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Unannounced Care Inspection
of
Kingsway

16 April 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 16 April 2015 from 10.00 to 19.30.
The focus of this inspection was continence management which was underpinned by selected criterion from DHSSPS (NI) Care standards for Nursing Homes April 2015:

Standard 4: Individualised Care and Support
Standard 6: Privacy, dignity and Personal Care
Standard 21: Heath care
Standard 39: Staff training and development.

Overall on the day of inspection, concerns and areas for improvement were identified and are required to be addressed to ensure that care in the home is safe, effective and compassionate. These areas are set out in the Quality Improvement Plan (QIP) within this report. Refer also to section 1.2 below.

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 section 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 4 September 2015.

1.2 Actions/Enforcement Resulting from this Inspection

As a result of this inspection, an urgent action record regarding staffing, patient dependency levels and the management of restraint was issued to the registered manager at the end of the inspection. These actions are required to be addressed without delay to ensure the safety and wellbeing of patients.

RQIA were concerned that the quality of care and services within Kingsway was below the minimum standard expected. The inspection findings were reported to senior management in RQIA, following which a decision was taken to hold a serious concerns meeting with the registered persons. The inspection findings were communicated in correspondence to the registered persons and the meeting took place at RQIA on 29 April 2015.

At this meeting an action plan was presented detailing how these matters are to be addressed. It was agreed that this action plan would be reviewed by RQIA. It was further agreed that the registered persons would be given a period of time to address these issues. RQIA will carry out a follow-up inspection to assess compliance with the legislative requirements and care standards.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**6**	**7**

The details of the Quality Improvement Plan (QIP) within this report were discussed with the registered manager, Stuart Johnstone, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Care Circle Limited/Ciaran Sheehan	**Registered Manager:** Stuart Mathew Johnstone
Person in Charge of the Home at the Time of Inspection: Stuart Mathew Johnstone	**Date Manager Registered:** 15/10/14
Categories of Care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of Registered Places:** 69
Number of Patients Accommodated on Day of Inspection: 60	**Weekly Tariff at Time of Inspection:** £593 - £1163

3. Inspection Focus

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

Standard 4: Individualised Care and Support, criterion 8
Standard 6: Privacy, dignity and Personal Care, criteria 1, 3, 4, 8 and 15
Standard 21: Heath care, criteria 6, 7 and 11
Standard 39: Staff training and development, criterion 4.

4. Methods/Process

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

- discussion with the registered manager
- discussion with patients
- discussion with staff
- review of care records
- observation during an inspection of the premises
- evaluation and feedback.

The inspector met with nine patients individually and with the majority of others in groups, three nursing staff, five care staff and two patient's visitors/representatives.

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
- three patient care records and a number of daily care charts
- a selection of policies and procedures
- guidance for staff in relation to continence care
- complaints
- restraint register
- monthly quality visits.

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 3 March 2015. This inspection was conducted as a follow up to assess compliance and progress following a previous medicines management inspection on 7 October 2014. The inspection of 3 March 2015 demonstrated significant improvement in the management of medicines. The completed QIP was returned and approved by the pharmacy inspector.

5.2 Review of Requirements and Recommendations from the last Care Inspection

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 29 (5)	It is required that a report in respect of the unannounced monitoring visit in accordance with Regulation 29 is available for each month. The report compiled should reflect the findings made at the time of the visit to the home. Reports should state the identity of the person who carried out the unannounced monitoring visit.	**Met**
	Action taken as confirmed during the inspection: A review of Regulation 29 monthly quality reports evidenced that these were available and up to date. The identity of the person carrying out the visits was recorded.	
Requirement 2 **Ref**: Regulation 14 (2) (c)	It is required that at the time of each patient's admission to the home, the following information should be completed on the day of admission to the home. •a validated nursing assessment such as Roper, Logan and Tierney •a validated bedrail assessment •a validated pressure risk assessment such as Braden Pressure Ulcer risk •a validated nutritional risk assessment such as MUST •a validated falls risk assessment •a validated safe moving and handling assessment •an assessment of the patient's skin integrity or body map assessment record.	**Not Met**
	Action taken as confirmed during the inspection: A review of care records evidenced that the majority of risk assessments had not been completed at the time of admission to the home. This requirement has not been met and has been stated for a second time.	

Requirement 3 **Ref**: Regulation 16 (1) & (2) (a)	It is required that a nursing plan is prepared as to how the patient's needs in respect of his health and welfare are to be met and that the patient's plan is kept under review. The registered person must ensure that care plans contain the necessary detail to direct care and that they are revised and updated to reflect the current treatment prescribed.	**Met**
	Action taken as confirmed during the inspection: In the three records examined the care plans were found to be up to date and reflective of the patients' needs. There was evidence that these were being reviewed monthly.	
Requirement 4 **Ref**: Regulation 13 (1) (b)	It is required that the registered person shall ensure that the nursing home is conducted so as to make proper provision for the nursing and where appropriate, treatment and supervision of patients. Wound care must be delivered as prescribed and records maintained to evidence delivery.	**Partially Met**
	Action taken as confirmed during the inspection: A review of two care records evidenced inconsistency in evidencing the delivery of wound care. One record was appropriately maintained but the other record did not provide sufficient detail to confirm that wound care was being delivered as prescribed. This requirement has been partially met and will be stated for the second time.	

Requirement 5 **Ref**: Regulation 19 (1) (a), schedule 3, 2 (k)	The registered person must maintain contemporaneous notes of all nursing provided to the patient. Repositioning charts and daily fluid charts must be accurately maintained to evidence care delivered.	**Not Met**
	Action taken as confirmed during the inspection: An examination of repositioning charts confirmed that there were regularly no entries made to confirm the repositioning of patients for 8 hours and over. The charts did not state the frequency of repositioning required for each patient. The actual position of the patient was not recorded on the chart, for example, right side, left side, back. An examination of fluid balance charts found these to be inconsistently completed. They included only the intake of the patient and not the output and did not set an individualised fluid intake target. This requirement has been stated for the second time.	

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 5.2	The registered manager should ensure the evidence based Bristol Stool chart is consistently referred to and recorded in the assessment and care planning care records for each patient.	**Not Met**
	Action taken as confirmed during the inspection: An examination of three care records and a sample of bowel charts could not evidence that the Bristol stool chart was referred to in the assessment and care planning records. This recommendation has been stated for the third time.	
Recommendation 2 **Ref**: Standard 25.13	A summative report of the home's patient satisfaction consultation process and learning outcomes should be developed and made available to patients and their representatives.	**Carried forward until next inspection**
	Action taken as confirmed during the inspection: This was not examined during this inspection and has been carried forward until the next inspection.	
Recommendation 3 **Ref**: Standard 5.6	It is recommended that bowel function, reflective of the British Stool Chart is recorded on admission as a baseline measurement and thereafter in patients' daily progress records.	**Not Met**
	Action taken as confirmed during the inspection: An examination of three care records and a sample of bowel charts could not evidence that the Bristol stool chart was recorded on admission or referred to in daily progress notes. This recommendation has been stated for the second time.	

Recommendation 4 **Ref**: Standard 11.7	The registered nurse's competency and capability assessment should include pressure ulcer/wound care management and be reviewed annually by the registered manager.	**Carried forward until next inspection**
	Action taken as confirmed during the inspection: This was not examined during this inspection and has been carried forward until the next inspection.	
Recommendation 5 **Ref**: Standard 30.9	It is recommended that staff meetings take place on a regular basis and at least quarterly.	**Met**
	Action taken as confirmed during the inspection: Minutes of staff meetings were made available at inspection and staff confirmed that they were attending these meetings.	
Recommendation 6 **Ref**: Standard 5.6	It is recommended that all drinks offered are recorded as either consumed or refused.	**Not Met**
	Action taken as confirmed during the inspection: Fluid charts were inconsistently completed and did not record if drinks were consumed or refused. This recommendation has been stated for the second time.	
Recommendation 7 **Ref**: Standard 5.4	It is recommended that assessments and care plans are reviewed and updated on at least a monthly basis or more often if required.	**Met**
	Action taken as confirmed during the inspection: An examination of three care records evidenced that care plans were being reviewed on a monthly basis. Any risk assessments were being reviewed monthly but not all risk assessments were in place for each patient. This recommendation has been met; however, for further information on the completion of risk assessments refer to section 5.2, requirement 2.	

5.3 Continence Care and Management

Is Care Safe? (Quality of Life)

There were up to date policies in place for continence care and management and care of urinary catheters. NICE guidelines on the management of faecal incontinence were available for staff but no other guidance was available.

Discussion with the registered manager and staff confirmed that staff had received training in continence care in the past. Further continence training was to be provided by the local Trust in May 2015. The registered manager confirmed that he was trained and competent in male catheterisation and was supporting the registered nurses in the home to develop their competency in this aspect of care.

All staff spoken with were knowledgeable about the important aspects of continence care including the importance of dignity, privacy and respect as well as skincare, hydration and reporting of any concerns.

Is Care Effective? (Quality of Management)

Of the three records examined only one patient had a continence assessment completed. There was evidence that continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. The care plans reviewed addressed the patients' assessed needs in regard to continence management. Urinalysis was undertaken as required and patients were referred to their GPs as appropriate.

Review of care records and discussion with patients evidenced that either they or their representatives, had been involved in discussions regarding the agreeing and planning of nursing interventions.

Monthly quality monitoring within the home included an audit of care records which incorporates continence care.

Discussion with staff and observation evidenced that there were adequate stocks of continence products available in the nursing home.

Is Care Compassionate? (Quality of Care)

A number of issues were identified in relation to continence care by patients, relatives and staff.

Patients reported that they were waiting for up to an hour for buzzers to be answered and confirmed that they had been incontinent in the meantime. Patients were of the opinion that there were not enough staff, so they tended to rush in and out and there were interruptions to the care being provided as care staff were called away to help someone else. Others stated that they had to wait to be bathed and fed.

Care assistants stated that their numbers had been reduced in recent months on the nursing unit. They stated that patients were waiting for 20 to 30 minutes for the toilet and had been incontinent in the meantime. They also reported that patients were waiting to be bed bathed and were being left for long periods in chairs without repositioning. One staff member

commented that they were struggling to meet the basic needs of the patients particularly in regards to continence care and fluid intake. Another stated that the continence care "was the best they could provide under the circumstances."

All care assistants were of the opinion that they were unable to provide the standard of care they would like to give.

Two registered nurses spoken with were of the opinion that continence care was of a good standard and that the care assistants reported any concerns. One did comment that the documentation of continence care could be improved and that care staff needed reminded to empty urinary catheter bags.

Two relatives also commented that their loved ones had to wait for a long time for buzzers to be answered.

Areas for Improvement

It is recommended that additional guidelines relating to the management of continence/incontinence are made available to staff; for example:

- RCN continence care guidelines
- British Geriatrics Society Continence Care in Residential and Nursing Homes
- NICE guidelines on the management of urinary incontinence

It is recommended that a continence assessment is undertaken for all patients.

Please refer to section 5.4 for more information regarding staffing and the patients', relatives' and staff comments detailed above and the actions taken.

Number of Requirements	**0**	**Number of Recommendations**	**2**

5.4 Additional Areas Examined

5.4.1 Staffing and staff comments

Staff and patients commented on the use of agency staff and the high turnover of staff in recent months. Following the comments of patients, relatives and staff the duty rotas for weeks commencing 30 March, 6 April and 13 April 2015 were examined. This evidenced that a number of morning shifts in the nursing unit had not been sufficiently staffed. There was also significant use of agency nurses and care assistants to cover shifts.

During discussion the registered manager provided a breakdown of current patient dependency levels using the Rhys Hearn tool (1970). Current staffing levels had been calculated using this tool. During discussion it was emphasised that while this tool was a useful guide in ensuring that the assessed needs of patients were met, an overreliance on this calculation should be avoided.

As well as reports from patients, relatives and staff of delays in answering buzzers and providing continence care there were also concerns raised by staff that patients were sitting too long in their chairs without repositioning. As detailed in section 5.2, gaps of up to eight

hours or more between repositioning were evidenced from a review of repositioning charts. This was concerning due to the risk of the development of pressure ulcers.

Staff also reported that patients had to wait for bed baths in the morning. Some staff also reported having insufficient time to offer fluids to dependent patients and it was noted that fluid charts were inconsistently completed.

Questionnaires were distributed to staff and comments included:

"I feel the quality of care is excellent and reflective in the attitudes of the residents."
"Management is excellent and supportive."
"Not enough staff!"
"I feel that the vast majority of my colleagues are very caring with the residents."
"At times I have not been satisfied with the level of privacy and dignity and respect. There are a number of staff that do genuinely care for residents but not all."

Since the last care inspection five complaints had also been received via RQIA's duty system from relatives and staff alleging medicines management issues, staffing levels, inappropriate care practices and shortfalls in care provision. Another complaint from an anonymous staff member alleging shortfalls in care provision was received in the week following the inspection.

Following consideration of all the evidence presented an urgent action record was issued on the day of inspection. This required the current dependency levels of patients to be submitted and these were provided prior to RQIA leaving the home. Staffing levels were found to be reflective of the calculated dependency levels of patients. In addition the registered persons were required to review the numbers and deployment of staff to ensure that patients' needs were being met in a timely manner and to inform RQIA of the outcome. The response to the urgent action record was received within the required timeframe and a number of actions were proposed by the registered manager.

Following the inspection RQIA senior management were consulted and the registered persons were invited to a serious concerns meeting at RQIA on 29 April 2015 at which they were invited to present an action plan as to how these concerns were to be addressed.
The registered provider presented an action plan and copies of this were required to be submitted to RQIA for review by 8 May 2015. This was received within the required timeframe. It was agreed to allow the registered provider a period of time to implement the action plan and to address the concerns raised. RQIA will continue to monitor the quality of service provided in Kingsway and will carry out a follow-up inspection to assess compliance with the legislative requirements and care standards. A requirement has been made regarding staffing numbers and deployment to ensure the needs of patients are met.

5.4.2 Care practices

Relationships between staff and patients were observed to be cordial and friendly. Staff were observed assisting patients at meal times and to the lounges. Hospitality staff were offering regular drinks and snacks in the lounges. Patients and relatives confirmed that the majority of staff were friendly, polite and kind.

A number of patients were observed in the downstairs lounge seated in tilting chairs and in wheelchairs with lap straps in place. The restraint register was reviewed and these patients were not included within this register. An urgent action record was issued on the day of

inspection. This required that the use of lap belts and tilted chairs be reviewed to ensure that the decision making process was clear, that multi-disciplinary discussion had taken place and care plans reviewed by 24 April 2015.

The response was received within the required time frame and offered assurances that the care plans and consent forms were being reviewed, multi-disciplinary involvement sought where appropriate and risk management strategies put in place. In addition staff training and awareness has been arranged and the restraint register updated. A requirement has been made in this regard and the outcomes will be monitored as part of ongoing inspection activity.

5.4.3 Management of complaints

Given the number of complaints by staff, patients and relatives the complaints records were reviewed. These were presented in a file containing only two complaint records. There was evidence that these complaints were appropriately responded to. However, there was no complaints book in use and the arrangements for recording complaints was found to be insufficiently robust to evidence that complaints were managed appropriately.

A requirement has been made. This was discussed with RQIA senior management and was discussed at the serious concerns meeting on 29 April 2015. At this meeting, as part of the action plan presented, the registered providers confirmed that actions were to be taken to inform patients and their representatives of the complaints process. In addition, measures were to be taken to strengthen the complaints process to ensure this was more robust and systematic.

5.4.4 Comments by patients and relatives

As part of the inspection process patients and their representatives were consulted and questionnaires issued. Some comments received are detailed below:

Patients' comments

Patients were unable to complete the questionnaires but comments made during discussion included:

"I sometimes have to wait for the buzzer but I am otherwise happy."
"Some carers are good but others are not. I have to wait for the buzzer. I waited for an hour and had to sit in my own mess."
"I can go to the toilet myself but I see others waiting a long time."
"Staff have no time for the residents and care is hurried."
"The girls are pretty good but they are short staffed."

Patients' representatives' comments

Two relatives commented on the care provided. One relative commented that staff were always kind and friendly but that the patients could be waiting a long time for their buzzer to be answered. Another relative commented that their loved one had to wait for the buzzer and it was often too late. They were of the opinion that the home was always short staffed and that more and more staff were leaving due to the stress. They had raised issues with the home management before but stated that they felt there was no point as issues were not being addressed. Refer to section 5.4.3 for more details of the actions taken regarding complaints management.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mr Stuart Johnstone as part of the inspection process. The timescales commence from the date of inspection.

The registered persons 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 persons 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 Home 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 persons to detail the actions taken to meet the legislative requirements stated. The registered persons 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 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 **Ref**: Regulation 14 (2) (c) **Stated:** Second time **To be Completed by:** 16 July 2015	It is required that at the time of each patient's admission to the home, the following information should be completed on the day of admission to the home. •a validated nursing assessment such as Roper, Logan and Tierney •a validated bedrail assessment •a validated pressure risk assessment such as Braden Pressure Ulcer risk •a validated nutritional risk assessment such as MUST •a validated falls risk assessment •a validated safe moving and handling assessment •an assessment of the patient's skin integrity or body map assessment record.
	Response by Registered Manager Detailing the Actions Taken: All validated tools and assessments are contained within individual care profiles. Training and clinical supervision sessions are being held with the RN's during June. These sessions will be performed by the Home Manager to ensure protocols and procedures for completion of documentation on admission are clear.
Requirement 2 **Ref:** Regulation 13 (1) (b) **Stated:** Second time **To be Completed by:** 16 July 2015	It is required that the registered person shall ensure that the nursing home is conducted so as to make proper provision for the nursing and where appropriate, treatment and supervision of patients. Wound care must be delivered as prescribed and records maintained to evidence delivery.
	Response by Registered Manager Detailing the Actions Taken: Wound care documentation has been put in place and will be monitored through the auditing process. Staff made aware of referral process through tissue viability.
Requirement 3 **Ref:** Regulation 19 (1) (a) Schedule 3, 2 (k) **Stated:** Second time **To be Completed by:** 16 July 2015	The registered person must maintain contemporaneous notes of all nursing provided to the patient. Repositioning charts and daily fluid charts must be accurately maintained to evidence care delivered.
	Response by Registered Manager Detailing the Actions Taken: All recording of all daily charts is being monitored by senior staff. Team Leaders and RN's are spot checking throughout the day. Company trainer has performed clinical supervisions with care staff regarding the importance of accurate recording.

Requirement 4 Ref: Regulation 20 (1) (a) (b) **Stated:** First time **To be Completed by:** 16 July 2015	The registered persons must review staffing to ensure that suitably qualified, competent and experienced person are working at the nursing home in such numbers as are appropriate for the health and welfare of patients. The registered persons must also ensure that the employment of any persons on a temporary basis will not prevent patients from receiving such continuity of nursing as is reasonable to meet their needs.
	Response by Registered Manager Detailing the Actions Taken: Staffing is reviewed to meet dependency levels within the home and to ensure correct skill mix. Recruitment and training is ongoing to ensure all staff are professionally qualified, fully inducted and all relevent area's in the home are staffed to meet the needs and welfare of the patients. The distribution and skill mix of staff is currently under review.
Requirement 5 Ref: Regulation 14 (5) & (6) **Stated:** First time **To be Completed by:** 16 July 2015	The registered persons must review the use of lap belts and tilted chairs for individual patients to ensure this is the only practicable means of securing the patients welfare. In addition the circumstances/ decision making process for the use of restraint and the type of restraint used must be recorded including the nature of the restraint.
	Response by Registered Manager Detailing the Actions Taken: All patients who currently have lap straps in place are being reviewed involving the patient, NOK and multi disciplinary team. Where it is agreed this is the only practicable means of ensuring the patients welfare a care plan has been implemented in agreement with all involved in the decision making process. The restraint register has been reviewed to include evidence of care planning and risk assessment and will be audited monthly.
Requirement 6 Ref: Regulation 24 (1) (2) (3) & (4) **Stated:** First time **To be Completed by:** 16 July 2015	The registered persons must have robust procedures in place for the management of complaints.
	Response by Registered Manager Detailing the Actions Taken: All complaints are recorded in the complaints register and will be audited monthly.

Recommendations	
Carried forward until next inspection **Ref:** Standard 25.13 **Stated:** First time	A summative report of the home's patient satisfaction consultation process and learning outcomes should be developed and made available to patients and their representatives.
	Response by Registered Manager Detailing the Actions Taken: Quality assurance questionnaires will be distributed early September 2015 to all Residents and Relatives. A full analysis report will be made available to Residents and their representatives when completed.
Carried forward until next inspection **Ref:** Standard 11.7 **Stated:** Second time	The registered nurse's competency and capability assessment should include pressure ulcer/wound care management and be reviewed annually by the registered manager.
	Response by Registered Manager Detailing the Actions Taken: All Registered Nurses will have an annual competency assessment carried out. These will commence in June
Recommendation 1 **Ref:** Standard 5.2 **Stated:** Third **To be Completed by:** 16 July 2015	The registered manager should ensure the evidence based Bristol Stool chart is consistently referred to and recorded in the assessment and care planning care records for each patient.
	Response by Registered Manager Detailing the Actions Taken: Registered Nurses will reflect in daily progress notes the use of the Bristol Stool Chart
Recommendation 2 **Ref:** Standard 5.6 **Stated:** Second time **To be Completed by:** 16 July 2015	It is recommended that bowel function, reflective of the British Stool Chart is recorded on admission as a baseline measurement and thereafter in patients' daily progress records.
	Response by Registered Manager Detailing the Actions Taken: Baseline measurement of bowel function using the Bristol Stool Chart will be recorded on continance assessment on admission.
Recommendation 3 **Ref:** Standard 5.6 **Stated:** Second time **To be Completed by:** 16 July 2015	It is recommended that all drinks offered are recorded as either consumed or refused.
	Response by Registered Manager Detailing the Actions Taken: All drinks offered will be recorded

Recommendation 4 **Ref**: Standard 4.8 **Stated:** First time **To be Completed by:** 16 May 2015	It is recommended that additional guidelines relating to the management of continence/incontinence are made available to staff; for example: • RCN continence care guidelines • British Geriatrics Society Continence Care in Residential and Nursi Homes • NICE guidelines on the management of urinary incontinence
	Response by Registered Manager Detailing the Actions Taken: Guidelines relating to incontinance are available.
Recommendation 5 **Ref:** Standard 21.6 **Stated:** First time **To be Completed by:** 16 July 2015	Continence assessments should be completed at the time of admission to the home for each patient.
	Response by Registered Manager Detailing the Actions Taken: Continance assessments will be completed on admission.

Registered Manager Completing QIP	Maggie Jess	**Date Completed**	09.06.2015
Registered Person Approving QIP	Ciaran Sheehan	**Date Approved**	9th June 2015
RQIA Inspector Assessing Response	**Karen Scarlett**	**Date Approved**	15/6/15

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

Please provide any additional comments or observations you may wish to make below: