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Unannounced Care Inspection
of
Lisadian House

8 October 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 8 October 2015 from 09.50 to 15.00 hours.

The focus of this inspection was continence management which was underpinned by selected criteria from the DHSSPSNI Care Standards for Nursing Homes (2015):

Standard 4: Individualised Care and Support; Standard 6: Privacy, Dignity and Personal Care; Standard 21: Heath care and Standard 39:Staff Training and Development .

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 21 April 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	**2**	**13**

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

2. Service Details

Registered Organisation/Registered Person: Elim Trust Corporation	**Registered Manager:** See below
Person in Charge of the Home at the Time of Inspection: Ms Esther Bell	**Date Manager Registered:** Ms Esther Bell – registration pending
Categories of Care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of Registered Places:** 45
Number of Patients Accommodated on Day of Inspection: 38	**Weekly Tariff at Time of Inspection:** £593 - £608

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 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 ten patients individually and with the majority of others in groups, six care staff, one ancillary staff member and three nursing staff.

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 induction records
- six care records and a selection of daily charts
- a selection of policies and procedures
- incident and accident records
- care record audits
- guidance for staff in relation to continence care
- minutes of staff meetings
- records of complaints

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 17 June 2015. The completed QIP was returned and approved by the pharmacy inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection

Quality Improvement Plan		
Last Care Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref**: Regulation 14 (2) (c) **Stated:** Third and final time	It is a requirement that at the time of each patient's admission to the home, the following minimum 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. • A validated nutritional risk assessment such as MUST. • A validated falls risk assessment. • A validated safe moving and handling assessment. • A validated continence assessment.	**Met**
	Action taken as confirmed during the inspection: The care record of one recently admitted patient evidenced that the risk assessments had been completed promptly on admission to the home.	

Requirement 2 **Ref:** Regulation 16 (2) (b) **Stated:** Third and final time	It is a requirement that care plans are kept up to date and reflect the patient's current assessment of need and the action taken to meet that need. • Registered nurses must ensure there is evidence of risk assessment and individual assessment of need to show the decision making process when applying any form of restrictive practice. • Bedrail risk assessments must be reviewed monthly or more often as deemed appropriate as per the home's policy.	**Met**
	Action taken as confirmed during the inspection: There was evidence in the care records that a risk assessment for the use of restrictive practices had been completed. The risk assessment was reviewed at least monthly. There was further evidence in the care records that the decision making process had been discussed and agreed with the patient or their representatives.	
Requirement 3 **Ref:** Regulation 15 (2) (a) (b) **Stated:** Second time	The responsible person must ensure that a review of all risk assessments including but not limited to pressure ulcer, manual handling and nutritional assessment is undertaken at least monthly or more often as the patient's condition changes.	**Met**
	Action taken as confirmed during the inspection: There was evidence in the care records that risk assessments were being updated at least monthly.	
Requirement 4 **Ref:** Regulation 16 (1) **Stated:** Second time	The responsible person must ensure that when a risk is identified in the risk assessments a corresponding care plan must be prepared as to how the patient's needs in respect of his health and welfare are to be met.	**Met**
	Action taken as confirmed during the inspection: There was evidence in the care records that when a risk was identified a corresponding care plan was in place to address this. One patient was found to require a care plan for the management of pressure ulcer risk and the manager agreed to complete this urgently.	

Requirement 5 **Ref:** Regulation 30 (1) (a-g) **Stated:** Second time	The responsible person shall give notice to the RQIA without any delay of the occurrence of any death, illness or other event adversely affecting a patient in the nursing home in compliance with regulation 30.	**Met**
	Action taken as confirmed during the inspection: An examination of the incident and accident records evidenced that RQIA were being appropriately notified of these.	
Requirement 6 **Ref:** Regulation 13 (7) **Stated:** First time	Items stored on toilet cisterns in shared patients' bathrooms must be removed and stored appropriately in accordance with best practice in infection prevention and control.	**Not Met**
	Action taken as confirmed during the inspection: On inspection of the premises a number of items including wipes, gloves, bags and slings were observed to be stored in bathrooms. This is not in accordance with best practice in infection prevention and control. This requirement has not been met and has been stated for the second time. In addition a further recommendation has been made that infection prevention and control practices are regularly audited and actions taken to address any deficits.	
Requirement 7 **Ref:** Regulation 16 (2) (b) **Stated:** First time	Care plans must be reviewed at least monthly to reflect the current needs of the patients.	**Met**
	Action taken as confirmed during the inspection: There was evidence within the care records that care plans had been reviewed at least monthly and were reflective of the current needs of the patients.	

Last Care Inspection Recommendations		**Validation of Compliance**
Carried forward until next inspection **Ref:** Standard 26.6 **Stated:** First time	The responsible person must ratify any revision of or introduction of new, policies and procedures.	**Met**
	Action taken as confirmed during the inspection: A selection of new policies was reviewed and had been found to be ratified by the general manager. Responsibility for the ratification of policies has been delegated to the general manager by the registered provider. It was noted that some of the policies were not dated when reviewed. A further recommendation has been made in this regard.	

Carried forward until next inspection **Ref:** Standard 28.1 **Stated:** First time	The responsible person must ensure that staff who are newly appointed complete a structured orientation and induction. • On the day of inspection there was insufficient evidence to verify that 1 newly appointed staff nurse had received an appropriate induction. The general manager must send confirmation that this induction has been completed within two weeks post inspection	**Partially Met**
	Action taken as confirmed during the inspection: The induction of one newly appointed registered nurse was reviewed. This was partially completed and had not been signed by the inductee. This recommendation has been partially met and has been stated for the second time.	
Recommendation 1 **Ref**: Standard 6.4 **Stated:** Second time	It is recommended that the fluid intake and output of each patient, where this is being monitored, is reconciled in to the case records.	**Not Met**
	Action taken as confirmed during the inspection: A review of the fluid balance charts found that the fluid intake of patients was not always totalled correctly. The fluid intake and output was not reconciled to the progress notes. This recommendation has not been met and has been stated for the third and final time.	
Recommendation 2 **Ref**: Standard 5.7 **Stated:** Second time	It is recommended that falls audits are undertaken at least monthly in order to identify and reduce risk for patients.	**Partially Met**
	Action taken as confirmed during the inspection: There was evidence that the manager was undertaking a daily audit of falls which counted the number of falls per month. To help reduce the risk of falls this audit requires further development in order to capture more relevant data on each fall and to analyse this data to identify any patterns or trends. This recommendation has been partially met and has been stated for a third and final time.	
Recommendation 3 **Ref**: Standard 28.4	The training needs of individual staff for their roles and responsibilities must be identified and arrangements put in place to meet them.	**Met**

Stated: Second time	This could not be verified at the time of inspection. Training required includes but is not limited to: • Safeguarding of vulnerable persons • Record Keeping • Wound care training • Nutrition and Dysphagia training • Human rights training	
	Action taken as confirmed during the inspection: The staff training records were reviewed. These were clearly presented in a suitable format and evidenced that a rolling programme of mandatory training was ongoing. It was noted that there were significant numbers of staff who had not yet received safeguarding of vulnerable adults training. The general manager stated that she was aware of this and was arranging further staff training. A further recommendation has been made.	
Recommendation 4 **Ref**: Standard 36.2 **Stated:** First time	The following policies should be reviewed to reflect current best practice guidelines and to take in to consideration the spiritual, psychological and cultural needs of patients. • Breaking bad news /communicating effectively • Death of a patient/resident • Care of the terminally ill patient/ resident.	**Met**
	Action taken as confirmed during the inspection: These policies had been reviewed, dated and signed. They included reference to best practice guidelines.	
Recommendation 5 **Ref**: Standard 20.2 **Stated:** First time	End of life and after death arrangements should be discussed with the patient / their representatives, as appropriate, and documented in their care plan. This should include the patient's wishes and take account of their cultural and spiritual preferences and preferred place of death/care.	**Carried forward until the next inspection**
	Action taken as confirmed during the inspection: This recommendation was not examined at this inspection and will be carried forward until the next inspection.	

Recommendation 6 **Ref**: Standard 32.1 **Stated:** First time	The following guidance should be made available to staff for reference as required: GAIN - Palliative and end of life care in nursing homes and residential care homes guidance (2013)	**Met**
	Action taken as confirmed during the inspection: These guidelines were available for staff to reference as required.	
Recommendation 7 **Ref**: Standard 37.4 **Stated:** First time	It is recommended that there is a complete switch over made from paper records to electronic records within six weeks post inspection in order to ensure that patients' care records are accurate and up to date.	**Met**
	Action taken as confirmed during the inspection: There had been a complete switch over from paper records to electronic records as planned.	
Recommendation 8 **Ref**: Standard 35.4 **Stated:** First time	Audits of care records should be undertaken and the findings acted upon to enhance the standards of record keeping.	**Met**
	Action taken as confirmed during the inspection: Care record audits were being generated from the new electronic system on at least a monthly basis. These were available to the manager and the general manager who were responding to any deficits in a timely manner. In addition, each registered nurse was alerted on logging on to the system that reviews of risk assessment and care plans were due.	

5.3 Continence Care and Management

Is Care Safe? (Quality of Life)

There was a policy in place for continence care and management but this had yet to be dated and signed. As previously stated, a recommendation has been made in this regard. There was a procedure dated from 2008 for staff in relation to catheter care but there was no policy in place based on current best practice guidelines. A recommendation has been made. Best practice guidelines in continence care were not available for staff to consult and a recommendation has been made. Examples of this guidance include the following:

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

A review of the training records evidenced that two staff had received formal continence training. In discussion staff stated that they had received "on the job" mentoring in relation to continence care. This was discussed with the manger and the general manager who stated that further training could be arranged given that a number of new care assistants had recently been appointed. A recommendation has been made. A number of registered nurses had received training in male catheterisation and were in the process of gaining their competency in this area of practice.

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)

Review of patients' care records evidenced that bladder and bowel continence assessments were undertaken for all patients. The outcome of these assessments, including the type of continence products to be used, was incorporated into the patients' care plans on continence care.

There was evidence in patients' care records that bladder and bowel assessments and continence care plans were reviewed and updated on a monthly basis or more often as deemed appropriate. The care plans reviewed addressed the patients' assessed needs in regard to continence management.

The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected. Urinalysis was undertaken as required and patients were referred to their GPs as appropriate. Arrangements were in place to obtain advice and support from external health professionals and services.

Review of patients' 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 was also taking place within the home including an audit of care records which incorporated continence care.

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

Is Care Compassionate? (Quality of Care)

During the inspection staff were noted to treat the patients with dignity and respect. Good relationships were very evident between patients and staff. Staff were observed to respond to patients' requests promptly. Patients confirmed that they were happy in the home and that staff were kind and attentive. Two patients consulted complained that their buzzers were not always answered promptly and this information was relayed to the manager. Please refer to section 5.4.1 for further information.

Areas for Improvement

A recommendation has been made that a catheter care and management policy be developed with reference to current best practice guidelines in order to guide the practice of staff.

A recommendation has been made that up to date continence guidelines are made available to staff for use as required.

A recommendation has been made that staff are supported through training or other means to develop their knowledge and skills in relation to continence care and management.

Number of Requirements	**0**	**Number of Recommendations**	**3**

5.4 Additional Areas Examined

5.4.1. Comments of patients, patient representatives and staff

As part of the inspection process patients, their representatives and staff were consulted. Their comments are included below.

Patients

In general patients were happy with the care provided and with the staff. Two patients were concerned that on occasion their call bells were not answered promptly. One patient went on to say that this had improved recently. These concerns were discussed with the manager to enable appropriate action to be taken to address this. Patients were happy with the food provided. Comments to the inspector on discussion included:

“There is not the like of them (the staff). I don’t want to go anywhere else.”
“The staff are very kind and they come quickly.”
“You have to wait a long time here.”

Patients’ representatives

No patients’ representatives spoke with the inspector.

Staff

In general the staff consulted were happy working in the home. They expressed satisfaction with the training they had received and with the support of the newly appointed manager. One staff member stated that they found the mornings were very rushed and they did not have the time they would like to spend with patients. An examination of the duty rota found that sufficient numbers of staff were on duty to meet the needs of patients. The manager stated in discussion that the staff were divided in to teams and that she continues to reinforce with staff the need for more effective working across the teams. No other concerns were raised.

5.4.2. Wound care

One patient's wound dressing was found to be in a poor condition. This was highlighted to the staff nurse who agreed to renew this. The staff nurse stated that the Trust tissue viability nurse (TVN) had visited and recommended a dressing regime which they were following. The staff nurse agreed to consult the TVN again that day to ask for further advice as the regime was proving ineffective. This patient's care record was reviewed and although there was evidence of referral to the TVN and regular wound dressings being done there was no care plan in place to direct the care of the patient or to state the required frequency of the dressing. A recommendation has been made in relation to wound care documentation.

5.4.3. Equipment

It was noted that one patient's pressure relieving cushion was in a very poor state of repair and could not be effectively cleaned. A requirement has been made that all pressure relieving cushions are reviewed for any signs of damage and replaced if required.

5.4.4. Complaints management

The complaints record was reviewed and there had been no entries since August 2014. The manager stated in discussion that the complaints tended to be minor and were sorted out quickly. A recommendation has been made that all complaints be recorded appropriately and the outcomes documented. In addition, a recommendation has also been made that the complaints records should be audited at least monthly to effectively identify any patterns or trends.

5.4.5. Management arrangements

The current manager was appointed two weeks ago and had submitted an application to become the registered manager which will be assessed by RQIA.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Esther Bell, manager, 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.

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 any 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 13 (7) **Stated:** Second time **To be Completed by:** 8 November 2015	Items stored on toilet cisterns in shared patients' bathrooms must be removed and stored appropriately in accordance with best practice in infection prevention and control. **Ref: Section 5.2** **Response by Registered Person(s) Detailing the Actions Taken:** Plastic storage containers will be placed in the bathrooms in order to store items in accordance with infection prevention and control. Staff have been informed at staff meeting regarding same.
Requirement 2 **Ref:** Regulation 27 (2) (c) **Stated:** First time **To be Completed by:** 8 November 2015	The registered person should ensure that pressure relieving cushions are in a good state of repair and replaced as required. **Ref: Section 5.4.3** **Response by Registered Person(s) Detailing the Actions Taken:** Pressure relieving cushions which were in poor condition have been replaced.

Recommendations	
Carried forward until the next inspection **Ref:** Standard 20.2 **Stated:** First time	End of life and after death arrangements should be discussed with the patient / their representatives, as appropriate, and documented in their care plan. This should include the patient's wishes and take account of their cultural and spiritual preferences and preferred place of death/care. **Ref: Section 5.2** **Response by Registered Person(s) Detailing the Actions Taken:** An Advanced Care Plan meeting is carried out annually with the GP, Nurse Manager, NOK and resident (if appropriate). If the patient's condition deteriorates, this will be discussed further in relation to specific details and to ensure previous decisions are unchanged.
Recommendation 1 **Ref**: Standard 6.4 **Stated:** Third and final time **To be Completed by:** 8 November 2015	It is recommended that the fluid intake and output of each patient, where this is being monitored, is reconciled in to the case records. **Ref: Section 5.2** **Response by Registered Person(s) Detailing the Actions Taken:** Night Staff record the input/out of residents who are under observation in the daily notes at the end of every shift.

Recommendation 2 **Ref**: Standard 5.7 **Stated:** Third and final time **To be Completed by:** 8 December 2015	It is recommended that falls audits are undertaken at least monthly in order to identify and reduce risk for patients. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: There is a daily falls audit in place and now a monthly audit is undertaken to establish if there are any common factors contributing to falls.
Recommendation 3 **Ref**: Standard 28.1 **Stated:** Second time **To be Completed by:** 8 November 2015	The responsible person must ensure that staff who are newly appointed complete a structured orientation and induction. • On the day of inspection there was insufficient evidence to verify that 1 newly appointed staff nurse had received an appropriate induction. The general manager must send confirmation that this induction has been completed within two weeks post inspection **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Induction is complete.
Recommendation 4 **Ref**: Standard 36 **Stated:** First time **To be Completed by:** 30 December 2015	It is recommended that all policies are dated when issued or reviewed. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Home policies are being reviewed and are dated and timed as such.
Recommendation 5 **Ref**: Standard 46, criterion 2 **Stated:** First time **To be Completed by:** 8 November 2015	It is recommended that there is an established system in place to assure compliance with best practice in infection prevention and control. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Regular supervision of staff has been put in place to ensure best practice in relation to handwashing etc in accordance with infection prevention and control.
Recommendation 6 **Ref**: Standard 39, criterion 4 **Stated:** First time **To be Completed by:** 30 December 2015	It is recommended that the training needs of individual staff in relation to the safeguarding of vulnerable adults are met without delay. **Ref: Section 5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Staff have received training and further training is to be arranged in order to ensure new staff and those who require an update, do so.

Recommendation 7 **Ref**: Standard 4, criterion 8 **Stated:** First time **To be Completed by:** 14 June 2015	Best practice guidelines should be made available to staff for reference as required. Examples include: • British Geriatrics Society Continence Care in Residential and Nursing Homes • RCN continence care guidelines • NICE guidelines on the management of urinary incontinence in women • NICE guidelines on the management of faecal incontinence **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: These have been made available in the Nurses' office.
Recommendation 8 **Ref:** Standard 36 **Stated:** First time **To be completed by:** 30 December 2015	A policy in relation to catheter care and management should be developed with reference to current best practice guidelines and this shared with staff. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: This will be put in place and staff made aware of same.
Recommendation 9 **Ref:** Standard 36 **Stated:** First time **To be completed by:** 30 December 2015	It is recommended that staff are supported through training or other means, to develop their knowledge and skills in relation to continence care. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Training in relation to continence care has been arranged for 26th and 27th November 2015.
Recommendation 10 **Ref**: Standard 4 **Stated:** First time **To be Completed by:** 8 November 2015	It is recommended that care plans are in place to direct the care of wounds in accordance with the prescribed dressing regime. **Ref: Section 5.4.2**
	Response by Registered Person(s) Detailing the Actions Taken: Care plans have been put in place.

Recommendation 11 **Ref**: Standard 16, criterion 11 **Stated:** First time **To be Completed by:** 8 November 2015	It is recommended that records are kept of all complaints including the details of communications with the complainant, the result of any investigations, the action taken and whether or not the complainant is satisfied with the outcome. **Ref: Section 5.4.4** **Response by Registered Person(s) Detailing the Actions Taken:** A new complaints book is now in place.
Recommendation 12 **Ref**: Standard 16 **Stated:** First time **To be Completed by:** 8 December 2015	It is recommended that audits of complaints are undertaken on a regular basis and the findings used to improve the quality of the service provided. **Ref: Section 5.4.4** **Response by Registered Person(s) Detailing the Actions Taken:** Audits will be undertaken on a bi-monthly basis of complaints and the findings relayed to staff in order to improved the standard of care provided.

Registered Manager Completing QIP	Esther Bell	**Date Completed**	18/11/15
Registered Person Approving QIP	Elaine Hill	**Date Approved**	18/11/15
RQIA Inspector Assessing Response	Karen Scarlett	**Date Approved**	18/11/15

Please ensure this document 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: