Unannounced Care Inspection Report
20 May 2016

Edgewater Lodge

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

1.0 Summary

An unannounced inspection of Edgewater Lodge (Orlock and Seaview units) took place on 20 May 2016 from 09.40 to 16.30 hours. Edgewater Lodge has two separate registrations. Orlock and Seaview units are within one registration and Copeland and Lighthouse 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?

Management confirmed that they had successfully recruited a number of permanent staff and the use of agency staff across staff grades and all shifts 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 the observation of care delivery. Weaknesses were evident in the environment from a dementia perspective, for example: lack of orientation and visual cues.

Some weaknesses in the delivery of care were identified. Recommendations were made to drive improvements, as detailed in section 4.3.

Is care effective?

The review of patient care records evidenced that registered nurses assessed, planned, evaluated and reviewed care in accordance with Nursing and Midwifery Council (NMC) guidelines. There was one exception and this was in relation to responding to behaviours/ distressed reaction displayed by patients and a requirement regarding staff training has been made. One care record reviewed had not been completed 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. A recommendation has also been made regarding the safe storage of records, in particular the supplementary records maintained by care staff.

The observation of the evening meal in Orlock unit did not evidence best practice in dementia care regarding the dining experience for patients. Support and guidance should be provided to staff to ensure the dining experience for patients is enjoyable and meaningful and a requirement and recommendations have been made.

Is care compassionate?

Systems were in place to obtain the views of patients, patients' relatives/representatives and staff on the running of the home. For example, the manager had commenced staff meetings, relatives meetings and completed the organisations quality of life indicators on a daily basis. In the short time the manager has been in post 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 evidence 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. Requirements and recommendations have been made to seek compliance and drive improvements, as detailed within sections 4.3, 4.4 and 4.5 of the report.

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.

For the purposes of this report, the term 'patients' will be used to described those living in Edgewater Lodge which provides both nursing and residential care.

1.1 Inspection outcome

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

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 inspection

The most recent inspection of the home was an announced estates inspection on 28 July 2015. 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 Healthcare/Dr. Claire Royston	**Registered manager:** Vera Ribeiro (registration pending)
Person in charge of the home at the time of inspection: Vera Ribeiro	**Date manager registered:** Registration Pending
Categories of care: RC-DE, NH-DE	**Number of registered places:** 38

3.0 Methods/processes

Specific methods/processes used in this inspection include the below.

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 10 patients, three care staff, ancillary staff and one registered nurse. There were no relatives who wished to meet with the inspector at the time of the inspection.

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

Questionnaires for patients, relatives and staff to complete and return were left for the home manager to distribute. Please refer to section 4.5 for further comment.

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 28 July 2015

The most recent inspection of the home was an announced estates inspection. The completed QIP was returned and approved by the estates inspector and will be validated at the next estates inspection. There were no issues to be followed up during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 11 May 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 36 **Stated:** First time	It is recommended that the following policy guidance is updated: • Communication policy should include reference to the regional guidance for breaking bad news • The palliative care manual which incorporates palliative and end of life care, death and dying should reference the GAIN Guidelines for Palliative Care and End of Life Care in Nursing Homes and Residential Care Homes November 2013 and the regional guidance on breaking bad news. • The palliative care manual should also be updated in respect of point 12 in the policy of death to record that records are maintained for not less than 6 years in accordance with Regulation 19(2)(4) of the Nursing Homes Regulations (Northern Ireland) 2005.	**Met**
	Action taken as confirmed during the inspection: The review of the palliative and end of life care policies evidenced that the required amendments had been made. The communication policy had been similarly updated. The timeframe within the palliative care manual had been amended.	
Recommendation 2 **Ref:** Standard 39 **Stated:** First time	It is recommended that the registered person ensures that all grades of staff receive training on the following; 1. Palliative / End of life care 2. Breaking bad news communication skills	**Met**
	Action taken as confirmed during the inspection: Information supplied by the home 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 following the inspection of May 2015. Training has been scheduled for the 15th and 20th June 2016. The manager stated it is anticipated that by the end of June the majority of staff will have completed this training.	

4.3 Is care safe?

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 and dependency 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 and to facilitate the continuity of care. In addition to nursing and care staff 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. Relatives' perspective on staffing arrangements is unknown as there were no relatives present at the time of the inspection who wished to meet with us. However, one relative commented positively in the returned questionnaire regarding the staff and delivery of care.

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 home manager had systems in place to monitor staff attendance and compliance with training. The statistics for completed mandatory training were between 80 to 90% and 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 home 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 and were waiting for a date and time to be confirmed by the manager. A recommendation has been made that the systematic completion of the planned programme of staff annual appraisal and supervision is viewed as a priority.

Staff spoken with clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility. Observation of the delivery of care in Orlock 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.

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 quality 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. Orlock unit was being redecorated at the time of the inspection. New flooring, curtains and soft furnishing had been purchased. The redecoration had enhanced the appearance of the unit. Discussion with the home manager and regional manager informed that they were aware of the need to upgrade the environment, particularly in Orlock suite and the process had commenced. A malodour was present in one area of the unit; the area was identified to the home manager. The environment of Seaview unit was not assessed, on this occasion, to the same extent as the remaining three registered units which comprise Edgewater Lodge. A dementia audit should be completed in Orlock and Seaview units to identify any further action which is recommended to ensure the environment is conducive to the needs of persons with dementia and a recommendation was made. 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 on 02 June 2016.

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

Areas for improvement

A dementia audit should be completed regarding the environment of Orlock and Seaview units. 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 should be viewed as a priority and the manager systematically undertakes and completes the programme of staff annual appraisal and regular recorded supervision.

Number of requirements	**0**	**Number of recommendations**:	**2**

4.4 Is care effective?

A review of 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. The home was participating in an initiative with the dieticians in the South Eastern Health and Social Care Trust whereby a 'virtual ward round' was completed and patients weights were being monitored by the dieticians on a monthly basis.

Two issues were evident following the review of patients care records. During the observation of the evening meal, staff had stated that they had implemented a behaviour management strategy for a patient. There was no information within the patient's care record to evidence either a specific behaviour or that a care plan to guide staff as to how to support the perceived behaviour had been written. A requirement has been made that staff undertake training in responding to behaviours/distressed reactions. The second issue was that there was a lack of consistency in respect of the completion and maintenance of care records in accordance with NMC guidelines. The manager completes audits of patient care records, on a rotational basis, however as was evidenced by the review of patient care records it was recommended that a robust system regarding the auditing of care records was 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, as far as possible.

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. A recommendation has been made regarding 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. A more suitable arrangement for the storage of these records should be established.

Staff spoken with expressed their confidence in raising concerns with the home's staff/ management. One staff member stated "the manager has an open door policy and you can go to her at anytime".

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. 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 home 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.

We observed the serving of the evening meal in Orlock unit. Whilst the quality of the meal 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 fully 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 recommendation has been made dining experience for patients is reviewed, enhanced and is in accordance with professional standards and guidelines and best practice in dementia care.

A requirement has been made that a rolling programme of training is provided for staff in respect of best practice in dementia care, refer to section 4.5 for further information. As discussed previously in this section a behaviour management strategy was observed to have been implemented by staff with one patient. The behaviour management strategy, as observed, did not promote and protect the dignity of the patient. This was discussed with the home manager and regional manager and the behaviour management strategy ceased immediately.

Areas for improvement

Staff must undertake training in responding to behaviours. The care afforded to patients who display behaviours that challenge/distressed reactions must be in accordance with professional guidelines and DHSSPS Care Standards for Nursing Homes 2015.

The dining experience for patients should 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.

Records which details patient information should be stored safely.

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 bedrooms, as was their personal preference. 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. However, as discussed in section 4.4 regarding the importance of promoting the dignity of patients and responding to behaviours that challenge and the patients dining experience, staff in Orlock and Seaview units should have training in dementia care and practice. The promotion of a positive dementia culture and the inclusion of persons with dementia in all aspects of daily life is paramount and a requirement in respect of dementia training has been made. The manager should also establish robust systems, for example staff supervision, to ensure knowledge gained through training is embedded into practice. A recommendation has been made in section 4.3 regarding this.

In discussion with the 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 was maintained of all compliments received.

Discussion with the manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. This was undertaken on a daily basis whereby the manager completes a quality of life assessment which includes seeking the opinions of patients, relatives and staff. Views and comments recorded were analysed centrally by Four Seasons Healthcare and an action plan developed and shared with staff, patients and representatives, where appropriate.

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.

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' representatives:
"Now that extra staff have been appointed the carers have more time for the patients in Orlock unit."
"The new manager has made a huge difference, the place is taking on a new look, new chairs, new flooring and the unit is being painted."

Areas for improvement

A rolling programme of dementia specific training should 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 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 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 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.

Staff 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.

Feedback at the conclusion of the inspection was given to Vera Ribeiro, Applicant Manager and Alana Irvine, Regional Manager. Ms Irvine had assumed regional responsibility of Edgewater Lodge in February 2016, as had the 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 including redecoration and refurbishment of a number of areas in Orlock unit. 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 stabilising of the staff team. As of 9 June 2016 Ms Ribeiro is the registered manager of the home.

Areas for improvement

Two requirements and five recommendations have been made in relation to safe, effective and compassionate care to secure compliance and drive improvements.

Number of requirements	**2**	**Number of recommendations**:	**5**

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 20 (1) (c) (i) **Stated:** First time **To be completed by:** 30 September 2016	The registered person must ensure staff have the necessary knowledge and skills, through training, to support patients in relation to responding to behaviours/ distressed reactions. Registered nurses must have the necessary knowledge and skills to assess, plan and review care regarding behaviour management in accordance with professional standards and the DHSSPS Care Standards for Nursing Homes 2015. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: In addidtion to the E Learning module there have been two sessions for staff face to face training on Managing Distressed Reactions and a further session is planned. Through this training and supported by the Resident Experience Support Manager Registered Nurses are developing their knowledge in the assessment, planning and review of a resident who demonstrates a distressed reaction.
Requirement 2 **Ref:** Regulation 20 (1) (c) (i) **Stated:** First time **To be completed by:** 31 October 2016	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: Sections 4.4 and 4.5**
	Response by registered provider detailing the actions taken: There 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 provider 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 43 **Stated:** First time **To be completed by:** 30 September 2016	The registered person must ensure the environment of the home 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**
	Response by registered provider 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.
Recommendation 3 **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 provider 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 4 **Ref**: Standard 12 **Stated:** First time **To be completed by:** 30 June 2016	The registered person should ensure that the dining experience for patients 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**
	Response by registered provider 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.
Recommendation 5 **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 provider 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.

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
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews