Unannounced Care Inspection Report
19 May 2016

Edgewater Lodge

Address: Copeland and Lighthouse Suites, 4 Sunnydale Avenue, Donaghadee, BT21 0LE
Tel No: 028 9188 8044
Inspector: Heather Sleator

1.0 Summary

An unannounced inspection of Edgewater Lodge took place on 19 May 2016 from 10.00 to 17.00 hours. Edgewater Lodge has two separate registrations. Copeland and Lighthouse units are within one registration and Orlock and Seaview units comprise the remaining registration. Management, management systems and staffing arrangements for all four units are centralised in the home and staff may move between units depending on patients' needs and the staffing levels in a unit at any given time.

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?

Since the last care inspection in March 2016, management confirmed that they had successfully recruited a number of permanent staff and the use of agency staff across staff grades and all shifts, particularly night duty, had been greatly reduced. Recruitment does however, remain an on-going process. The positive impact of the recruitment efforts on the delivery of care and the patients' experience was evidenced through discussion with patients and relatives, observation of care delivery and review of care records. There was a lack of consistency in the delivery of care and the patients' experience and the review of care records between Copeland and Lighthouse units. Weaknesses were evident in the environment of Lighthouse unit from a dementia perspective, for example: lack of orientation and visual cues.

Some weaknesses in the delivery of dementia care were identified. Requirements and recommendations were made to drive improvements, as detailed in section 4.3

Is care effective?

Review of four patient care records evidenced that registered nurses assessed, planned, evaluated and reviewed care in accordance with Nursing and Midwifery Council (NMC) guidelines. One record reviewed had not been completed as consistently and in accordance with NMC guidelines. A recommendation has been made in relation to a systematic and robust approach to the auditing of care records and also the safe storage of records, in particular the supplementary records maintained by care staff.

The observation of the midday meal in Lighthouse unit did not evidence best practice in dementia care regarding the dining experience for patients. Staff require support and guidance to ensure the dining experience for patients is enjoyable and meaningful.

The majority of patients and relatives spoken with expressed their confidence in raising concerns with the home's staff or management. Two relatives spoke with the inspector in Copeland unit and expressed their support and praise for the staff.

Is care compassionate?

Staff interactions with patients in Copeland unit were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect; and call bells were answered promptly. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. This knowledge and attentiveness by staff was confirmed in discussion with two relatives. Significant areas for improvement have been identified regarding dementia care and practice in Lighthouse unit and are detailed in sections 4.3, 4.4 and 4.5 of this report.

Systems were in place to obtain the views of patients, patient relatives/representatives and staff on the running of the home. For example, the manager had commenced staff meetings, relatives meetings and completes the Four Seasons Health Care quality of life indicators on a daily basis. In the short time the manager has been in the home improvements have been made. However, weaknesses were in evidence regarding the delivery of dementia care and practice at the time of the inspection.

Is the service well led?

There was evidenced of systems and processes in place to monitor the delivery of care and services within the home. However, requirements and recommendations have been stated in the sections relating to the safe, effective and compassionate delivery of care to seek compliance and drive improvements.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	3	4

Details of the QIP within this report were discussed with Vera Ribeiro, applicant manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

1.2 Actions/enforcement taken following the most recent care inspection

The most recent inspection of the home was an unannounced care inspection. 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, 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 Dr Claire Royston	**Registered manager:** Vera Ribeiro (applicant manager)
Person in charge of the home at the time of inspection: Vera Ribeiro	**Date manager registered:** Registration Pending
Categories of care: NH-DE, NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 37

3.0 Methods/processes

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

Prior to inspection the following information was analysed:
- 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 returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with 15 patients, five care staff, ancillary staff, two registered nurses and two patient's representatives.

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 inspectors.

Questionnaires for patients, relatives and staff were left for the home manager to distribute. Please refer to section 4.5 for further comments in respect of questionnaires.

The following were examined during the inspection:
- validation evidence linked to the previous QIP
- staff roster
- staff training records
- staff induction records
- staff competency and capability assessments
- staff recruitment records
- staff supervision and appraisal planner
- complaints and compliments records
- incident and accident records
- records of quality audits and
- records of staff, patient and relatives meetings

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 9 February 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. Areas to be followed up included; wound care management, quality auditing of the environment and in respect of infection prevention and control procedures and the completion of supplementary care records/charts. Please refer to section 4.2 for further information.

4.2 Review of requirements and recommendations from the last care inspection dated 9 February 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 12 (1)(a)(b) **Stated:** First time	The registered person shall ensure that any patients with pressure areas/wound management needs, has care and treatment delivered in accordance with their identified regime of care. All records pertaining to this area of practice should be updated and reviewed as required.	**Met**
	Action taken as confirmed during the inspection: A review of two patient care records evidenced that wound care management was undertaken and recorded in accordance with best practice (NICE) guidelines.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 39 **Stated:** Second time	It is recommended that the registered person ensures that all grades of staff receive training on the following; 1. Palliative / End of life care 2. Breaking bad news communication skills.	**Met**
	Action taken as confirmed during the inspection: Information supplied by the manager regarding palliative and end of life care training for staff was that 35% of staff in the home have either completed online training or attended face to face training in following the inspection of May 2015. Training has been scheduled for the 15th and 20th June 2016.It is anticipated that by the end of June the majority of staff will have completed this training.	

Recommendation 2 **Ref:** Standard 44 **Stated:** First time	It is recommended that an environmental/infection control audit is conducted to ensure the home is well maintained in accordance with infection prevention and control best practice and actions are recorded accordingly. A copy of the action plan should be submitted with the QIP. In addition, the issues identified at this inspection should be actioned appropriately.	**Met**
	Action taken as confirmed during the inspection: An environmental audit which included infection prevention and control measures was completed. The audit identified a number of vanitory units, in patients' bedrooms which required replacement. A programme of replacement was commenced and to date 11 units have been replaced.	
Recommendation 3 **Ref**: Standard 40 **Stated:** First time	It is recommended that staff are supervised and their performance appraised to promote the delivery of quality care and services in accordance with the homes company policy and guidance referred to in the DHSSPS Care Standards for Nursing Homes, April 2015.	**Met**
	Action taken as confirmed during the inspection: A programme annual appraisal and staff supervision had recently commenced. Refer to section 4.3 for further information.	
Recommendation 4 **Ref**: Standard 23 **Stated:** First time	It is recommended that repositioning charts contain documented evidenced that a skin inspection of pressure areas has been undertaken at the time of each repositioning and comments recorded reflect the actual condition of the skin.	**Met**
	Action taken as confirmed during the inspection: Repositioning charts of patients in both Copeland and Lighthouse suites were reviewed. Records evidenced that staff were reporting on the condition of patients' skin at the time of each repositioning.	

4.3 Is care safe?

The home 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 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. Staffing levels therefore may increase or decrease depending on the patient occupancy levels in each unit. The manager also stated that they were actively recruiting nursing and care staff so as to reduce the number of agency staff hours to facilitate the continuity of care. In addition to nursing and care staff staffing rosters it was confirmed that administrative, maintenance, catering, domestic and laundry staff were on duty daily. Staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. Staff also stated that staffing levels were sufficient as long as the full complement of staff rostered to work were present; refer to section 4.5 for further comment. Relatives commented positively regarding the staff and care delivery.

A review of three personnel files evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. Discussion with the manager and review of records evidenced that the arrangements for monitoring the registration status of registered nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

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. Three completed induction programmes were reviewed. The programmes included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme, the employee and the inductor signed the record to confirm completion and to declare understanding and competence. The manager also signed the record to confirm that the induction process had been satisfactorily completed.

Training was available via an e learning system, internal face to face training arranged by management and training provided by the local health and social care trust. The review of staff training records evidenced that the manager had systems in place to monitor staff attendance and compliance with training. The statistics for completed mandatory training were between 80 to 90 percent however the home manager stated there had been some difficulties regarding the new e learning system and changes in the staff team.

The regional manager reviews and reports on the staff training statistics at the monthly quality monitoring visit. Discussion with the manager, staff on duty and a review of records confirmed that systems had recently been put in place to ensure that staff received an annual appraisal and regular supervision. In discussion staff confirmed that they knew the appraisal and supervision process was recommencing. A recommendation has been made that the planned programme of staff annual appraisal and supervision is viewed as a priority and the manager systematically undertakes and completes staffs annual appraisal and regular recorded supervision.

Staff spoken with in Copeland unit clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility. Observation of the delivery of care in Lighthouse unit evidenced that further training in dementia care practice was required. Please refer to section 4.4 for further information.

The manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. Training records reflected that 88% of staff had undertaken safeguarding training in the past 12 months. Annual refresher training was considered mandatory by the home. A review of documentation confirmed that any safeguarding concern was managed appropriately in accordance with the regional

safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

Four patient care records were reviewed, two from each unit. The review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required in three of the four records. Please refer to section 4.4 for further information regarding patient care records.

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, since the last care inspection in 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 rooms and storage areas. Copeland unit was found to be warm, well decorated, fresh smelling and clean throughout. Lighthouse unit did not evidence the same level of décor and malodours were present. The environment in Lighthouse unit should be an enabling environment for persons with dementia. There was a lack of visual cues for patients, the lounge was not attractive and comfortable and the carpet was stained. The dining room did not provide information and orientation for patients regarding the dining experience. This was concerning and was discussed with the home manager and regional manager who were informed a requirement would be stated that a dementia audit is completed regarding the environment of Lighthouse unit. An action plan should be developed in accordance with the outcome of the dementia audit and the findings of the inspection.

A comprehensive and detailed action plan in respect of the environment and dementia practice was submitted to RQIA by Alana Irvine, regional manager, on 25 May 2016 and was further updated 2 June 2016.

Fire exits and corridors were observed to be clear of clutter and obstruction.

Areas for improvement

A dementia audit is to be completed regarding the environment of Lighthouse unit. An action plan should be developed in accordance with the outcome of the dementia audit and the findings of the inspection.

The planned programme of staff annual appraisal and supervision is viewed as a priority and the manager systematically undertakes and completes staffs annual appraisal and regular recorded supervision.

Number of requirements	**1**	**Number of recommendations**:	**1**

4.4 Is care effective?

A review of four patient care records evidenced that initial plans of care were based on the pre admission assessment and referral information
Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians and palliative care nurse facilitators. Four patient care records were reviewed, two from each unit. A lack of consistency was evident in respect of the completion and maintenance of care records in accordance with NMC guidelines in one of the units. The manager completes audits of patient care records, on a rotational basis, and despite this and as evidenced by the review of patient care records, it is recommended that a robust system regarding the auditing of care records is established until such times as a consistent approach by registered nurses is in evidence. There was evidence that the care planning process included input from patients and/or their representatives, if appropriate

Supplementary care charts were being completed by staff on a regular basis. Repositioning charts evidenced that staff were commenting on the condition of patients' skin at each time of repositioning. Nutritional and fluid intake records also evidenced that they had been completed following mealtimes and at regular intervals throughout the day. We observed the serving of the midday meal and cross referenced the recorded nutritional and fluid intake of a patient who was observed to eat and drink little at midday. This was discussed with the manager who stated that staff will be informed of the importance of accurately recording in patients' nutritional and fluid records.

Staff demonstrated an awareness of the importance of contemporaneous record keeping. A recommendation is stated regarding the patient confidentiality and the storage of records and patient information. Supplementary care records for example; repositioning charts and food and fluid intake charts were observed in the lounge and were accessible to patients and/or visitors. The files were also observed to be in a poor state. A more suitable arrangement for the storage of these records should be established.

Patients and representatives spoken with expressed their confidence in raising concerns with the home's staff/ management. Patients and representatives spoken with were aware of who their named nurse was and knew the management team. One patient stated, "I would go to the nurse first but I've never had any complaints about here."

Discussion with the manager and staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication. Staff spoken with confirmed that the shift handover provided the necessary information regarding any changes in patients' condition. The manager commenced in the home in February 2016 and a staff meeting was held in March 2016. Five staff questionnaires were returned prior to the issue of this report. Two staff respondents stated staff meetings were not held regularly and that records of these meeting were not maintained. A review of the minutes of the staff meeting of March 2016 did not list the staff who had attended. In discussion with the manager it was confirmed that staff meetings would take place regularly, at least quarterly, and that the minutes would be posted in the staff room for those staff who were unable to attend the meeting to access. Staff who attended the meeting would be listed on the minutes, in future. A relatives meeting was held in February 2016. The minutes of the meeting evidenced a number of action points, the majority of which had been addressed by the manager.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Staff also confirmed that if they had any concerns, they would raise these with the manager. Three staff responded by questionnaire and stated they did not feel the manager was approachable if they had a concern nor did the manager promptly address any concerns raised. The establishment of the regular staff meeting forum may facilitate communication between management and staff in the home.

We observed the serving of the midday meal in Lighthouse unit. Whilst the quality of the meals provided was good staff need to improve and enhance the dining experience for patients. The environment of the dining room did not provide any orientation or visual cues for patients, dining tables were not set, a visual choice of meals was not offered and fluids were not managed appropriately. The dining experience for patients should be enjoyable, pleasurable and meaningful. A requirement has been made. The serving of the lunch in Copeland unit was observed to be well organised with all of the patients being attended to in a timely manner. The meals were nicely presented and smelt appetising. All of the patients spoken with enjoyed their lunch. The outlook from the dining room in Copeland and a small number of bedrooms is of the bin area and back of the kitchen. A recommendation has been made that the outside area where patients look directly on is tidied and/or screened to enhance the view for patients.

Areas for improvement

The dining experience for patients must be reviewed, enhanced and is in accordance with professional standards and guidelines and best practice in dementia care.
A robust system regarding the auditing of patients care records should be established and where a shortfall is identified the care record is re-audited to ensure that remedial action had taken place.

Any record which details patient information should be stored safely.

The outside area visible from the dining room and some bedrooms in Copeland unit should be cleared and/or screened off from patients view.

Number of requirements	**1**	**Number of recommendations**:	**3**

4.5 Is care compassionate?

Observations throughout the inspection evidenced that there was a calm atmosphere in the home and staff were quietly attending to the patients' needs.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. Patients in Copeland unit were very responsive to staff and strong relationships were evident. We observed numerous occasions when staff offered patients' choice and took time to find out what the patients wanted when it was not always apparent and patients were unable to express their wishes clearly. Staff were observed responding to a patient, who was unsettled, very skilfully, sensitively and maintained the dignity of the individual. Staff spoken with in both units, were knowledgeable regarding patients likes and dislikes and individual preferences however, as observed, there was a lack of engagement with patients in Lighthouse unit. The lack of engagement was evident through limited conversation or interaction with patients in Lighthouse unit, when sitting in the lounge, assisting patients with their midday meal

or activities of daily living. The inclusion of persons with dementia in all aspects of daily life is paramount and a rolling programme of training in dementia care practice is a requirement of this report. The manager should also establish robust systems to ensure knowledge gained through training is embedded into practice. A recommendation has been stated in section 4.3 regarding this. Greater attention should be given to patients' personal care, particularly in Lighthouse unit. This was discussed with the home manager and who agreed to address this with staff immediately.

The arrangements for the provision of activities in the home were not assessed on this occasion. The home employs two personal activities leaders (PAL's) who work Monday to Friday. At the time of the inspection 11 patients, from all four of the units in the home attended a luncheon club in the local community centre in Donaghadee.

In discussion with the home manager it was confirmed that numerous compliments had been received by the home from relatives and friends of former patients. Thank you cards were displayed in the home and a record is maintained of all compliments which are received.

The following are some comments we received from patients:
'It's very good here.'
'The food is fabulous.'
'I'm never lonely here.'
'Can't speak highly enough of staff.'
'The food is good, there's always an alternative.'

We met with two relatives during the inspection who stated:
'I'm more than happy with (my relative's) care.'
'I can't speak highly enough of the staff.'

Questionnaires

As part of the inspection process we issued questionnaires to staff, patients and patients' representatives. The returned questionnaires were generally positive regarding the quality of nursing and other services provided by the home. Specific comments are detailed below:

The following comments were provided by patients:
'I feel the home is understaffed as on occasion one can be kept waiting, this is not staffs' fault.'
'No one has ever asked my opinion about day to day life in the home.'

The following comments were provided by staff:
'Sometimes there is not enough staff on duty.'
'Sometimes communication isn't so good due to being so busy.'
'I don't think the unit is adequately staffed per dependency of patients.'
'Rarely have team meetings and feel the manager doesn't listen when approached as too busy.'

Patients and staff have commented on staff shortages. The home manager is advised to review and continue to monitor the home's staffing arrangements, in conjunction with the comments and address the issues, where applicable.

Areas for improvement
A rolling programme of dementia specific training must be provided for staff. The training should include all aspects of daily life including for example; understanding dementia, personal care, the dining experience and communication (both verbal and non-verbal)

Number of requirements	1	Number of recommendations:	0

4.6 Is the service well led?

Discussion with the home manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion patients were aware of the roles of other staff in the home and to whom they should speak to if they had a concern.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed.

Staff confirmed that they had access to the home's policies and procedures.

Discussion with the home 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 DHSSPS Care Standards for Nursing Homes 2015.

Representatives spoken with confirmed that they were aware of the home's complaints procedure and that they were confident that staff/management would manage any concern raised by them appropriately.

Discussion with the manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with the 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, audits were completed in accordance with best practice guidance in relation to falls, incidents/accidents. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice

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

Areas for improvement have been identified in the sections discussing the delivery of safe, effective and compassionate care.

Feedback at the conclusion of the inspection was given to Vera Ribeiro, manager and Alana Irvine, regional manager. Ms Irvine had assumed regional responsibility of Edgewater Lodge in February 2016, as had the home manager. Both Ms Ribeiro an Ms Irvine demonstrated their commitment to address the issues identified during the inspection and had also identified a number of areas and were actively seeking to address these, for example; the recruitment and retention of staff and improvements to the environment, for example, redecoration and refurbishment of a number of areas in the home. Ms Irvine stated that the management team of Edgewater were not focusing, at this stage on the occupancy level of the home, rather on the recruitment, development and stablishing of the staff team. As of 9 June 2016 Ms Ribeiro is the registered manager of the home.

Areas for improvement

Three requirements and four recommendations have been made in relation to safe, effective and compassionate care to seek compliance and drive improvements.

Number of requirements	**3**	**Number of recommendations**:	**4**

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Vera Ribeiro, Applicant Manager and Alana Irvine, Regional Manager, 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 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 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 12 (1) (b) and (c) **Stated:** First time	The registered person must ensure the environment of the home; in particular, Lighthouse unit reflects current best practice guidelines for dementia care. A dementia audit should be completed and an action plan developed and implemented based on the findings of the audit. **Ref: Section 4.3**
To be completed by: 30 September 2016	**Response by registered person detailing the actions taken:** A dementia audit has been completed by the Resident Experience Support Manager, this identified changes recommended to enhance the environment to ensure compliance with current best practice guidelines. An action plan has been implemented and is being worked through within an agreed timeframe.
Requirement 2 **Ref:** Regulation 13 (1) (a) and (b) **Stated:** First time	The registered person must ensure that the dining experience for patients, particularly in Lighthouse unit, reflects current best practice guidelines for dementia care. The home manager must ensure staff adhere to best practice guidelines at all times. **Ref: Section 4.4**
To be completed by: 30 September 2016	**Response by registered person detailing the actions taken:** The FSHC Quality Dining Audit has been completed for each unit and an action plan implemented. The dining experience was included in the Resident Experience Training and meals and mealtimes will continue to be observed to ensure a positive dining experience is achieved for our residents and staff adhere to best practice guidelines.
Requirement 3 **Ref:** Regulation 20 (1) (c) (i) **Stated:** First time	The registered person must ensure that an on-going programme of staff training in relation to dementia practice is undertaken by staff and a robust system is established that evidences training undertaken by staff is embedded into practice. **Ref: Section 4.5**
To be completed by: 31 October 2016	**Response by registered person detailing the actions taken:** here has been one training session for staff on person centred care and resident experience training with a second session arranged. The Dementia Care Framework Module on E-learning is being completed by all staff. The Resident Experience Support Manager has been allocated to the home and is working alongside staff to enhance their understanding of dementia to ensure residents assessed needs are met in a person centred manner.

Recommendations	
Recommendation 1 **Ref**: Standard 40 **Stated:** First time **To be completed by:** 30 September 2016	The registered person should ensure that the planned programme of staff annual appraisal and supervision is viewed as apriority and that there is a systematic approach to the completion of the programme of staff annual appraisal and regular recorded supervision. **Ref: Section 4.3**
	Response by registered person detailing the actions taken: Annual appraisals have commenced and a matrix is now in place to identify appraisals completed and those due. A supervision matrix is in place for all staff and sessions consist of both individual and group supervision. These can be in response to identified areas of practice improvement, to increase knowledge and share best practice or as requested by the individual member of staff,
Recommendation 2 **Ref**: Standard 4.10 **Stated:** First time **To be completed by:** 31 August 2016	The registered person should ensure that a robust system regarding the auditing of patients care records is established and where a shortfall is identified the care record is re-audited to ensure that remedial action has taken place. **Ref: Section 4.4**
	Response by registered person detailing the actions taken: There is a system in place to audit residents care records through the FSHC Quality of Life, this will generate an action plan which is allocated to a Registered Nurse to address within an agreed timeframe. On completion of the actions the records are reviewed to confirm all have been addressed appropriately and this will be signed off by the Registered Manager.
Recommendation 3 **Ref**: Standard 37.1 **Stated:** First time **To be completed by:** 31 July 2016	The registered person should ensure that any record retained in the home which details patient information is stored safely and in accordance with DHSSPS policy, procedures and guidance and best practice standards. **Ref: Section 4.4**
	Response by registered person detailing the actions taken: All resident records are stored safely and securely and in keeping with FSHC Information Governance Policy, DHSSPS policy, procedures and guidance and best practice.

Recommendation 4 **Ref**: Standard 44.2 **Stated:** First time	The registered person should ensure that the outside area visible from the dining room and some bedrooms in Copeland unit is cleared and/or screened off from patients view. **Ref: Section 4.4**
To be completed by: 31 July 2016	**Response by registered person detailing the actions taken:** The area referred to has had a new fence erected which has improved the view from the identified windows.

Please ensure this document is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address

The Regulation and Quality Improvement Authority

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