Colinvale Court
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Unannounced Care Inspection
of
Colinvale Court

07 September 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 7 September 2015 from 10.30 to 14.30 hours in response to concerns which had been brought to the attention of RQIA by the commissioning Trust.

On the day of the inspection, concerns and areas of improvement were identified and are required to be addressed to ensure that care in the home is safe, effective and compassionate.

Following the inspection, RQIA served four Failure to Comply Notices in relation to Colinvale Court in terms of Regulation 10 (1), Regulation 12 (1) (a) (b), Regulation 13 (1) (a) (b) and Regulation 20 (1) (a) of The Nursing Homes Regulations (Northern Ireland) 2005. In addition, a Notice of Proposal to impose conditions on the registration of Colinvale Court was issued in respect of noncompliance with the aforementioned regulations. Refer also to section 1.2 below.

The inspection also sought to assess progress with the requirements and recommendations made at the last inspection. As a result of this inspection one requirement was not met and has been subsumed into a failure to comply notice. Of the eight recommendations made at the previous inspection, three recommendations were not met and have been subsumed into a failure to comply notice. One recommendation was not met and was stated for a second time and four recommendations made during the previous inspection were not reviewed and have been carried forward for review at the next inspection.

These recommendations relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 12 August 2015.

1.2 Actions/Enforcement Resulting from this Inspection

As a result of this inspection, RQIA were concerned that the quality of care and service provided by Colinvale Court was below the minimum standard expected. Following consultation with senior management in RQIA, it was agreed that a meeting would be held with the registered person with the intention of issuing four Failure to Comply Notices. The Failure to Comply Notices relate to governance and management arrangements, the competence of the registered nursing staff to deliver safe and effective care, the quality of nursing care and the health and welfare of patients. In addition, RQIA also sent correspondence to the registered provider stating its intention to issue a Notice of Proposal to impose conditions on the registration of the home.

A meeting was held on 11 September 2015 at the offices of RQIA. As a result four Failure to Comply Notices were issued. The date by which compliance must be achieved for the Notices issued under Regulation 10 (1) and Regulation 20 (1) (a) is 1 October 2015.

The date by which compliance must be achieved for the Notices issued under Regulation 12 (1) (a) (b) and Regulation 13 (1) (a) (b) is 15 October 2015. Follow up inspections will be undertaken to assess compliance.

In addition a Notice of Proposal to place conditions on the registration of the home was issued to the registered person. The following conditions are proposed:

1. *There will be no new admissions to the home until RQIA is satisfied that there are robust governance and management arrangements in place, and there is compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes April 2015.*

2. *In the absence of a registered manager, the registered person must ensure that a nurse manager with sole responsibility for Colinvale Court, is working in the home. The nurse manager must take control of the delivery of care to patients and the day to day management of the home.*

3. *The registered person must ensure that regulation 29 monthly reports and copies of any other monitoring reports are provided to RQIA within three working days of the visits/reports having been completed. This condition will continue until RQIA is satisfied that the home is operating in sustained compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes April 2015.*

Following the inspection RQIA contacted the commissioning Trust to apprise them of the inspection findings. In particular, concerns were shared regarding the care of four identified patients. The Trust representative agreed to conduct urgent multi-disciplinary care reviews for these four patients. In addition, they have advised RQIA that they will contact all patients' representatives to inform them of the concerns identified. The commissioning Trust were also informed of the outcomes following the meeting on 11 September 2015.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**0**	**5**

As outlined previously, one requirement was not met and has been subsumed into a failure to comply notice. Of the eight recommendations made at the previous inspection, three recommendations were not met and have been subsumed into a failure to comply notice. One recommendation was not met and was stated for a second time and four recommendations made during the previous inspection were not reviewed and have been carried forward for review at the next inspection.

The details of the Quality Improvement Plan (QIP) within this report were discussed with Geetha Rajappan, acting manager and Mr Raymond Murphy, registered provider, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Mr Raymond Liam Murphy	**Registered Manager:** Stephanie Shannon (not currently working in the home)
Person in Charge of the Home at the Time of Inspection: Mrs Geetha Rajappan (acting manager)	**Date Manager Registered:** 1 April 2005
Categories of Care: NH-DE	**Number of Registered Places:** 50
Number of Patients Accommodated on Day of Inspection: 34	**Weekly Tariff at Time of Inspection:** £593 per week

3. Inspection Focus

An unannounced inspection was undertaken on 7 September 2015 as a result of concerns which had been brought to the attention of RQIA by the commissioning Trust. These included concerns regarding the governance and management arrangements, the competency of a number of registered nursing staff and the quality of nursing care which was impacting on the health and welfare of patients.

It is not the remit of RQIA to investigate complaints made by or on behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a potential breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; which in this case, resulted in an inspection of the home.

Following discussion with senior management, it was agreed that the inspection would focus on the following areas:

- Management and governance arrangements
- Staffing, staff competence and staff supervision arrangements
- Quality of nursing care provided to patients

The inspection also sought to assess progress with the issues raised during and since the previous inspection.

4. Methods/Process

Specific methods/processes used in this inspection include the following:

- discussion with the acting manager
- discussion with the registered provider
- discussion with staff
- discussion with patients

- observation during an inspection of the premises
- evaluation and feedback

The inspectors met with seven patients individually and with the majority of others in groups, three care staff, three registered nursing staff and three ancillary staff.

Prior to inspection the following records were analysed:

- review of the previous care inspection report and QIP
- record of issues raised with RQIA via the duty system
- incident reports submitted in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005.

The following records were examined during the inspection:

- the staff duty rota
- care record audits
- four patient care records and other care documentation
- menu planner for patients.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of Colinvale Court was an unannounced care inspection on 12 August 2015. The completed QIP is due for return on 29 September 2015.

5.2 Review of Requirements and Recommendations from the last care Inspection

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: **Ref**: Regulation 16 (1) and 16 (2) (b) **Stated:** First time	The registered person must ensure that nursing care records are revised as and when patients' needs change. **Action taken as confirmed during the inspection**: The timescale for the achievement of compliance with this requirement was the 11 September 2015 and therefore had not been reached at the time of this inspection. However, a review of four patient care records identified that risk assessments and care plans were either not in place, not sufficiently reviewed in response to the changing needs of patients or contained conflicting information. This was impacting on the care delivery to patients at the time of the inspection. For further information on records and record keeping please refer to section 5.3.4.	**Not Met and subsumed into a Failure to Comply Notice**

	This requirement has not been met and has been subsumed into a Failure to Comply Notice.	
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 18.6 **Stated:** First time	Evidence should be present in nursing care records that the use of a restrictive practice is in accordance with best practice guidelines. Nursing care records should evidence the reason for the restrictive practice, monitoring and the regular evaluation.	**Not Met and subsumed into a Failure to Comply Notice**
	Action taken as confirmed during the inspection: The timescale for the achievement of compliance with this recommendation was the 30 September 2015 and therefore had not been reached at the time of this inspection. However, a review of care records evidenced that progress had not been made to improve record keeping in regards to restrictive practice. This was impacting on the care delivery to patients at the time of the inspection. This recommendation has not been met and has been subsumed into a Failure to Comply Notice.	
Recommendation 2 **Ref**: Standard 4.3 **Stated:** First time	Patients' life story information should be developed and readily available to enable staff to engage with patients' in a meaningful way. Staff should action the decisions made with families and health care professionals to develop life story books.	**Carried forward for review at the next inspection**
	Action taken as confirmed during the inspection: The timescale for the achievement of compliance with this recommendation was the 30 September 2015 and therefore had not been reached at the time of this inspection. This recommendation was not reviewed. This recommendation will be carried forward for review at the next inspection.	

Recommendation 3 **Ref**: **Ref**: Standard 26.5 & 25.6 **Stated:** First time	Staff should follow agreed strategies to support patients who display distressed reactions. When recording in respect of distressed reactions, staff should accurately describe the behaviour, staff interventions, if any, and the patient's response to care interventions. Staff should not generalise displayed behaviours when recording, for example, stating 'in bad form'.	**Carried forward for review at the next inspection**
	Action taken as confirmed during the inspection: The timescale for the achievement of compliance with this recommendation was the 30 September 2015 and therefore had not been reached at the time of this inspection. This was not examined at the inspection. This recommendation will be carried forward until the next inspection.	
Recommendation 4 **Ref**: Standard 4.1 **Stated:** First time	A detailed plan of care should be generated from a comprehensive, holistic assessment from the time of admission and completed within five days of admission to the home.	**Carried forward for review at the next inspection**
	Action taken as confirmed during the inspection: The registered provider confirmed that they had voluntarily closed to admissions in agreement with the commissioning Trust. Following a meeting with the registered provider at RQIA on 11 September 2015 a Notice of Proposal was issued formally requiring the registered provider to cease all admissions to the home until further notice. Records in relation to new admissions were not examined during this inspection. This recommendation will be carried forward until the next inspection.	
Recommendation 5 **Ref**: Standard 12.20 **Stated:** First time	Dining arrangements in the two units currently in use, Beech and Oak, should be reviewed to ensure patients have the opportunity to sit at the dining table, if they wish to. The number of patients per lounge/dining room should be reviewed to ensure the area has the capacity to accommodate 15 plus patients.	**Not Met**
	Action taken as confirmed during the inspection:	

	There was no evidence that the dining arrangements had been reviewed to ensure that all patients could be accommodated at the dining table should they wish to be. The majority of patients had their meals served on tables pushed up to their seats in the lounge. This recommendation has not been met and has been stated for the second time.	
Recommendation 6 **Ref**: Standard 4.9 **Stated:** First time	Staff should be explicit when recording the personal care afforded to patients, at any given time. Care records, including personal care charts, should evidence the actual care given.	**Carried forward for review at the next inspection**
	Action taken as confirmed during the inspection: Personal care charts for patients were not examined at this inspection. However, the general standard of presentation of the patients fell below the standard expected. Please refer to section 5.3.3 for further information. This recommendation will be carried forward for review at the next inspection.	
Recommendation 7 **Ref**: Standard 35.6 **Stated:** First time	Quality audits, for example, an audit of nursing care records, should evidence the remedial action taken when a shortfall has been identified. Evidence should also be present to confirm management have verified that the remedial action had been completed.	**Not Met and subsumed into a Failure to Comply Notice**
	Action taken as confirmed during the inspection: Care record audits for August, completed by the acting manager, identified shortfalls. These had been referred to the primary nurses to address but the primary nurses had not signed the audit or indicated that action had been taken to address the deficits identified. An examination of the care records further evidenced that remedial action had not been taken to address issues identified, such as, completing or updating risk assessments or completing or updating care plans. This recommendation has not been met and has been subsumed into a Failure to Comply Notice.	

Recommendation 8 **Ref:** Standard 35.6 **Stated:** First time	Management should ensure that a robust system for monitoring the tasks/work allocated to staff has been completed to a satisfactory standard, should be in evidence.	**Not Met and subsumed into a Failure to Comply Notice**
	Action taken as confirmed during the inspection: The standard of cleanliness in the home was found to have fallen below the expected standard. It was evident that the system for allocating duties to staff was insufficiently robust to ensure a satisfactory standard. Please refer to section 5.3.1 for further information. This recommendation has not been met and has been subsumed into a Failure to Comply Notice.	

5.3 Areas examined

5.3.1 Management and Governance Arrangements

The registered manager is not currently working in Colinvale Court and the acting manager Mrs Geetha Rajappan confirmed her intention to return to her substantive post within the next two weeks. The registered person indicated that plans were underway to secure the appointment of a new manager by 21 September 2015. However, at the meeting on 11 September 2015 the registered provider confirmed that he had been unable to secure this appointment.

A safeguarding investigation remains ongoing in relation to Colinvale Court. As a result of this investigation information in relation to the competency of a number of the registered nursing staff was shared with RQIA by the commissioning Trust and it was confirmed that this issue is being dealt with under separate cover. During the inspection on 7 September 2015 RQIA also identified issues in relation to the competency of staff and their ability to deliver safe and effective care. There was limited evidence that the registered nurses on duty recognised the needs of patients, were proactively addressing them or directing patient care. Registered nurses on duty failed to identify the needs of patients in relation to personal care, nutrition and hydration and wound care.

The cleanliness of the home had fallen below the standard expected. The floors and walls of a number of patients' bedrooms were not clean and there were malodours evident in a number of patients' bedrooms and bathrooms. In one bathroom the toilet was found to be soiled, the surface of the bath compromised and the sink outlet rusted. Dining room chairs were found to have a build-up of food waste and the fridges in the dining areas were not clean.

It was concerning that these issues had not been identified or addressed by management. The condition of the environment was further symptomatic of the lack of management oversight and the absence of robust governance systems. A recommendation which had been made in this regard at the last inspection has been subsumed into a Failure to Comply Notice.

RQIA are concerned that the current management arrangements are not sufficient to ensure the required improvement in patient care outcomes. Following this inspection a Failure to Comply Notice was issued under Regulation 10 (1) of the Nursing Homes Regulations (Northern Ireland) 2005.

5.3.2 Staffing

As previously stated a safeguarding investigation is ongoing in relation to Colinvale Court. As a result of this investigation information in relation to the competency of a number of registered nursing staff was shared with RQIA. During the inspection on 7 September 2015 RQIA also identified issues in relation to the competency of staff to deliver safe and effective care. Please refer to section 5.3.1 for more information.

In one instance one of the inspectors requested that a patient's wound dressing, which was overdue and in a poor condition, be renewed that day. The registered nurse advised that they may not have sufficient time during their shift to attend to this. There were three registered nurses on duty at the time. However, there was no evidence of team work or reallocation of duties to ensure that patients' needs were met.

Following this inspection a Failure to Comply Notice was issued under Regulation 20 (1) (a) of the Nursing Homes Regulations (Northern Ireland) 2005.

5.3.3 Quality of nursing care

Out of 34 patients accommodated on the day of the inspection, 11 were being nursed in bed. The explanations given for this varied. Care staff stated that some of the patients prefer to rise later in the morning. However, it was later identified that these patients had missed their breakfast and had only been offered tea and biscuits on rising.

The acting manager and staff confirmed that three of these patients were waiting for seating assessments by the Occupational Therapist (OT) from the commissioning Trust. However, there was no evidence that referrals for seating assessments had been made or followed up. In one instance a care assistant stated that one of the patient's awaiting a seating assessment had been nursed in bed for a period of approximately two months. Current best practice would indicate that nursing patients in bed for extended periods may be detrimental to their health and welfare. It was concerning that referrals to allied health professionals were either not completed, carried out in a timely manner, or followed up to ensure the needs of patients were being met.

Concerns were also identified in relation to the condition of one patient. A review of the patient's care records confirmed that over recent weeks there were numerous changes to the patient's health. The changes in health were being managed individually and there was no evidence that staff recognised the overall deterioration in the patient's health. Nor was there evidence that appropriate onward referrals were being made.

During an estates inspection undertaken on 18 August 2015 an issue in relation to a mechanical hoist had been identified and the hoist had been removed until such times as it had been replaced or repaired. Staff confirmed during discussion that the hoist had not been repaired and that only one hoist was available for patient transfers.

Staff also confirmed that as a result of this, patients would be required to wait until the hoist was free before they could be transferred. During the meeting with RQIA on 11 September 2015 the registered provider confirmed that two new hoists had been purchased and were now available for patient transfers.

The planned menu was not being followed. Catering staff advised that the planned menu was under review. However, nursing staff had not been consulted as part of the review. In addition, reference had not been made to current best practice guidance in relation to menu planning in a nursing home setting. Records of food being served were not being retained in sufficient detail to determine the food and fluid intake of each patient. During the meeting with RQIA on 11 September 2015 the registered provider confirmed that some action had been taken to address these issues.

There was no evidence of fluids being made available to patients outside of meal times and several patients were observed to have dry and cracked lips. The serving of the mid-morning snack was observed and patients were offered either tea or milk with biscuits. No juice or water was provided and there were no options made available for patients on a modified diet.

Patients were observed to be unkempt and greater attention was required in regards to nail care, mouth care, hair care, shaving and clothing choice. It was noted that some patients remained in pyjama bottoms with only their top half appropriately dressed. Some patients' clothing was soiled, mismatched, ill-fitting and/or worn. Another patient's incontinence pad was clearly visible above the waistband of their trousers, with limited evidence of attention being paid to their dignity.

A number of additional care practices were also observed in which staff failed to demonstrate the appropriate level of dignity and respect for patients.

Following this inspection a Failure to Comply Notice was issued under Regulation 12 (1) (a) and (b) of the Nursing Homes Regulations (Northern Ireland) 2005.

5.3.4 Health and welfare of patients

A review of the care records of two patients observed to have wounds was undertaken. This identified a number of concerns in relation to the management of wound care. Dressings for both patients were observed to be in a poor condition. On reviewing the care records it was confirmed that both of the patients had been assessed by the commissioning Trust tissue viability nurse specialist and care prescribed. However, there was a lack of evidence that the dressings were being carried out in accordance with the prescribed frequency. In addition records in relation to wound care were being retained in three different locations making it difficult to ascertain when the wound care had been delivered. The records did not reflect the current condition of the wounds at each dressing change or the condition of the dressings on a daily basis.

Evidence that best practice in relation to potentially restrictive practices had been adhered to was not available in a number of care records reviewed. Although a risk assessment was carried out for the use of bed rails there was no documentary evidence of consent/discussion with the next of kin or care manager in relation to the use of bed rails or other potentially restrictive devices, such as pressure mats. There was no evidence of multi-disciplinary consultation in the decision making processes in relation to the use of these devices.

A recommendation made in this regard at the last inspection has been subsumed into a failure to comply notice.

A review of care records evidenced that risk assessments and care plans were either not in place, not sufficiently reviewed in response to the changing needs of patients or contained conflicting information.

For example, in one patient record examined there were two care plans in place both referring to the frequency of nightly checks. One stated that these should be conducted half hourly the other hourly. In the same care record the patient was assessed as requiring supervision when mobilising and the care plan stated the patient was independent. In another patient care record the patient's care plan was not updated to reflect a recent deterioration in their mobility.

Poor quality copies of risk assessments were also evident rendering these illegible. As a result of this the reader was unable to determine the patients' assessed needs.

The folders of the patient care records examined were broken and required replacement. Poor archiving of information in the patient care records resulted in the files being overly cumbersome. As a result of these issues RQIA were concerned that nursing staff would not be able to establish the needs of patients to ensure the delivery of safe and effective care.

It is of concern that assessments of need, nursing care records, nursing interventions and instructions from allied health professionals were not completed or followed up in a timely manner to ensure the needs of patients were being met.

Following this inspection a Failure to Comply Notice was issued under Regulation 13 (1) (a) and (b) of the Nursing Homes Regulations (Northern Ireland) 2005.

5.3.5 Comments of patients and staff

As part of the inspection process patients and staff were consulted. No patients' representatives were available for consultation at the inspection.

Patient comments

The majority of the patients were unable to communicate verbally with the inspectors. A number of patients did chat to the inspectors and were found to be cheerful and content. One patient commented that the food was very good.

Staff comments

Staff spoken with were generally happy working in the home. One care assistant stated that they were sometimes short staffed but they worked well as a team. Another care assistant was undertaking her induction to the home and commented that the other staff were helping her to settle in. No concerns were raised.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP.

Details of this QIP were discussed with Mrs Geetha Rajappan, acting manager and Mr Raymond Murphy, registered provider, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/acting 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/acting 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.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

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

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/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. 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 weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that any requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 4.3 **Stated:** First time **To be Completed by:** 30 October 2015	**Carried forward from previous inspection** Patients' life story information should be developed and readily available to enable staff to engage with patients' in a meaningful way. Staff should action the decisions made with families and health care professionals to develop life story books.
	Response by Registered Person(s) Detailing the Actions Taken: The management and nursing team has compiled a detailed record of the residents life story information for all residents within the home, these are available for any interested parties or professional bodies. The information contained in the life stories has been created with input from patients, families, staff and other health care professionals. this is being updated on an ongoing basis as and when appropriate and the information is being used to enhance the personal and daily living care of each individual resident. It is the intention of the home to audit the life story record of each individual, on a monthly basis and as part of the overall care plan audit.
Recommendation 2 **Ref**: Standard 4.1 **Stated:** First time **To be Completed by:** 30 October 2015	**Carried forward from previous inspection** Staff should follow agreed strategies to support patients who display distressed reactions. When recording in respect of distressed reactions, staff should accurately describe the behaviour, staff interventions, if any, and the patient's response to care interventions. Staff should not generalise displayed behaviours when recording, for example, stating 'in bad form'.
	Response by Registered Person(s) Detailing the Actions Taken: Staff meetings have been held recently with all nursing staff and healthcare employees, where they have been informed of the need to provide greater detail and accurate documentation in relation to challenging behaviour. This will be carried out by way of behavioural charts, careplans and nursing notes. It is intended that all staff members will utilise their knowledge of individual life stories of the residents, as this will assist in determining the appropriate interventions required for the behaviour of the individual resident. To further support this we can confirm that the appropriate documents are available to assist professional bodies such as dementia outreach teams, psychogeriatrican GP etc. in the assessment and treatment of Individual residents. This documentation will be reviewed daily by staff nurse on duty and further audited monthly by management.

Recommendation 3 **Ref**: Standard 4.1 **Stated:** First time **To be Completed by:** 30 October 2015	**Carried forward from previous inspection** A detailed plan of care should be generated from a comprehensive, holistic assessment from the time of admission and completed within five days of admission to the home.
	Response by Registered Person(s) Detailing the Actions Taken: The home is not currently accepting new admissions. However the management team is in the process if compiling a suitable admission pack for nursing staff, which will ensure that the relevant timelines are strictly adhered to for the comprehensive holistic assessment. This includes the necessary detail being recorded within the five days of admission thus enabling nursing and care staff to identify any significant needs of a new resident. The management team will review the admission file of all new residents within 7 days of admission and sign off appropriate documentation
Recommendation 4 **Ref**: Standard 4.9 **Stated:** First time **To be Completed by:** 30 October 2015	**Carried forward from previous inspection** Staff should be explicit when recording the personal care afforded to patients, at any given time. Care records, including personal care charts, should evidence the actual care given.
	Response by Registered Person(s) Detailing the Actions Taken: Since the date of the inspection all care plans have been reviewed and updated,a careplan audit is bering carried out by management weekly. All staff have been informed of the importance of record keeping including all personal care charts. The staff nurse on duty will sign the documentation at the end of each shift and it has been emphasised at recent staff meetings, the responsibility of the staff nurse on duty to monitor and ensure that all documentation regarding personal care is maintained accurately. Further training is currently being sourced to enhance the input by care staff and nursing staff, thus enabling us to achieve a high standard of care documentation
Recommendation 5 **Ref**: Standard 12.20 **Stated:** Second time **To be Completed by:** 30 October 2015	Dining arrangements in the two units currently in use, Beech and Oak, should be reviewed to ensure patients have the opportunity to sit at the dining table, if they wish to. The number of patients per lounge/dining room should be reviewed to ensure the area has the capacity to accommodate 15 plus patients.
	Response by Registered Person(s) Detailing the Actions Taken: a full review of the dining arrangements in colinvale has been carried out, with the input from both staff residents and familiesA decision has been agreed to convert the dayroom in beech unit into a central dining aarea for the majority of residents at meal times.to safeguard against any undue congestion. this action is ongoing currently and being monitored daily for any improvement or issues arising to be dealt with as quickly as possible

Registered Manager Completing QIP	.vincy vincent	**Date Completed**	5/11/15
Registered Person Approving QIP	raymond murphy	**Date Approved**	5/11/15
RQIA Inspector Assessing Response	Karen scarlett	**Date Approved**	3/12/15

Please provide any additional comments or observations you may wish to make below:

Please complete in full and returned to Nursing.Team@rqia.org.uk from the authorised email address