Culmore Manor Care Centre
RQIA ID: 1172
39 Culmore Road
Londonderry
BT48 8JB

Inspector: Aveen Donnelly
Inspection ID: IN023510

Tel: 02871359302
Email: ciaran.burke@larchwoodni.com

Unannounced Care Inspection
of
Culmore Manor Care Centre

13 August 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced care inspection took place on 13 August 2015 from 10.00 to 17.00.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying and Standard 32 - Palliative and End of Life Care.**

Overall on the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

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

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 25 June 2014.

1.2 Actions/Enforcement Resulting from this Inspection

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	2	9

The total number of requirements and recommendations above includes both new and those that have been ‘restated’.

The details of the Quality Improvement Plan (QIP) within this report were discussed with the registered manager as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Larchwood Care Homes/Ciaran Henry Sheehan	**Registered Manager:** Ciaran Burke
Person in Charge of the Home at the Time of Inspection: Ciaran Burke	**Date Manager Registered:** 28 December 2012
Categories of Care: NH-PH, NH-I	**Number of Registered Places:** 56
Number of Patients Accommodated on Day of Inspection: 53	**Weekly Tariff at Time of Inspection:** Trust rates

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards and theme have been met:

Standard 19: Communicating Effectively
Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

4. Methods/Process

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

Prior to inspection the following records were 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; and
- pre inspection assessment audit.

During the inspection, we observed care delivery/care practices and undertook a review of the general environment of the home. We met with six patients, three care staff, three nursing staff and four patient's visitors/representative.

The following records were examined during the inspection:

- validation evidence linked to the previous QIP;
- staffing arrangements in the home;
- seven patient care records;
- staff training records;
- complaints records;
- policies for communication and end of life care; and
- policies for dying and death and palliative and end of life care.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The last inspection of the home was an announced estates inspection on 9 June 2015. The QIP from the report of that inspection was returned to RQIA by the provider and assessed by the estates inspector on 16 July. The inspector plans follow up activity in respect of one issue relating to replacement of light fittings throughout the home. The provider has stated that this work is planned for completion during September 2015.

5.2 Review of Requirements and Recommendations from the last care Inspection on 25 June 2015.

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref: Regulation 16 (1)** **Stated: First time**	The registered person shall ensure that a pain management care plan is maintained for patients who require wound care intervention.	**Met**
	Action taken as confirmed during the inspection: A review of two patient care records confirmed that pain management care plans were in place for patients who required wound care intervention. Care plans were appropriate and evaluated on a regular basis.	
Requirement 2 **Ref: Regulation 27 (2) (b), 13 (7)** **Stated: First time**	The registered person shall ensure that identified bedroom carpets are replaced.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager confirmed that there was a programme of refurbishment ongoing in the home. There were no carpets identified during inspection that required replacement.	

Requirement 3 **Ref: Regulation 27 (2) (b)** **Stated: Second time**	The registered person shall ensure that the following issues are addressed: • replace chipped vanity units; and • replace curtains in the day room	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed to the inspector, that seven chipped vanity units had been replaced since the previous inspection and that the curtains in the day room had been replaced.	
Requirement 4 **Ref: Regulation 20 (1) (a)** **Stated: First time**	The registered person shall having regard to the size of the nursing home, the statement of purpose and the number and needs of patients. Ensure that at all times suitably qualified competent and experiences persons are working at the nursing home in such numbers as are appropriate for the health and welfare of patients. This requirement is made in regard to the shortfall of one registered nurse from 8am-2pm.	**Met**
	Action taken as confirmed during the inspection: Staffing arrangements were reviewed. The registered manager confirmed that there was an additional registered nurse on duty from 8am -2pm.	
Requirement 5 **Ref: Regulation 20 (1)(c)(i)** **Stated: First time**	The registered person shall ensure that staff as appropriate are trained in the following areas: • Moving and Handling; • Fire Safety; and • Care Planning (registered nurses).	**Partially Met**
	Action taken as confirmed during the inspection: Training records were unavailable on the day of inspection. Following the inspection, training records were forwarded to RQIA and were reviewed. All staff had completed moving and handling and fire safety training. These elements of the requirement have been met. There was no evidence that registered nurses had been provided with training in care planning. Following the inspection, the registered manager	

	confirmed that plans were in place for the training to be delivered. This element of the requirement has not been met and is stated for the second time.	
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref: Standard 5.3** **Stated: First time**	It is recommended that the patients' pressure relieving equipment in use on patients' beds and when sitting out of bed be addressed in patients' care plans on pressure area care and prevention. **Ref: Management of Wounds and Pressure Ulcers**	**Not Met**
	Action taken as confirmed during the inspection: A review of three patient care records confirmed that pressure relieving cushions were not consistently included in care plans. Only one out of three care plans reviewed included this information. This recommendation is stated for the second time.	
Recommendation 2 **Ref: Standard 5.2** **Stated: First time**	It is recommended that a pain assessment be maintained in patients' care records (if applicable).	**Not Met**
	Action taken as confirmed during the inspection: Four patient care records were reviewed. Three out of four patients did not have pain assessments completed. One patient had a pain assessment completed. However, it had not been updated in six months. This recommendation is stated for the second time.	

Recommendation 3 **Ref: Standard 5.3** **Stated: First time**	It is recommended that written evidence is maintained in patients' care records to indicate that discussions had taken place with patients, and their representatives in regard to planning and agreeing nursing interventions	**Not Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager confirmed that care plans were discussed during the patients' care review meetings. However, two out of the four patient care records reviewed, identified that care reviews had not been held within the previous 12 months. The registered manager agreed to further develop the process for involving patients and or their representatives in the development of care plans. This recommendation is stated for the second time.	
Recommendation 4 **Ref: Standard 6.2** **Stated: First time**	It is recommended that all entries in case records are dated, timed and signed, and made in such a way that the original entry can still be read.	**Not Met**
	Action taken as confirmed during the inspection: Four care records were reviewed. Entries were generally well maintained. However, a review of four patient care records identified one care plan that had not been dated. There was also one entry in another patient's progress notes that had not been dated. A review of three patient care records identified that entries were not consistently accompanied by the designation of the signatory. In two patient care records, the designation had been entered in six out of 13 entries and one patient's care records had the designation recorded in three out of 13 entries. This recommendation is stated for the second time.	

5.2 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

Policies and procedures regarding communicating effectively and breaking bad news were reviewed. These policies reflected current best practice, including regional guidelines on Breaking Bad News. Discussion with staff confirmed that they were knowledgeable regarding this policy and procedure.

A sampling of training records evidenced that staff had not completed training in relation to communicating effectively with patients and their families/representatives or on breaking bad news. A review of the staff induction programme did however include a section regarding communication impairments and communication techniques.

Is Care Effective? (Quality of Management)

Two care records reviewed reflected patient individual needs and wishes regarding the end of life care. Recording within records, included reference to the patient's specific communication needs. There was evidence within the records reviewed that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs and that breaking bad news, options and treatment plans were also discussed, where appropriate.

Discussion with the registered manager and discussion with three nursing staff identified that not all the registered nursing staff had experience of breaking bad news to relatives. Staff consulted with identified a training need in this regard.

Two domestic staff were consulted and confirmed that the nursing staff communicated to them, when a patient's condition was deteriorating.

Is Care Compassionate? (Quality of Care)

One registered nurse consulted with was able to describe how they delivered bad news effectively. All staff consulted showed they had empathy towards family members during this period.

Six patients and four patient representatives commented positively on the relationship between staff and patients. One relative commented that a complaint that was raised had been addressed immediately. All patient representatives stated that the staff made them feel welcome in the home.

We observed staff interacting with patients and observed them responding to patients in a dignified manner. Fluids were offered to patients regularly throughout the inspection and patients were assisted appropriately. The home had a quiet, peaceful atmosphere and all patients were observed to be comfortable in their surroundings.

A review of compliments records in the home confirmed that patient representatives were appreciative of the care provided to them when patients were receiving end of life care.

Areas for Improvement

Staff should receive training in breaking bad news, as appropriate to their roles and responsibilities. A recommendation is made to address this.

Number of Requirements:	**0**	**Number of Recommendations**: *1 recommendation is made under Standard 20 below	***1**

5.3 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

Is Care Safe? (Quality of Life)

Policies and procedures on the management of end of life care and death and dying were available in the home. However, the policy entitled "*End of Life Care*", issued 24 July 2014, did not reference best practice guidance such as Guidelines and Audit Implementation Network (GAIN) Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes, 2013. A recommendation is made to address this.

The GAIN Guidelines for Palliative and End of Life Care in Nursing Homes and Residential Homes, 2013 were not available in the home.

A policy on the management of death and dying was available and the management of the deceased person's belongings and personal effects was included in the policy. Staff demonstrated good understanding of the importance of how patient's personal effects are managed following their death, however, they were not aware of other best practice guidelines in relation to the theme.

Training records did not evidence that staff were trained in the management of death, dying and bereavement or palliative and end of life care. Registered nursing staff were unaware of current best practice guidelines in relation to palliative and end of life care. One registered nurse referred to using the Liverpool Care Pathway and one carer also stated that they had received training in the Liverpool Care Pathway. This was discussed with the registered manager, who provided assurances that the Liverpool Care Pathway was not in use in the home.

Discussion with three nursing staff and a review of two care records confirmed that:

- there were arrangements in place for staff to make referrals to specialist palliative care services; and
- staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken.

There was no formal protocol for timely access to any specialist equipment or drugs in the home, however discussion with three registered nurses confirmed that staff were aware of the procedure to follow, if they these were required. Registered nurses stated that they were proactive in ensuring that adequate supplies of medication were ordered and that medications would be ordered in anticipation of need.

There was no specialist equipment, in use in the home on the day of inspection. Registered nurses consulted were aware that update training in the use of syringe drivers could be accessed through the local healthcare trust nurse.

There was no palliative care ink nurse identified in the home. However, discussion with three registered nurses confirmed that they were knowledgeable of the role of the local healthcare trust palliative care nurse and that advice was sought through this service or through the patient's general practitioner.

Is Care Effective? (Quality of Management)

A review of two care records evidenced that patients' needs for palliative and end of life care were assessed and reviewed on an ongoing basis. This included the management of hydration and nutrition, pain management and symptom management. There was evidence that the patient's wishes and their social, cultural and religious preferences were also considered. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements.

A key worker/named nurse was identified for each patient approaching end of life care. There was evidence that referrals had been made to the specialist palliative care team and where instructions had been provided, these were evidently adhered to.

Discussion with the manager, staff and a review of two care records evidenced that environmental factors had been considered. Management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying.

A review of notifications of death to RQIA during the previous inspection year confirmed that they were maintained appropriately.

Is Care Compassionate? (Quality of Care)

Discussion with staff and a review of two care records evidenced that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences regarding end of life care. Three nursing staff consulted demonstrated an awareness of patient's expressed wishes and needs as identified in their care plan.

Arrangements were in place in the home to facilitate, as far as possible, in accordance with the persons wishes, for family/friends to spend as much time as they wish with the person. Family were encouraged to utilise vacant rooms for overnight stays and families would be provided with refreshments and meals regularly throughout this period.

From discussion with the manager, staff and a review of the compliments record, there was evidence that arrangements in the home were sufficient to support relatives during this time. There was evidence within compliments/records that relatives had commended the management and staff for their efforts towards the family and patient.

Discussion with the manager and a review of the complaints records evidenced that no concerns were raised in relation to the arrangements regarding the end of life care of patients in the home.

All staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death and that they would ensure that the home was represented at patients' funerals.

From discussion with the manager, it was evident that arrangements were in place to support staff following the death of a patient. However, one staff member commented that when staff themselves are recently bereaved, it is upsetting for them to be involved in the care of someone who is nearing end of life. The staff agreed that this could be addressed by assigning staff members accordingly until they were emotionally stronger. One staff member stated that their experience of having had a death in their own family had resulted in a great deal of empathy with family members in this situation.

Information regarding support services was available and accessible for staff, patients and their relatives. This information included contact details for specialist palliative care services for patients living with a terminal illness.

Areas for Improvement

The following policy and guidance documents should be developed and made readily available to staff:

A policy on palliative and end of life care in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines which* should include the out of hours procedure for accessing specialist equipment and medication and the referral procedure for specialist palliative care nurses.

Training in palliative care and end of life care must be provided to all staff, as appropriate to their roles and responsibilities. This training should include the procedure for breaking bad news.

Number of Requirements:	**0**	**Number of Recommendations:**	**2**

5.4 Additional Areas Examined

Meals and mealtimes

The menu was reviewed and there was no choice available for the evening meal, for patients who required a therapeutic diet. This was discussed with the registered manager who provided assurance that patients are offered an alternative meal, if they did not like the meal on the day. Considering that the only choice available to patients on therapeutic diets, for their evening meal, is soup and mashed potato, a recommendation is made to address this.

Incorporated into this recommendation is the need for the menu to be displayed in a more suitable and easy to read format.

Questionnaires

As part of the inspection process we issued questionnaires to staff, patients and their representatives.

Questionnaire's issued to	Number issued	Number returned
Staff	10	8
Patients	5	2
Patients representatives	4	4

All comments on the returned questionnaires were in general positive. Some comments received are detailed below:

Staff

'The nursing staff here are fantastic. They are very approachable.'
'I love it here. I would not stay if the patients weren't being treated well.'
'I enjoy getting to know the patients and their families. You do not get that in the hospitals.'
The home that works 'together as a team' can deliver a high standard of care.'
'It can be hard to be involved in the care of someone who is dying, when you are recently bereaved yourself.'
'Patients who are bed-bound need us to spend more time with them, rather than rushing through their care.'
'The care to residents is very good.'
'We are in a privileged position to be caring for people at the most vulnerable time of their lives.'

Two staff members commented that they would benefit from training in end of life care.

Patients

'You'll not find much wrong here. It is grand.'
'I get everything I need.'
'I couldn't complain.'
'I get what I want. They involve me in things.'
'The staff are great. I always have laugh and joke with them.'
'All the staff are kind and make me feel at home.'

One patient expressed concerns regarding the home being short staffed and that the dependency level was very high. The patient stated that:

"other patients have to wait up to two hours, if in need of assistance going to the toilet. Mealtimes are the worst as so many patients need help with eating."

Another patient commented that there is plenty to drink during the day and that staff encourage all the patients to drink a lot, however at night time, calls for fluids take too long to be answered and the patient stated that they could not sleep because of the discomfort of being thirsty.

The above comments were discussed with the registered manager, who agreed to monitor call bell response times on a regular basis. Consideration should also be given to conducting the audits during meal-times and on the night shift. A recommendation is made.

Patients' representatives

'I have no concerns whatsoever. I see the staff and know that they are happy in their work.'
'The staff make me feel very welcome and when young children visit, they are treated like royalty.'
'Any complaints I ever had, were dealt with immediately.'
'I have no concerns.'
'Everything is satisfactory, for the short time (my relative) has been here.'
'The staff are very friendly and provide excellent care.'

Regulation 29 monthly monitoring report

A review of the monthly regulation 29 monitoring report identified that visits were conducted on a regular basis. An action plan was devised and areas that were identified for improvement were generally followed up on during the next visit. However, the report identified in three consecutive months that the competency and capability assessment for registered nurses had not been completed for one identified staff member. This was discussed with the registered manager, who provided assurances that this would be addressed. A recommendation is made to address this.

Environment

We observed two bedroom doors that were wedged open. This practice is unacceptable and must cease. The registered manager provided assurance that approved door holding devices would be installed. A requirement is made to address this.

There was a clothes rack in place in two lounges that was used to display unnamed clothes. This was discussed with the registered manager who agreed that this should not be a permanent fixture in the lounges. Assurances were provided that these would be moved to an appropriate location.

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.1 Statutory Requirements

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

6.2 Recommendations

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

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref: Regulation 20 (1)(c)(i)** **Stated: Second time** **To be Completed by: 10 October 2015**	The registered person shall ensure that staff as appropriate are trained in the following areas: • care planning (registered nurses). **Follow up on previous issue** **Response by Registered Person(s) Detailing the Actions Taken:** Two dates have been scheduled during October/.November to provide training in this area.
Requirement 2 **Ref: Regulation 27 (4) (b)** **Stated: First time** **To be Completed by: 10 October 2015**	The registered persons must ensure that the practice of using door wedges to keep bedroom doors open, does not occur. **Ref section 5.4** **Response by Registered Person(s) Detailing the Actions Taken:** Door wedges are not used to keep bedroom doors open Manager is providing on the floor to review on ongoing basis. Request has been made for outstanding Maglocks to be installed.
Recommendations	
Recommendation 1 **Ref: Standard 5.3** **Stated: Second time** **To be Completed by: 10 October 2015**	It is recommended that the patients' pressure relieving equipment in use on patients' beds and when sitting out of bed be addressed in patients' care plans on pressure area care and prevention. **Follow up on previous issue** **Response by Registered Person(s) Detailing the Actions Taken:** Pressure relieving equipment in use is addressed in care plans as recommended. (Patient ref. CMJC28)
Recommendation 2 **Ref: Standard 5.2** **Stated: Second time** **To be Completed by: 10 October 2015**	It is recommended that a pain assessment be maintained in patients' care records (if applicable). **Follow up on previous issue** **Response by Registered Person(s) Detailing the Actions Taken:** Pain assessments are maintained where applicable. Abbey pain scores are utilised and the clinical lead nurses are auditing files for compliance
Recommendation 3 **Ref: Standard 5.3** **Stated: Second time** **To be Completed by:**	It is recommended that written evidence is maintained in patients' care records to indicate that discussions had taken place with patients, and their representatives in regard to planning and agreeing nursing interventions **Follow up on previous issue**

10 October 2015	**Response by Registered Person(s) Detailing the Actions Taken:** Copies of care plan consent forms have been distributed to nursing staff to seek consent for care planning from relatives. This will be audited and outstanding consents will be forwarded by letter to next of kins and a copy kept in the care files.
Recommendation 4 **Ref: Standard 6.2** **Stated: Second time** **To be Completed by: 10 October 2015**	It is recommended that all entries in case records are dated, timed and signed, and made in such a way that the original entry can still be read. **Follow up on previous issue**
	Response by Registered Person(s) Detailing the Actions Taken: Registered nurses are required to ensure that all entries are dated, signed and timed.
Recommendation 5 **Ref: Standard 36.2** **Stated: First time** **To be Completed by: 10 December 2015**	The registered persons should ensure that the following policies and guidance documents are developed and made readily available to staff: A policy on palliative and end of life care in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines which* should include the out of hours procedure for accessing specialist equipment and medication and the referral procedure for specialist palliative care nurses. **Ref section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: The GAIN (2013) Palliative Care Guidelines are available for staff information and guidance within the home. These guidelines are easily accessable for all staff.
Recommendation 6 **Ref: Standard 39.4** **Stated: First time** **To be Completed by: 10 December 2015**	The registered persons should ensure that training is provided to staff, relevant to their roles in: • breaking bad news; • death, dying and bereavement; and • palliative and end of life care **Ref sections 5.2 and 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: A file has been compiled for staff information/reference in relation to Palliative and End of Life Care. This resource file includes guidance/training materials including Introduction to Palliatve Care, Loss & Grief, Spiritual Assessment, Breaking Bad News, Best Practice in the last hours and days of Life and Care Planning for the resident with Palliative Care Needs. These resources are utilised within the company to develop staff awareness.
Recommendation 7 **Ref: Standard 12** **Stated: First time**	The registered persons should ensure that the daily menu is displayed in a suitable format so that patients/residents know what is available at each mealtime. Patients who require a therapeutic diet should also be provided with a

To be Completed by: 10 October 2015	choice of meal at the evening meal. **Ref section 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Menus have been reviewed and reformatted and are available for all residents. The evening meal contains two choices both of which are available are available in therapeutic diet form. Additional requests are facilitated.
Recommendation 8 **Ref: Standard 35.16** **Stated: First time** **To be Completed by: 10 October 2015**	The registered persons should audit the call bell response times on a regular basis. This audit should include response times at or nearing change of shifts and during meal times. **Ref section 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Call Bell response times are now included in the audit schedule of the home and will be audited quarterly or more frequently if issues arise through complaints or care reviews.
Recommendation 9 **Ref: Standard 39.9** **Stated: First time** **To be Completed by: 10 October 2015**	The registered persons should ensure that staff competency and capability assessments are completed for all registered nurses. **Ref section 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Competency and capability assessments are completed for all registered nurses as recommended (Ref.UBRMN)

Registered Manager Completing QIP	C.Burke	**Date Completed**	05.10.15
Registered Person Approving QIP	Ciaran Sheehan	**Date Approved**	6 th October 15
RQIA Inspector Assessing Response	Aveen Donnelly	**Date Approved**	07/10/2015

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