The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
3 October 2017

Clandeboye

Type of Service: Nursing Home (NH)
Address: 35 Cardy Close, Bangor, BT19 1AT
Tel No: 028 91 271011
Inspector: Donna Rogan

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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.

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 52 persons.

3.0 Service details

Organisation/Registered Provider: Four Seasons Healthcare Maureen Claire Royston	Registered Manager: Joanne Roy
Person in charge at the time of inspection: Joanne Roy	Date manager registered: 9 December 2010
Categories of care: Nursing Home (NH) DE – Dementia	Number of registered places: 52

4.0 Inspection summary

An unannounced inspection took place on 03 October 20173 from 10.00 to 17.00 hours.

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 2015.

The inspection assessed progress with any areas for improvement identified during and 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.

There was good practice found in relation to; the home environment, infection prevention and control, the management of accidents and incidents, communication between residents, staff and other key stakeholders, dignity and privacy, listening to and valuing patients and their representatives.

A number of positive comments were received from staff, patient representatives and patients. Patients said they were happy with the care provided and enjoyed living in the home. Those who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

As a result of the inspection, RQIA was concerned that some aspects of the quality of care and service delivery within Clandeboye were below the minimum standard expected. Patient daily progress records were not appropriately updated; audits of wound care, care plans and supplementary records were not well maintained. Governance arrangements failed to identify and correct the situation. A decision was taken to hold a serious concerns meeting in relation to seeking assurances from the responsible person. The serious concerns meeting took place at RQIA offices on 10 October 2017.

During the meeting, the responsible individual acknowledged the failings and provided a robust action plan detailing the actions taken or to be taken to ensure compliance with the regulatory breaches identified. RQIA were satisfied with the information and assurances provided.

Areas requiring improvement were identified across all four domains as outlined in the quality improvement plan (QIP). Please refer to section 7.0.

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.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	6	*4

*One area for improvement under the care standards is stated for a second time. Details of the Quality Improvement Plan (QIP) were discussed with Joanne Roy, registered manager, 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.

4.2 Action/enforcement taken following the most recent inspection dated 16 November 2016

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 16 November 2016. 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

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents (SAI's), potential adult safeguarding issues and whistleblowing.
- the returned QIP from the previous care inspection
- the previous care inspection report

During the inspection the inspector met with 15 patients, eight staff, and three patient's visitor/representatives. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives and eight for patients were left for distribution.

The following records were examined during the inspection:

- staffing arrangements in the home
- one staff personnel file to review recruitment processes

- staff induction
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- five patient care records
- a review sample of patient care charts including food and fluid intake charts and reposition charts
- governance arrangements
- complaints record
- staff meetings
- RQIA registration certificate
- monthly quality monitoring reports in accordance with DHSSPS Care Standards for Nursing Homes 2015

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as 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 most recent inspection dated 16 November 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector.

This QIP will be validated by the pharmacist inspector at the next medicines management inspection.

6.2 Review of areas for improvement from the last care inspection dated 5 October 2016

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 15 **Stated:** First time	The registered provider must ensure that the care record is updated to reflect the identified patient's condition and a care plan should be put in place to manage the condition. Wound care should also be managed in keeping with best practice.	**Met**

	Action taken as confirmed during the inspection: This record was appropriately updated. The registered manager confirmed that supervision was held with registered nursing staff in relation to record keeping and the management of wound care.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 38 **Stated:** First time	The registered provider should ensure pre-employment health assessments are completed during the selection and recruitment process.	**Met**
	Action taken as confirmed during the inspection: A recruitment checklist has been implemented to ensure all documentation is completed. Confirmation was received that all staff have a pre-employment health assessment on file. The review of one staff file evidenced that this was in place.	
Area for improvement 2 **Ref**: Standard 6 **Stated:** First time	The registered provider should review the provision of the nurse call system in bedrooms where patients are being nursed in bed.	**Partially Met**
	Action taken as confirmed during the inspection: The registered person confirmed that a nurse call will be located in all patients' bedrooms unless there is an identified entrapment risk. It was confirmed that following such an identified risk that an entrapment risk assessment would be completed, agreed and placed in the residents care file. However, one patient in bedrest who was heard calling out for assistance did not have a nurse call bell in place. They did not have the relevant entrapment risk assessments in place or a plan of care to manage the issue. An area for improvement is made in this regard under the care standards for a second time.	

Area for improvement 3 **Ref**: Standard 12 **Stated:** First time	The registered provider should review the supply of equipment to aid patients' dexterity whilst managing mealtimes in order to maintain patients' independence and their dignity.	**Met**
	Action taken as confirmed during the inspection: A review of the lunch time meal evidenced that there was a supply of equipment available to maintain patients' independence and dignity.	
Area for improvement 4 **Ref**: Standard 35 **Stated:** First time	The registered provider should ensure that staff and relatives meetings are reintroduced and are regularly conducted. Minutes and any actions taken as a result should be retained	**Met**
	Action taken as confirmed during the inspection: Quarterly staff and relatives meetings have been re-instated. The registered manager also seeks opinions from relatives through FSHC 'Quality of Life Programme'.	

6.3 Inspection findings

6.4 Is care safe?

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

The registered manager confirmed the planned daily staffing levels for the home and confirmed that these levels were subject to regular review to ensure the assessed needs of the patients were met. The registered manager confirmed that agency use in the home has increased recently due to difficulties in selection and recruitment. A review of induction processes evidenced that agency staff were appropriately inducted to the home and usually shadowed a permanent member of staff throughout their shift. The registered manager confirmed that where possible, agency staff are block booked to assist with continuity.

A review of the staffing rota for weeks commencing 25 September 2017 to 15 October 2017 evidenced that the planned staffing levels were generally adhered to. However, one shift in both Dufferin and Stewart suites was evidenced to not be filled at the time of the inspection. All registered nurses spoken to stated, that dependency in the home was high and that they were having difficulty in ensuring patient care records were up to date. This was discussed with the registered manager and an area of improvement is made in this regard.

Patients or their representatives did not express any concerns regarding staffing levels.

With the exception of one patient with complex nursing needs, (see section 6.5 for further comment) the observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Staff recruitment information was available for inspection and records were maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work and records were maintained.

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. Review of the training matrix/schedule for 2016/17 indicated that training was planned to ensure that mandatory training requirements were met. Staff demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility.

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).

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified. One issue for concern was raised with the registered manager regarding the management of a patient identified with complex needs. Confirmation was received from the registered manager that the matter was referred to the relevant safeguarding team.

Review of five 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. However, a review of one patient's care record that was being nursed in bed and was heard to call out for assistance was not provided with a nurse call bell. The registered nurse stated that a call bell may place the patient at greater risk of harm. A review of the patients care record evidenced a lack of rationale for the absence of a call bell; there was also no plan of care in place to manage the patient's needs if help was required. An area for improvement is made under the care standards for a second time in this regard.

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA 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 rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients/representatives/staff spoken with were complimentary in respect of the home's environment. The cleanliness of the home is to be commended.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, training, infection prevention and control, and the home's environment. The home's domestic team are to be commended on the cleanliness of the home at the time of the inspection.

Areas for improvement

The following areas were identified for improvement.

An area for improvement was made under regulation in relation to staffing.

An area for improvement was made under the care standards in relation to managing the nurse call system for a second time.

	Regulations	Standards
Total number of areas for improvement	1	1

6.5 Is care effective?

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

Review of five patient care records evidenced that a range of validated risk assessments were completed as part of the admission process. However, as previously stated the review evidenced that one care record did not contain a risk assessment in relation to a patient at risk from harm due to inappropriate use of the nurse call bell lead.

The review of care records identified that they were not developed, maintained and reviewed in response to the changing needs of the patient. A review of wound care records for three identified patients, evidenced gaps in the delivery of care and documentation was not in keeping with best practice guidelines. There was insufficient evidence that wound care was being managed in keeping with the home's policies and procedures nor the National Institute of Clinical Excellence (NICE) guidelines. For example, two care records did not have a care plan in place to manage two skin tears. One care record did not evidence that the patient's dressing had been completed in accordance with their plan of care, nor was the dressing evidenced in the daily notes or the ongoing wound care chart. The description of two wounds identified for another patient did not consistently describe the state of the wound; both wounds were described in the same care plan which was confusing to the reader. The record was also not consistently updated when the dressings were completed. The registered nurse stated

that both wounds had been redressed; however, records were not maintained in keeping with best practice. Two areas for improvement under regulation were made in relation to care planning and the management of wound care.

Another patient who was prescribed a benzodiazepine three times a day did not have their care plan reviewed in a timely way to assess the level of effectiveness of the medication. There was no evidence of a review of the use of this medicine in the daily notes and the monthly evaluation of care was meaningless and described the care plan as, “care plan continues” or “care as planned”. An area for improvement is made under the care standards in this regard.

One identified patient with complex needs did not have appropriate care plans established to direct staff and assure care delivery for five days post admission. Observation of care practice did not evidence that the management of catheter care was sufficiently robust. There was no care plan in place to manage the catheter and there was no care plan in place to manage an identified skin tear. We directed staff to address this deficit at the time of the inspection. The registered manager was also directed to refer the care of this patient to the trust as a potential safeguarding matter. Confirmation that the referral was completed was received by RQIA. An area for improvement under regulation was made in relation to the management of catheter care. Another area for improvement is made that this patient’s care record is updated to accurately reflect their care needs to guide and advise staff.

There was also a lack of evidence that the registered nurses were reviewing the fluid and food intake of patients within the progress record in care records. There were also gaps in the recording of repositioning charts. Supplementary care records should be maintained accurately so as to inform of the wellbeing of the patients. An area for improvement is made under the care standards in this regard.

The concerns identified in patient care records should have been identified through the quality monitoring process in place. The review of the audits of care records evidenced that whilst audits had been completed there was no evidence that the issues identified had been addressed as the audits had not been followed up. Wound care audits were also maintained; however, they were ineffective in quality assuring the management of wounds and focused more on a statistical analysis of numbers and grades of wounds occurring. An area for improvement is made under regulations that the auditing system is robust and effective in ensuring the quality of wound care and care records is maintained in accordance with best practice.

The shortfalls outlined above were discussed at the serious concerns meeting, as previously stated. At this meeting an action plan was provided by the registered persons and assurances given that necessary actions had been taken to ensure the quality of nursing care afforded to patients in the areas outlined. These included, but were not limited to; a full review of documentation of all patients who have wounds, a full review on the use of supplementary charts, a review of care plans, and training provided for all registered nurses in relation to delivery of care and record keeping. The responsible persons advised that enhanced governance monitoring and governance systems have and will be implemented to assure the delivery of safe, effective care.

RQIA were assured by the information and assurances given, however, areas for improvement under regulation have been identified in regards to the quality of nursing care and care records.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Observation of the morning handover meeting confirmed that communication between all staff grades was effective. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition.

The majority of staff spoken with 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. Some staff spoken with felt that staffing pressures was adding to them not getting the care plans updated in a timely way. These comments were discussed at the serious concerns meeting and assurances were given that these would be addressed appropriately.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to communication between patients, staff and other key stakeholders. Staff were observed in their interactions and delivery of care to be compassionate and treated patients with dignity and respect.

Areas for improvement

The following areas for improvement under regulations related to; the quality of nursing care and care records. Four areas for improvement under the regulation were made in relation to care planning, the management of wound care, the management of catheter care, review the identified patients care plan to ensure it is updated. An area for improvement was made under the care standards in relation to ensuring the evaluation of care is meaningful and accurately reflects of how effective the care plan is. Another area for improvement in relation to the care standards is made in relation to the management of supplementary care records.

	Regulations	Standards
Total number of areas for improvement	4	2

6.6 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 interactions with patients were observed to be compassionate, caring and timely. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

The serving of lunch was observed in the main dining rooms in both units. Lunch commenced at 12.30 hours. Patients were seated around tables which had been appropriately laid for the meal. Food was served directly from the kitchen and in heated trollies when patients were ready to eat or be assisted with their meals. Staff sat alongside patients when assisting with meals and patients were observed to be assisted in an unhurried manner. Staff wore the appropriate aprons when serving or assisting with meals and patients wore clothing protectors where required. The food served appeared nutritious and appetising. The mealtime was well

supervised. Food was covered when transferred from the dining room. A range of drinks were offered to the patients. Patients appeared to enjoy the mealtime experience.

A programme of activities was displayed on a notice board outlining the planned activities, patients spoken with confirmed that they liked to participate. A record of patients' participation was included in the care planning process. The activity programme was found to be varied, and individualised in accordance to patients' wishes feelings and interests. The management of activities in the home are to be commended on this occasion.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Eight staff members were consulted to determine their views on the quality of care within Clandeboye.

Some staff comments were as follows:

"I love working here, however, there have been a few staffing difficulties lately and there is a lot of agency staff in use."
"This is an excellent home to work in, management is so approachable."
"Staffing constraints prevents us from getting our paperwork completed in a timely way."
"The care is good, I enjoy working here."
"If we had more staff, this home would be just perfect."
"I can't complain; I love working here."
"It's such a homely home we all work well together."

Ten staff questionnaires were left in the home to facilitate feedback from staff not on duty on the day of inspection. Five of the questionnaires were returned within the timescale for inclusion in the report. Four of the respondents were either satisfied or very satisfied that care was safe, effective, compassionate and well led. One questionnaire returned expressed dissatisfaction regarding staff shortages and felt, "they had no time to provide good personal care".

Fifteen patients were consulted during the inspection. Some patient comments were as follows:

"I am happy."
"I think it's good here."
"I like the food."
"I have no worries."
"I think we are well looked after."

Three patient representatives were consulted during the inspection. All three patient representatives were very positive in their feedback regarding the care provision in the home. All were confident that their relative was well cared for and that if they had any concerns they would be confident in raising them with the registered manager. Ten relative questionnaires were left in the home for completion. None of the relative questionnaires were returned within the timeframe for inclusion in the report.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the registered 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, the management of activities and communication with staff, relatives and patients.

Areas for improvement

There were no areas for improvement identified in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 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.

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

A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed. Discussion with the 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 Care Standards for Nursing Homes 2015. A copy of the complaints procedure was displayed at the reception area in the home.

A compliments record was maintained to record the compliments received, some compliments observed were as follows;

"Thank you for all you have done for my …"
"Thank you to all the staff for all the lovely care and compassion you have given to our …"

Discussion with the registered manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, regular audits were completed in accordance with best practice guidance in relation to accidents; incidents; complaints; medication; and infection prevention and control. Wound care audits were

maintained; however, as previously stated they were ineffective in quality assuring the management of wounds and focused more on a statistical analysis of numbers and grades of wounds occurring. Care plan audits were also maintained; however, the completed audits were not re checked to ensure compliance. An area for improvement is made in relation to maintaining audits they are effective, meaningful and followed up where issues are identified and in compliance under the regulations.

Staff consulted confirmed that they would be confident in raising any concerns with the home's management. Discussion with the registered 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.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

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. Copies of the reports were available for patients, their representatives, staff and trust representatives. However, they failed to identify and correct the shortfalls identified above. An area of improvement is made under the care standards that the issues raised in this report are identified for monitoring and should evidence the progress made in ensuring the issues raised in this report are addressed in a timely way.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, quality improvement and the management of complaints and incidents.

Areas for improvement

An area for improvement is made under regulation in relation to the management of wound and care record auditing. An area for improvement made under the care standards in relation to ensuring the issues identified during the inspection are monitored and reviewed during the regulation 29 monitoring visits.

	Regulations	Standards
Total number of areas for improvement	1	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Joanne Roy, registered manager, as part of the inspection process. 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) (a) **Stated:** First time **To be completed by:** 30 October 2017	The registered person shall ensure that at all times suitably qualified, competent and experienced persons are working at the nursing home in such numbers and skill mix as are appropriate for the health and wealth of patients. **Ref: Section 6.4**
	Response by registered person detailing the actions taken: All residents dependencies are reviewed at least on a monthly basis and more often if dependency changes. Staffing levels and skill mix reflect the dependencies of the current residents in the home. All staff receive a comprehensive induction when commencing in post and competancies are all up to date. Competancies will be monitored through the monitoring process.
Area for improvement 2 **Ref:** Regulation 12 (1) (b) **Stated:** First time **To be completed by:** 30 October 2017	The registered person shall ensure that all patients identified as having a wound or pressure ulcer shall have their wounds managed in accordance with NICE guidance in relation to practice and record keeping. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: Those residents that have an identified wound or pressure ulcer all have a documented initial wound assessment and comprehensive care plan in place. Compliance is being monitored on a weekly basis by the Home Manager and evidenced on the Datix system. All nurses have received further training and supervision on accountability and documenation required for good practice.
Area for improvement 3 **Ref:** Regulation 15 (2) **Stated:** First time **To be completed by:** 30 October 2017	The registered person shall ensure that care records are kept under review and revised at any time when it is necessary to do so having regard to any change of circumstances. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: All care files have had an audit completed. All actions raised as the result of the audits are currently being addressed by nursing staff. A full matrix is now in place to establish when the 6 month audit is due. Any resident returning from a period in hospital has their file audited within 48hrs of return

Area for improvement 4 **Ref:** Regulation 13 (1) **Stated:** First time **To be completed by:** 30 October 2017	The registered person shall ensure that the delivery of urinary catheter care is maintained in accordance with best practice and that all appropriate records are available for inspection. **Ref: Section 6.5**
	Response by registered person detailing the actions taken: Care files of all residents with urinary catheters in place have a full audit completed and any deficits found have been addressed. Each of these residents has a fluid balance chart in place which is being completed as per policy and best practice. These booklets are being spot checked daily by the HM or designated person. Care Staff have had supervision regarding the accurate maintenance of supplementary charts.
Area for improvement 5 **Ref:** Regulation16 (1) (b) **Stated:** First time **To be completed by:** 30 October 2017	The registered person shall ensure that the identified care record is updated to reflect the patients care needs. Care plans should always be completed in a timely way following their admission to the home.
	Response by registered person detailing the actions taken: The identified care record is now fully updated and reflects the residents care needs. This will be monitored through the audit process.
Area for improvement 6 **Ref:** Regulation 17 **Stated:** First time **To be completed by:** 30 November 2017	The registered person shall ensure that wound care and care record audits they are effective, meaningful and followed up where issues are identified and in compliance under the regulations. **Ref: Section 6.6**
	Response by registered person detailing the actions taken: The registered person is reviewing wound documentation on a weekly basis and signing to evidence the review. The internal datix system is being updated to evidence compliance. This will be monitored by the RM.

<table>
<tr><th colspan="2">Action required to ensure compliance with The Care Standards for Nursing Homes (2015).</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 6

Stated: Second time

To be completed by:
30 October 2017</td><td>The registered provider should review the provision of the nurse call system in bedrooms where patients are being nursed in bed.

Ref: Section 6.4</td></tr>
<tr><td>Response by registered person detailing the actions taken:
The Registered provider has reviewed all the residents who are currently either nursed in bed or choose to remain in their bedroom and all have a nurse call lead where appropriate. If there is an identified risk in place, then a risk assessment will be in place in residents file which will evidence discussions with the appropriate persons</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 4

Stated: First time

To be completed by:
30 October 2017</td><td>The registered person shall ensure that the evaluations of care are meaningful and accurately reflects the appropriateness of the care plan.

Ref: Section 6.4</td></tr>
<tr><td>Response by registered person detailing the actions taken:
All Staff who complete evaluations of care have had training and supervision with regards to their accountability with their completion of care records. This will be monitored through the auditing process.</td></tr>
<tr><td rowspan="2">Area for improvement 3

Ref: Standard 35

Stated: First time

To be completed by:
30 October 2017</td><td>The registered person shall ensure that the issues identified during the inspection are considered during the unannounced monthly monitoring visits by the senior management team; thus ensuring that improvements are made and appropriately sustained.

Ref: Section 6.7</td></tr>
<tr><td>Response by registered person detailing the actions taken:
The quality improvement plans resulting from all inspections will be reveiwed by the Regional Manager during their monthly visit. Evidence of compliance will be monitored and documented to ensure improvements are sustained and maintained.</td></tr>
<tr><td rowspan="2">Area for improvement 4

Ref: Standard 4

Stated: First time

To be completed by:
30 October 2017</td><td>The registered person shall ensure that supplementary care records are maintained accurately so as to inform of the wellbeing of the patients.

Ref: Section 6.5</td></tr>
<tr><td>Response by registered person detailing the actions taken:
All staff completing supplementary charts have received refresher training and undergone supervisions regarding the completion of these charts. Compliance is being monitored daily by the Home Manager or designated person</td></tr>
</table>

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

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