Unannounced Care Inspection Report
27 April 2016

The Tilery

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Inspector: Sharon Loane

1.0 Summary

An unannounced inspection of The Tilery took place on 27 April 2016 from 10.30 to 16.30.

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?

The premises and grounds were safe and well maintained and suitable for their stated purpose. Overall staff recruitment was maintained in line with regulation and standards and staff were provided with a structured induction and appropriate training. A review of records evidenced shortfalls in monitoring staffs registration with The Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC). There was a lack of evidence that a robust system was in place to monitor the registration status of registered nurses and care staff on a regular basis and according to records examined a number of care staff were not registered with NISCC. A recommendation has been made in this regard. Some concerns were raised by staff in regards to staffing arrangements, however observations made during the inspection evidenced minimal impact to patients care. RQIA discussed these negative comments with the registered person who gave their assurance that staffing arrangements were appropriate to meet the needs of the patients'. The registered person agreed to review the current staffing arrangements and inform RQIA of any actions taken.

Is care effective?

Discussion with patients, representatives and staff evidenced that care was effective. This was further validated from review of care records. Recommendations have been stated regarding the care planning process, the management of nutrition, repositioning records and record keeping. Compliance with these stated recommendations will enhance the current systems and processes in place to ensure that the effectiveness of care delivery.

Is care compassionate?

Observations on the day of inspection and comments from patients, their representatives and staff evidenced that the delivery of care was compassionate and that there were positive outcomes for patients. There were no areas for improvement identified in this inspection.

Is the service well led?

There was evidence that in most areas of operational management, systems had been developed and established in the home and that the services provided by the home were regularly monitored and evaluated. A recommendation has been made under the well led domain in regards to the auditing of care plans. In addition, a recommendation made under the safe domain will enhance and ensure safe care and also demonstrate good leadership within the service.

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	0	6

Details of the QIP within this report were discussed with Claire Stranney, registered person and Ann Dooris, senior staff nurse as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken 24 August 2015. 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, whistleblowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Claire Stranney	**Registered manager:** Martina Mc Govern
Person in charge of the home at the time of inspection: Ann Dooris, senior staff nurse	**Date manager registered:** 20 December 2013
Categories of care: RC-I, NH-I	**Number of registered places:** 36

3.0 Methods/processes

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 plan (QIP) and 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. Seven patients, three care staff, two registered nurses, two ancillary staff and the activities co-ordinator were consulted.

The following records were examined during the inspection:

- Validation evidence linked to the previous care inspection QIP
- Staffing arrangements in the home
- Three patient care records
- Staff training records
- One staff recruitment file
- NMC and NISCC registration records
- Complaints record
- A sample of audits
- Accident and incident records
- Records relating to prevention and protection of adults at risk
- Staff induction, supervision and appraisal records
- Records of meetings for staff, patients and patient representatives
- Monthly monitoring reports in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005
- Policies and procedure

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 24 August 2015

The most recent inspection of the home was an unannounced medicines management inspection of 24 August 2016. The completed QIP was returned and approved by the pharmacist inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered person, as recorded in the QIP will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 16 July 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 20 (1)(c)(i) **Stated:** Second time	It is required that all registered nurses receive training on male and female catheterisation, care of supra-pubic catheters and management of stoma care until 100% compliance is achieved.	**Met**
	Action taken as confirmed during the inspection: A review of training records evidenced that 14 registered nurses had completed training on 14 December 2015 in regards to male and female catheterisation provided by the Clinical Education Centre. There was recorded evidence that an education request had been submitted to the Clinical Education Centre for training in Stoma Care. To date this request has not been facilitated however; there was evidence of ongoing communication with regards to same, the most recent 25 April 2016. RQIA were satisfied with the evidence taken in regards to this requirement.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 20.2 **Stated:** First time	It is recommended that care plans are developed to reflect the patient's /patient representative's wishes to further enhance the delivery of person centred care at end of life.	**Met**
	Action taken as confirmed during the inspection: A review of three care plans evidenced that care plans had been further developed in this area of practice and the recommendation has been met.	

Recommendation 2 **Ref**: Standard 46 **Stated:** First time	It is recommended that an audit of the environment including equipment and furniture is undertaken to assure compliance with best practice in regards to infection prevention and control within the home in relation to the issues identified in section 5.5.3.	**Met**
	Action taken as confirmed during the inspection: An environmental audit had been completed on the 6 October 2015 and subsequently at monthly intervals. An action plan had been devised and evidence of actions taken. There was evidence that appropriate actions had been taken in relation to the specific issues identified at the previous care inspection in regards to infection prevention and control.	

4.3 Is care safe?

The senior staff nurse confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota for weeks commencing 18 and 25 April 2016 evidenced that the planned staffing levels were adhered to on most occasions. There were some occasions that planned staffing levels were not met due to unexpected staff sickness. The senior registered nurse advised that whilst every effort is taken to cover these shifts it can be difficult to get cover internally and by the agencies. This was evidenced at this inspection, as an agency who had agreed afternoon cover contacted the home at short notice to advise that the staff member had reported sick. The senior registered nurse advised that they had reviewed the afternoon duties and had made alternative arrangements. The senior registered nurse advised that the home were continuing to experience difficulty in recruiting registered nurses and there was evidence that there were occasions when the minimum skill mix of at least 35% registered nurses was not maintained over a 24 hour period. This had been previously raised during previous care inspections, and RQIA were satisfied that the home were trying their best to recruit registered nurses and where a second nurse was not rostered for night duty alternative arrangements were in place. No issues in relation to the provision of care were observed, nor were there any concerns raised by patients and / or their representatives. During the inspection, one staff member spoken with raised their concerns regarding the staffing levels during the day shift with particular reference to staff sickness and staffing levels in the afternoon. Post inspection, information has also been received in returned staff questionnaires in relation to staffing levels not being adequate to meet the needs of the patients and that at night time the patients are late going to bed and on some occasions after 1.00am. No concerns were raised by any of the patients spoken with during the inspection and/or in any of the returned questionnaires.

These concerns were discussed with the registered person post inspection, who advised that they would be present in the home at night on a frequent basis and has never observed this practice. Assurances were provided by the registered person that the current staffing arrangements are adequate to ensure the needs of the patients are being met. The registered person agreed to address these concerns with the staff team and keep the staffing arrangements under review and inform RQIA of any actions taken.

A discussion with the administrator and a review of one staff member's personnel file evidenced that the recruitment process was in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2. A checklist was retained in each file as an aide memoire to ensure all required information and documents were available.

The arrangements in place to confirm and monitor the registration status of registered nurses with the Nursing and Midwifery Council (NMC) and care staff registration status with the Northern Ireland Social Care Council (NISCC) were discussed with the senior registered nurse and the administrator. The records reflected that the last checks completed for the registration status of nurses on the NMC website was 23 February 2016. The renewal dates for registration were recorded. At the time of inspection there were seventeen registered nurses working in the home; only the registration of 10 nurses had been checked. RQIA requested that the registered manager, as a matter of urgency, provide confirmation of the NMC registration of all nurses employed in the home. Confirmation was subsequently received before the end of the inspection, that all of the nurses currently employed had a live registration with the NMC.

A review of the register to check care staff registration with the Northern Ireland Social Care Council (NISCC) evidenced that 13 care staff were registered and the duty rotas evidenced that a total of 26 care staff were employed. The office administrator advised that the registered manager carried out monthly checks however; the last record for checks available was the 27 January 2016. Discussions with care staff confirmed that the registered manager had advised staff of their responsibility to complete the registration process to enable them to fulfil their role and responsibilities. Whilst this information was acknowledged the registered manager needs to develop and maintain a robust system to ensure care staffs registration status. A recommendation has been made in regards to the monitoring of registration status with the relevant bodies.

Discussion with staff and review of records confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. A recently appointed care staff member advised that the induction process involved training both e-learning and face to face and a three week period in which they were supernumerary to shadow senior colleagues. The staff member also advised that an induction booklet was completed by themselves and staff who had been involved in the mentoring process. This new employee advised that the registered manager took time to discuss any outcomes at the end of each shift worked. This practice is commended.

Training was available via an e-learning system known as EVO learning and face to face training arranged by the home for practical elements and any additional areas identified in accordance with the needs of the patients accommodated. A review of the training matrix for 2016, confirmed that the majority of staff had already completed the theoretical components for all mandatory training requirements. The administrator advised that the compliance date for completion of the theory components was the end of April 2016 and that practical sessions were currently been organised. There were systems in place to monitor staff attendance and compliance with training.

The senior registered nurse and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. Care staff were aware of how and to whom they should report concerns within the home. The senior registered nurse was knowledgeable of the contact details of the Trust adult safeguarding team. Annual refresher training was considered mandatory by the home.

A review of documentation confirmed that any safeguarding concerns were managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

Discussions with the senior registered nurse and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to relevant bodies. A random selection of accidents and incidents recorded since the last care inspection evidenced that these had been appropriately notified to RQIA in accordance with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005. The registered manager completed a monthly analysis of falls which included investigations and reporting information.

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

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The home was fresh smelling, clean and comfortable and had a very "homely" ambience. A number of bedrooms viewed were personalised with photographs, pictures and personal items. Since the last inspection, the home had completed an environmental audit which was completed on a monthly basis and actions identified had been followed up appropriately. The registered person(s) are currently reviewing the arrangements for shared rooms within the home and building works were operational which was being managed appropriately and RQIA have been notified. These works will further enhance the homes environment, patient's experience and comforts.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas for improvement

A robust system should be implemented and maintained to confirm that registered nurses employed have a live registration with the Nursing and Midwifery Council (NMC) and that all care staff are registered or in the process of registering with the Northern Ireland Social Care Council (NISCC).

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

4.4 Is care effective?

A review of three patient care records evidenced that initial plans of care were based on the pre-admission assessment and referral information provided by the commissioning trust. 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. One of the care records reviewed evidenced that a number of risk assessments and care plans had not been completed within five days of admission to the home.

There was evidence that the care planning process included input from patients and/or their representatives, as appropriate. There was evidence of regular communication with patient representatives within the care records. Care records in the majority reflected the assessed needs of patients and were kept under review.

Two issues identified during the review of care records were discussed with the senior registered nurse during feedback. A review of one care record evidenced that information recorded in the assessment of needs was not consistent with information recorded in the care plan in regards to the patient's nutritional and dietary needs. The assessment of needs identified that the patient required a liquidised diet and the care plan recorded a soft diet. The senior registered nurse and the SALT assessment confirmed that the patient required a "liquidised diet" and the registered nurse confirmed that they were receiving their food choices accordingly.

A second care plan reviewed in relation to pressure and/or wound management evidenced that no care plan was available for the treatment and care delivered for identified wounds as per the wound charts. In addition, monthly evaluations were recorded to evidence the care given and the effectiveness of the treatment delivered. The senior registered nurse advised that a care plan had been developed however it must have been displaced.

A recommendation has been made in regards to ensuring that care records are maintained up to date and reflective of patient's needs. Care plan audits had been completed for both care records and failed to identify these shortfalls. Refer to section 4.6 for further information regarding the auditing of care records. A further recommendation is stated in regard to the quality and depth of the care records audit.

Supplementary care charts including repositioning charts and food and fluid intake charts evidenced that on some occasions records were not maintained in accordance with best practice guidance, care standards and legislative requirements. Firstly, in relation to repositioning charts the following shortfalls were identified; there was evidence in one repositioning record examined that the repositioning needs of the patient were not met, with up to gaps of five hours between positional changes, when the care plan advised two-three hourly repositioning. Discussion with the senior registered nurse advised that the patient had been repositioned however; staff had not recorded their care delivery. During the inspection staff were observed repositioning patients throughout the course of the inspection. In addition, records did not always reflect the condition of the patients' skin at time of repositioning. A recommendation has been made in this regard.

Secondly, a review of food and fluids charts identified the following issues; the legibility of the record was difficult as the record had been photocopied with previous entries recorded. A review of a food chart for one identified patient evidenced that the patient's nutritional needs were not being met as per the dietician's recommendations. Two recommendations have been made.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition. A handover report was also completed for each shift and shared with relevant staff.

Discussion with the senior registered nurse and staff confirmed that staff meetings were held on a three monthly basis and records were maintained. Records of minutes for the most recent staff meeting, 13 January 2016, evidenced the names of those attending with signatures recorded to validate their attendance, minutes of discussions and any actions agreed. Staff stated they were comfortable discussing any issues with management and stated that the registered manager was very "approachable" and was very involved in the day to day care in the home. Staff also advised that the registered person was in the home on most days.

A discussion with the registered person during the inspection confirmed that they were very knowledgeable in regards to the patients, for example they were able to greet the patient and their relatives by name. The registered person was very aware of any operational / management issues within the home. This is commended.

All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals and of how to make appropriate referrals for advice and support.

Discussion with the senior staff nurse and review of records evidenced that patients and/or relatives meetings were held on annual basis. Minutes were available.

Patient and representatives spoken with knew the registered manager and expressed their confidence in raising concerns with the home's staff/ management.

Areas for improvement

Assessments and care plans should be commenced on the day of admission based on a pre-admission assessment, and fully completed within five days of admission to the home. Care plans should accurately reflect the patient's individual assessed need, care and treatment required and any include recommendations from relevant health and social care professionals.

The registered person should ensure contemporaneous recording of repositioning charts and that records are maintained in accordance with best practice for example; comments should be recorded in regards to the condition of the patient's skin.

Patient's nutritional needs are met in line with current best practice and there is a system in place to monitor compliance with any special nutritional requirements.

The registered person should ensure all records are legible and in accordance with NMC guidelines.

Number of requirements	**0**	**Number of recommendations**:	**4**

4.5 Is care compassionate?

Observations throughout the inspection evidenced that staff interactions with patients were compassionate, caring and timely. Consultation with seven patients individually and others in smaller groups, confirmed that they were afforded choice, privacy, dignity and respect. Patients also confirmed that staff spoke with them in a polite and courteous manner.

Comments received from patients included;

"Staff are kind, we are well cared for"
"Well looked after, staff are kind"
"Well looked after treated with respect and privacy"
"Very good home, staff are attentive and jolly".

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Staff were able to demonstrate their knowledge of the patients identified needs, life experiences and what was important to individuals.

Patients were observed to be sitting in the lounge(s), or in their bedroom, as was their personal preference. Patients appeared well dressed and there was evidence of staff's attention to detail regarding patients personal care, for example, ladies clothing were accessorized with co-ordinating neck scarfs and jewellery. Observation of care delivery confirmed that patients were assisted appropriately, with respect, and in a timely manner.

Discussions with patients confirmed their enjoyment with the activities provided within the home. A range of activities are provided to meet the needs of the patients and time was afforded to patients on a one to one basis. A discussion with the activities co-ordinator demonstrated their passion and enthusiasm to ensure that patients' experiences were positive in this regard.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

Three patients' representatives spoken with were confident that they were happy with the standard of care in the home and the level of communication maintained.

Comments included;
"No issues about care what so ever"
"At time of admission the staff were very through regarding information, satisfied with all aspects of care"
"No concerns raised, staff are marvellous".

Ten questionnaires were issued to patients' representatives and two were completed and returned. The respondents' were all complementary regarding the quality of care delivered.

Five questionnaires were issued to patients and four were completed and returned. All of the respondents consistently complimented the home for the quality of care delivered.

Ten questionnaires were issued to nursing, care and ancillary staff and two were returned at time of writing this report. The responses to the questions were generally positive and one respondent indicated that in their opinion the delivery of safe, effective and compassionate care was good. The second respondent did not fully complete the questionnaire. The two questionnaires returned stated that staffing levels were not adequate with particular reference to night duty and indicated that this had an impact on how staff completed their duties and also on patients care needs not being met in a timely manner. This matter has also been referred to in section 4.3 of the report and the registered person/manager should review these comments and inform RQIA of any action taken in respect of staffing arrangements.

In addition, both respondents provided negative comments in regards to the management of the home indicating that management were not approachable and did not promptly address any concerns raised. These comments made were not consistent with the information received from staff, patients and / their representatives during the inspection process and have been shared with the registered persons for further consideration.

Discussion with the senior registered nurse confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. A copy

of the Annual Quality Report for 2015 -2016 evidenced the planned improvements for the home and timescales were identified.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations:	0

4.6 Is the service well led?

The certificate of registration issued by RQIA and the homes certificate of public liability insurance were appropriately displayed in the foyer of the home. Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered.

Staff spoken with were knowledgeable regarding the organisational structure within the home. Staff were knowledgeable in regards to their role, responsibilities and function. In discussion patients were in the majority aware of the roles of staff in the home and whom they would speak with should they have any concerns. Discussions with staff also confirmed that there were good working relationship with management and that management were responsive to any suggestions or concerns raised. A response received from two staff questionnaires included some negative comments with regards to the management and leadership of the home. Please refer to section 4.5 of the report.

A review sample of the policy and procedures manual evidenced that these were in accordance with statutory requirements and there was a process of systematic review in place to ensure compliance with policies and procedures. Staff confirmed that they had access to the home's policies and procedures.

Patients and representatives spoken with confirmed that they were aware of the home's complaints procedure and stated that they were confident that staff and/or management would address any concern raised by them appropriately. Records were maintained of all complaints received and these included details of the complaint, all communications with complainants, and the result of any investigations; the action taken; whether or not the complainant was satisfied with the outcome and how this level of satisfaction was determined.

Discussion with the registered person, senior registered nurse and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. Areas for auditing included the following examples; care records, infection prevention and control practices, falls, complaints , quality of food, quality assurance, bedrails , environmental and housekeeping. Audits were completed consistently at regular intervals and 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. A review of minutes from staff meetings evidenced that audits were discussed identifying any learning and/outcomes. This is good practice.

Following the review of audits completed for care records examined at inspection, the auditing process had not identified the shortfalls evidenced in regards to care planning. Whilst it was acknowledged that the audit tool used was robust, a more systematic approach should be considered. This was discussed during feedback and a recommendation has been made in regard to the quality and depth of the care records audit.

Discussion with the registered person and review of records evidenced that the monthly monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. An action plan was generated following each monitoring visit to address any areas for improvement. There was evidence that actions had been followed up and actioned appropriately. Copies of the reports were available for patients, their representatives, and staff and Trust representatives.

Areas for improvement

The registered manager should review the quality and depth of the care records auditing to assure the safe delivery of quality care. A recommendation has been made.

As previously discussed in this report issues were identified with the arrangements in place to confirm and monitor the registration status of registered nurses with NMC and care staff with NISCC. One recommendation was stated in this regard. These procedures whilst ensuring safe care, also demonstrate good leadership within the service.

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

5.0 Quality improvement plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

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

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on 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 person may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

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

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the service. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements: No requirements resulted from this inspection.	
Recommendations	
Recommendation 1 **Ref**: Standard 38.3 **Stated:** First time **To be completed by:** 20 June 2016	A system should be implemented to ensure that registered nurses' registration with the Nursing and Midwifery Council (NMC) and care staffs' registration with Northern Ireland Social Care Council (NISCC) is checked on a regular basis. **Ref : Section 4.3**
	Response by registered person detailing the actions taken: NMC nurse registrations are checked monthly and records maintained. NISCC register checked and records maintained.
Recommendation 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 20 June 2016	Assessments and care plans should be commenced based on the pre admission assessment on the day of admission and fully completed within five days of admission to the home. Care plans should accurately reflect the patient's individual assessed need, care and treatment required and any include recommendations from relevant health and social care professionals. **Ref: Section 4.4**
	Response by registered person detailing the actions taken: Nursing staff are completing individual assessments and careplans within 5 days of admission. Careplans reflect the care and treatment required and recommendations received from relevant health and social care professionals.
Recommendation 3 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 20 June 2016	The registered person should ensure contemporaneous recording of repositioning records and records should be in accordance with best practice guidelines. **Ref: Section 4.4**
	Response by registered person detailing the actions taken: Staff record repositioning charts accurately and in accordance with best practice guidelines. Repositioning charts are audited daily by Manager or Nurse in charge.

Recommendation 4 **Ref**: Standard 12 Criteria 12 **Stated:** First time **To be completed by:** 20 June 2016	The registered manager should ensure that patient's nutritional needs are met in line with current best practice and there is a system in place to ensure nutritional needs are met in regards to any prescribed nutritional treatment and care required. **Ref: Section 4.4**
	Response by registered person detailing the actions taken: Reiterated to Nursing staff to ensure patient nutritional needs are met as per dietician recommendations which are also recorded on patients careplans.
Recommendation 5 **Ref**: Standard 4 Criteria 9 **Stated:** First time **To be completed by:** 20 June 2016	The registered person should all records are legible and in accordance with NMC guidelines. **Ref: Section 4.4**
	Response by registered person detailing the actions taken: Staff instructed to only use photocopied records which are legible and in accordance with NMC guidelines.
Recommendation 6 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 20 June 2016	The registered manager should review the quality and depth of the care records auditing to assure the safe delivery of quality care. **Ref: Section 4.4 & 4.6**
	Response by registered person detailing the actions taken: The careplan audit has been reviewed to assure the safe delivery of quality care to the patients.

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

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