Unannounced Care Inspection Report
24 May 2017

Meadowbank

Type of service: Nursing Home
Address: 11a Trench Road, Londonderry, BT47 2DT
Tel no: 02871347281
Inspector: Aveen Donelly

1.0 Summary

An unannounced inspection of Meadowbank took place on 24 May 2017 from 09.00 to 17.00 hours.

The inspection sought to assess progress with any issues raised 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.

Is care safe?

There were areas of good practice identified throughout the inspection in relation to staff recruitment practices; training and development; adult safeguarding arrangements; infection prevention and control practices; and risk management.

Although the recruitment practices included most of the information required, an area for improvement was identified in relation to the need to record explanations for any gaps in employment histories; the induction records should also be maintained in the home.

Is care effective?

There were some examples of good practice found throughout the inspection in relation to the care records, review of care delivery and effective communication systems.

Areas for improvement were identified during the inspection in relation to the monitoring of bowel records; patients' representatives' involvement in the care planning processes; and the care records.

Is care compassionate?

Areas of good practice were found throughout the inspection in relation to the culture and ethos of the home, treating patient with dignity and respect. A number of comments from the consultation process and the returned questionnaires are included in the main body of the report.

No areas for improvement were identified during the inspection.

Is the service well led?

There was evidence of good practice identified in relation to the governance and management arrangements; management of complaints and incidents; quality improvement processes and maintaining good relationships within the home. It was evident that action had been taken to improve the effectiveness of the care in the home; the majority of areas identified for improvement in the previous care inspection ad been met.

An area for improvement was identified in relation to the management of Chief Nursing Officer (CNO) alerts regarding staff that had sanctions imposed on their employment by professional bodies

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	*6

* The total number of requirements and recommendations above includes one recommendation that has been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ryan O'Donnell, acting 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.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 12 May 2017. This inspection resulted in no requirements or recommendations being made. There were no further actions required to be taken following the most recent inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), 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 Maureen Claire Royston	**Registered manager:** Ryan O'Donnell (acting)
Person in charge of the home at the time of inspection: Ryan O'Donnell	**Date manager registered:** Not applicable
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 35

3.0 Methods/processes

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

Prior to inspection we analysed the following information:

- 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. Questionnaires were distributed to patients, relatives and staff. We also met with one patient, three care staff, two registered nurses, one patients' representative and one visiting professional.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- five patient care records
- staff training records for 2016/2017
- accident and incident records
- audits in relation to care records, wounds and falls
- records relating to adult safeguarding
- complaints received since the previous care inspection
- the system for managing urgent communications, safety alerts and notices
- one staff recruitment and selection record
- staff induction, supervision and appraisal records
- records pertaining to NMC and NISCC registration checks
- minutes of staff, patients' and relatives' meetings held since the previous care inspection
- annual quality report
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 12 May 2017

The most recent inspection of the home was an unannounced medicines management inspection. This inspection resulted in no requirements or recommendations being made. There were no further actions required to be taken following the most recent inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 16 June 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13 (1)(a) **Stated:** First time	The registered persons must review the serving of meals on the Oakwood unit, to ensure that the food is kept hot until served to patients.	**Met**
	Action taken as confirmed during the inspection: Inspector confirmed that the serving of meals had been reviewed; this included supervisions held with the staff; and spot checks undertaken by the registered manager and the person designated the responsibility of conducting the monthly quality monitoring reports. The meals served were observed to be kept hot.	
Requirement 2 **Ref**: Regulation 30 (1) (c) **Stated:** First time	The registered person must ensure that any serious injury sustained in the home is reported to RQIA. This refers particularly to head injuries	**Met**
	Action taken as confirmed during the inspection: A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. Incidents were also reviewed as part of the monthly quality monitoring visits, to ensure that all notifiable incidents had been submitted.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 38 **Stated:** First time	The registered persons should ensure that the recruitment and selection process is further developed to ensure that a record is maintained in regards to whether or not the AccessNI criminal checks received are clear.	**Not Met**
	Action taken as confirmed during the inspection: Although enhanced criminal records checks were completed with AccessNI; and the reference number and date received were recorded, we were unable to verify whether or not the criminal checks were clear. This recommendation was not met and has been stated for the second time.	

Recommendation 2 **Ref**: Standard 35.4 **Stated:** First time	The registered persons should ensure that the food safety audit is further developed, to ensure that there is regular monitoring of the food temperatures, served in the Oakwood unit.	**Met**
	Action taken as confirmed during the inspection: A review of records confirmed that temperature checks were maintained for all foods prepared in the kitchen.	

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. A review of the staffing rota for week commencing 15 May 2017 evidenced that the planned staffing levels were generally adhered to. The manager explained that there was currently one registered nurse and two care staff vacancies. These vacancies were being filled by agency staff or permanent staff working additional hours. Some care staff had been recruited and were going through the appropriate checks before starting in post.

Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty. Discussion with patients and representatives evidenced that there were no concerns regarding staffing levels. One staff member commented in relation to the staffing levels; these comments were relayed to the registered manager to address. All staff consulted with stated that the patients' needs were always met.

Staff recruitment information was available for inspection and records were generally maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks and satisfactory references were sought, received and reviewed prior to staff commencing work and records were maintained. However, there was no explanation recorded for gaps in employment histories. This meant that although most of the information required, to demonstrate that prospective employees were suitable to work with vulnerable adults, further action was required, to ensure that these details were available. A recommendation has been made in this regard.

Staff consulted with confirmed that they received induction; and shadowed experienced staff until they felt confident to care for the patients unsupervised. They also stated that the induction period could be extended, depending on the previous experience of the person.

On completion of the induction programme, the employee and the inductor signed the induction record to confirm completion and to declare understanding and competence; however, these records were not consistently maintained. A recommendation has been made in this regard.

Discussion with the manager and staff confirmed that there were systems in place to monitor staff performance and to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, undertook competency and capability assessments and completed annual appraisals. Individual supervisions were also conducted with staff in response to learning that was identified from incidents. For example, where there were shortfalls in relation to wound care management, supervisions were undertaken with staff,

to promote learning and prevent recurrence; wound care competencies were also undertaken with all registered nurses. Refer to section 4.4 for further detail.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was kept up to date. A review of staff training records confirmed that staff completed e-learning (electronic learning) modules on basic life support, medicines management, control of substances hazardous to health, fire safety, food safety, health and safety, infection prevention and control, safe moving and handling and adult prevention and protection from harm. Overall compliance with training was monitored by the registered manager and this information informed the responsible persons' monthly quality monitoring visit in accordance with regulation 29. It was evident that training requirements were reviewed in response to any incidents which occurred in the home.

Discussion with the manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC).

The 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. There were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion 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. Where any shortcomings were identified safeguards were put in place.

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

A review of the accident and incident records confirmed that the falls risk assessments and care plans were generally completed following each incident, care management and patients' representatives were notified appropriately.

Where the use of bedrails or lap-belts were required, there was evidence that these were managed appropriately in accordance with best practice. Risk assessments were in place and there was evidence of regular safety checks.

Areas for improvement

Areas for improvement were identified in relation to further developing the recruitment process to ensure explanations are recorded for any gaps in employment histories; and in relation to the induction records.

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

4.4 Is care effective?

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

There were some areas of good practice identified during the inspection. For example, the care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals. Patients who were identified as requiring a modified diet, had the relevant assessments were completed. The prescribed modified diet was included in the care plan, together with recommended strategies for ensuring correct feeding techniques were utilised or maintaining optimum posture.

Patients were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring patients' weights and recording any incidence of weight loss. Where patients had been identified as being at risk of poor nutrition, staff completed daily food and fluid balance charts to record the amount of food and drinks a patient was taking each day. Referrals were made to relevant health care professionals, such as GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause of the patient's poor nutritional intake.

Where patients were unable to eat normally; there was evidence that the percutaneous endoscopic tubes used to feed the patients, were managed appropriately; and that oral care was provided on a regular basis.

Registered nurses spoken with confirmed that care management reviews were arranged by the relevant health and social care trust. These reviews were generally held annually but could be requested at any time by the patient, their family or the home.

Personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored.

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. The Patient Register was checked by the manager on a regular basis.

Discussion took place with the manager, regarding an incident where wound care had not been managed in accordance with best practice. This matter had been referred to the appropriate bodies and measures had been put in place to prevent recurrence; these included a review of the registered nurses' wound competencies; implementation of a weekly wounds audit; and the development of a written communication system. During the inspection, we were able to verify that wounds were regularly assessed, care plans were evaluated after each dressing change and that dressings had been changed according to the care plan. Wound care records were also supported by the use of photography in keeping with the home's policies and procedures and the National Institute of Clinical Excellence (NICE) guidelines.

Although RQIA were satisfied on this occasion that wound care was being managed well, we will continue to monitor this during future inspection.

Despite the areas of good practice identified, there were areas of improvement evidenced during this inspection. For example, the system for recording patients' bowel movements was confusing in that patients' bowel movements were recorded on four separate forms. Bowel movements were recorded on the daily care sheet; the record of toileting; the bowel monitoring chart; and in the patients' daily progress notes. Although assurances were provided during the last inspection that this would be addressed, it was disappointing that this matter had not been addressed. The review of the bowel records evidenced that they were not accurately maintained and where gaps were identified, there was no evidence that registered nurses had taken the appropriate action. This was discussed with the manager. A requirement has been made in this regard.

Although the care booklets completed by care staff, were consistently completed, there was no information recorded on the care booklets, to direct staff on the frequency of repositioning required; or on the specific consistency of foods and fluids required. This was discussed with the manager; a recommendation has been made in this regard.

Patients who were receiving antibiotics for acute infections did consistently have care plans in place, in response to the infections. A recommendation has been made in this regard.

Although there was evidence within the care record of regular communication with patients' representatives, we were unable to evidence that the care planning process included input from patients and/or their representatives, if appropriate. A recommendation has been made in this regard.

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. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Discussion with the manager confirmed that staff' meetings were held on a regular basis and records were maintained. 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 manager

A review of records evidenced that patients' and/or relatives' meetings were not held on a regular basis. However, the manager obtained feedback from three patients' representatives on a weekly basis, to ascertain their views on the home environment and the safety of the care provided in the home. Each quarter had a different focus, such as the environment; housekeeping; the social life of the home; and the dining experience.

There was only one patients' representative in attendance on the day of the inspection; they expressed their confidence in raising concerns with the home's staff/management.

Areas for improvement

Areas for improvement were identified during the inspection in relation to the monitoring of bowel records; patients' representatives' involvement in the care planning processes; and the care records.

Number of requirements	1	Number of recommendations	3

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. 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.

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.

A dedicated staff member was employed to provide activities in the home. There was a list of activities displayed in the home in order to assist patients to choose which to participate in. Those consulted with stated that there were always different activities the patients could participate in. On the day of the inspection, some patients received reflexology treatments; and it was evident that they enjoyed this very much. Discussion with staff also confirmed that the opportunities for patients to attend external activities were provided on a regular basis. A number of staff members were available to drive the home's minibus. This meant that patients could be brought out frequently. Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home. Hairdressing services were provided on a regular basis.

Consultation with the staff confirmed that they felt they have the necessary skills to communicate effectively with the patients and that if additional support was required, they would get this from the manager. Where patients had difficulties communicating, a communication profile was in place, to ensure that the staff understood the patients' abilities in terms of speech, use of makaton signs, gestures and expected behaviours. This information was included in the care plans. Where appropriate, referrals had been made to the speech and language therapists, to provide specialist advice on how to meet the patients' communication needs.

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. The annual quality report was completed on 2 May 2016 and included the overall satisfaction rate of patients and relatives as being 98 percent. This is commended. There was evidence that suggestions for improvement had been considered and used to improve the quality of care delivered.

An electronic feedback system on the quality of life (QOL) was also situated in the reception area. This was available to relatives and other visitors to give general feedback in relation to satisfaction levels with the care and general services provided or answer specific feedback on the theme of the month. When we visited the home, the theme was 'Dining'. The feedback was summarised automatically by the system and the results were available to the manager and the regional manager. Views and comments recorded were analysed and if required, responses could be addressed with the individual or through a meeting with patients, relatives or staff.

The one patients' representatives spoken with confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and the relatives in a kindly manner.

Care plans detailed the 'do not attempt resuscitation' (DNAR) directive that was in place for the patients, as appropriate. This meant up to date healthcare information was available to inform staff of the patient's wishes at this important time to ensure that their final wishes could be met. Where appropriate patients' wishes in relation to contact details and burial instructions, were included in the care plan.

During the inspection, we met with one patient, three care staff, two registered nurses, one patients' representative and one visiting professional. Some comments received are detailed below:

Staff

"The standard of care is very high".
"The care is very good, we try to do the right thing for the patients' individual needs".
"It is very good; the nurses really support the care workers".
"All is fine".

One staff member commented in relation to the pressures of being short staffed. As discussed in section 4.3, observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty. RQIA were also satisfied that the recent recruitment efforts made would address any shortfall in staffing levels. The individual staff' comments were relayed to the registered manager to address.

Patients

"I am getting on very well".

Patients' representatives

"I have no concerns, the girls are excellent".

Visiting professionals

"They seem very good, there are no concerns".

We also issued ten questionnaires to staff and relatives respectively; and five questionnaires were issued to patients. No questionnaires were returned by patients or relatives. Eight staff had returned their questionnaires, within the timeframe for inclusion in this report. Comments and outcomes were as follows:

Staff: respondents indicated that they were either 'very satisfied' or 'satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. One respondent commented in relation to the staffing levels. As discussed in section 4.3, RQIA were satisfied that the patients' needs were being met; and that recent recruitment efforts would address any shortfalls.

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

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

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

Discussion with the manager and staff evidenced that there was a clear organisational structure within the home and the staff spoken with were clear in describing their roles and responsibilities.

The manager took over the management responsibility of the home on 3 January 2017, having worked in the home previous to this, in a different capacity. It was evident that action had been taken to improve the effectiveness of the care in the home; the majority of areas identified for improvement in the previous care inspection had been met. All those consulted with knew who the manager was and stated that they were responsive to any suggestions or concerns raised. Staff described the manager in positive terms; comments included 'hand on heart, the patients come first to him' and 'he is very good'. There was a system in place to identify the nurse in charge of the home in the absence of the registered manager if concerns were raised.

Discussion with the manager and a 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, wound management, care records, infection prevention and control, environment, complaints, 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. We were also assured that auditing processes for wound care management had recently been further developed in response to learning gained from an incident.

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. However, there was a lack of evidence that the patients involved in incidents had been analysed as part of this audit. Given that there was a low incidence of falls in the home, advice was given to the manager in relation to this. 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. These were reviewed by the regional manager, who conducted the responsible individual's monthly monitoring visit in accordance with regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the manager and review of records evidenced that monthly quality monitoring visits were completed in accordance with the regulations and/or 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.

The manager explained that only one complaint had been received from the last care inspection; and that this was in the process of being investigated. This management of this complaint will be followed up at future inspection. The manager was aware of the complaints procedures in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. The complaints procedure was displayed in two areas of the home. However, one of the complaints procedures displayed included reference to the care quality commission (CQC), which is the regulatory body in England. This was relayed to the manager to address.

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. However, the system in place to manage Chief Nursing Officer (CNO) alerts regarding staff that had sanctions imposed on their employment by professional bodies, was not sufficiently robust. This was discussed with the manager. A recommendation has been made in this regard.

Areas for improvement

An area for improvement was identified in relation to the management of Chief Nursing Officer (CNO) alerts regarding staff that had sanctions imposed on their employment by professional bodies

Number of requirements	0	**Number of recommendations**	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ryan O'Donnell, manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/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 provider 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 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 provider meets legislative requirements based on The 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 provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to web portal for assessment 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 provider 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 provider 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 13 (1) (a) and (b) **Stated:** First time **To be completed by:** immediately from the day of the inspection	The registered persons shall ensure that registered nurses have oversight of the bowel records to ensure that gaps in recording are identified and acted upon. The system for recording bowel movements must also be reviewed to ensure that the records are accurate. **Ref: Section 4.4** **Response by registered provider detailing the actions taken:** Bowel records are now kept in one file for each unit to lessen any confusion and ensure better oversight of nursing staff. Compliance will be monitored by the Registered Mangaer.
Recommendations	
Recommendation 1 **Ref**: Standard 38 **Stated:** Second time **To be completed by:** 21 July 2017	The registered persons should ensure that the recruitment and selection process is further developed to ensure that a record is maintained in regards to whether or not the AccessNI criminal checks received are clear. **Ref: Section 4.2** **Response by registered provider detailing the actions taken:** When received Access NI will now state whether or not there have been any disclosures as part of the checking process.
Recommendation 2 **Ref**: Standard 38.3 **Stated:** First time **To be completed by:** 21 July 2017	The registered persons shall ensure that the recruitment processes are further developed to ensure explanations are recorded for any gaps in employment histories. **Ref: Section 4.3** **Response by registered provider detailing the actions taken:** The interviewing panel will review application forms prior to interview and asertain reasons for employment gap during interview.This will be recorded on the interview notes as evidence
Recommendation 3 **Ref**: Standard 39.1 **Stated:** First time **To be completed by:** 21 July 2017	The registered persons shall ensure that induction records are retained in the home for inspection. **Ref: Section 4.3** **Response by registered provider detailing the actions taken:** As per policy staff inductions are to be completed and retained within the care home for any newly employed staff or that of agency staff on their first posting within the care home. Completion of completion will be monitored through the internal auditing system. .

Recommendation 4 **Ref**: Standard 4.5 **Stated:** First time **To be completed by:** 21 July 2017	The registered persons shall ensure that patients' representatives' are involved in the care planning processes. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Letters have been sent to all next of kin requesting that they make contact with the care Home to discuss their relatives care planning. Contact to be made with Care management team to highlight the need to involve the next of kin of their client in care planning. Care plans to be discussed and signed with next of kin during annual reviews.
Recommendation 5 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 21 July 2017	The registered persons shall ensure that the care staff booklets provide clear instruction for care staff on the frequency of repositioning required; and on the prescribed consistency of food and fluids. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Supervision sessions have been held with care staff with regards the information required to be recorded in all daily care charts. Compliance will be be monitored through spot checks carried out by Home Manager and further supervision offered where required.
Recommendation 6 **Ref**: Standard 35.18 **Stated:** First time **To be completed by:** 21 July 2017	The registered persons shall implement a robust system to manage alerts received in relation to medication, equipment and devices; and Chief Nursing Officer (CNO) alerts regarding staff who have sanctions imposed on their employment by professional bodies **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: Contact made via email to change contact email from Home Administrator to Home Manager to ensure all alerts are received. These will be printed and made available one received.

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