most recent inspection of the home was an unannounced care inspection undertaken on 21 November 2018. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings including registration information, and any other written or verbal information received.

During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept.

Questionnaires and 'Have We Missed You' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire.
A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined during the inspection:

- duty rota for all staff for weeks commencing 26 August 2019 to 16 September 2019
- staff training records
- incident and accident records
- one staff recruitment and induction file
- six patient care records
- a selection patient care charts including topical medicine administration, thickener administration, personal care records, food and fluid intake charts and reposition charts
- a sample of governance audits/records
- complaints record
- compliments received
- staff supervision and appraisal planner
- minutes of staff meetings
- evidence of fire drills
- a sample of reports of visits by the registered provider.

Areas for improvement identified at the last inspection were reviewed and assessment of compliance recorded as either met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the last care inspection dated 21 November 2018

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
Area for improvement 1 **Ref**: Regulation 13 (7) **Stated:** Second time	The registered person shall ensure suitable arrangements are in place to minimise the risk/spread of infection between patients and staff. This area for improvement is made in reference to the issues highlighted in section 6.4 of the previous care inspection report.	**Met**
	Action taken as confirmed during the inspection: Observation of practice and review of the environment evidenced this area for improvement has been met.	

Area for improvement 2 **Ref**: Regulation 19 (5) **Stated:** First time	The registered person shall ensure information about a patient's health and treatment is handled confidentially. **Action taken as confirmed during the inspection**: Review of the environment confirmed information about a patient's health and treatment is handled confidentially.	**Met**
Area for improvement 3 **Ref**: Regulation 13 (1) (a) (b) **Stated:** First time	The registered person shall ensure that nursing staff promote and make proper provision for the nursing, health and welfare of patients and where appropriate treatment and supervision of patients. This area for improvement is made in reference to the following: • ensuring care plans accurately reflect prescribed care in the management of infection and best practice guidance is adhered to • ensuring care plans accurately reflect the frequency of repositioning patients who are at risk of pressure damage. **Action taken as confirmed during the inspection**: We reviewed the management of skin integrity and management of infection. Records for one identified patient confirmed they were at risk of developing pressure damage. They had an appropriate care plan in place which detailed the frequency of repositioning. Records review for a patient who had a recent infection confirmed the care plan had been appropriately updated to reflect the current infection.	**Met**
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 4.9 **Stated:** Second time	The registered person shall ensure that supplementary care records, specifically, repositioning charts, are completed in an accurate, comprehensive and contemporaneous manner.	**Met**

	Action taken as confirmed during the inspection: Review of a selection of repositioning charts evidenced these were completed in keeping with best practice guidance.	
Area for improvement 2 **Ref**: Standard 35 **Stated:** Second time	The registered person shall ensure monthly audits should be completed in accordance with best practice guidance. Any shortfalls identified should generate an action plan to ensure learning is disseminated and the necessary improvements can be embedded into practice. This area for improvement is made with specific reference to auditing of care records, wounds, incidence of infection, hand hygiene and use of PPE.	**Partially met**
	Action taken as confirmed during the inspection: Examination of records evidenced this area for improvement has been partially met. This is discussed further in 6.6 of this report. **This area for improvement has been partially met and has been subsumed into a regulation.**	

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

We arrived at the home at 12.10 hours and were greeted by the manager who was friendly and welcoming. They confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for weeks commencing 26 August 2019 to 16 September 2019 evidenced that although the planned staffing levels were adhered to; the manager has been working increased hours as a nurse on the floor. This is discussed further in section 6.6. Rotas also confirmed that catering and housekeeping staff were on duty daily to meet the needs of the patients and to support the nursing and care staff.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patient's needs. Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients. Patients spoken with indicated

that they were happy with the care they received and that they felt safe and happy living in Ambassador.

Review of one staff recruitment file confirmed staff were recruited in accordance with relevant statutory employment legislation and mandatory requirements. Appropriate pre-employment checks are completed and recruitment processes included the vetting of applicants to ensure they were suitable to work with the patients in the home. We noted that the pre-employment health assessment was not obtained before making an offer of employment. This was discussed with the manager and assurances were given that this process would be reviewed by the human resources department.

Review of records confirmed that a comprehensive induction was given to one recently recruited employee. The manager confirmed a robust system in place to monitor staffs' registrations with their relevant professional bodies. Although requested at the start of the inspection these records were not made available for review. This will be reviewed at a future care inspection.

Discussion with staff and the manager confirmed that systems were in place for staff training, supervision and appraisal. We discussed the low uptake of elements of mandatory training with the manager; particularly safeguarding of vulnerable adults and moving and handling training. The manager must ensure that mandatory training for all staff has been completed in a timely manner to achieve 100 percent compliance. This was identified as an area for improvement under regulation. Review of staff supervision and appraisal planners evidenced that annual appraisals and twice yearly supervisions were not being completed for all staff. To ensure supervision and appraisal requirements were met, an area for improvement under the care standards was made.

Records reviewed confirmed nurse in charge competencies had not been completed since 2016. This was discussed with the responsible person post inspection who confirmed they had been completed since and records were available. This will be reviewed at a future care inspection.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the manager confirmed that the regional operational safeguarding policy and procedures were embedded into practice.

We reviewed accidents/incidents records since January 2019 in comparison with the notifications submitted by the home to RQIA. Records were maintained appropriately although we identified two notifications which were not submitted in accordance with regulation. This was discussed with the manager who agreed to submit the outstanding notifications retrospectively.

We identified one accident which had not been recorded in the accident book used by the home. We advised the manager to review the current system and suggested the use of a bound pre-printed book with carbon copies may be more robust.

Records confirmed that on at least a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging. If required, an action plan was devised to address any identified deficits. This information was also reviewed as part of the monthly monitoring visits.

Observation of practices, discussion with staff and review of records evidenced that infection prevention and control (IPC) measures were generally well adhered to. Staff were knowledgeable in relation to best practice guidance with regard to hand hygiene and use of personal protective equipment (PPE) and were observed to wash their hands/use alcohol gels and use PPE at appropriate times.

A review of records evidenced that appropriate risk assessments had been completed prior to the use of restrictive practices. There was also evidence of consultation with relevant persons. During review of care records we observed some inconsistencies in the completion of bedrail risk assessments. This was discussed with the manager who agreed to review the care records and discuss with the appropriate nursing staff. During review of the environment we observed bedside tables to be placed in front of patients in the lounge area to allow them to place drinks on for convenience. We reminded the manager to consider patients ability to leave their chairs when placing tables beside patients.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, fresh smelling and clean throughout.

Many of the bedrooms inspected did not have a lockable space for patients. In addition some bedrooms did not have a nurse call bell. This was discussed with the manager who agreed to audit all bedrooms to ensure patients have access to a lockable space unless they state otherwise. The audit will further ensure that those patients who cannot use the nurse call bell system or on an appropriate supervision regime.

Fire exits and corridors were observed to be clear of clutter and obstruction. Records evidenced that systems were in place to manage and record fire drills and fire alarm tests within the home.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to adult safeguarding, infection prevention and control and the home's environment.

Areas for improvement

One area for improvement under regulation was identified in relation to staff training. A further area for improvement under the care standards was identified with regards to staff supervision and appraisal.

	Regulations	Standards
Total number of areas for improvement	1	1

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of six patient care records evidenced that a range of validated risk assessments were completed and reviewed as required. These assessments informed the care planning process. Care plans for the most part were in place to direct the care required and reflected the assessed needs of the patient. We reviewed the management of falls, restrictive practice, wound management and skin integrity, management of infections and records of patient recently admitted to the home. Care records contained details of the specific care requirements in each of the areas reviewed and a daily record was maintained to evidence the delivery of care. However, we did identify some deficits regarding elements of care planning and record keeping.

We reviewed care records for a patient recently admitted to home. It was pleasing to see detailed records reflecting the assessed needs of patient and associated risk assessments. However, the registered nursing staff failed to develop all care plans to guide staff on a daily basis in a timely manner. Some care plans were not completed until up to and including a week post admission. An area for improvement under the regulations was made.

We were pleased to see the improvement regarding the management of skin integrity and infection. Appropriate care plans were in place and had been updated as required. We encouraged the manager to ensure the frequency of skin checks are recorded in patients care plans as required

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It was positive to note that the care record for one patient who had recently experienced an unwitnessed fall evidenced relevant and accurate information concerning the patient's assessed needs in relation to being at risk of falling. The patient's care plan was reviewed and falls risk assessment was updated post fall. It was disappointing to note that the clinical and neurological observations recorded were not in keeping with best practice guidance or reflected in the daily progress notes. This was discussed with the manager who agreed to address this with staff as required.

Concerns were identified in relation to wound management. Review of records for one identified patient evidenced their care plan had not been updated to reflect the podiatrist's recommendations. The care plan in use did not direct staff as to how often the wound was required to be dressed and deficits were identified with regard to evaluation of the care delivered. This was discussed with the manager and identified as an area for improvement under regulation.

Deficits were identified in review of some care records. Whilst we found evidence of good patient centred care plans and associated care evaluation, we found additional evidence that some care plans had not been updated to reflect the assessed needs of the patient. Some risk assessments regarding the use of bedrails had not been updated in line with planned care. In addition, some of the records were repetitive, not personalised and patient centred. The manager must ensure that care records are wholly reflective of care planning directions and completed to demonstrate adherence to the plan as required. An area for improvement was made under the care standards.

Review of supplementary care charts such as food and fluid intake records, behaviour charts and repositioning charts evidenced these were well completed. We identified some deficits in record keeping with regard to personal care. We asked the manager to review the system currently in use to ensure an accurate record is maintained. Staff should record when care has been offered but refused and evidence any further attempts that were made for care delivery. This will be reviewed at a future care inspection.

We observed the serving of the evening meal. Patients were assisted to the dining room and staff were observed assisting patients with their meal appropriately. Patients appeared to enjoy the mealtime experience and were offered a choice of meals and drinks. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks, how to modify fluids and how to care for patients during mealtimes.

Discussion with staff evidenced they were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they would raise theses with the manager or the nurse in charge. When we spoke with staff they had a good knowledge of patients' abilities and level of decision making; staff knew how and when to provide comfort to patients because they knew their needs well.

All grades of staff consulted with demonstrated the ability to communicate effectively with their colleagues and other health care professionals. Staff were also aware of the requirements regarding patient information and patient confidentiality.

Discussion with manager and review of records confirmed that staff meetings were held regularly and records maintained.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to communication at shift handover and teamwork.

Areas for improvement

Two new areas for improvement under the regulations were identified in relation to developing care plans in a timely manner and wound management.

One new area for improvement under the care standards was identified in relation to patient centred evaluation of care.

	Regulations	Standards
Total number of areas for improvement	2	1

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. It was pleasing to see care delivered by all staff in such an understanding and empathetic manner.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. The environment in the home had been adapted to promote positive outcomes for the patients. Many of the bedrooms were personalised with possessions that were meaningful to the patients and reflected their life experiences.

We reviewed the compliments file within the home. Some of the comments recorded included:

"I can't thank you enough for the exemplary hard work you do both physically and emotionally alongside such patience and compassion."
"Thank you for the support we received from all the staff and we were happy that….was so well cared for."

Consultation with 11 patients individually, and with others in smaller groups, confirmed they were happy and content living in Ambassador. Some of the patients' comments included:

"It's dead on. They may sure you are looked after."
"They are looking after me very well."
"We are very well looked after. They are very dedicated people."
"I have a good feeling about here. There is company for me here and the food is nice."
"It's number one."
"It is good. The staff are dead on. Anything you need they get it for you."
"I am well enough cared for. I like the staff."

One questionnaire received from a patient reported a high level of satisfaction with the care provided. Some of the comments included the following:

"Maria is my best carer. She does everything for me."

Five relative questionnaires were provided; we had four responses within the timescale specified. The respondents were either satisfied or very satisfied with care across all four domains. Some of the comments received included:

"Some care assistants do find time to have a chat while there is a task to be completed. If it was completed they would be more relaxed for their chat."
"We visit our relative regularly and we usually find them in good form. I think a little more stimulation would help deal with boredom."

We spoke with one relative during the inspection. Some of the comments received included:

"It is absolutely first class. We are so happy. Good communication from the staff and the door is always open."

Staff were asked to complete an online survey; we received no responses within the expected timeframe. Four members of staff were spoken with during the inspection. All reported to be happy and content working in the home and spoke fondly of the patients they care for.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients.

Areas for improvement

No new areas for improvement were identified during the inspection in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

Since the last inspection there has been no change in management arrangements. A review of the duty rota evidenced that the manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with staff evidenced that the manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the manager.

A number of audits were completed to assure the quality of care and services; areas audited included care plans, IPC, hand hygiene, the home environment, complaints and accidents and incidents. We commended the manager on the improvement in audit systems with regards to hand hygiene and PPE use. Most audits generated action plans that highlighted areas for improvement and there was evidence that the deficits identified were actioned as required. We did however identify deficits with regard to the care record audit. There was evidence that there was limited audit activity since May 2019, with the audits not identifying the shortfalls highlighted previously in the report. Auditing of care records was identified as an area for improvement under the care standards during the care inspection on 21 November 2018. This has been subsumed into an area for improvement under regulation.

We evidenced a lack of sufficient management hours and the resultant impact on governance arrangements. The manager was working many of her allocated management hours in the capacity of registered nurse. Whilst we commended the manager for her passion for compassionate care, the inspection clearly identified an associated impact and a number of deficits in the overall quality assurance/governance and delivery of care were identified. The areas of concern include:

- uptake in staff training
- staff supervision and appraisal
- deficits in wound management
- shortfalls in the quality of patient care records
- the lack of a robust care record audit and the failure to identify the deficits previously referenced.

To ensure robust governance arrangements are developed and adhered to an area for improvement under the regulations was made.

Discussion with the manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. Review of records evidenced that quality monitoring visits were completed on a

monthly basis on behalf of the responsible individual in accordance with the relevant regulations and standards.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed appropriately in line with best practice guidance. Patients spoken with said they would be confident if they raised a complaint that it would be dealt with accordingly. We asked the manager to ensure staff are aware that expressions of dissatisfaction from patients and relatives should be managed as a complaint.

Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to management of incidents and maintaining good working relationships.

Areas for improvement

Two new areas for improvement under the regulations were identified in relation to care record audits and governance arrangements.

	Regulations	Standards
Total number of areas for improvement	2	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Amelia Noach, registered manager, as part of the inspection process and with Emer Bevan, responsible person, during a phone call on 17 September 2019. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales. Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 20 (1) (c) (i) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the persons employed by the registered person to work in the nursing home receive mandatory training appropriate to the work they are to perform. Updates in mandatory training should be delivered in a timely manner. Ref: 6.3
	Response by registered person detailing the actions taken: As detailed on Page 6 and in Section 6.6 of the report, the Registered Manager has been working deligently as a Nurse to ensure the standard of care delivered to our residents does falter. This is reflected in the comments made in Section 6.5. This has been necessary due to the challenges faced by the Home in recruiting Care staff of an appropriate standard and with sufficient experience. As a result, training has been running behind schedule for 2019. The Registered Provider and Registered Manager have remedied this in the month of October and are aware of the necessity to complete mandatory training in Q4 of 2019. Additional training which supplements mandatory training and adds much value to the delivery of care is also ongoing.
Area for improvement 2 **Ref**: Regulation 16 (1) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that initial care plans are developed for newly admitted patients from day one of admission to guide staff in the immediate delivery of care. The care plans should be further developed within five days of admission, reviewed and updated in response to the changing needs of the patient. Ref: 6.4
	Response by registered person detailing the actions taken: The Registered Provider will ensure that Nursing staff all undergo training on care planning so that care planning commences from admission. In cases whereby consultation with the patient or the patient's representative is not possible within the initial five days, nursing staff will prepare care plans according to the limited information available. This information may need to be ammended or updated when patient representation is available.

Area for improvement 3 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that patients have an appropriate assessment and care plan in place to direct staff in the management of wounds. These should be updated to reflect professional's recommendations as required. Care records should accurately reflect ongoing assessment, care delivery and meaningful evaluation. Ref: 6.4
	Response by registered person detailing the actions taken: The Home had one wound to manage at the time of inspection. The Care plan was in place including input from podiatrist. Plan of care had been drawn up to guide nursing staff and adhered to as closely as possible. Staff complemented by podiatrist and Consultant in Vascular Podiatry Clinic for management of wound.
Area for improvement 4 **Ref:** Regulation 10 (1) **Stated:** First time **To be completed by:** 31 October 2019	The registered person shall ensure monthly care record audits are completed in accordance with best practice guidance. The audit should consider the quantitative and qualitative aspects of the care records. Any shortfalls identified should generate an action plan to ensure corrective actions are taken, learning is disseminated and the necessary improvements can be embedded into practice. Ref: 6.6
	Response by registered person detailing the actions taken: As stated in Regulation 10 (1) the Manager and Provider manage the Home as per the Statement of Purpose and the needs of the patients, with due care competence and skill. To complement this, the Registered Manager will endeavour to carry out monthly care record audits in accordance with best practice guidelines. Any deviations from the monthly audit will be communicated to the Registered Provider with a valid justification for same.
Area for improvement 5 **Ref:** Regulation 10 (1) **Stated:** First time **To be completed by:** With immediate effect	The registered persons must ensure that robust governance arrangements are put in place to ensure that the deficits identified in the report are appropriately actioned. Ref: 6.6
	Response by registered person detailing the actions taken: The appointment of a Care Co-ordinator is imminent and is expected to assist the Registered Manager in reviewing and managing training, appraisals, audits and make the governance arrangements more robust.

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 40.2 **Stated:** First time **To be completed by:** 16 November 2019	The registered person shall ensure all staff have a recorded annual appraisal and supervision no less than every six months. A supervision and appraisal schedule shall be in place, showing completion dates and the name of the appraiser/supervisor. Ref: 6.3
	Response by registered person detailing the actions taken: All Supervisions are now complete for 2019 and Appraisals are scheduled to be completed in November 2019.
Area for improvement 2 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure accurate and contemporaneous nursing records are kept of all nursing interventions, activities and procedures carried out in relation to each patient, in accordance with NMC guidelines. Care plans, daily records and care plan reviews should be patient centred and meaningful. Ref: 6.4
	Response by registered person detailing the actions taken: The completion of accurate and contemporaneous nursing records continues to provide a challenge. 1:1 training has been arranged for all Nursing staff so as to ensure that meaninful, patient centred and relevant care plans are produced.

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

The Regulation and Quality Improvement Authority

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