Fruithill Nursing Home
RQIA ID: 1253
20 Fruithill Park
Andersonstown
Belfast
BT11 8GD

Inspector: Karen Scarlett
Inspection ID: 022146

Tel: 02890617717
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# Unannounced Care Inspection
# of
# Fruithill Nursing Home

## 18 August 2015

The Regulation and Quality Improvement Authority
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## 1. Summary of Inspection

An unannounced care inspection took place on 18 August 2015 from 09.50 to 14.30 hours.

This inspection was underpinned by one standard and one theme from the DHSSPSNI Care Standards for Nursing Homes (2015). **Standard 19 - Communicating Effectively; Theme 'End of Life Care' incorporating criteria from Standard 20 – Death and Dying; and Standard 32 - Palliative and End of Life Care.**

Overall on the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

### 1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 13 January 2015.

### 1.2 Actions/Enforcement Resulting from this Inspection

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

### 1.3 Inspection Outcome

| | Requirements | Recommendations |
|---|---|---|
| **Total number of requirements and recommendations made at this inspection** | **3** | **7** |

The details of the Quality Improvement Plan (QIP) within this report were discussed with Leeann Noble, nurse in charge, as part of the inspection process. Feedback was also given via telephone to Orla Sheehan, registered provider and Vera Ribeiro, manager, on 19 August 2015. The timescales for completion commence from the date of inspection.

## 2. Service Details

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| **Registered Organisation/Registered Person:**<br>Ms Orla Frances Sheehan | **Registered Manager:**<br>N/a |
| **Person in Charge of the Home at the Time of Inspection:**<br>Leeann Noble | **Date Manager Registered:**<br>Vera Ribeiro – application not yet received |

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| **Categories of Care:**<br>NH-LD, NH-I, NH-PH, NH-PH(E), NH-TI | **Number of Registered Places:**<br>35<br>There shall be a maximum of two patients accommodated in category NH-LD. The home is approved to provide care on a day basis only to 2 persons. |
| **Number of Patients Accommodated on Day of Inspection:**<br>33 | **Weekly Tariff at Time of Inspection:**<br>£623 - 682 |

## 3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards and theme have been met:

**Standard 19: Communicating Effectively**
**Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)**

## 4. Methods/Process

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

- discussion with the nurse in charge
- discussion with patients
- discussion with staff
- review of care records
- observation during an inspection of the premises
- evaluation and feedback.

The inspector met with six patients individually and with others in groups, five care staff, two nursing staff, two ancillary staff and one patient's visitors/representative.

Prior to inspection the following records were analysed:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report.

The following records were examined during the inspection:

- staff duty rotas
- staff training records
- staff competency and capability records

- staff induction records
- four care records
- a selection of policies and procedures
- incident and accident records
- monthly quality monitoring reports by the registered provider
- guidance for staff in relation to palliative and end of life care.

## 5. The Inspection

### 5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced medicines management inspection on 20 July 2015. The completed QIP has been returned and approved by the pharmacy inspector.

### 5.2 Review of Requirements and Recommendations from the last care Inspection

<table>
<tr><th colspan="2">Last Care Inspection Statutory Requirements</th><th>Validation of Compliance</th></tr>
<tr><td rowspan="2">Requirement 1<br><br>Ref: Regulation 13(7)<br><br>Stated: Second time</td><td>The registered person must make suitable arrangements to minimise the risk of infections and toxic conditions and the spread of infection between patients and staff by:<br><br>• Ensuring a foot operated pedal bin is in place for the disposal of paper towels following hand-washing in order to prevent re-contamination of hands by touching the lid<br>• Ensuring the laundry system is reviewed to separate laundered (clean) items from those which still require to be laundered<br>• Equipment should not be stored in bathroom areas.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:<br>An inspection of the premises evidenced that foot operated pedal bins were available throughout the home. A previous store room had been converted to house washing machines ensuring that clean items were separated from items waiting to be laundered. Staff consulted confirmed that the system was working well.<br><br>It was ascertained in a telephone conversation with the registered provider on the day after the inspection that a variation application had not been submitted for a change of the use of the room.</td></tr>
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| | The relevant forms were sent to the registered provider by RQIA's registration department following the inspection. A recommendation has been made in this regard.<br><br>The bathroom areas were not being used for storage of inappropriate equipment and a review of staff meeting minutes evidenced that this had been reinforced with staff.<br><br>This requirement has been met. | |
| **Requirement 2**<br><br>**Ref**: Regulation 13(7)<br><br>**Stated:** First time | The registered person must ensure that<br><br>• The fridge in the dining room is kept clean<br>• the dining room is not used as a storage area<br>• the floor of identified store is kept clean<br>• commode buckets in the sluices are stored off the floor. | **Partially Met** |
| | **Action taken as confirmed during the inspection**:<br>An inspection of the premises found that the fridge in the dining room was not clean. The nurse in charge stated that this fridge was not in use but there were food items found in the fridge.<br><br>The dining room was no longer being used as a storage area and was observed to be tidy and uncluttered.<br><br>All floors in the home were found to be clean.<br><br>Commode buckets were found to be stored on the floor and stacked inside one another not in accordance with best practice in infection prevention and control.<br><br>This requirement has been partially met and the elements concerning the fridge and the commode buckets have been stated for a second time. | |
| **Requirement 3**<br><br>**Ref**: Regulation 16 (1)<br><br>**Stated:** First time | The registered person must ensure that a care plan is in place to address needs identified through the assessment process in relation to wound care. | **Met** |
| | **Action taken as confirmed during the inspection**: | |

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| | Care records of patients with wounds were reviewed and care plans were found to be in place as required. However, it could not be ascertained from the record how often the wound had been redressed and the condition of the wound at each dressing change.<br>Furthermore, the care plan for one patient had not been updated to reflect a change to the dressing being used.<br>This requirement has been met but a further requirement has been made in relation to wound care documentation. | |
| **Requirement 4**<br><br>**Ref**: Regulation 19 (1) (b)<br><br>**Stated:** First time | The registered person must ensure that patients' records are kept securely to ensure confidentiality is maintained. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>All patients' records were now being held securely and confidentially.<br><br>This requirement has been met. | |
| **Last Care Inspection Recommendations** | | **Validation of Compliance** |
| **Recommendation 1**<br><br>**Ref**: Standard 19.1<br><br>**Stated:** First time | The registered person must ensure that<br><br>• Bowel and bladder assessments are completed for all patients<br>• separate care plans to manage continence are in place for each individual assessed need. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>A review of the care records evidenced that bowel and bladder assessments had been completed. The findings of these assessments had been incorporated in to a care plan for the individual.<br><br>This recommendation has been met. | |
| **Recommendation 2**<br><br>**Ref**: Standard 26<br><br>**Stated:** First time | The registered person must ensure that policies and procedures in relation to continence management are reviewed in line with current best practice as defined by professional bodies and national standard setting organisations. | **Not Met** |

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| | **Action taken as confirmed during the inspection**:<br>Although up to date continence guidelines were available for staff, the continence management policy had not been updated to reflect these.<br><br>This recommendation has not been met and has been stated for the second time. | |

## 5.3 Standard 19 - Communicating Effectively

### Is Care Safe? (Quality of Life)

There was no policy or procedure available on communicating effectively/ delivering bad news. Best practice guidelines including the regional guidelines on Breaking Bad News were available in a resource folder for staff. A recommendation has been made that a policy on delivering bad news is developed with reference to current guidelines.

A review of training records evidenced that staff had not undertaken training in relation to communicating effectively with patients and their families/representatives. However, discussion with staff evidenced that they were knowledgeable regarding this aspect of care.

### Is Care Effective? (Quality of Management)

Care records reflected patient's individual needs and wishes regarding end of life care. Records included reference to the patient's specific communication needs such as sensory or cognitive impairment. A review of care records evidenced that the breaking of bad news was discussed with patients and/or their representatives, options and treatment plans were also discussed, where appropriate.

There was evidence within care records reviewed that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs.

### Is Care Compassionate? (Quality of Care)

Staff spoken with were knowledgeable about how to communicate sensitively with patients and their family members/ representatives. They emphasised the importance of privacy and regular, ongoing communication to build up effective, professional relationships with patients and their representatives. There was evidence of this communication in the care records examined.

One patient's relative was spoken with and stated that they were delighted with the care provided in the home. They stated that they had never had cause to complain and staff were very kind and had come to know them and the patient very well.

Observations on the day of inspection confirmed that relationships between staff, patients and relatives were friendly and relaxed. Patients' needs were being met promptly and in a dignified manner.

**Areas for Improvement**

It is recommended that a policy on communicating sensitively / delivering bad news be developed and made available to staff with reference to best practice guidelines.

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| **Number of Requirements:** | **0** | **Number of Recommendations**: | **1** |

## 5.4 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

**Is Care Safe? (Quality of Life)**

Two policies entitled “death of a resident” and “terminally ill” were available. These had not been reviewed since 2010 and were therefore, not reflective of best practice guidance such as the Gain Palliative Care Guidelines (2013). A recommendation had been made that the policy for dying and death be updated to reflect current best practice guidelines and this is shared with staff.

Training records evidenced that three nursing staff had completed e-learning training in end of life care and advanced care planning this year. Greater numbers of staff would require training given that the home is specifically registered for the care of the terminally ill and a recommendation has been made in this regard. Registered nursing staff and care staff were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines (2013).

Discussion with nursing staff and a review of care records confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with the staff and a review of care records evidenced that staff were proactive in identifying when a patient’s condition was deteriorating or nearing end of life and that appropriate actions had been taken.

A protocol for timely access to any specialist equipment or drugs was in place and discussion with staff confirmed their knowledge of the protocol.

Staff were trained and competent in the management of syringe drivers and were supported by the local Trust nursing staff in this regard.

**Is Care Effective? (Quality of Management)**

A review of care records evidenced that patients’ needs for palliative and end of life care were assessed and reviewed on an ongoing basis. This included the management of hydration and nutrition, pain management and symptom management. There was evidence that the patient’s wishes and their social, cultural and religious preferences were also considered. Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements.

A named nurse was identified for each patient approaching end of life. There was evidence that referrals had been made to the specialist palliative care team and where instructions had been provided, these were evidently adhered to. Staff commented on the value of this support.

Discussion with the staff and a review of care records evidenced that environmental factors had been considered as a patient neared the end of life. Management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying.

A review of notifications of death to RQIA during the previous inspection year evidenced that these had been appropriately managed.

**Is Care Compassionate? (Quality of Care)**

Discussion with staff and a review of care records evidenced that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences regarding end of life care. Staff consulted demonstrated an awareness of patient's expressed wishes and needs as identified in their care plan. Some of the staff stated that they would sit with the patient and offer prayers, as appropriate, or hold the patient's hand as they neared end of life. Patients' spiritual advisors were made welcome and there was a weekly mass held in the home.

Arrangements were in place to facilitate, as far as possible, in accordance with the persons' wishes, for family/friends to spend as much time as they wished with the person. A comfortable chair was provided in the patient's room and there was also access to an upstairs lounge. Regular beverages and snacks were given to family members and they were welcome to sit at any time.

From discussion with the staff, relatives and a review of the compliments record, there was evidence that arrangements in the home were sufficient to support relatives during this time. There was evidence within compliments records that relatives had highly commended the management and staff for their efforts towards the family and patient. A review of the complaints records evidenced that no concerns were raised in relation to the arrangements regarding the end of life care of patients in the home.

Staff consulted confirmed that they were given an opportunity to pay their respects after a patient's death. Prior to the remains of the deceased person leaving the home staff stated that it was customary for them to gather in the main reception area to join in prayers with the family. In addition, tray bakes and a card were sent to the family and members of staff would attend the memorial services.

From discussion with the manager and staff, it was evident that staff were supported by their manager and the team following the death of a patient. Information regarding support services was available and accessible for staff, patients and their relatives.

**Areas for Improvement**

It is recommended that the policy for dying and death be updated to reflect current best practice guidelines and this is shared with staff.

It is recommended that staff update their knowledge of palliative and end of life care by training or other means in accordance with the statement of purpose and the needs of the patients.

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| **Number of Requirements:** | **0** | **Number of Recommendations: *1 recommendation made is stated under Standard 19 above** | **3** |

### 5.5 Additional Areas Examined

#### 5.5.1. Environment

An inspection of the premises found these to be well presented to a good standard of hygiene and décor. Window boxes and hanging baskets had been prepared with the help of patients and placed outside, making an attractive display. Staff and one relative consulted commented on the homely and friendly atmosphere in the home.

A number of issues were identified with infection prevention and control. It was noted that the emergency call pull cords in the bathrooms required fully wipeable covers. Moving and handling slings were hanging on pegs in the corridors including toileting slings. Toileting slings should be provided for single patient use or decontaminated between each use. A previous requirement in relation to infection control has also been stated for a second time. A recommendation has therefore, been made that regular auditing of the environment and infection control practices are undertaken to ensure compliance with best practice in infection prevention and control.

Throughout the home tubs of thickening agent were found which were either not labelled or tubs labelled for one patient were in another patient's room. This is a prescribed product and should labelled and administered only to the patient for whom it has been prescribed. A requirement has been made in this regard.

The lunch time meal was observed and it was noted that patients were being assisted appropriately by staff and were enjoying their meals. It was noted, however, that the patients had no clothing protectors but were wearing blue plastic aprons. Some of the patients' clothes had become soiled as a result. This was discussed with the nurse in charge who explained that there had been a delay in supplying freshly laundered clothing protectors due to short notice sickness of the laundry staff member on the day of inspection. The protectors were delivered to the dining room toward the end of the meal. The nurse assured the inspector that these were usually available to patients and any patients affected were promptly assisted to change their clothes. This will continue to be monitored as part of ongoing inspection activity.

#### 5.5.2. Comments of patients, patients' representatives and staff

As part of the inspection process patients, their representatives and staff were consulted and questionnaires issued. All comments were generally positive. Some comments received are detailed below.

**Patients**

No patients completed questionnaires but those patients spoken with were positive about the home and the staff. They commented on the kindness of the staff and the good quality of the food provided. No concerns were raised on the day of inspection.

Some of the patients were unable to communicate verbally with the inspector but indicated by positive gestures that they were happy in the home. Patients were observed to be well presented and dressed appropriately.

**Patients' Representatives**

One patient's relative was spoken with and they commented on the friendliness and helpfulness of staff. They spoke very highly of the care provided to their loved one and raised no issues of concern.

**Staff**

Questionnaires were issued to staff and one was returned within the required timeframe. The respondent commented:

"Care in our home is delivered to a high standard. Our staff are warm, caring and compassionate and treat all our residents like one of their own family."

Those staff spoken with were happy working in the home and most of them had been working in the home for a number of years. They commented on the friendly atmosphere, good team working and the support given by the registered provider. No concerns were raised by the staff.

### 5.5.3. Management arrangements

A new manager, Vera Ribeiro, had been recently appointed and was not available on the day of inspection. In a telephone conversation with the registered provider on 19 August 2015 she confirmed that a letter had been sent to RQIA notifying us of the change of manager and she was currently undertaking her induction. The registered provider confirmed that Vera Ribeiro intends to apply to become the registered manager of the home.

### 5.5.4. Records kept in the home

The monthly reports of the registered provider's visits were requested for 2015 but could not be found by the nursing staff. It was agreed that these would be forwarded to RQIA by 26 August 2015. The registered provider sent these to RQIA by email later on the day of the inspection. The registered provider stated that she had been working on these the day before the inspection and they were in another office. It was reinforced with the registered provider that these should always be available for inspection.

An examination of the off duty rota found that these had not been updated to reflect the actual staff who had worked in each 24 hour period and did not always indicate who had covered a vacant shift. Two different versions of one week's off duty were presented. A recommendation has been made that the off duty rota is kept up to date and clearly reflects the staff who worked over each 24 hour period and the capacity in which they worked.

## 6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Staff Nurse Leeann Noble as part of the inspection process.

Further feedback was given via telephone to Orla Sheehan, registered provider and Vera Ribeiro, manager, on 19 August 2015. 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.

### 6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

### 6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes, April 2015. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

### 6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/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. 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 home. 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 home.

## Quality Improvement Plan

| Statutory Requirements | |
|---|---|
| **Requirement 1**<br><br>**Ref**: Regulation 13 (7)<br><br>**Stated:** Second time<br><br>**To be Completed by:**<br>18 September 2015 | The registered person must ensure that:<br><br>• the fridge in the dining room is kept clean<br>• commode buckets in the sluices are stored off the floor.<br><br>**Response by Registered Person(s) Detailing the Actions Taken:**<br>Fridge in the dining room, used for daily stock of residents supplements, has has schedule attached to ensure domestic staff clean on a daily basis.<br>Domestic staff to ensure commode buckets are not stored on the floor when cleaning sluice room. Supervisions to be carried with staff, as needed. |
| **Requirement 2**<br><br>**Ref:** Regulation 16 (2) (b)<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>18 September 2015 | The patient's care plan must be kept under review in relation to wound care. The care plan must reflect the current dressing in use. The wound must be reassessed at each dressing change and this assessment documented in accordance with best practice guidelines.<br><br>**Response by Registered Person(s) Detailing the Actions Taken:**<br>New informative folder in place for nurses, with best practice guidelines and clear instruction about the procedures regarding wounds / treatment and records. Nurses to attend training if deemed necessary.<br>Care plans for wounds reviewed by Nurse Manager on a monthly basis. |
| **Requirement 3**<br><br>**Ref:** Regulation 13 (4) (b)<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>31 October 2015 | Prescribed thickening agent should be labelled and only be administered to the patient for whom it is prescribed.<br><br>**Response by Registered Person(s) Detailing the Actions Taken:**<br>Each resident prescribed with thickening agents, has own stock stored in his/her room according to guidelines. Spot audits, and supervision carried with staff to ensure administration according best-practice guidelines |

| Recommendations | |
|---|---|
| **Recommendation 1**<br><br>**Ref**: Standard 26<br><br>**Stated:** Second time<br><br>**To be Completed by:**<br>30 November 2015 | The registered person must ensure that policies and procedures in relation to continence management are reviewed in line with current best practice as defined by professional bodies and national standard setting organisations. |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>Policy manual under review. All policies are being revised according to must recent guidelines for good practice. Policies and procedures regarding continence management will be in place by date requested. Staff awareness raised in regards to records, and training needs identified.<br>Continence management informative folder will be held on Nurses station to easy access for nurses and care staff. |
| **Recommendation 2**<br><br>**Ref**: Standard 19<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>30 November 2015 | It is recommended that a policy on communicating sensitively / delivering bad news be developed and made available to staff with reference to best practice guidelines. |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>As stated above Policy Manual under review. New policy regarding communicating sensitively and delivering bad news will be added as appropriate to Manual.<br>Community resources gathered in order to provide staff with more information and update skills regarding this subject. |
| **Recommendation 3**<br><br>**Ref**: Standard 20<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>30 November 2015 | The policy for dying and death should be updated to reflect current best practice guidelines and this shared with staff. |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>Policy to be reviewed, updated and in place with new Manual.<br>Community resources gathered in order to update staff knowledge and skills in this matter. |
| **Recommendation 4**<br><br>**Ref**: Standard 20<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>30 November 2015 | Staff should update their knowledge of palliative and end of life care by training or other means in accordance with the statement of purpose and the needs of the patients. |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>Palliative and end of life care training made available for all nurses on on-line platform. Discussed with community facilitator regarding training calendar for the following months in order to identify adequate training for staff. Palliative care information folder with best practice guidelines in nurses station for all staff consultation. |

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| **Recommendation 5**<br><br>**Ref**: Standard 41<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>30 November 2015 | The off duty rota should be kept up to date and clearly reflect the staff who worked over each 24 hour period and the capacity in which they worked. |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>Staff rotas are organised into three different departments, registered nurses, care assistants and ancillary/kitchen. All staff aware that changes to the rota are only made by the nurse manager or nurse sister. nurse manager to verify and transcribe rotas according to needs as to ensure rota is clear. |
| **Recommendation 6**<br><br>**Ref**: Standard 44<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>30 September 2015 | A variation application should be submitted to RQIA in relation to the change of the use of a store room to a laundry room. |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>A minor variation application to change a general store into a laundry room is being summited by the proprietor. |
| **Recommendation 7**<br><br>**Ref**: Standard 46<br><br>**Stated:** First time<br><br>**To be Completed by:**<br>30 September 2015 | Regular audits of the environment and infection control practices should be undertaken and actions taken as appropriate, to ensure compliance with best practice in infection prevention and control. |
| | **Response by Registered Person(s) Detailing the Actions Taken:**<br>Health and safety current guidelines under review. Audits to be undertaken / actioned and recorded according to current minimum standards for nursing homes and most updated best practice guidelines. |

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| **Registered Manager Completing QIP** | Vera Ribeiro | **Date Completed** | 16.10.2015 |
| **Registered Person Approving QIP** | Orla Sheehan | **Date Approved** | 20.10.2015 |
| **RQIA Inspector Assessing Response** | Karen Scarlett | **Date Approved** | 21.10.2015 |

***Please ensure the QIP is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address***