

Unannounced Care Inspection Report

4 – 5 May 2016



Carnalea

Address: 20-30 Crawfordsburn Road, Bangor, BT19 1BE
Tel No: 028 9145 1121
Inspector: Dermot Walsh

1.0 Summary

An unannounced inspection of Carnalea took place on 4 May 2016 from 10.00 to 17.20 and 5 May 2016 from 09.35 to 15.30.

The inspection sought to assess progress with issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

Arrangements for monitoring the registration status of nursing and care staff were well managed. Safe systems of recruitment were applied well. Weaknesses were identified in the delivery of safe care, specifically in relation to compliance with best practice in infection prevention and control and with a training need noted within the home. One requirement and two recommendations have been stated to secure compliance and drive improvement.

Is care effective?

There was evidence that assessments informed the care planning process. Staff were aware of the local arrangements for referral to other health professionals. Communications between health professionals were recorded within the patients' care records. A weakness has been identified in the delivery of effective care specifically in relation to the accurate completion of fluid balance charts. However, it is acknowledged that staff were following a directive from Four Seasons Health Care regarding the completion of the fluid balance charts. Staff meetings should take place on a quarterly basis for all members of staff. Care plans must reflect the patients' current assessed needs. One requirement and three recommendations have been made in this domain.

Is care compassionate?

There was evidence of good communication in the home between staff and patients. Patients and their representatives were very praiseworthy of staff and a number of their comments are included in the report.

Is the service well led?

Audits reviewed, evidenced actions taken to address any shortfalls. This had been verified by the registered manager. Systems were in place to manage urgent communications, safety alerts and notices. Monthly monitoring visits included an overview of governance arrangements within the home and formulated an action plan to address any shortfalls identified. There were no requirements or recommendations stated in the well led domain. In total two requirements and five recommendations have been made in the other three domains as detailed above. One requirement stated, was acknowledged to have been out of the registered manager's control as it was a directive from Four Seasons Health Care.

This inspection was underpinned by The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	2	5

Details of the Quality Improvement Plan (QIP) within this report were discussed with the registered manager, Josette Fernandez and the acting regional manager, Ann Devoy, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced finance inspection undertaken on 14 January 2016. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare Dr Claire Royston	Registered manager: Josette Fernandez
Person in charge of the home at the time of inspection: Josette Fernandez	Date manager registered: 08/02/2016
Categories of care: NH-DE, NH-I, NH-PH, NH-PH(E), NH-TI	Number of registered places: 73

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the previous care inspection report and the returned quality improvement plan (QIP)
- pre inspection assessment audit

During the inspection we met with eight patients individually and others in small groups, two patient representatives, six care staff, three registered nursing staff, one visiting professional and one ancillary staff member.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

Questionnaires were also left in the home to facilitate feedback from patients, their representatives and staff not on duty. Nine patient, nine staff and seven patient representative questionnaires were left for completion.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- three patient care records
- staff training records
- staff induction template
- complaints records
- incidents / accidents records since the last care inspection
- minutes of staff meetings
- a selection of audit documentation
- a recruitment file
- competency and capability for nurse in charge
- monthly monitoring reports in keeping with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- fire log book
- duty rota from 25 April – 8 May 2016

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 14 January 2016

The most recent inspection of the home was an unannounced finance inspection dated 14 January 2016. The completed QIP was returned and approved by the finance inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered person, as recorded in the QIP will be validated at the next finance inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 5 May 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 Ref: Standard 36 Stated: First time	It is recommended that the following policy guidance is updated; <ul style="list-style-type: none"> • Communication policy should include reference to the regional guidance for breaking bad news • The palliative care manual which incorporates palliative and end of life care, death and dying should reference the GAIN Guidelines for Palliative Care and End of Life Care in Nursing Homes and Residential Care Homes November 2013 and the regional guidance on breaking bad news. • The palliative care manual should also be updated in respect of point 12 in the policy of death which records that records are maintained for 3 years. Regulation 19(2) (4) stipulates that records should be retained for not less than 6 years from the date of the last entry. 	Met
	Action taken as confirmed during the inspection: Appropriate amendments to the documents named above have been completed.	
Recommendation 2 Ref: Standard 39 Stated: First time	It is recommended that the registered person ensures that all grades of staff receive training on the following; <ol style="list-style-type: none"> 1. Palliative /End of life care 2. Breaking bad news communication skills 	Met
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of training records confirmed 29 staff have received training on Palliative / End of Life Care incorporating Breaking Bad News.	

4.3 Is care safe?

The registered manager 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. The registered manager also confirmed the documents related to the recording of dependency levels were disposed of. It was agreed that these records would be maintained in a file to validate the staffing levels on duty at that particular time period. A review of the staffing rota from 25 April 2016 to 8 May 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients, representatives and staff evidenced all but one staff member had no concerns regarding staffing levels. One out of four returned patient questionnaires was of the opinion that the home required additional night duty staff. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Discussion with the registered manager and review of training records evidenced that they had a robust system in place to ensure staff attended mandatory training. The registered manager would review training records monthly and identified training needs would be communicated to staff through an online 'care blox' system. Once a staff member signed in online to commence duty, the care blox message would appear to remind the staff to complete the named training.

Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility. Observation of the delivery of care evidenced that training had been embedded into practice. However, one staff member was observed assisting a patient with their meal. Through discussion, it transpired that the staff member had never received appropriate training on assisting patients with meals. A recommendation was made.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC). NMC and NISCC checks were monitored monthly and evidenced within a file. Monthly checks were signed as verified by the registered manager.

A review of the recruitment process evidenced a safe system in practice. Relevant checks and interviews had been conducted prior to the staff member commencing in post.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. Discussion with the registered manager confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process. There was evidence that risk assessments informed the care planning process.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since 15 September 2015 confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining room and storage areas. The rooms and communal areas reviewed were clean and spacious. An ongoing refurbishment programme was in place. The home was in the process of being redecorated throughout and furniture was being replaced where necessary. Fire exits and corridors were observed to be clear of clutter and obstruction. However, a range of issues were identified within the homes which were not managed in accordance with infection prevention and control guidelines:

- inappropriate storage in identified rooms
- rusting commodes and shower chairs in use
- commodes and shower chairs not effectively cleaned after use
- unlabelled net pants in use
- a ripped squab in use in an identified patient's room
- no clinical waste bins available in identified communal bathrooms

The above issues were discussed with the registered manager on the day of inspection and a requirement was made. An assurance was provided by the registered manager that these areas would be addressed with staff to prevent recurrence. A recommendation was made that management systems are put in place to ensure compliance with best practice in infection prevention and control.

Areas for improvement

It is recommended that any staff assisting patients with their meals will have first undergone training in doing so.

It is required that the registered person ensures the infection control issues identified on inspection are managed to minimise the risk and spread of infection.

It is recommended that a more robust system is put in place to ensure compliance with infection prevention and control procedures.

Number of requirements	1	Number of recommendations:	2
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4.4 Is care effective?

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process. Care plans had been reviewed monthly although a recommendation was made to ensure that care plans accurately reflected the current assessed care need of the patient. One patient's mobility care plan stated the patient mobilised independently whereas the patient's progress notes identified the patient was unable to mobilise.

Care records adhered to recommendations prescribed by other healthcare professionals such as speech and language therapist (SALT) or dieticians. There was good evidence in one of the files reviewed that the care plans were updated immediately after a SALT review.

Recommendations from other care professionals were documented within patient care records on an 'MDT Communication Sheet'. A 'Professional Communication Sheet' was also observed within the patient care records. This was discussed with the registered manager as professionals from the same disciplines were recording recommendations on both documents. It was agreed that one document only should be within the patient care records to record communication from other healthcare professionals. The registered manager agreed to bring this to the staffs' attention.

Fluid balance charts in use in the home stipulated 'prescribed nutritional drinks should only be recorded as fluid intake where a person is on fluids only with no solid food intake.' This was discussed with a senior community dietician who confirmed that all liquid intakes should be included on a patient's fluid balance chart. This would be particularly significant if a patient was on a prescribed fluid restriction relating to a medical condition. A requirement was made to ensure the accurate recording of patients' fluid intake. As the fluid balance chart had been designed for use by Four Seasons Health Care, this requirement was discussed with the regional manager, Alana Irvine, by telephone on 24 May 2016. The regional manager agreed to liaise with the appropriate personnel within Four Seasons Health Care in relation to the requirement. RQIA would expect this information to be disseminated throughout Four Seasons Health Care.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. Records are stored securely in lockable cabinets at the nursing stations.

There was no evidence available on the review of three patients' care records of patients' and/or their representatives' involvement in the assessment and care planning process. A recommendation was made

Registered nurses were aware of the local arrangements and referral process to access other relevant professionals, for example General Practitioner's (GP), SALT, dietician and TVN.

Discussion with the registered manager confirmed that general staff meetings were held twice yearly in each of the units. Registered nurse meetings for all registered nurses within the home were conducted twice yearly. Separate staff meetings were also held for domestic and kitchen staff twice yearly. There were no separate meetings conducted for care staff to attend. It was recommended that all staff have the opportunity to attend staff meetings on a quarterly basis. Minutes of meetings were made available to all relevant staff and maintained in a file. The registered manager confirmed action plans had been developed as a result of the staff meetings although these were disposed of following their successful outcome. It was agreed that action plans and any evidence of their outcomes should be maintained with the minutes to evidence actions taken as a result of the staff meeting.

Notices had been displayed and unit managers were informing relatives of a joint patient/relative meeting scheduled for 20 May 2016. Food questionnaires were also being sent out to all patients for completion to ascertain their views on meals served within the home. The registered manager also confirmed that they operate an open door policy to allow relatives and patients to converse with them at any time.

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 could raise these with their line manager and /or the registered manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Patients and representatives were confident in raising any concerns they may have with the staff and/or management.

Information leaflets were available to staff, patients and/or representatives at the entrance to the home. These included information on bereavement, incontinence, dementia care, terminal illness, infection prevention and control issues, hearing loss, pressure care and advice on elder abuse. Information leaflets on similar topics were also located at the first floor reception.

Areas for improvement

It is recommended that the patients care plans reflect the patients' current specific assessed needs.

It is required that patients' fluid balance charts are completed in full to include all liquids taken throughout the day.

It is recommended that there is evidence within the patients' care records of patient and/or representative involvement in the assessment and care planning process.

It is recommended that all staff have an opportunity to attend a quarterly staff meeting.

Number of requirements	1	Number of recommendations:	3
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4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent. Nine staff questionnaires were left in the home to facilitate feedback from staff not on duty on the day of inspection. Six of the questionnaires were returned to RQIA. The respondents were positive in their feedback. On inspection three registered nurses, six carers and one ancillary staff member were consulted to ascertain their views of life in Carnalea.

Some staff comments are as follows:

'I'm very happy here.'

'I wouldn't work anywhere else.'

'The teamwork here is great.'

'I love it here.'

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives, and staff on the running of the home. A 'Quality of Life' feedback system was available at the reception area in Carnalea. This is an iPad which allows patients, relatives/representatives, visiting professionals and/or staff to provide feedback on their experience of Carnalea. A portable iPad is also available to record feedback from patients unable to give feedback at reception. This feedback is ongoing and is shared with the regional manager. Anyone completing the feedback has the option to remain anonymous or leave their name. Management have the option to contact people who leave their contact details to gain further clarification on the feedback received.

All feedback reports are acknowledged by the registered manager. Any actions taken as a result of the feedback is submitted to Four Seasons Health Care head office. Views and comments recorded were subsequently analysed and an action plan was developed and shared with staff, patients and representatives through staff and relative meetings. Any urgent feedback would be included within the 'shift report' and any agreed actions would also be recorded within the shift report and the communication section of the patients care record if appropriate. The registered manager confirmed the results and any actions taken would also be included within the Annual Quality Report.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. Consultation with eight patients individually, and with others in smaller groups, confirmed that living in Carnalea was safe, effective, compassionate and well led. Nine patient questionnaires were left in the home for completion. Four patient questionnaires were returned within the timeframe. The responses from the patients would indicate a high level of satisfaction with this service.

Some patient comments are as follows:

'I'm happy here.'

'The care here couldn't be better.'

'The care is excellent.'

'I'm very comfortable. We are well looked after.'

'It's absolutely brilliant here but the foods not great.'

Two patient representatives were consulted on the day of inspection. Seven relative questionnaires were left in the home for completion. Four relative questionnaires were returned within the timeframe. The respondents were positive within their feedback of the service.

Some representative comments are as follows:

'I am very happy with the care my wife is getting.'

'Everyone has been very pleasant.'

A visiting professional consulted on the day of inspection was complimentary about the home's staff and confirmed that previous instructions left in the home regarding patient care had been followed.

Areas for improvement

No areas for improvement were identified during the inspection under the compassionate domain.

Number of requirements	0	Number of recommendations:	0
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4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. The date the manager was registered was 8 February 2016. Staff were able to describe their roles and responsibilities.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed. Discussion with the registered manager evidenced that the home was operating within its registered categories of care.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DOH Care Standards for Nursing Homes 2015. The complaints procedure was displayed at reception and was also attached to the back of some patients' bedroom doors.

Policies and procedures were maintained electronically. Staff had 24 hour access to online facilities. The registered manager confirmed that new policies and any reviews on policies or procedures were communicated to staff via the previously mentioned care blox system.

A compliments file was maintained to record and evidence compliments received. Some examples of compliments received are as follows:

'I write to thank you and all the staff for everything you did for my father. I cannot properly express how indebted we feel to all of you.'

'Words cannot express how grateful I am for all the love, care and attention you all gave my mum.'

'Just to say thank you for all the care and attention you gave me.'

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, monthly audits were completed in accordance with best practice guidance in relation to wound analysis, care records, infection prevention and control, falls, medicines management, complaints, restraint, bed rails, hand hygiene, personal protective equipment, hoists/slides, health and safety and incidents/accidents.

As previously indicated in section 4.3, the system to monitor best practice compliance with infection prevention and control requires further development. Six monthly food questionnaires are given to patients for completion to obtain feedback on the standard of food available to patients and a 'Quality Dining Audit' was also conducted six monthly. Online 'TRaCA' audits are conducted on housekeeping, daily/weekly medications management, health and safety, resident care, weight loss and the homes governance arrangements. All TRaCA audits demand an 'actions taken' section to be completed for every audit even if the audit had achieved 100 percent compliance. The action taken could be confirmation that the information was shared with staff. All actions taken are documented online by the registered manager. The system would notify the registered manager of any audit that had not been actioned.

Urgent communications, safety alerts and notices were reviewed by the registered manager on receipt and, where appropriate, were shared with staff. A system was in place to ensure that all relevant staff had read the communication or had been notified about it.

Discussion with the registered manager and review of records evidenced that monthly monitoring reports were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. An action plan was generated within the report to address any areas for improvement and a review of the previous action plan was included within the report. Copies of the reports were available for patients, their representatives, staff and trust representatives.

Discussions with staff confirmed that there were good working relationships within the home and that management were responsive to any suggestions or concerns raised.

Areas for improvement

No areas for improvement were identified during the inspection under the well led domain.

Number of requirements	0	Number of recommendations:	0
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5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered manager, Josette Fernandez and the acting regional manager, Ann Devoy, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to Nursing.Team@rqia.org.uk and assessed by the inspector.

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 registered person/manager from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements

Requirement 1

Ref: Regulation 13 (7)

Stated: First time

To be completed by:
7 June 2016

The registered person must ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection.

Ref: Section 4.3

Response by registered person detailing the actions taken:

All infection control issues identified during the inspection have now addressed.

1. Correct storage of wheelchairs is in place.
2. Rusting commodes and shower chairs which had been identified as a concern prior to the inspection have been replaced.
3. All communal bathrooms now provided with clinical waste bins.
4. Those residents assessed as requiring incontinence products have their net pants individually labelled.
5. Ripped squab replaced.
6. Decontamination process of equipment reviewed with relevant staff.

Requirement 2

Ref: Regulation 19
(1) (a)

Stated: First time

To be completed by:
31 May 2016

The registered person must ensure that fluid balance charts are recorded accurately and include any volume of supplement drinks consumed by the patient.

Ref: Section 4.4

Response by registered person detailing the actions taken:

FSHC Nutritional policy is to be amended and this will include guidance on the recording of all fluid supplements on fluid balance charts for those residents who have been assessed as requiring fluids to be monitored.

As advised by the Resident Experience Regional Manager via email, the fluid balance booklet will be updated to reflect this guidance.

Recommendations

Recommendation 1

Ref: Standard 39

Stated: First time

To be completed by:
10 May 2016

The registered person should ensure that any staff member assisting patients with their meals will have had appropriate training completed prior to undertaking the task.

Ref: Section 4.3

Response by registered person detailing the actions taken:

All mandatory training has been completed for the identified new staff member. Newly recruited staff will complete their training during their induction period.

<p>Recommendation 2</p> <p>Ref: Standard 46 Criteria (1) (2)</p> <p>Stated: First time</p> <p>To be Completed by: 14 June 2016</p>	<p>The registered person should ensure that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home.</p> <p>Particular attention should focus on the areas identified on inspection.</p> <p>Ref: Section 4.3</p> <hr/> <p>Response by Registered Person(s) Detailing the Actions Taken: Each Unit Manager will carry out Infection control audits as per FSHC Infection Control Audit planner. The outcome of these will be reviewed and monitored by the Registered Manager and Infection Control Link Nurse and the action plan signed off when completed.</p>
<p>Recommendation 3</p> <p>Ref: Standard 4 Criteria (5) (6) (11)</p> <p>Stated: First time</p> <p>To be Completed by: 31 May 2016</p>	<p>The registered person should ensure that care records evidence patients and/or their representatives' involvement in the care planning of the patients care to meet their needs. If this is not possible the reason should be clearly documented within the care record.</p> <p>Ref: Section 4.4</p> <hr/> <p>Response by registered person detailing the actions taken: Signatures of the residents or representatives are now obtained in the Residents' care plan. Signatures are also obtained for rewritten care plans. Should the case arise where this is not possible a written record will be documented to reflect this.</p>
<p>Recommendation 4</p> <p>Ref: Standard 4</p> <p>Stated: First time</p> <p>To be completed by: 30 June 2016</p>	<p>The registered person should ensure that holistic assessments of patient need, inform the care plans and where the assessment of need changes, the care plan is amended/renewed to reflect the change.</p> <p>Care plans not reflective of current care needs should be discontinued.</p> <p>Ref: Section 4.4</p> <hr/> <p>Response by registered person detailing the actions taken: Care plans have been updated to reflect the current needs of the Residents. This will be monitored through the Resident Care TRaCA audit and an action plan will be put in place to address any non compliance with a time frame to address.</p>
<p>Recommendation 5</p> <p>Ref: Standard 41</p> <p>Stated: First time</p> <p>To be completed by: 30 June 2016</p>	<p>The registered person should ensure that all staff have an opportunity to attend staff meeting on a quarterly basis.</p> <p>Ref: Section 4.4</p> <hr/> <p>Response by registered person detailing the actions taken: Quarterly meetings in all units are now scheduled.</p>



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