Unannounced Post-Registration Care Inspection Report
19 June 2017

Gillbrooke Nursing Home

Type of Service: Nursing Home
Address: 107 Clabby Road, Fivemiletown, BT75 0QY
Tel No: 02889521888
Inspector: Aveen Donnelly

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 provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care and residential care for up to 25 persons.

3.0 Service details

Organisation/Registered Provider: Gillbrooke Care Centre Ltd John James Wesley Kerr	**Registered Manager:** See below
Person in charge at the time of inspection: Hazel Latimer	**Date manager registered:** Hazel Latimer – acting - no application required
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. Residential Care (RC) I – Old age not falling within any other category.	**Number of registered places:** 25 comprising: 5 – RC-I 20 – NH-I, NH-PH The home is also approved to provide care on a day basis for up to 3 persons.

4.0 Inspection summary

An unannounced inspection took place on 19 June 2017 from 09.45 to 16.45.

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 Care Standards for Nursing Homes 2015.

The term 'patients' is used to describe those living in the home which provides both nursing and residential care

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

There were examples of good practice found throughout the inspection in relation to the governance and management arrangement; care delivery and the care records. Patients were treated with dignity and respect. All those consulted with stated that the change of ownership had been managed well and good working relationships were evident within the home.

Areas for improvement made in relation to the regulations related to the fire safety arrangements and the registered nurses' oversight of the patients' fluid intake records. Areas for improvement made under the care standards related to the recruitment processes; the recording of registered nurses' registration checks; the recording of agency staff inductions; repositioning records; staff awareness of the correct decontamination procedures for bedpans; the accuracy of the staffing duty rota; and the falls audit.

Patients said they were happy with the care and services provided.

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	2	7

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Hazel Latimer, manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

4.2 Action/enforcement taken following the previous inspection dated 12 October 2016

The most recent inspection of the home was an unannounced care inspection undertaken on 12 October 2016. Other than those actions detailed in the QIP no further actions were required to be taken.

5.0 How we inspect

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing
- 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 the inspector met with five patients, three care staff, two registered nurses, one kitchen staff, one domestic staff and three patients' representatives. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives and eight for patients were left for distribution.

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

The following records were examined during the inspection:

- staffing rota
- one staff recruitment and selection record
- staff induction, supervision and appraisal records
- staff training records for 2016/2017
- accident and incident records
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- emergency evacuation register
- six patient care records
- two patient care charts including food and fluid intake charts
- annual quality report
- compliments records
- RQIA registration certificate
- certificate of public liability
- audits in relation to care records and falls
- complaints received since the previous care inspection
- minutes of staff' and relatives' meetings held since the previous care inspection
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

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

The findings of the inspection were provided to the manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 12 October 2016

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

6.2 Review of areas for improvement from the last care inspection dated 12 October 2016

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation **20 (1) (a)** **Stated:** First time	The registered provider must ensure that the deficit in registered nurse hours is addressed and that the manager is enabled to fulfil all management responsibilities including formal staff supervision and auditing processes.	**Met**

	Action taken as confirmed during the inspection: Discussion with the manager confirmed that a registered nurse had recently been recruited, which enabled the manager to work day-time hours. There was evidence that supervisions with staff had commenced with staff and plans were in place to complete these with all staff, using a rolling programme.	
Area for improvement 2 **Ref**: Regulation **20 (1) (c) (i)** **Stated:** First time	The registered provider must ensure that persons employed to work at the nursing home receive mandatory training.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas.	

6.3 Inspection findings

6.4 Is care safe?

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

The 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 12 June 2017 evidenced that the planned staffing levels were adhered to.

Discussion with patients and their representatives evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty. Two staff members commented in relation to the staffing levels; these comments were relayed to the manager during feedback.

The manager confirmed that there were no registered nurse vacancies; a number of part-time staff had recently been recruited and were going through the appropriate checks before starting employment.

Staff consulted with confirmed that communication was well maintained in the home and that appropriate information was communicated in the shift handover meetings.

Discussion with the manager and a review of one personnel file evidenced that recruitment processes were generally in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. Where nurses and carers were employed, their registrations were checked with NMC and NISCC, to ensure that they were suitable for employment. The review of recruitment records evidenced that enhanced criminal records checks were completed with AccessNI prior to the staff member starting work in the home. For agency staff, their profile was maintained, which included information on the AccessNI check and NMC/NISCC checks.

Although the manager had obtained most of the information required, to demonstrate that prospective employees were suitable to work with vulnerable adults, further action was required, to ensure that all the required information was received, prior to staff starting in post. For example, one staff member only had one reference received, prior to starting work in the home. In addition, the reasons applicants left their previous roles was not asked for on the job application form. This was discussed with the manager and has been identified as an area for improvement under the care standards.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. The manager explained that new staff were given a two week induction period, to allow them to familiarise themselves with the patients and the home's systems. However, discussion with the manager confirmed that records were not maintained on agency staff inductions. This has been identified as an area for improvement under the care standards.

As discussed in section 6.2, discussion with the manager and staff confirmed that systems had recently been put in place to monitor staff performance and to ensure that staff received support and guidance. All those consulted with stated that they felt well supported in their practice. Where the manager became aware of any serious adverse incidents that occurred in other homes, this information was shared with the staff in the home, for learning purposes.

A review of records and discussion with staff confirmed that training had been provided in all mandatory areas and records were kept up to date. A review of staff training records confirmed that staff completed face to face training 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 manager. The records reviewed confirmed that the majority of staff had, so far this year, completed their mandatory training. For agency staff, the manager also received a profile which included details on their compliance with mandatory training requirements.

The manager explained the arrangements for monitoring the registration status of the staff with the NMC/NISCC. However, records were not retained of the monthly checks which were undertaken. This has been identified as an area for improvement under the care standards.

Staff consulted with, were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. The staff understood what abuse was and how they should report any concerns that they had. Guidance on whistleblowing was displayed near the nurses' station. Discussion with the manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. The manager was the identified safeguarding champion for the home.

Review of patient care records evidenced that 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 consistently completed following each incident and that care management and patients' representatives were notified appropriately.

A review of the home's environment was undertaken which included a number 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.

Although the home was generally found to be clean, the clinical waste bins were situated in the corridor; and also in an area where patients were seated. This was discussed with the manager who agreed to address this.

Bedpans were also observed in the sluice room, steeped in cleaning solution. Discussion with staff evidenced that they were not knowledgeable regarding the correct cleaning procedures for cleaning bedpans. This was discussed with the manager and has been identified as an area for improvement under the care standards.

Although the majority of fire exits were observed to be clear of clutter and obstruction, one fire door was observed to have wheelchairs and other items stored there. This was discussed with the manager, who ensured that the items were moved immediately. This has been identified as an area for improvement under the regulations.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the governance and management arrangements.

Areas for improvement

Areas for improvement made under the regulations related to the fire safety arrangements. Areas for improvement made under the care standards related to the recruitment processes; the recording of registered nurses' registration checks; the recording of agency staff inductions; and staff awareness of decontamination procedures for bedpans.

	Regulations	Standards
Total number of areas for improvement	1	4

6.5 Is care effective?

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

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.

There were a number of examples of good practice found throughout the inspection in this domain. For example, registered nurses were aware of the local arrangements and referral process to access other relevant professionals including General Practitioner's (GP), Speech and language therapist (SALT), dietician and Tissue Viability Nurse specialists (TVN). Discussion with registered nurses and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

Patients who were identified as requiring a modified diet, had the relevant risk assessments completed. Care plans in place were reflective of the recommendations of SALT and care plans were kept under review.

Where patients had been identified as having a poor food intake, their weights were regularly monitored. This ensured that any weight loss was identified and appropriate action taken in a timely manner.

Care plans had been developed for patients who had urinary catheters in place, to ensure that they were managed in keeping with best practice guidance. Where patients were prescribed antibiotic therapy for the treatment of acute infections, care plans had been developed in relation to this; and patients who were prescribed regular analgesia had validated pain assessments completed which were reviewed in line with the care plans.

A review of wound care records evidenced that wound care was managed in line with best practice. A review of the daily progress notes of one patient evidenced that the dressing had been changed according to the care plan. However, discussion with staff evidenced that repositioning records were not maintained in relation to the care delivered. This has been identified as an area for improvement under the care standards.

A sampling of fluid intake charts evidenced that the registered nurses did not have oversight of the patients' fluid intake records. For example, in one patient's record, entries such as 'diet and fluids taken well' were recorded on days when the patient's fluid intake had not been good. This has been identified as an area for improvement under the care standards.

There was evidence of regular communication with 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.

Staff meetings were held on a regular basis and records were maintained and made available to those who were unable to attend. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. All those consulted with confirmed that if they had any concerns, they could raise these with the staff and/or the manager. A relatives' meeting had been held on 25 May 2017 and records were available.

There was information available to staff, patients, representatives in relation to advocacy services. A suggestion box was also available near the main entrance to the home.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to care practices and care delivery; communication between residents, staff and other key stakeholders was well maintained.

Areas for improvement

An area for improvement made under the regulations related to the registered nurses' oversight of patients' fluid intakes. An area for improvement made under the care standards related to maintaining repositioning records.

	Regulations	Standards
Total number of areas for improvement	1	1

6.6 Is care compassionate?

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

Staff interactions with patients were observed to be compassionate, caring and timely. 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 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.

Patients stated that they were involved in decision making about their own care. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

We observed the lunch time meal in the dining room. The lunch served appeared appetising and patients spoken with stated that they were satisfied with the meals provided. The atmosphere was quiet and tranquil and patients were encouraged to eat their food; assistance was provided by staff, as required. Tables were set with tablecloths and specialist cutlery and plate guards were available to help patients who were able to maintain some level of independence as they ate their meal. Patients were offered a choice of meals, snacks and drinks throughout the day.

One patient was identified as having a specific communication difficulty. A review of this patient's care record confirmed that a person-centred care plan had been developed.

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. The care staff provided activities to the patients for 2 hours every day. The designated care staff member was identified on the duty rota and records were maintained. Comments from patients varied in relation to the provision of activities; some were happy; and others stated that they were bored and that there was a lack of variety in the activities provided. This was relayed to the manager to address.

There was evidence of regular church services to suit different denominations. The 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. At the time of the inspection no one was receiving end of life care.

Discussion with the 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. An annual quality audit had been undertaken; views and comments recorded were analysed and areas for improvement had been 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 manager, staff, relatives and a review of the compliments record, there was evidence that the staff cared for the patients and their relatives in a kindly manner. We read some recent feedback from patients' representatives. One comment included praise for the staff for their 'compassion and kindness' when they cared for a patient who was receiving end of life care.

During the inspection, we met with five patients, three care staff, two registered nurses, one kitchen staff, one domestic staff and three patients' representatives. Some comments received are detailed below:

Staff

"I am happy, I have no concerns, the care is good".
"It is first class".
"We have a very good home, the staff are professional and caring".
"The care is excellent, good staff".
"I am happy enough".

Two staff members commented in relation to the staffing levels; these were relayed to the manager during feedback.

Patients

"I have no complaints".
"It is extraordinary, this place is bursting at the seams with kindness and love, first class".
"It is alright, I have no complaints".

Patients' representative

"They are very good".
"They are wonderful really, we have no complaints".
"It is very good, no concerns".

We also issued ten questionnaires to staff and relatives respectively and eight questionnaires to patients. Eight staff, eight patients and five relatives had returned their questionnaires, within the timeframe for inclusion in this report. Comments and outcomes were as follows:

Patients: respondents indicated that they were either 'satisfied' or 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. No written comments were provided.

Relatives: respondents indicated that they were either 'satisfied' or 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led. One respondent provided written comment in relation to the staffing levels.

Staff: respondents indicated that they were either 'satisfied' or 'very satisfied' that the care in the home was safe, effective and compassionate; and that the home was well-led.

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 of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients. Mealtimes were well managed.

Areas for improvement

No areas for improvement were identified during this inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

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

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.

There was evidence of good working relationships and all those spoken with stated that they felt that management were responsive to any suggestions or concerns raised. All those consulted with described the manager in positive terms; comments included 'she would do her utmost to support you' and 'she is a very good support'. All those consulted with stated that the change in of ownership had been managed well.

Staff were able to describe their roles and responsibilities. Discussion with the manager and staff evidenced that there was a clear organisational structure within the home. There was a system in place to identify the person in charge of the home, in the absence of the manager.

Discussion with the manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes 2015. Staff, patients and patients' representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients confirmed that they were confident that staff/management would manage any concern raised by them appropriately. Patients were aware of who the manager was.

There were systems in place to monitor and report on the quality of nursing and other services provided. Care record audits were undertaken every month; and there was evidence that appropriate actions had been taken to address any shortfalls identified.

The manager compiled information on a monthly basis in relation to falls that had occurred in the home and this information was sent to the local health and social care trust every quarter. Although there was evidence that any patterns or trends identified informed the care plan evaluations; there was no formal analysis of the falls undertaken by the manager. This has been identified as an area for improvement under the care standards.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the previous care inspection, confirmed that these were appropriately managed.

Discussion with the manager and review of records evidenced that quality 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 registered manager and a review of relevant records evidenced that all areas identified in the action plan had been addressed.

A review of the staffing rotas evidenced that amendments had been made using 'tippex'. This was discussed with the manager. An area of improvement has been identified under the care standards.

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. However, the system for maintaining alerts for staff that had sanctions imposed upon their employment by their professional bodies was not up to date. This was discussed with the manager. Following the inspection, the manager confirmed to RQIA by email on 28 June 2017, that this matter had been addressed.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the governance and management arrangements. The change in ownership had been managed well.

Areas for improvement

Areas for improvement made under the care standards related to the use of corrective fluid on the staff duty rota; and the falls audit.

	Regulations	Standards
Total number of areas for improvement	0	2

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Hazel Latimer, 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 to Nursing.Team@rqia.org.uk for assessment by the inspector.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 27 (4) (b) **Stated:** First time **To be completed by:** Immediate from the day of the inspection	The registered person shall ensure that there are precautions in place that minimise the risk of fire and protects patients, staff and visitors in the event of a fire. This refers specifically to the observed practice of storing wheelchairs and other items in front of the fire exit on the ground floor. Ref: Section 6.4
	Response by registered person detailing the actions taken: All staff are aware not to block the fire exit in back porch with wheelchairs and a notice on the door states that. Fire Training regularly carried out - last training n 26th April, 2017 and more training planned for 9th August, 2017. Fire regulations in Gillbrooke are very robust. It is not practice to store wheelchairs in front of fire doors. The wheelchairs are stored in the back porch further down the hall - unfortunately two chairs were left in front of the door and were immediately moved when brought to my attention. The overall fire assessment of the home was reviewed on the 4th July, 2017 by a trained fire assessment officer.
Area for improvement 2 **Ref:** Regulation 13 (1) (a) and (b) **Stated:** First time **To be completed by:** 17 August 2017	The registered person shall ensure that registered nurses have oversight of the patients' fluid intake records and that this is accurately reflected in the daily progress notes. Ref: Section 6.5
	Response by registered person detailing the actions taken: Registered Nurses made aware that documentation in daily progress notes reflects accurately fluid intake. Intake and output totals are always documented in progress notes every 24 hours.
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)	
Area for improvement 1 **Ref**: Standard 38.3 **Stated:** First time **To be completed by:** 17 August 2017	The registered person shall ensure that the recruitment processes are reviewed to address the areas identified during this inspection. This refers specifically to the references being received before employees start to work in the home; and in relation to the reasons staff leave their previous places of employment. Ref: Section 6.4
	Response by registered person detailing the actions taken: Recruitment processes are robust in Gillbrooke. This instance was one occasion which was an oversight and the one reference in question had been received.

	Application Forms have been amended to ask why staff leave their previous places of employment
Area for improvement 2 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 17 August 2017	The registered person shall ensure that records are maintained of the monthly NMC and NISCC checks undertaken by the manager. Ref: Section 6.4
	Response by registered person detailing the actions taken: Manager and administrator checked NMC & NISCC records manually on line prior to inspections. Manager and administrator now check, print, sign and date montly NMC and NISCC checks and keep hard copies of these..

Area for improvement 3 **Ref**: Standard 39.1 **Stated:** First time **To be completed by:** 17 August 2017	The registered person shall ensure that a record is maintained of the induction provided to agency staff. Ref: Section 6.4
	Response by registered person detailing the actions taken: Induction forms now available for agency staff in order to maintain records
Area for improvement 4 **Ref**: Standard 46.2 **Stated:** First time **To be completed by:** 17 August 2017	The registered person shall ensure that care staff are aware of the decontamination procedures for cleaning bedpans. Ref: Section 6.4
	Response by registered person detailing the actions taken: All staff made aware of the correct procedure for cleaning bedpans.
Area for improvement 5 **Ref**: Standard 23 **Stated:** First time **To be completed by:** 17 August 2017	The registered person shall ensure that repositioning records are maintained for patients who are at risk of developing pressure damage. Ref: Section 6.5
	Response by registered person detailing the actions taken: Repositioning records in place for patients who are at risk of developing pressure damage.
Area for improvement 6 **Ref**: Standard 22.10 **Stated:** First time **To be completed by:** 17 August 2017	The registered person shall ensure that an auditing process is developed in relation to falls. This audit should include an action plan where any patterns or trends have been identified. Ref: Section 6.7
	Response by registered person detailing the actions taken: Falls audit form developed with action plan where a pattern is evident.
Area for improvement 7 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 17 August 2017	The registered person shall ensure that a permanent record is maintained of the staffing rotas; and the practice of amending duty rotas, as described in section 6.7, should cease. Ref: Section 6.7
	Response by registered person detailing the actions taken: A permanent record of staffing rotas is maintained and are amended in red. It is not practice to use tippex, unfortunately this had happened due to a lot of changes being made and the rotas becoming illegible on a few occasions.

Please ensure this document is completed in full and returned to Nursing.Team@rqia.org.uk

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