Unannounced Care Inspection Report
9 August 2016

Templemoyle

Type of Service: Nursing Home
Address: 41a Whitehill Road, Eglinton BT47 3JT
Tel No: 0287181 1461
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Templemoyle took place on 9 August from 9:45 to 16:45 hours.

The inspection sought to assess progress with issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

A robust system for mandatory training was in place and staff were knowledgeable regarding their responsibilities in adult safeguarding. Systems were in place to ensure sufficient staffing levels and safe recruitment practices. The home was generally found to be clean. However, weaknesses were evidenced pertaining specifically to the cleanliness of the sluice rooms; the security of the treatment room and storage of cleaning chemicals; and the frequency of registered nurses' registration checks with the Nursing and Midwifery Council (NMC). Three requirements have been made in order to drive improvement.

Is care effective?

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 such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. Risk assessments informed the care planning process. Communication was well maintained in the home and staff, patients' and relatives' meeting were held on a regular basis. All those consulted with expressed their confidence in raising concerns with the home's staff/ management.

Is care compassionate?

There was evidence of good relationships between staff and patients and staff were noted to be delivering care in a patient and timely manner. Patients spoken with commented positively on the care provided and a number of positive comments are included in the report. Weaknesses were identified in relation to the serving of meals. A recommendation has been made in this regard. Compliance with this recommendation will further drive improvements in this domain.

Is the service well led?

There was evidence that systems were in place for incident reporting, auditing and management of safety alerts. Monthly monitoring visits were carried out in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005 and an action plan was put in place with evidence that issues had been addressed month on month.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	3	1

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. 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 care inspection undertaken on 1 March 2016. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (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: Elizabeth Kathleen Mary Lisk	**Registered manager:** Jeya Pratheeksha
Person in charge of the home at the time of inspection: Jeya Pratheeksha	**Date manager registered:** 9 January 2015
Categories of care: NH-I, NH-PH	**Number of registered places:** 30

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 five patients, three care staff, two registered nurses, one domestic staff member and two patients' representatives.

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 2015/2016
- accident and incident records
- audits in relation to care records and falls
- records relating to adult safeguarding
- one staff recruitment and selection record
- complaints received since the previous care inspection
- 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
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- a selection of policies and procedures.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 01 March 2016

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

4.2 Review of requirements and recommendations from the last care inspection dated 1 March 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 32.1 **Stated:** Second time	The following policies and guidance documents should be developed and made readily available to staff: • A policy on communicating effectively in line with current best practice, such as DHSSPSNI (2003) *Breaking Bad News.* • 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 referral procedure for specialist palliative care nurses; the process for notifying RQIA in the event of a death; and management of a sudden or unexpected death. **A copy of the policies should be submitted to RQIA with the returned QIP.**	**Met**
	Action taken as confirmed during the inspection: A review of the above policies confirmed that they had been reviewed.	
Recommendation 2 **Ref**: Standard 6.1 **Stated:** First time	Staff should be trained in the delivery of personal care, to ensure that patients are treated with respect and dignity. This refers specifically to patients' personal care and grooming needs. **Evidence should be available in the home that the training, in whatever form, has taken place.**	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of records confirmed that this had been addressed. There were no concerns observed in regards to the patients' personal care or grooming needs on the day of the inspection.	

Recommendation 3 **Ref**: Standard 35.7 **Stated:** First time	The regulation 29 monthly monitoring report should monitor the standard of personal care and grooming of patients accommodated within the home, to ensure that the areas identified in this report are addressed.	**Met**
	Action taken as confirmed during the inspection: A review of the regulation 29 monthly monitoring reports evidenced that the standard of personal care and grooming of patients had been monitored.	
Recommendation 4 **Ref**: Standard 4.7 **Stated:** First time	Care record audits should be further developed, to ensure that specific areas are identified and follow up action is taken to address the identified deficits.	**Met**
	Action taken as confirmed during the inspection: The care record audits had been further developed and there was evidence of re-audit, where required, to ensure that identified deficits had been actioned.	
Recommendation 5 **Ref**: Standard 46.3 **Stated:** First time	Decontamination records should be further developed to ensure that deficits are identified and appropriate action is taken in response to specific areas identified for improvement.	**Met**
	Action taken as confirmed during the inspection: A review of decontamination records confirmed that commodes and commode pots had been cleaned on a daily basis.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and stated 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 the week commencing 1 August 2016 evidenced that the planned staffing levels were generally adhered to. Discussion with patients evidenced that there were no concerns regarding staffing levels. Staff were observed assisting patients in a timely and unhurried way. Discussion with staff confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

There was evidence that new staff completed a structured orientation and induction programme to ensure they developed their required knowledge to meet the patients' needs. One completed induction programme was reviewed. The induction programme included a written record of the areas completed and the signature of the person supporting the new employee.

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 training 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. Observation of the delivery of care and discussion with staff evidenced that training had been embedded into practice.

Discussion with the registered 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 and annual appraisals. A review of one completed assessment, confirmed that the registered nurse, who had the responsibility of being in charge of the home, had their competency assessment reviewed annually.

There were systems in place for the recruitment and selection of staff. A review of one personnel file evidenced that the recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. Where nurses and carers were employed, their PIN numbers were checked with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC), to ensure that their registrations were valid. Staff consulted stated that they had only commenced employment once all the relevant checks had been completed. The review of recruitment records evidenced that enhanced criminal records checks were completed with Access NI and a record was maintained of the date received. The registered manager was knowledgeable regarding the procedure to follow when information was received on the Access NI certificate.

Although the registered manager stated that the arrangements were in place for monitoring the registration status of nursing staff with the Nursing and Midwifery Council (NMC), a review of the records evidenced that they had not been checked between May and August 2016. Although all registered nurses' registrations were confirmed on the day of the inspection, a review of the records confirmed that one registered nurse had renewed their registrations during this period. A requirement has been made in this regard.

The staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. A review of documentation confirmed that any potential safeguarding concern was managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

Validated risk assessments were completed as part of the admission process and were reviewed as required. These 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 completed following each incident, care management and patients' representatives were notified appropriately.

The treatment room door was observed to be unlocked and patients' medication was observed on the counter. Discussion with the registered nurse confirmed that the lock had been broken since the previous week. There was no evidence of any efforts made to replace the broken lock, to ensure that the treatment room was secure. This posed a potential risk to patients. A requirement has been made in this regard.

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. Whilst RQIA acknowledge that the home was free from odours and outbreaks of infection, the overall cleanliness of the sluice rooms in the home were below the standard expected in accordance with infection control best practice.

The following issues were identified but not limited to:

- A foot pedal on a clinical waste bin was not working.
- clinical waste bins and buckets not cleaned to a satisfactory standard
- tiles were coming away from the wall
- cupboards were untidy, storing continence pads which had been removed from their packaging
- bottles of cleaning chemicals stored on the window sills
- dirt and debris on the floor and sinks
- plastic basins, buckets and vases stored on the floor
- sinks, toilet bowls and toilet brushes were dirty
- paper signage was observed to be un-laminated

When we made the registered manager aware of these issues, the sluice rooms were cleaned immediately. A review of the cleaning schedules for the sluice rooms evidenced gaps in completion. For example, the records evidenced that one sluice room had not been cleaned between 24 July 2016 and 6 August 2016. These issues were discussed with the registered manager, who provided assurances that the sluice rooms specifically would be included in home's infection prevention and control audits. A requirement has been made that the issues listed above pertaining to infection prevention and control are addressed.

Some armchairs were observed to be worn and had the foam exposed. These matters were discussed with management at feedback who ensured that the chairs were removed from patient use, on the day of the inspection. This will be monitored at future inspection.

Fire exits and corridors were maintained clear from clutter and obstruction.

Areas for improvement

A requirement has been made that registered nurses' registrations are checked on a regular basis with the Nursing and Midwifery Council.

A requirement has been made that unnecessary risks to the health or safety of patients are identified and so far as possible eliminated. This refers particularly to the treatment room which must be kept locked, when not in use; and the storage of cleaning materials in keeping with COSHH regulations.

A requirement has been made that infection prevention and control issues identified are actioned as required. Systems and protocols must be established to ensure compliance with best practice in infection prevention and control within the home.

Number of requirements:	**3**	**Number of recommendations:**	**0**

4.4 Is care effective?

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. Risk assessments informed the care planning process and both were reviewed as required. For example, records in relation to the management of wounds/pressure ulcers indicated that when a patient was identified as being at risk of developing a pressure ulcer, a care plan was in place to direct staff on the management of this risk. Where applicable, specialist healthcare professionals were involved in prescribing care in relation to the management of wounds. Wound assessments and care plans reflected the progress of the wound and this was reflected in the daily progress notes.

Patients were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring patients' weights and identifying any incident 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.

A review of five patient care records evidenced that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines. One patient who displayed behaviours which challenge had a care plan in place to address the behaviour. Discussion with the registered nurse confirmed that the staff had a good awareness of the specific triggers in relation to the patient's behaviour and how to manage/avoid upset to the patient.

Patients who were identified as requiring a modified diet had the relevant speech and language therapist (SALT) assessments in place; and malnutrition risk assessments had been completed. Patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans.

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 such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians. Registered nurses consulted with were aware of the local arrangements and referral process to access other multidisciplinary professionals.

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. Discussion with the registered manager and a review of records confirmed that any recommendations made as a result of the care review process were followed up and actioned.

A review of supplementary care records evidenced that these 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.

A review of patients' weights evidenced that these were being monitored to ensure that any identified weight loss was referred 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. The care planning process included input from patients and/or their representatives, if appropriate, and there was evidence of regular communication with patient representatives within the care records.

Discussion with staff confirmed that nursing and care staff were required to attend a handover meeting at the beginning of each shift and discussions at the handover provided the necessary information regarding any changes in patients' condition. Staff also confirmed that communication between all staff grades was effective. A communication book was utilised to enable staff to know of any changes that had occurred, when they returned from annual leave. Discussion with the registered manager confirmed that staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. The most recent general staff meeting was held on 7 June 2016. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities.

Discussion with the registered manager and review of records evidenced that patients and/or relatives meetings were held on a regular basis; however these were historically poorly attended. The registered manager had met with individual patients on a regular basis and records were maintained of any concerns identified. The most recent patients' meeting was held on 26 May 2016 and a relatives' meeting is planned to be held on 17 August 2016.

Staff, patients and their representatives spoken with expressed their confidence in raising concerns with the home's staff/ management. One patients' representative discussed a specific area of concern, regarding their relative not being assisted to eat the meals provided. This was communicated to the registered manager on the day of the inspection to address.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with five patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Discussion with patients also confirmed that staff consistently used their preferred name and that staff spoke to them in a polite manner. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Patients were offered a choice of meals, snacks and drinks throughout the day. Menus were displayed clearly in each dining room; however they were not correct on the day of the inspection. This was discussed with the registered manager who addressed this. We observed the lunch time meal in the dining rooms on the first and second floors. The atmosphere was quiet and tranquil and patients were encouraged to eat their food. Tables were set, in advance of the meal being served; however the majority of patients ate off portable table, whilst being seated in armchairs. One patient was observed eating his meal at

a table, which was also being used to set up trays with deserts. Although, all those spoken with stated that the food was always very nice, hot food plates were not consistently covered, when being delivered to the patients' bedrooms. These practices showed that patients' dignity had not been considered. A recommendation has been made in this regard.

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. Staff supported patients to maintain friendships and socialise within the home. A list of activities was displayed near the front entrance that included games and an number of puzzles; pampering sessions; arts and crafts; and gardening activities. Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

Social care plans were in place to provide information to staff to ensure that patients' social care needs were met individually.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. Views and comments recorded were analysed and areas for improvement were acted upon.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the registered 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. We read some recent feedback from patients' representatives. One comment included: "knowing that (name) is so well cared for is a blessing".

As part of the inspection process, consulted with five staff, five patients and two patients' representatives. All comments received were positive and are detailed below:

Staff

"We have a good caring staff here. The staff have 'good hearts' and that is a good sign".
"I am very happy. The residents are well looked after".
"I would give the home a score of eight out of ten, because we are not perfect, but everyone is good to the patients".
"The care is very good".

Patients

"It is very good".
"You get anything you need".
"The staff are quite polite".
"No problems here".

Although all the patients spoken with confirmed that their needs were being met, two patients stated that they felt there was not always sufficient staff available and stated that there were often delays in having their nurse call bells responded to. Given that call bells were responded to in a timely manner on the day of the inspection, these comments were communicated to the registered manager to address.

Patients' representatives

One patients' representative commented that missing laundry continued to be problematic, despite having raised this with the management in the past. Another patients' relative described concerns regarding her relative not being assisted to eat the meals provided. These matters were communicated to the registered manager to address.

In addition to speaking with patients, relatives and staff RQIA provided questionnaires. At the time of writing this report two questionnaires were returned respectively for patients, relatives and staff. No written comments were provided on the returned questionnaires.

Areas for improvement

A recommendation has been made that the mealtime experience is reviewed to ensure that it is respectful and the environment is conducive to eating.

Number of requirements:	0	Number of recommendations:	1

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff consulted with confirmed that they had been given a job description on commencement of employment and were able to describe their roles and responsibilities. There was a system in place to identify the person in charge of the home, in the absence of the registered manager.

The home's philosophy of care and mission statement were displayed in the reception area. Information regarding a manger's surgery was also displayed.

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.

The manager confirmed that the policies and procedures for the home were currently in the process of being reviewed. Staff confirmed that they had access to the home's policies and procedures.

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 DHSSPS Care Standards for Nursing Homes 2015. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/representatives confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Patients were aware of who the registered manager was. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

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. These included medication and equipment alerts and alerts regarding staff that had sanctions imposed on their employment by professional bodies.

Discussion with the registered manager evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, the registered manager outlined how the following audits were completed in accordance with best practice guidance:

- falls
- wound management
- medicines management
- care records
- infection prevention and control
- environment audits
- maintenance audits
- follow up on care reviews
- complaints
- health and safety
- patient register
- personnel files
- staff training
- activities
- finance audit

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.

Discussion with the registered manager confirmed that a range of audits were conducted on a regular basis. An audit of patients' falls was used to reduce the risk of further falls. A sample audit for falls confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends, on a monthly basis.

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.

Discussion with the registered manager and review of records evidenced that monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, and copies of the reports were available for patients, their representatives, staff and trust representatives. An action plan was generated to address any areas for improvement. Discussion with the manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

Areas for improvement

No areas of improvement are identified in this domain.

Number of requirements:	0	Number of recommendations:	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the registered 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 may enhance service, quality and delivery.

5.3 Actions taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk 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 20 (1) (a) **Stated:** First time **To be completed by:** 06 October 2016	The registered persons must ensure that registered nurses' registrations are checked on a regular basis with the Nursing and Midwifery Council. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: On-line confirmation service has been set up with the NMC and details will be checked on the first Monday of each month.
Requirement 2 **Ref**: Regulation 14 (2) (c) **Stated:** First time **To be completed by:** 06 October 2016	The registered persons must ensure that unnecessary risks to the health or safety of patients are identified and so far as possible eliminated. The treatment room must be kept locked, when not in use. Cleaning materials must be appropriately stored in keeping with COSHH regulations. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: The door to the Treatment room, is now self-closing and has been fitted with a keypad for entry. Cleaning materials are being stored in a locked store room.
Requirement 3 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** 06 October 2016	The registered person must ensure that infection prevention and control issues identified are actioned as required. Systems and protocols must be established to ensure compliance with best practice in infection prevention and control within the home. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: A new indepth cleaning record has been developed to ensure that all areas of sluice rooms have been cleaned. This has been implemented from the 1/10/16

Recommendations	
Recommendation 1 **Ref**: Standard 12 **Stated:** First time **To be completed by:** 06 October 2016	The registered persons should review the mealtime experience to ensure that is respectful and the environment is conducive to eating. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: A staff meeting was called all staff have been made aware of the importance of offering residents the choice of eating in the dining room or dining areas.

The Regulation and Quality Improvement Authority

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