Unannounced Care Inspection Report
19 November 2020

Gillbrooke Nursing Home

Type of Service: Nursing Home (NH)
Address: 107 Clabby Road, Fivemiletown, BT75 0QY
Tel No: 028 8952 1888
Inspector: Jane Laird

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

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which provides care for up to 25 patients.

3.0 Service details

Organisation/Registered Provider: Gillbrooke Care Centre Ltd **Responsible Individual:** John James Wesley Kerr	**Registered Manager and date registered:** Jennifer McCaffrey 20 January 2020
Person in charge at the time of inspection: Jennifer McCaffrey	**Number of registered places:** 25 A maximum of 2 named patients in category NH-LD. The home is approved to provide care on a day basis for up to 3 persons.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH (E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 21

4.0 Inspection summary

An unannounced inspection took place on 19 November 2020 from 11.00 to 19.15 hours.

Due to the coronavirus (COVID-19) pandemic the Department of Health (DoH) directed RQIA to continue to respond to ongoing areas of risk identified in homes. In response to this, RQIA decided to undertake an inspection to this home.

The following areas were examined during the inspection:

- staffing
- care delivery
- care records
- Infection Prevention and Control (IPC) measures
- the home's environment
- leadership and management arrangements.

Details of the inspection findings and areas for improvement are discussed within section 6.2 and the Quality Improvement Plan (QIP) within this report.

Comments received from patients and staff during the inspection, are included in the main body of this report.

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	5	*6

*The total number of areas for improvement includes one standard which has been stated for a third and final time.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Jennifer McCaffrey, 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.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection, registration information, and any other written or verbal information received.

This included the following records:

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

Questionnaires and 'Tell us' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was also left for staff inviting them to provide feedback to RQIA online.

The following records were examined during the inspection:

- staff duty rota for weeks commencing 9 November 2020 and the 16 November 2020
- seven patients' daily reports and care records
- one patient's repositioning charts
- complaints ledger
- incident and accident records
- a sample of governance audits/records
- two staff recruitment and induction files
- record of staff mandatory training
- monthly quality monitoring reports from September 2020
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)

- registered nurses competency and capability assessments
- fire risk assessment
- legionella risk assessment
- hot and cold water temperatures
- water sampling test results
- a sample of documents relating to the premises and maintenance management of firefighting equipment, alarm systems, fire doors, room temperatures and weekly fire alarm test activation.

Areas for improvement identified at the last inspection were reviewed and an assessment of compliance was recorded as met or partially met.

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

6.0 The inspection

6.1 Review of areas for improvement from previous inspection

The most recent inspection of the home was an announced medicines management inspection undertaken on 22 September 2020. There were no actions required following this inspection.

Areas for improvement from the last care inspection 23 October 2019		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13 (1) (a) (b) **Stated:** Second time	The registered person shall ensure that the nursing, health and welfare of patients is in accordance with their planned care and the recommendations of other health care professionals. Specific reference to care plans and daily records: • Action taken should be documented within daily records when set fluid targets have not been maintained. • Care plans should reflect the patients preferred time to rise. • Care plans need to be personalised to reflect the patients current needs. • Dietary care plans to include the patient's dietary/fluid type and level of assistance required.	**Met**

	Action taken as confirmed during the inspection: Review of a sample of care records evidenced that this area for improvement has been met. This is discussed further in section 6.2.3.	
Area for improvement 2 **Ref:** Regulation 27 **Stated:** First time	The registered person shall ensure that the environmental and infection prevention and control issues identified during this inspection are urgently addressed.	**Met**
	Action taken as confirmed during the inspection: Review of governance audits and the environment evidenced that this area for improvement has been met. This is discussed further in section 6.2.5.	
Area for improvement 3 **Ref**: Regulation 27 (2) (t) **Stated:** First time	The registered person shall, having regard to the number and needs of the patients, ensure that a risk assessment to manage health and safety is carried out and updated when necessary. With specific reference to: • radiators • over bed lights • exposed pipes in identified en-suites	**Met**
	Action taken as confirmed during the inspection: Observation of the environment and review of governance records evidenced that this area for improvement has been addressed. This is discussed further in section 6.2.5.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 23 **Stated:** Second time	The registered person shall ensure that there are clear and documented processes for the prevention, detection and treatment of pressure damage. With specific reference to ensuring: • that the settings on pressure relieving mattresses are maintained at the correct setting and included in the patients care plan. • Where a patient has been repositioned the frequency should reflect the current care plan and state the intervention on each repositioning.	**Partially met**

	Action taken as confirmed during the inspection: Review of a sample of care records and observation of pressure relieving mattresses evidenced that this area for improvement has not been fully addressed and is discussed further in section 6.2.3. This area for improvement has not been fully met and has been stated for a third and final time.	
Area for improvement 2 **Ref**: Standard 35 **Stated:** Second time	The registered person shall ensure that robust management systems are appropriately established to effectively monitor and report on the safe delivery of care in the home. The registered manager must ensure: 1. Environmental audits provide clear action plans when deficits are identified 2. Maintenance checks of the building are carried out and recorded on a weekly/monthly basis as required.	**Met**
	Action taken as confirmed during the inspection: Review of environmental audits and maintenance records evidenced that this area for improvement has been met.	

6.2 Inspection findings

6.2.1 Staffing

On arrival to the home at 11.00 hours we were greeted by the manager and staff who were helpful and attentive. There was a pleasant, relaxed atmosphere in the home throughout the inspection and staff were observed to have caring, cheerful and friendly interactions with patients.

The manager advised us of the daily staffing levels and how these levels were reviewed regularly to ensure the assessed needs of the patients were met. On review of staff duty rotas it was unclear if the planned staffing levels had been adhered to as shifts were recorded as '8 – 8' and were therefore not specific to either day or night duty. This was discussed with the manager and an area for improvement was stated.

Observation throughout the inspection evidenced that the number and skill mix of the staff on duty met the needs of the patients. Discussion with staff confirmed that they were satisfied with the current staffing arrangements. Comments from staff included:

- “Very supported by management.”
- “Great teamwork.”
- “I enjoy my work.”
- “Getting on the best.”
- “Everyone works well as a team.”

We discussed staff training specific to the Mental Capacity Act (Northern Ireland) 2016 deprivation of liberty safeguards (DoLS) and were advised by the manager that the majority of staff had completed level 2 training. However, staff such as registered nurses with overseeing responsibilities had not completed level 3 training. The manager agreed to have this training implemented with ongoing monitoring to ensure full compliance. This will be reviewed at a future inspection.

6.2.2 Care delivery

Patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in Gillbrooke nursing home. Staff demonstrated a detailed knowledge of patients’ wishes, preferences and assessed needs and of how to provide comfort if required.

Staff were observed attending to patients specific requests and were compassionate in their approach. Patients’ bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences. Comments from patients included:

- “The manager is the best person here.”
- “Staff are very friendly.”
- “Couldn’t say a bad word about any of them.”
- “Food is great.”

Three questionnaires were returned which did not indicate if they were from a relative or a patient. The respondents were very satisfied with the service provision within the home.

We confirmed through discussion with staff and patients that systems were in place to ensure good communications between the home, patient and their relatives during the Covid-19 visiting restrictions. Some examples of the efforts made included**;** video calls, telephone calls, visits to the window and onsite visits in accordance to COVID-19 visiting guidance.

We observed the delivery of meals and/or snacks throughout the day and saw that staff attended to the patients’ needs in a prompt and timely manner. Seating and dining arrangements had been reviewed by the management of the home to encourage social distancing of patients in line with COVID-19 guidance. Staff wore the appropriate personal protective equipment (PPE) and sat beside patients when assisting them with their meal. A menu was displayed within each of the two lounge areas but did not offer a choice of two main meals or a date to confirm that it was the menu for that day. This was discussed with the manager as an area for improvement.

We observed the use of a monitoring device on an identified patient which we considered to be restrictive practice. On review of the patient’s care records it was identified that there was no documentation for the use of this restrictive intervention and there was no evidence that this had been discussed with the care manager from the commissioning Trust. We discussed the need to ensure that patients’ freedom of movement is suitably promoted and not inappropriately restricted with the manager and an area for improvement was stated. Following the inspection

written confirmation was received by the manager that relevant documentation had been completed and an application for DoLS had been submitted by the care manager.

6.2.3 Care Records

As discussed in section 6.1 above, care plans were person centred and generally reflected the assessed needs of the patient. However, on review of patient profiles and admission records within patient care files, we identified a number of medical conditions where care plans had not been implemented. We further identified that moving and handling risk assessments had not been updated in several months for three patients. This was discussed with the manager who advised that not all medical history remained relevant to the patients' current treatment but agreed to review these records and to update moving and handling risk assessments where necessary. This was identified as an area for improvement.

Observation of four patients' pressure relieving mattresses confirmed that one mattress was not set according to the correct weight of the patient and a further patient's mattress was not in accordance to the recommended mattress within the care records. The manager confirmed that there were no patients within the home currently with any skin pressure damage but acknowledged the importance of ensuring that the mattress is set at the correct weight of the patient unless otherwise instructed and agreed to review all relevant care plans.

The manager further advised that repositioning charts are implemented where necessary in accordance to the assessed needs of the patient and that repositioning charts were currently not required for any patient. The manager provided evidence of supplementary charts specific to repositioning which were recently discontinued for one patient who no longer required more frequent monitoring of their skin. On review of these repositioning charts it was identified that they had been completed during the night whilst the patient was in bed and on rising the following morning but a record of repositioning had not been maintained during the day. We further identified that the recommended frequency of repositioning was not on the chart or within the patient's care plan. As mentioned in section 6.1 above specific to the settings on pressure relieving mattresses and repositioning records an area for improvement which was identified at a previous inspection has been stated for a third and final time.

We reviewed care records regarding wound care for one patient. The care plan and evaluation records provided conflicting information regarding the recommended dressing type/treatment to be applied and the frequency of dressing renewal. The manager acknowledged that the care plan should have been updated to reflect the changes in the dressing type/frequency of renewal and an area for improvement was stated.

6.2.4 Infection Prevention and Control (IPC) measures

Upon entering the home, it was noted that the manager only recorded the inspector's temperature at the inspector's request; the manager was reminded of the need to obtain the temperature of all persons entering the home in line with the current COVID-19 guidelines for visiting care homes.

We were advised by staff that temperature checks were being completed on all patients and staff twice daily and that any concerns or changes were reported to the manager and/or nurse in charge.

Staff were knowledgeable regarding the symptoms of Covid-19 and how to escalate any changes in a patient's usual presentation to the person in charge. Staff also said that if they

themselves felt unwell, they would inform the person in charge and isolate, at home, as per regional guidance.

We found that there was an adequate supply of PPE and hand sanitising gel within the home and an area identified to safely remove PPE. Staff demonstrated an awareness of the various types of PPE with the majority of staff observed applying and removing PPE correctly. However, we observed one staff member without a face mask in an area where patients were seated and brought this to the attention of the manager to action as necessary.

On discussion with the manager about staff breaks it was identified that staff did not have a designated area and described how they had their meals within the patients' dining room. We discussed the importance of implementing zones within the home for staff to ensure that the regional COVID-19 guidance is adhered to. Following the inspection written confirmation was received regarding the temporary change of a bedroom for staff breaks until a more suitable location is established.

As discussed in section 6.1 above, an area for improvement regarding environmental and IPC issues had been addressed by the manager since the previous inspection; however, other deficits regarding staff practices specific to IPC were identified. We observed a number of patient chairs stored within en-suites; hoist slings, urinal bottles and clean towels stored in a communal bathroom; clean mop heads stored within a sluice room; and a number of used razors were stored in containers along with toothbrushes in several patient bedrooms. We further identified wheelchairs, cleaning equipment and a cleaning trolley that were unclean. Despite nearly all staff having completed training in IPC, it was evident from the above findings that training had not been fully embedded into practice and an area for improvement was stated.

6.2.5 The home's environment

On review of the environment we observed a gap to the base of a door at the side entrance to the home and a fire resistant window with a crack which was discussed with the manager who agreed to action. We also observed that light pull cord covers were missing from a number of identified toilet areas. The manager advised that during daily walk arounds and monthly audits, deficits were addressed as they were identified and that refurbishment to the environment was ongoing with repair/replacement of furniture/equipment where necessary. The manager advised that painting of walls and door frames was required and discussed that recent refurbishment plans had been delayed due to the COVID-19 restrictions but that the work would recommence as restrictions were relaxed.

We identified topical medicine preparations within five patient bedrooms. On review of the preparations, the date of opening and/or label was missing on a number of preparations. We further identified that the date of opening on three of the preparations, exceeded the manufacturer's recommended shelf life. We brought this to the attention of the manager who removed the preparations from the identified bedrooms and requested the nurse to dispose of any expired preparations and replace where necessary. This information was shared with the pharmacy inspector and an area for improvement was stated.

We observed an unoccupied bedroom which was being used to store equipment. The door to this bedroom was propped open rendering the door ineffective in the event of a fire. This was discussed with the manager and an area for improvement was stated. We further discussed the importance of the rooms being used for the purpose that they were registered and requested

written information regarding the location of the room and that this was a temporary measure during the COVID-19 pandemic. Following the inspection, we received confirmation in writing from the manager that the room had been temporarily changed to a staff room.

As mentioned in section 6.1 above, regarding radiators, the manager advised that during daily walk arounds the temperature of radiators are checked to ensure they are maintained at the correct temperature to reduce the risk of scalding and further advised that a monthly risk assessment has been commenced. We reviewed a sample of maintenance records which confirmed that regular checks were being carried out on firefighting equipment, alarm systems, fire doors and weekly fire alarm test activation. The fire risk assessment had been completed on the 15 June 2020 and there were no actions required.

Maintenance records also included regular checks on room temperatures and hot and cold water. The manager further advised that a legionella risk assessment and water sampling was completed on 7 October 2020 within the home and agreed to forward the report following the inspection. RQIA received the legionella risk assessment and the water sample results on 23 November 2020 which specified that a number of actions were required to ensure that water systems are safe. The water samples indicated that there were low levels of legionella bacteria within the water systems. This information was shared with the estates inspector and further information was requested to establish if the necessary actions had been addressed. Written confirmation was received from the manager to confirm that the necessary actions had been completed.

6.2.6 Leadership and management arrangements

Since the last inspection there has been no change in management arrangements. A review of the duty rota evidenced that the manager's hours, and the capacity in which these were worked, were clearly recorded.

Review of two staff recruitment files evidenced that appropriate employment checks had been carried out in line with best practice. Induction records were also reviewed and maintained within employee files.

On review of a sample of accidents and incidents since the previous care inspection it was identified that a number of notifiable events had not been notified to RQIA. We requested the manager to review all accidents/incidents and to submit relevant information retrospectively. This was identified as an area for improvement.

We discussed the management of complaints with the manager who advised us that complaints were dealt with in accordance with the homes policy and procedure. However, review of the home's complaints records evidenced that a recent complaint had not been recorded within the complaints ledger. The manager agreed to review this and an area for improvement was made.

Discussion with the manager and review of records evidenced that quality monitoring visits were completed on a monthly basis by the responsible individual. Copies of the report were available for patients, their representatives, staff and trust representatives and provided information in relation to the conduct of the home. Where areas for improvement were identified, there was an action plan in place with defined timeframes.

Written confirmation was received on 20 November 2020 from the manager detailing immediate action that had been taken to address the issues identified during the inspection, followed by an

action plan on the 25 November 2020 detailing the measures that were implemented to address all deficits going forward, to improve the delivery of safe and effective care within the home.

Areas of good practice

Evidence of good practice was found in relation to friendly, supportive and caring interactions by staff towards patients.

Areas for improvement

Ten new areas were identified for improvement. These were in relation to the duty rota, menu, restrictive practice, care records, pressure area care, infection prevention and control (IPC), safe storage of medication, fire safety, notifiable events and complaints.

	Regulations	Standards
Total number of areas for improvement	5	5

6.3 Conclusion

Patients appeared to be content and settled in their surroundings. Staff were knowledgeable regarding the needs of patients and we were satisfied that the appropriate action had been taken to address any immediate issues identified during the inspection, with an action plan to address all other deficits.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Jennifer McCaffrey, manager, as part of the inspection process. The timescales commence from the date of inspection.

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

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

7.1 Areas for improvement

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

7.2 Actions to be taken by the service

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

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 16 (2) (b) **Stated:** First time **To be completed by:** 19 December 2020	The registered person shall ensure that a review of all patients care records is completed to ensure that: • care plans are implemented where medical history remains relevant • moving and handling risk assessments are reviewed and updated regularly. Ref: 6.2.3
	Response by registered person detailing the actions taken: Staff spoken to about the importance of Care Plans relating to residents medical history - this has been completed Monthly Update Sheet commenced for Moving & Handling Risk Assessment, staff had been documenting update in the Mobility Care Plan review - this has been commenced.
Area for improvement 2 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that infection prevention and control practices are reviewed. Specific reference to: • storage of equipment in communal bathrooms, en-suite/communal toilets and sluice rooms • system for cleaning wheelchairs • equipment used for cleaning including the cleaning trolley, are maintained. Ref: 6.2.4
	Response by registered person detailing the actions taken: Staff spoken to regarding the importance of Infection Control and the storage of equipment in en-suite/communal toilets, all items removed on the day of inspection. System already in place for the cleaning of equipment and staff reminded of the importance of keeping equipment clean. Cleaning Trolley immediately cleaned and staff reminded of the importance of regular cleaning.
Area for improvement 3 **Ref:** Regulation 27 (4) (b)	The registered person shall take adequate precautions against the risk of fire. With specific reference to ensuring that: • fire doors are not propped open.

Stated: First time **To be completed by:** With immediate effect	Ref: 6.2.5
	Response by registered person detailing the actions taken: All staff spoken to and reminded not to prop fire doors open and the risk involved by doing this. This will be monitored on a regular basis by the nurse in charge.

Area for improvement 4 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall review the management of topical medicine preparations to ensure they are appropriately stored, labelled and not used beyond their recommended shelf life. Ref: 6.2.5
	Response by registered person detailing the actions taken: Topical Medication found in bedrooms removed on day of inspection and replaced where necessary. Registered Nurses spoken to and reminded of the appropriate stroage needed for such items
Area for improvement 5 **Ref:** Regulation 30 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that RQIA are notified of any event in the home in accordance with Regulation 30. Ref: 6.2.6
	Response by registered person detailing the actions taken: Indident Forms identified at inspection were all sent to RQIA the following day and staff made aware of the importance of reporting events when necessary
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 23 **Stated:** Third and final time **To be completed by:** With immediate effect	The registered person shall ensure that there are clear and documented processes for the prevention, detection and treatment of pressure damage. With specific reference to ensuring: • that the settings on pressure relieving mattresses are maintained at the correct setting and included in the patients care plan • Where a patient has been repositioned the frequency should reflect the current care plan and state the intervention on each repositioning. Ref: 6.1 and 6.2.3
	Response by registered person detailing the actions taken: Staff spoken to about the improtance of documenting settings on pressure relieving mattresses and include this in the plan of care which has been completed and all repositioning charts completed fully and stated in the Care Plans. New mattresses purchased to ensure a high standard of care is maintained.
Area for improvement 2 **Ref**: Standard 41	The registered person shall ensure the staff duty rota clearly identifies the hours worked by staff in a format that differentiates between day and night duty.

Stated: First time **To be completed by:** 19 December 2020	Ref: 6.2.1 **Response by registered person detailing the actions taken:** Off Duty is now documented, night duty 8pm - 8am and day duty 8am - 8pm and a key code at the bottom of the Off Duty to differentiate between day and night duty.

Area for improvement 3 **Ref**: Standard 12 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the daily menu offers a choice of two main meals with the date displayed in a suitable format and in an appropriate location to reflect the meals on offer. Ref: 6.2.2
	Response by registered person detailing the actions taken: Head Cook spoken to regarding choice of two main meals every day and the menus dated and displayed in both days rooms each day. Implemented immediately
Area for improvement 4 **Ref**: Standard 18 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure the following in regards to the provision of care to patients who require the use of restrictive practices specific to monitoring devices: • must be reflected within the patients care plan and risk assessment • regular review of the restrictive measure which demonstrates it is necessary, proportionate and the least restrictive intervention available • evidence of consultation with the care manager, patient and next of kin where necessary • relevant deprivation of liberty safeguards (DoLS) documentation. Ref: 6.2.2
	Response by registered person detailing the actions taken: Staff spoken to about the importance of completing and documenting restrictive measures in care plans and risk assessments with regular review. Evidence is documented when in consultation with the care manager, resident and next of kin in regard to DOLS being put in place. I have tried to source DOLS Level 3 training for Registered Nurses - this has been unsuccessful at present but will continue to source.
Area for improvement 5 **Ref**: Standard 23 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that where a wound has been assessed as requiring treatment, a care plan and risk assessment is implemented to include the dressing type and frequency of dressing renewal and is updated when necessary to reflect any changes. Ref: 6.2.3
	Response by registered person detailing the actions taken: Staff spoken to regarding documenting wounds requiring treatment in care plan and risk assessments, to be updated when necessary and to include relevant information regarding wound dressing and when any changes arise

Area for improvement 6 **Ref**: Standard 16 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that all complaints received are appropriately recorded within the complaints ledger and managed effectively. Ref: 6.2.6 **Response by registered person detailing the actions taken:** New Complaints and Compliments Books have been commenced with immediate effect and any complaints made guidelines and protocol will be followed

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care