Unannounced Care Inspection Report
8 November 2017

Edgewater Lodge

Type of Service: Nursing Home (NH)
Address: Orlock and Seaview Suites, 4 Sunnydale Avenue, Donaghadee, BT21 0LE
Tel no: 028 9188 8044
Inspector: Heather Sleator and Michael Lavelle

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing and residential care care for up to 38 persons.

3.0 Service details

Organisation/Registered Provider: Four Seasons Healthcare **Responsible Individual(s):** Dr Claire Royston	**Registered Manager:** Mrs Vera Ribeiro
Person in charge at the time of inspection: Mrs Vera Ribeiro	**Date manager registered:** 9 June 2016
Categories of care: Nursing Home (NH) NH-DE – Dementia (Nursing) RC-DE – Dementia (Residential)	**Number of registered places:** 21 – Nursing 17 - Residential

4.0 Inspection summary

An unannounced inspection took place on 8 November 2017 from 09:30 to 18:40. On this occasion Seaview suite was not inspected due to the submission of an application of variation to change the registration of Seaview suite to that of a residential home. This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

The inspection assessed progress with any areas for improvement identified during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to staff induction, staff training, adult safeguarding, risk management, the home's environment and communication between residents, staff and other key stakeholders.

Areas requiring improvement were identified under regulation in relation to staff recruitment and selection procedures, wound care management and post falls management. Areas requiring improvement were identified under the care standards in relation to the registration of care staff with the appropriate professional body, staff approach to assisting patients at mealtimes, governance and quality auditing systems in the home.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	3	6

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Vera Ribeiro, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

4.2 Action/enforcement taken following the most recent inspection dated 14 February 2017

The most recent inspection of the home was an unannounced care inspection undertaken on 14 February 2017. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

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

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report

During the inspection the inspector met with 12 patients, nine staff, and one patients' visitor/representative. There were no visiting professionals present at the time of the inspection. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for relatives and ten for patients were left for distribution. A poster was given to the registered manager to display in the staff room inviting staff to respond to an on-line questionnaire.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- duty rota for all staff from 6 November 2017 to 12 November 2017
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction files
- two patient care records

- staff supervision and appraisal planners
- a selection of governance audits
- patient register
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 14 February 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and will be validated during this inspection.

6.2 Review of areas for improvement from the last care inspection dated 14 February 2017

<table>
<tr><th colspan="3">Areas for improvement from the last care inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Care Standards for Nursing Homes (2015)</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 4.8

Stated: First time</td><td>The registered provider should ensure care plans evidence the desired daily fluid intake for individual patients and the action to be taken, and at what stage, should the desired target not be met.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The review of three patient care records evidenced that the required information was present within patient care records</td></tr>
</table>

Area for improvement 2 **Ref:** Standard 4.8 **Stated:** First time	The registered provider should ensure that registered nurses monitor the daily fluid intake of patients assessed as being at risk of dehydration.	**Met**
	Action taken as confirmed during the inspection: The review of patient progress records evidenced that registered nurses were monitoring the daily fluid intake of patients.	
Area for improvement 3 **Ref:** Standard 12.21 **Stated:** First time	The registered provider should ensure that the dining experience for patients in the Orlock suite is reviewed and enhanced so as it is a pleasurable activity for persons living with dementia.	**Met**
	Observation of the patients' dining experience in the Orlock suite evidenced that the mealtime arrangements were undertaken in a calm and systematic manner by staff.	

6.3 Inspection findings

6.4 Is care safe?

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

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. During discussion staff concerns were raised regarding care assistant staffing levels and their ability to respond to patient's needs. However, a review of records, including the staff duty rota for week commencing 6 November 2017 evidenced that the dependency levels of patients were kept under review and that planned staffing levels were adhered to. In addition observation of the care delivered during this inspection, evidenced that patients' needs were met by the levels and skill mix of staff on duty. The registered manager was asked to review the concerns raised by staff regarding the staffing arrangements.

Staff recruitment information was available for inspection however records were not maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Two staff personnel files were reviewed. The first file contained two application forms, one of which was not dated. The two references provided were not from the dated application. Neither of the references were from the employee's most recent employer. In the second personnel file there was a gap of employment from 2013 until present recorded on the application form, yet there were two references from a recent employer. There was no evidence of employment gaps being documented or of a pre-employment health check.

The registered manager stated that this was an oversight and assurances were to given to address the omissions. Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work and records were maintained. Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. This has been identified and an area for improvement under regulation.

A review of records evidenced that a competency and capability assessment had been completed with nurses who were given the responsibility of being in charge of the home in the absence of the manager. However, not all of the assessments reviewed were current or had been dated and validated by the registered manager. The registered manager stated the updating of the competency and capability assessments would be viewed as a priority.

A review of the supervision and appraisal schedules confirmed that there were systems in place to ensure that staff received supervision and appraisal. However, as with the review of the competency and capability assessments the schedules did not evidence that the majority of staff had been in receipt of supervision and an annual appraisal. In discussion with staff, they confirmed they were in receipt of regular supervision and an annual staff appraisal. The governance arrangements regarding ensuring and evidencing staff are supported via supervision, annual appraisal and competency assessments are current and validated by the registered manager should be there. This has been identified as an area for improvement under the care standards.

Discussion with the registered manager and review of training records evidenced that they had a robust system in place to ensure staff attended mandatory training. The majority of staff were compliant with mandatory training requirements. The registered manager stated a letter was sent to staff who still required to complete some of their training modules. Staff training compliance is monitored by the regional manager for the home when completing the monthly quality monitoring visit. Supernumerary hours were in place to enable new staff members to work alongside a more experienced staff member to gain knowledge of the home's routines and policies and procedures and orientation to the home. Staff consulted confirmed that the training provided was relevant to their roles and responsibilities. Observation of the delivery of care evidenced that training had been embedded into practice.

Discussion with the registered manager and review of records evidenced that there were shortfalls identified in the arrangements for monitoring the registration status of care staff in accordance with Northern Ireland Social Care Council (NISCC). Evidence was not present that two staff had registered with NISCC and were outside the six month time period afforded by NISCC for social care workers new to the role. This was discussed with the registered manager and identified as an area for improvement under the care standards.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion for the organisation had been identified. A review of documentation confirmed that any potential 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 two patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and the majority reviewed as required. Refer to section 6.5 for care record review. There was evidence that risk assessments informed the care planning process.

Review of the 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 February 2017 confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included observations of a number of bedrooms, bathrooms, lounges, dining rooms and storage areas. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. Bedrooms and communal areas were clean and spacious. The home was found to be warm, well decorated, fresh smelling and clean throughout. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Fire exits and corridors were observed to be clear of clutter and obstruction. The review of the personal emergency evacuation plans (PEEP's) for patients in the home evidenced that whilst the information was current for all patients the folder had not been updated in Orlock to reflect the actual number of patients in the unit at the time of the inspection. This was brought to the attention of the registered manager who agreed to review and update the records immediately. However, this has been identified as an area for improvement under the care standards. The registered manager should establish a system to ensure that any record in relation to fire safety procedures is maintained accurately. The annual fire risk assessment of the home was undertaken on 6 November 2016. The registered manager stated the health and safety officer for the organisation who undertakes the fire risk assessments of the homes was scheduled for the following week. Discussion with the registered manager and a review of documentation evidenced that the recommendations of the report had been addressed.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to induction, training, adult safeguarding, risk management and the home's environment.

Areas for improvement

The following areas were identified for improvement in relation to staff recruitment and selection, the registration of care staff with appropriate professional body, implementation of robust governance quality auditing systems and the establishment of a system that ensures the personal emergency evacuation plans retained in the home are current at all times.

	Regulations	Standards
Total number of areas for improvement	1	3

6.5 Is care effective?

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

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

Care records accurately reflected the assessed needs of patients and were kept under review. There was evidence that recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN) were not adhered to. A review of wound care records for an identified patient evidenced significant gaps in the delivery of care. Wounds that required dressings to be renewed on alternate days had not been changed for up to and including four days. Wound care management should be in accordance with NICE clinical guidelines. This has been identified as an area for improvement under regulation.

In addition there were gaps identified in the monthly monitoring of the Malnutrition Universal Screening (MUST) Tool in one care record, where assessments were not carried out for two out of eight months. These deficits were discussed in detail with the nurse in charge and the registered manager who agreed to address the issue with registered nurses immediately.

A review of accident records evidenced that falls had occurred where the patient had sustained a head injury. On review of the care records neurological observations were not monitored appropriately following these falls. There was also evidence of inconsistencies in contacting the General Practitioner and next of kin. This was discussed with the registered manager and an area for improvement under regulation identified.

Supplementary care charts, for example repositioning records and food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislation.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. Patients' records were maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005. There was evidence of regular communication with representatives within the care records.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition.

Discussion with the registered manager confirmed that staff meetings were held at least three times a year and records were maintained. Staff confirmed that staff meeting were held every three to four months and that the minutes were made available. Minutes of meetings were available for review and included dates, attendees, topics discussed and decisions made. Additional staff meetings have taken place for housekeeping staff and health and safety meetings for the heads of units/teams.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and/or the registered manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Discussion with the registered manager and review of records evidenced that relative meetings were arranged on an annual basis. The registered manager also confirmed that the home operate an open door policy for patients and relatives. Review of the records evidenced that no one attended the relatives meeting arranged for the Orlock suite since the last inspection.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to audits and reviews and communication between residents, staff and other key stakeholders.

Areas for improvement

The following areas were identified for improvement in relation to wound care management and post falls management.

	Regulations	Standards
Total number of areas for improvement	2	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff interactions with patients were observed to be compassionate, caring and timely. Staff were observed chatting with patients when assisting them with everyday tasks. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

The serving of the midday meal was observed. Tables were attractively set with cutlery and napkins. The meals were nicely presented, were of good quality and smelt appetising. Patients who required a modified diet were afforded a choice at mealtimes; this was verified when reviewing the patients' meal choice record. The registered nurse and care assistants were observed supervising and assisting patients with their meals and monitoring patients' nutritional intake. Staff were observed respond in a timely manner to patients who were distressed or agitated. Food was also not covered when transferred from the dining room to the patients' preferred dining area and the registered nurse was observed attempting to assist two patients who were unable to eat independently with their lunch at the same time. This was discussed with the registered manager and identified as areas for improvement under the care standards.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. An electronic feedback system was also situated in the reception area. This was available to relatives and other visitors to give general feedback on an ongoing basis or answer specific questions on the theme of the month. The feedback was summarised automatically by the system and the results were available to the manager and the regional manager.

Three staff members were consulted to determine their views on the quality of care within Edgewater Lodge Care Home. A poster was given to the registered manager to be displayed in the staff room inviting staff to respond to an on-line questionnaire. No staff responded within the timeframe for inclusion in the report.

Some staff comments were as follows:

"I really like working here."
"The patients are happy."

Eight patient questionnaires were left in the home for completion. None of the patient questionnaires were returned within the requested timeframe.

Ten relative questionnaires were left in the home for completion. Five of the relative questionnaires were returned within the timeframe for inclusion in the report. All respondents indicated that they were either very satisfied or quite satisfied with the care provided in the home. Two of the respondents were neutral when answering a question in relation to being treated with compassion. None of the respondents made any additional comments on their questionnaires.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the registered manager for their information and action as required.

A number of patients' presented with distressed reactions during the inspection. Staff were observed to respond in a compassionate and dignified manner.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home and dignity and privacy.

Areas for improvement

The following areas were identified for improvement in relation to staffing arrangements during mealtimes and covering of meals during tray service.

	Regulations	Standards
Total number of areas for improvement	0	2

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. A review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Staff were able to identify the person in charge of the home.

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

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes 2015, a copy of which was easily available in the manager's office.

Staff were knowledgeable of the complaints process. A review of notifications of incidents to RQIA since the last care inspection of 13 February 2017 confirmed that these were managed appropriately. Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation restraint, the use of bed rails, wound management, infection prevention and control, complaints and 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 improvement had been embedded into practice. However, as discussed in section 6.4 shortfalls were identified in some aspects of the governance arrangements in the home, for example; the monitoring of the registration of staff with the appropriate professional body and the management of the personal emergency evacuation plans of patients. The need for robust governance arrangements has been identified as an area for improvement under the care standards.

As a further element of its Quality of Life Programme, Four Seasons Healthcare operate a Thematic Resident Care Audit ("TRaCA") which home managers can complete electronically. Information such as home governance, information governance, housekeeping, resident care and health and safety checks are recorded on various TRaCAs on a regular basis. This information was subject to checks by the regional manager once a month.

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

Discussion with the registered manager and review of records evidenced that Regulation 29 or monthly quality monitoring visits were completed in accordance with the regulations and the care standards. 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.

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

Areas of good practice

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

Areas for improvement

An area for improvement was identified regarding the implementation of robust governance and quality auditing systems.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Vera Ribeiro, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 21 (1) (b) **Stated:** First time **To be completed by:** 31 December 2017	The registered person shall ensure that all persons are recruited in accordance with best practice and legislation and that the efficacy of this is present in staff recruitment and selection files. Ref: Section 6.4
	Response by registered person detailing the actions taken: All new staff recruited have a check list held in the front of their personal file. This will ensure that all necessary checks and forms are held in place and that there will be no significant gaps of information as required. All personal folders for new staff will be completed appropriately before their actual start date and will be checked by the Home Manager. For the identified files at the time of the inspection, action has been taken to ensure these files have all information required with no gaps of information.
Area for improvement 2 **Ref:** Regulation 12 (1) (a) and (b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure patients' wounds are dressed in accordance with the recommendations prescribed by the Tissue Viability Nurse (TVN). Ref: Section 6.5
	Response by registered person detailing the actions taken: Wound documentation is currently reviewed at least once a month. This is now to be reviewed once a week by the Home Manager or Deputy Managers and signed on individual resident's documentation as being checked. If deemed necessary training / supervisions to be carried until documentation is maintained to standard.
Area for improvement 3 **Ref:** Regulation 13 (1) (b) **Stated:** First time **To be completed by:** With immediate effect	The registered person must ensure good practice guidance is adhered to with regard to post falls management. Ref: Section 6.5
	Response by registered person detailing the actions taken: Documentation is reviewed following every fall. Discussion and supervision has taken place with registered nurses to ensure good practice is adhered to with regard to post falls management.

Action required to ensure compliance with The Care Standards for Nursing Homes (2015).	
Area for improvement 1 **Ref:** Standard 35.6 **Stated:** First time **To be completed by:** 31 December 2017	The registered person shall ensure that effective quality monitoring and governance systems are implemented regarding the supervision and annual appraisal of staff and the competency and capability assessments for any nurse in charge of the home. Ref: Sections 6.4 and 6.7
	Response by registered person detailing the actions taken: A matrix is implemented for the new year in order to ensure effective quality monitoring and governance systems such as supervisions / appraisals / competencies and capabilities are implemented and effective carried. Current year matrix is being completed as only some staff appraisals are current outstanding.
Area for improvement 2 **Ref:** Standard 35 (13) **Stated:** First time **To be completed by:** 31 December 2017	The registered person shall have robust arrangements in place to ensure care staff are registered with the Northern Ireland Social Care Council (NISCC). Ref: Section 6.4
	Response by registered person detailing the actions taken: A check list has been implemented for new staff which indicates the appropraite time frame for staff to register with the NISCC. This date is immediately transferred to a NISCC monthy check list which will enable the registered person to follow up registration closely and act immediately if this is not completed within the time frame.
Area for improvement 3 **Ref:** Standard 48.7 **Stated:** First time **To be completed by:** 8 December 2017	The registered person shall ensure the personal emergency evacuation plans (PEEP's) are maintained in an up to date manner and reflect the current needs of patients' at any given time. Ref: Section 6.4
	Response by registered person detailing the actions taken: A folder with a copy of all resident's PEEPS will be maintained in each unit. Nursing staff will ensure PEEPS reflect resident's current needs and is kept updated if there is a change in any resident's condition, any admissions to hospital, etc and any discharges. The Registered person will ensure that this is checked on a weekly basis.

Area for improvement 4 **Ref:** Standard 12.11 **Stated:** First time **To be completed by:** With immediate effect	The registered provider should ensure that staffing levels and the deployment of staff during the lunch time meal facilitate staff to deliver care to patients in a safe, effective and compassionate manner. Ref: Section 6.6
	Response by registered provider detailing the actions taken: The person in charge of each unit will ensure that a competent person is present in the dining room during meal times and that staff are deployed appropraitely according to individual resident need and staff experience. Extra assistance from personal activity leaders is provided when indentified as required. This is evaluated on observation and discussion with nurse in charge of the unit.
Area for improvement 5 **Ref:** Standard 12 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that food transferred from the dining room is covered during tray service. Ref: Section 6.6
	Response by registered person detailing the actions taken: Frequent checks are carried out at meal times to ensure that food transferred from the dining room is always covered during tray service. The Registered Nurse will monitor this at each meal time.
Area for improvement 6 **Ref:** Standard 35.6 **Stated:** First time **To be completed by:** 31 December 2017	The registered person shall ensure that effective quality monitoring and governance systems are implemented regarding the supervision and annual appraisal of staff and the competency and capability assessments for any nurse in charge of the home. Ref: Sections 6.4 and 6.7
	Response by registered person detailing the actions taken: A matrix is implemented for the new year in order to ensure effective quality monitoring and governance systems such as supervisions / appraisals / competencies and capabilities are implemented and effective carried . Current year matrix is being completed as only some staff appraisals are current outstanding.

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

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The Regulation and Quality Improvement Authority

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